HAWAII MEDICAL JOURNAL

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HAWAII MEDICAL ASSOCIATION 1856

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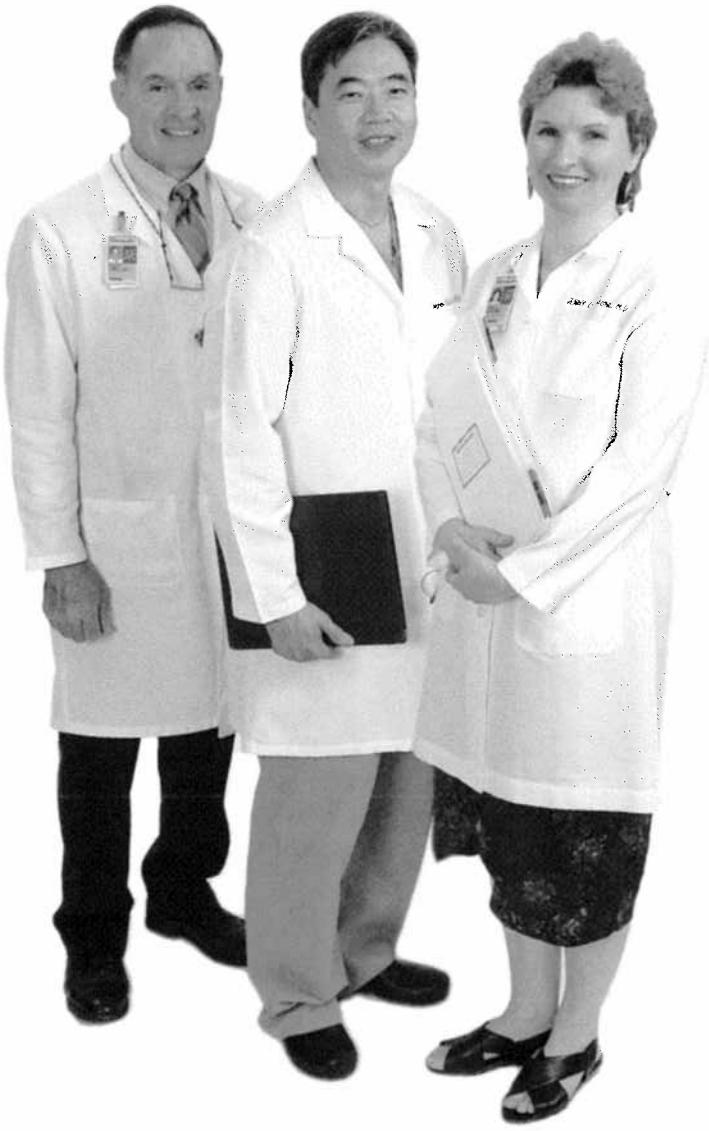

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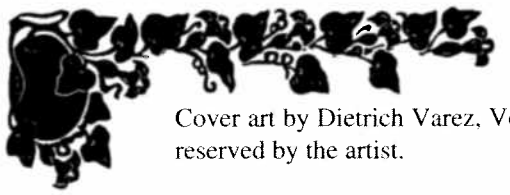


Cover art by Dietrich Varez, Volcano, Hawaii. All rights reserved by the artist.

Laukia

Laukia was a mythical woman who pursued her errant husband by riding the back of a turtle.

Editorial

Norman Goldstein MD
Editor, Hawaii Medical Journal

Editorial - April 2001

Our manuscripts this month deal with medical problems.

Problems include those reviewed by the Medical Claim Conciliation Panel, the issue of Box Jellyfish in Waikiki, and a "pseudo-pseudo" problem.

While attending the risk management seminar sponsored by the Hawaii Association of Physicians for Indemnification (HAPI), I heard the views of two attorneys with a great deal of experience – Edmond Burke, Esq., specializing in medical malpractice, and L. Richard Fried, Jr., Esq., representing "the other side," i.e. the plantiffs in medical malpractice. Their full presentations were originally printed in the Hawaii Bar Journal in August 2000, and are here reprinted for our readers, with permission of the Hawaii Bar Journal. If, after reading these manuscripts, you have the inclination and interest to serve on the Panel, I am sure that Ed Burke and Rick Fried would be happy to give you further information. The Medical Claims Conciliation Panel can use more medical assistance.

The second paper concerns the problems of box jellyfish stings in Hawaii. The authors emphasized their study does not pertain to Portuguese Man of War, but to Box Jellyfish. Hot packs appear to help the stings somewhat; cold packs probably do not help much; and the authors actually prefer spraying the Box Jellyfish stings with vinegar. Corollary question is why do the jellyfish appear on the 9th or 10th day after the full moon, and only on the leeward shore of Oahu, especially Waikiki Beach?

Craig Thomas MD and Susan Scott RN should be familiar to our readers. Craig is an Emergency Room physician, and Susan is the Marine Science writer for the Honolulu Star-Bulletin. They are authors of All Stings Considered - First Aid and Medical Treatment of Hawaii's Marine Injuries, reviewed in the Hawaii Medical Journal in November 1997.[1] Craig and Susan also have authored Pests of Paradise and Poisonous Plants of Paradise. This troika should be in every physician's office, first aid station, school nurse's office, and hospital emergency room in the state.

Pseudo-pseudo conditions in medicine usually present interesting problems. Robert Jim MD, presents a brief case report of a fictitious platelet clumping due to a delay in preparation of a blood smear. The Journal thanks Dr. Jim for his many contributions to the Journal, and to the publications committee of the Hawaii Medical Association.

Reference

1. Goldstein N. All Stings Considered: First Aid and Medical Treatment for Hawaii's Marine Injuries, Book Review Haw Med Journal v 56, 309 Nov 97.

Special Contribution

Risk Management
The Medical Claim Conciliation Panel

A Defense Prospective
by Edmund Burke, Esq.

And

A Claimant's View
by L. Richard Fried, Jr., Esq.

Editors note:
In the March issue of the Journal, we had two manuscripts written by physicians who were also attorneys, S.Y. Tan and Terry Shintani.

The authors of the following two manuscripts are attorneys, not physicians, but they know physicians and medicine and the legal problems of medicine.

A DEFENSE PROSPECTIVE
by Edmund Burke

When I first heard of the MCCP legislation in 1976, my reaction was absolutely negative. The idea of proceeding to a hearing of potentially complex issues of medical negligence with no discovery, no rules of evidence, and no binding result bordered on the ridiculous. The original hearings were almost traumatic involving such no-no's from trial practice as asking the opposing witnesses questions when you did not know the answer, listening to all kinds of hearsay on hearsay, and being confronted with written reports from opposing experts with no chance of cross examination. However, even without the rudimentary safeguards and procedures from a regular trial, it became evident that the basic facts of each case were placed on the table. The essentials of a case that would take 2 to 3 weeks to unfold before the jury were placed before the Panel in 3 to 4 hours. The give and take, comments, and questions from Panel members usually got to the heart of the matter and the decisions seemed to have a rational basis whether you agreed with them or not.

After watching this process through several cases, it soon became evident to me that many cases were being eliminated at the MCCP level and were not proceeding to suit. Most of the terminations were plaintiffs electing not to proceed to suit following an MCCP hearing. In some instances, the defense became convinced the case was a probable loser and settled. As a result of considerable experience in the process during the first year of operation, I was converted from a negative skeptic to a believer that the panel process did effectively

Continues on page 91

A.A. "Bud" Smyser
Dec. 18, 1920 - Mar. 19, 2001

A.A. "Bud" Smyser died at the Queen's Medical Center on March 19, 2001. Bud was a newspaper man for all his professional life. He worked at the Honolulu Star-Bulletin since 1946 as a reporter, City Editor, Managing Editor, Editor in Chief, and Editorial Page Editor. Bud officially retired in 1983, but continued to write his "Hawaii's World" column twice weekly. Abstracts of his life story have appeared in both Honolulu's daily newspapers. Editorial cartoonists Corky Trinidad of the Star-Bulletin and Dick Adair of the Advertiser have captured the feeling of his newspaper colleagues. And he touched a lot of people in Hawaii, with his early support of Hawaii Statehood; promotion of the Kaiser Permanente Health System; the Star-Bulletin stand on women's rights; formation of the East-West Center; fostering the Hospice movement in Hawaii; relief for cancer patients and others with pain; advice to the terminally ill patients and their physicians; and finally in his stand on Doctor-Assisted Death with Dignity.

> It would be a fitting tribute to the way Bud Smyser led his life, and to his passing, if Hawaii's lawmakers take a serious look at the work of the Blue Ribbon Committee on Living and Dying with Dignity, on which Smyser served.[1]

Bud died, as he lived, with dignity. A massive brain hemorrhage, caused by a fall at home in his garden, meant that there was no chance of saving his life. After emergency treatment at Queen's Medical Center, his family followed Bud's wishes in asking for no life-support measures. Bud passed away peacefully at 4 AM on Monday, March 19, 2001, without the need of physician assistance.

Bud served on our Governor's Blue Ribbon Panel on Living and Dying with Dignity, and he wrote very insightful pertinent columns in the Honolulu Star-Bulletin. Through the years, the Journal has reprinted his articles dealing with Hospice in Hawaii; reduction of pain in cancer patients; and the controversy over what I termed "DADD", Doctor Assisted Death with Dignity.

In this issue of the Journal, we reprint his last three columns as a special tribute to him. His last was written just one week before his fall, entitled "A Better Way to Die."

I had planned to propose that our medical school grant Bud Smyser an honorary medical degree for his thoughtful prose in support of hospice, pain relief, and doctor-assisted death with dignity. But Bud, as modest as he was, perhaps would have vetoed my proposal.

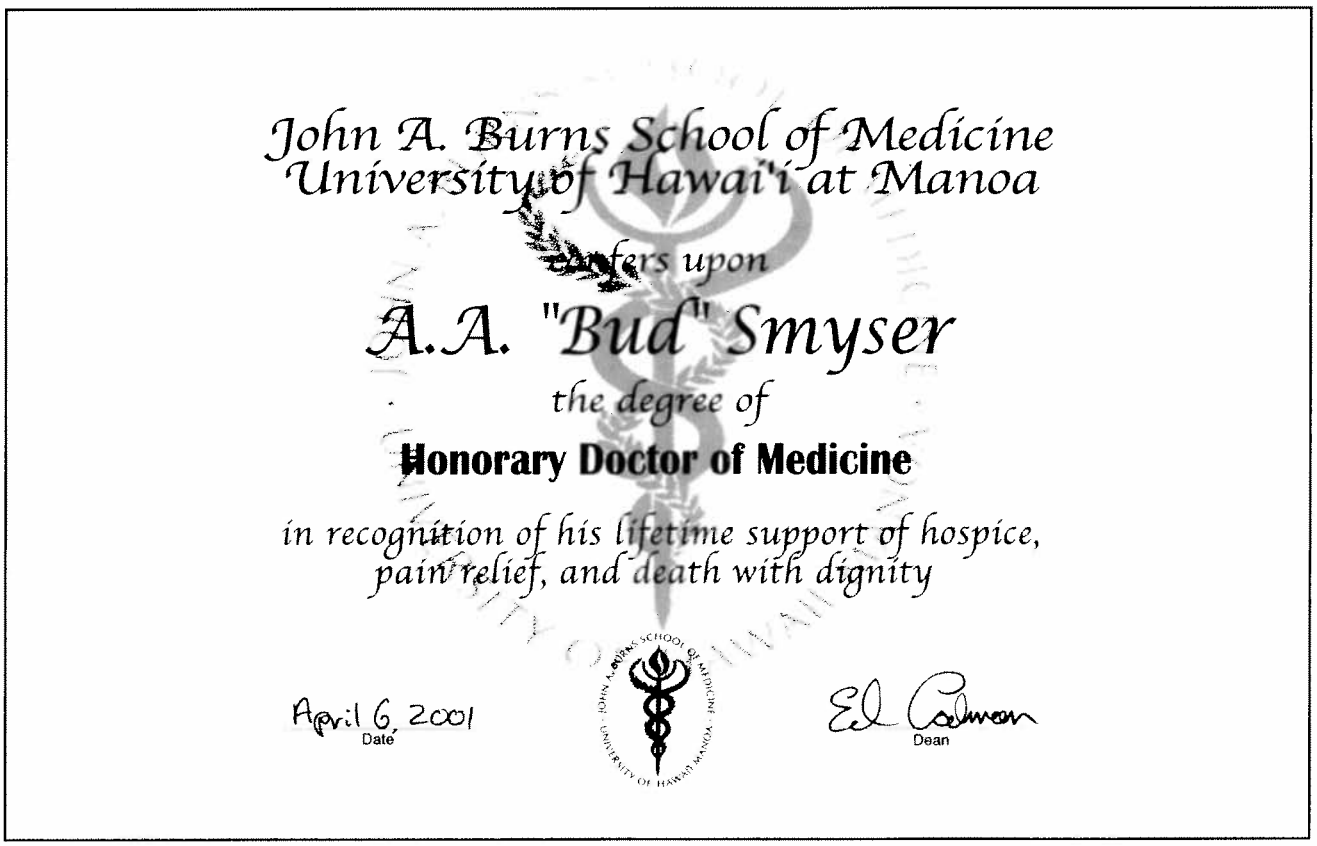
Well, Bud, you can't edit me now, so here it is:

A.A. "BUD" SMYSER,
HONORARY DOCTOR OF MEDICINE

Mahalo to his wife, Dee, and their family for sharing Bud with all of Hawaii.

Norman Goldstein, MD, Editor

1 Editorial on A.A. "Bud" Smyser: Com petitor, Conscience; Honolulu Advertiser, page A-16, Tuesday, March 20, 2001.



Hawaii's World by A.A. Smyser

Honolulu Star-Bulletin

3/19/01 Star-Bulletin, Evening Edition

More people should use hospice
August 10, 2000

You won't see an ad like this, but I rather wish you would:

WHAT'S SURER THAN TAXES?
DYING, that's what!
Why not do it comfortably and with grace?
Call Hospice months before the event.
You and your loved one will never regret it.

I am no longer involved with either St. Francis Hospice or Hospice Hawaii, the two providers on Oahu.

But I know they still are lovingly managed and can do wonders in the grace and comfort area for both terminally ill people and their loved ones.

I know too, that they have a common complaint. Patients ask their help too late – only about 20 days before dying on the average, sometimes only a few days before.

The U.S. government, which is fairly hard-headed about such things, is willing to fund hospice care for the last six months of life under both Medicare and Medicaid. Many medical plans do, too.

For most terminally ill people, hospice is a win-win choice. More appropriate care. Lower cost.

My first encounter with hospice was in London in 1977. The Star-Bulletin had run a series of articles on the inadequacies of terminal care. I wanted to see it done right.

I arranged to visit the very first modern hospice, St. Christopher's, in a quiet, middle-class residential district of London. It was a homey building where the nearly daily arrival of ambulances and hearses was mostly out of common view.

I entered with some apprehension, went away uplifted. One particular unplanned incidence is illustrative. A woman rushed up to my doctor-guide to exclaim: "Oh Dr. West, my father has his sense of humor back!"

Her father was a comic on the British Stage. He had been miserable at home in his final illness. St. Christopher's got rid of his pain, kept him in caring surroundings, and soon he was wise-cracking again.

Today hospice care can be either in-patient or at-home. The difference that makes either succeed is the loving skill of hospice personnel in ending pain, counseling loved ones, and arranging for an orderly closing of personal affairs.

The big hurdle – the one that makes most admissions too late – is that the patient himself or herself must recognize his or her terminal status, then ask to shift to hospice care.

This can be a be a terrible wrench, but one for the better. Many physicians are reluctant to push it. Perhaps they see it as a defeat for their aggressive treatment efforts. Timed fight, it is a wonderful relief from them – and that means timed several months before death rather than just 20 days or so.

I'm sorry you aren't likely to see the above great public service ad anywhere but in the column. But do keep it in mind.

When you or someone close to you is in need, don't hesitate to call a hospice, if only for advice: St. Francis Hospice's Sister Maureen Keleher Center at 595-7566, Hospice Hawaii at 924-9255.

Both have been at their kindly work for some 20 years and draw overwhelming praise for their efforts.

St. Francis has in-patient facilities in Nuuanu Valley and at its hospital's West Oahu annex. Hospice Hawaii has one at Enchanted Lake. It recently authorized a search for a Honolulu location.

Some readers know me as an advocate of doctor-assisted death in certain unbearable circumstances. But these likely would be less than 100 a year statewide. Hospices in Hawaii help about 1,500 people a year. They could, if asked, help several times that number.

Assisted death is on the ballot in Maine
September 28, 2000

Tuesday I wrote favorably about Hawaii's ballot question No.1 for Nov.7 – whether to insert into our state Constitution a provision that the University of Hawaii shall have autonomy over its own affairs. The state of Maine's ballot question No.1 also may have long-term significance here. It is allowing terminally ill patients to opt to shorten their lives with self-administered medications.

Supporters are optimistic of a victory but say they expect the Catholic Church to spend large amounts to defeat it. That spending will be focused on the remaining 40 days. Oncologists, who treat cancer, also are advertising against it.

The cause gained a prestigious endorsement form the editor of the influential New England Journal of Medicine, Maria Angell. She stated that relieving suffering is more important than extending life.

The Maine legislature refused to put the assisted death question on the ballot, but it got there by way of a citizen initiative that collected some 52,000 signatures, about 10 percent more than required.

The city editor of the newspaper in Maine's biggest city, Portland, is Linda Fullerton. She notes that bypassing the legislature with a ballot initiative has had previous successes in Maine, most recently to legalize marijuana for medical purposes.

Should a yes vote prevail in Maine, America then will have two states where assisted death is legal – Oregon and Maine. Usage in Oregon has been for far less than 1 percent of all deaths.

Governor Cayetano formed a panel in 1996 that in 1998 recommended Hawaii also allow assisted death. I was in the 11-7 majority that would provide it, under strict controls, to persons with intolerable suffering that can neither be cured nor palliated.

We left out the "terminally ill with less than six months to live" requirement that is law in Oregon and proposed for Maine. We joined with a national blue-ribbon panel that considered unrelievable intolerable suffering deserving of the option of death even if the patient is not terminal.

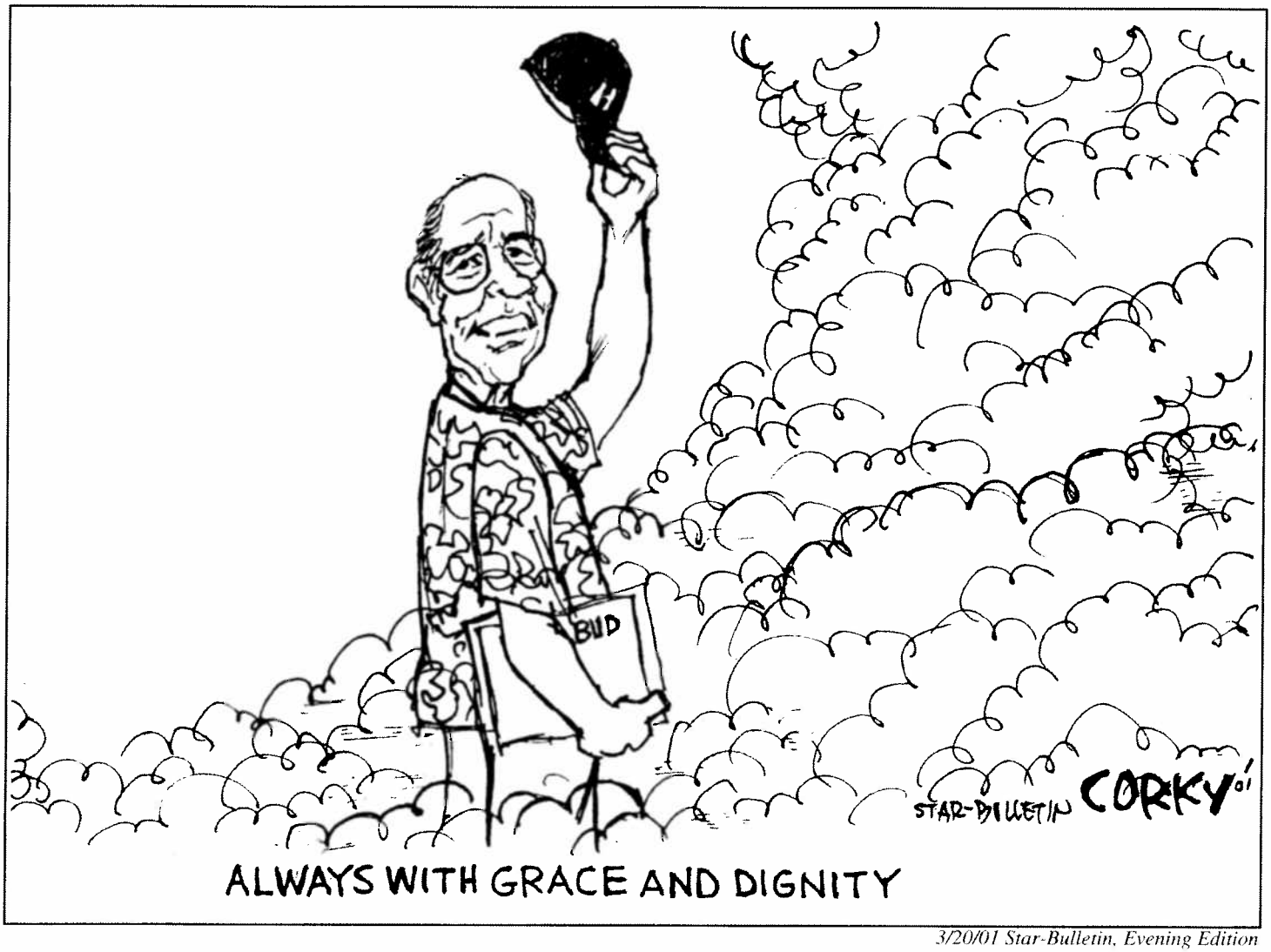
Committees in both houses of the Hawaii legislature heard our proposal but never brought it to a floor vote.

A victory in Maine might reinvigorate us for another try in 2002. Governor Cayetano is in favor. Opinion polls show a comfortable margin of public support. The Catholic Church will remain our major roadblock. It works to have strong influence with key legislators.

In Oregon, in the Maine referendum and in the Hawaii proposal the safeguards are many-tiered.

The Maine initiative requires two physicians to certify terminal status, an opinion by a physician familiar with the patient's disease, consultation with both palliative care specialist and a licensed counselor, two personally communicated requests form the patient plus one written one, a 15-day waiting period plus a final 48-hour waiting period. Phew!

The proposal for Hawaii is similarly wrapped in provisions to prevent abuse. My long-term hope is that experience will allow these to be simpler in the spirit of mercy.



3/20/01 Star-Bulletin, Evening Edition

A better way to die
March 19, 2001

HOW will you react if your physician says you are terminally ill? Most probably, after time to think about it, you:

>> Won't want to be a burden on your loved ones.

>> Will hope to avoid pain and indignity.

>> Will want to avoid being pauperized with treatment costs eating up dollars you want to leave to your heirs.

>> Would like assurance you won't die alone.

These reactions are common in the experience of Dr. Ira Byock, a recent lecturer here who has worked with hundreds of patients in Montana who have received such news.

He is a former president of the American Academy of Hospice and Palliative Medicine, a prominent spokesperson for the hospice movement and author of "Dying Well." His appearance here, sponsored by The Queen's Medical Center and Hospice Hawaii at Home, drew an SRO audience of 300.

Byock has learned that dying does not have to be agonizing. Physical suffering can *always* be relieved, he says.

Then, when people are relatively comfortable and know they will not be abandoned, they frequently find ways to make dying a rich experience. They can strengthen bonds with those they love, forgive and make up with those with whom they have differed, and create moments of profound meaning in their final passage.

It happens in Hawaii often, thanks to our seven hospices, but not often enough. Only about 20 percent of terminal patients here seek hospice care.

That's better than the national figure of 15 percent, but still woefully low for two reasons. First, hospice love and care can help most dying persons, not a measly one-fifth.

Second, most people wait too late to turn to it. Several months at least of hospice care are desirable. These usually can be covered by insurance. Unfortunately most patients and/or their care-givers wait until just a week or so before the end to call a hospice.

Why do so few choose this humanitarian way to die?

The answer in a February article in Hawaii Medical Journal is many-faceted:

>> Too many physicians are underinformed.

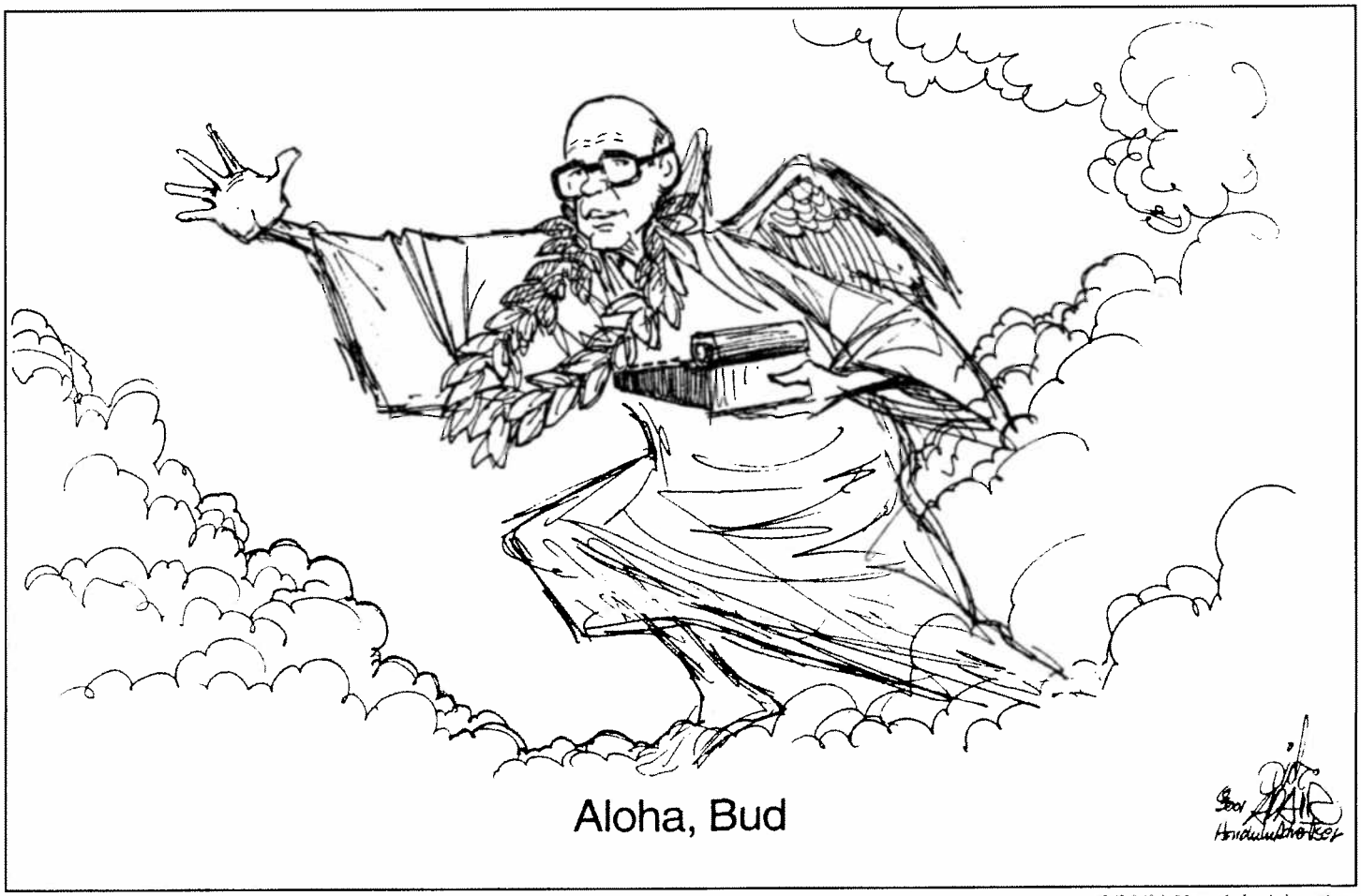
>> Even those who are informed may not find time to discuss preferences in dying while the patient is still well. Even allowing that attitudes may change, the best time to start is while in good health.

>> Family conflicts often suppress full discussion of options. This can lead to overtreatment and expense to even try — regardless of cost — to save a doomed loved one. Their inevitable deaths are made unnecessarily painful and prolonged.

>> Religious and cultural factors. Surveys show that most people would prefer to die at home yet our deaths overwhelmingly take place in hospitals or nursing homes.

Surveys in Hawaii also have shown that most people would like the option of doctor-assisted death or suicide. But most physicians oppose it.

Dr. Byock is not for it but welcomes debate over it because it calls more attention to the inhumanity of the way we often handle dying.



3/20/01 Honolulu Advertiser

Straub welcomes these outstanding new physicians

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Dr. Jeffrey Lunn is Board Certified in Anesthesiology and Critical Care Medicine. He received his Doctorate of Medicine from University of North Dakota School of Medicine. Residency at Mayo Graduate School of Medicine. Joins Straub after 18 years at the Mayo Clinic.

Dr. Audie Asistin is Board Certified in Anesthesiology. He received his Doctorate of Medicine from Fatima College of Medicine. Residency at University of Utah Medical Center.

CARDIOLOGY

Dr. David Lee is Board Certified in Cardiovascular Disease and a Fellow of The American College of Cardiology. Special interests include Invasive and Interventional Cardiology. He received his Doctorate of Osteopathic Medicine at the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri. Residency and Cardiology Fellowship at St. Francis Hospital of Evanston, IL. Fellowship in Vascular Medicine at the Cleveland Clinic Foundation.

GYNECOLOGY

Dr. Jenny Uramoto is Board Certified in OB/GYN. Special interests include adolescent gynecology, family planning, preventive care and menopause. She received her Doctorate of Medicine from University of Hawaii, John A. Burns School of Medicine. Residency at University of Hawaii, John A. Burns School of Medicine.

ORTHOPEDICS

Dr. David Manning is Board Certified in Orthopedic Surgery. Special interests include General Orthopedic practice with an emphasis on Sports Medicine and Arthroscopic Surgery. He received his Doctorate of Medicine at Northwestern University. Residency at University of California, San Francisco.

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GALDERMA

eliminate non-meritorious claims and led to settlement of some, but not all, meritorious claims.

Some Benefits of the MCCP

Early Elimination of frivolous or unmeritorious claims.

First of all, the parties receive from the MCCP process what they put into it. There are certain claimants' attorneys who look upon the MCCP as a temporary impediment to filing suit. They do not present a case, expect to lose at the MCCP, and sometimes wind up in a costly lawsuit which they lose. There are, however, certain cases involving complex medical issues that do not readily lend themselves to the MCCP process when "the devil is in the detail" and extensive discovery is needed to get the details. In the vast majority of cases going through the process of retaining an expert and having the case professionally evaluated points up strengths and weaknesses to both sides.

The cases where the plaintiff elects not to proceed with suit after an MCCP decision usually fall into two categories. The first involves claimants who proceed without counsel primarily to determine why the medical care received was not successful. These individuals are dissatisfied with the result, and in many cases shocked and surprised over what they perceive to be the sudden death or catastrophic injury to a loved one. They are primarily looking for answers which the defendant doctor unfortunately did not explain at the time of treatment or the time of death. They are not so much accusing the doctor of negligence as seeking an answer to the question of whether there was negligence. The MCCP process, including any comments by the Panel members, is often effective in satisfactorily answering these questions and terminating the claim.

The second example is the case that claimant's attorney proceeds to the Panel hearing without expert support or only very weak expert support. When expert evidence is utilized at an MCCP hearing, it is commonly presented by way of written report. Alternative methods of presenting include the expert testifying by telephone conference call, especially when out of state, and on relatively rare occasions the expert appearing at the hearing. A full on hearing with testimony from all of parties, supporting expert evidence, and submission of supporting medical literature gives the best prospect for an MCCP decision that reflects what a jury could be expected to do. One of the most important aspects of a well-conducted hearing is the opportunity to evaluate the witness quality of each party. In analyzing those cases that proceed no further after the MCCP, I have concluded that the plaintiffs have, for the first time, received a detailed explanation of why the bad result occurred and have been convinced that there was no wrongdoing. There may also be a change in the perception of the defendant doctor from the bad guy who caused the bad result to a reasonable person who did reasonable, rational things that proved unsuccessful.

From a defense viewpoint, certain well-presented plaintiff's cases plant the seeds for settlement. Even though a settlement may not be immediate and presuit, many of the motivating factors for an eventual settlement start out with impressions created at an MCCP hearing.

Elimination of some of the Plantiffs and some of the Defendants in Multi-Party Cases.

A very common scenario in MCCP claims is the case where nearly all medical care providers involved in claimant's treatment are named as respondents. This occurs especially in those situations where counsel is retained at the last minute before the running of a two-year statute, and feels compelled to name everyone in sight with the idea of later dismissals. Even where there has been a selective naming of respondents, there are many cases in which a given doctor has explained his or her role so convincingly during the hearing that they are not included in a later lawsuit. In somewhat rare instances where multiple plaintiffs have been included, the MCCP process may eliminate certain of the claimants. This is especially true in the mass tort cases such as silicon breast implants, Fen-Phen, etc.

Statistics Showing the Effect of the MCCP Process.

In evaluating the effectiveness of the MCCP process, it would be helpful to know what percentage of claims proceed no further after the MCCP decision. It would also be helpful to know how the MCCP decision correlates with verdicts and judgments if the case proceeds through suit. In Richard Fried's portion of this article, he describes the statistics indicating the percentage of cases that plaintiffs win or lose at the MCCP, and these statistics are contained in the annual report promulgated by the Department of Commerce and Consumer Affairs, State of Hawaii. Unfortunately, there are no published statistics that answer the above questions.

In the past, surveys have been taken, and in the early years of the MCCP, approximately 70 to 80% of the claims did not go on to lawsuits. I am advised by my insurance clients that although they have no hard and fast data on this point, roughly 55 to 60 % of the MCCP claims currently do not proceed into lawsuits.

Obviously of the cases that do proceed to lawsuits, many involve claims in which the MCCP has found no actionable negligence. Approximately 36% of medical malpractice lawsuits against doctors are settled. Forty-four percent are terminated either through voluntary dismissal or summary judgment. Of those cases that proceed through trial to jury verdict, approximately 76% are decided in favor of the defense. The above percentages are fairly rough approximations since no organization is attempting to maintain precise statistical data in these areas. These statistics are applicable to doctors and not to hospitals or claims against Kaiser. Claims against Kaiser are usually processed through arbitration, not the court system.

From the available data, both as far as MCCP results and lawsuit results, it is obvious that medical malpractice cases present a real challenge for plaintiffs. Success requires thorough and expensive preparation, and primarily the selection of knowledgeable, honest, and articulate experts. Each case that survives summary judgment has one or more expert witnesses supporting plaintiff's cause. It is, therefore, not enough just to have a supporting expert.

Claimant's attorney should also be aware that a defendant doctor has virtual veto power over the settlement of a case because of the consent clause in most insurance policies. There are real consequences to consenting to settlement from a professional viewpoint such as being reported to the National Data Bank and to the State of Hawaii Regulated Industries Complaint Office (RICO). An adverse decision by the MCCP, by a court, or settlement each trigger reporting to RICO. That organization will then initiate its own investigation and in certain cases the doctor's medical license may be in jeopardy.

Legislative modifications

It is the filing of a medial malpractice claim with the MCCP that tolls the statute of limitations. The filing of a lawsuit before an MCCP decision will not toll the statute.[1] Originally, cases filed with the MCCP that were taken off calendar for a hearing could languish indefinitely under MCCP jurisdiction. H.R.S. § 671-18 corrected this potential for indefinite delay by limiting the MCCP jurisdiction to 18 months.[2] The Administrator notifies the parties at the end of 18 months that jurisdiction has been terminated, the statute of limitations is running again, and the claimant is free to file suit.

In order to foster meaningful hearings before the MCCP, H.R.S. § 671-19 provides that the panel can determine when a party has not cooperated with the MCCP. If a lawsuit later follows, the trial court has discretion to sanction the non-cooperating party based upon the finding of lack of cooperation by the MCCP.

A filing of an MCCP claim against a doctor has the effect of requiring that doctor is to disclose the fact of a claim in later applications for hospital staff privileges, insurance applications, etc. The MCCP has now been empowered to determine that certain MCCP claims are frivolous, thus allowing such claims to be expunged from the MCCP records.[3]

Conclusion

The MCCP has proved beneficial in reducing the number of claims that would otherwise be initiated as lawsuits. The information learned by both plaintiffs and defendants during the MCCP process has facilitated the pretrial settlement of many cases. In order for the process to be effective, however, both sides need to be prepared and present at least the essence of the claim and the fundamental defense at the MCCP hearing. Since more cases are settled than tried, it is in the best interest of all parties to meaningfully share information through the MCCP process, as opposed to the lengthy discovery process in preparation for trial.

1. See *Tobosa v. Owens*, 69 Haw. 305, 741 P.2d 1280 (1987).
2. See also H.R.S. § 671-16.
3. See H.R.S. § 671-15.5(a).

Edmund Burke graduated from the U.S. Navel Academy (B.S., 1956) and University of California at Berkley (Boalt Hall, 1963). He has practiced in Hawaii since 1966, specializing in medical malpractice, products liability, personal injury, and commercial litigation.

A CLAIMANT'S VIEW OF THE MEDICAL CLAIM CONCILIATION PANEL

By L. Richard Fried, Jr.

The enactment of the law relating to the Medical Claim Conciliation Panel and related legislation was prompted by an alleged crisis in the area of malpractice insurance and was intended to stabilize the medical malpractice insurance situation by reintroducing some principles of predictability in spreading of risks.[1] The 1976 law established the short-lived patients compensation fund, put some limitations on fees and implemented other so-called "protections" for health care providers. One of the "protections" was the Medical Claim Conciliation Panel "MCCP".

The MCCP is responsible for conducting informal conciliation hearings on claims against healthcare providers before such claims can be filed as lawsuits. The decisions of the MCCP panels are advisory in nature and not binding on the parties, in the event that any party still wishes to pursue the matter in court.

The primary purpose of the MCCP programs are achieved when the parties make conscientious and thorough presentations to the MCCP panels. In such cases, the decisions rendered by the panels provide the parties with fairly accurate advisory determinations of the relevant merits of the claims, which should assist the parties in evaluating whether the claim should be pursued in the judicial system.

The MCCP also provides opportunities for the parties to exchange information in a relatively expedited and inexpensive manner, which in turn provides opportunities for the parties to explore the conciliation of meritorious claims prior to such claims being brought before a court.

Do the benefits of the MCCP process outweigh the drawbacks? I believe the answer is a resounding "yes". That being the case, how can a claimant's counsel make the process meaningful? Let me first review some of the procedural matters and I will then explain why I believe the benefits out-weigh the drawbacks and how those of us representing claimants can make the process meaningful.

MCCP Procedures

The claimant files a claim with the MCCP paying the appropriate filing fees before the expiration of the statute of limitations. This can be a simple letter setting forth the basis of the medical negligence and identifying the claimants and the respondents. Once the claim is filed, the statute of limitations is tolled for 60 days following the mailing of the panel decision or for a maximum of 18 months from the filing of the claim, whichever occurs sooner.

After the claim is filed, the hearing date is set at the Department of Commerce and Consumer Affairs (DCCA) offices. Recently, several plaintiff and defense lawyers met with Rod Maile, the administrator of the MCCP program. One of the major issues those of us representing claimants had was the time it took to obtain a hearing date. Maile has always been flexible and responsive with respect to changes to make the MCCP more efficient. As a result of our meeting, claimants' attorneys, if they use their offices for the hearing, can set the hearing at the time the claim letter is filed for a date not less than four months after the filing of the claim letter.

The MCCP consists of three persons, a doctor, an attorney and a chairperson, typically an attorney, but not required to be, according to Hawaii Revised Statutes H.R.S. § 671-11. The physician member of the panel is generally chosen from the same medical specialty as the health care provider named in the claim. If several physicians are named, the physician chosen is typically from a specialty that can best evaluate the case.

H.R.S. § 671 provides that anyone wishing to bring a lawsuit against a physician, osteopath D.O., podiatrist D.P.M., or hospital, licensed to practice or operate in the State of Hawaii, must first file a claim with the MCCP before filing a lawsuit. Thus claims against dentists including oral surgeons, chiropractors or psychologists do not require an MCCP filing. Nurses are covered by the MCCP because invariably they are an employee of a physician or hospital against whom a claim is brought and are covered via respondent superior. Rod Maile has informed me that at least one Circuit Court Judge in the First Circuit has ruled that a naturopath and a chiroprac-

tor may not be sued without first completing the MCCP process. My advice would be, particularly if the statute of limitations is approaching, to file concurrently with the MCCP and Circuit Court, if you have a claim against either a chiropractor or a naturopath.

Another positive outcome of the recent meeting between Rod Maile and several attorneys representing claimants and respondents, was the ability to name the panel chairperson for a particular case. If both or all of the parties agree and the person is an eligible panel chairperson (the Director of the DCCA will provide such a list), this can be accomplished by a written request to the Director of the DCCA.

The panel proceedings are not recorded and the outcome may not be used in any future litigation. The panel will include a suggested amount of damages, if the panel finds actionable negligence. Therefore, you must be prepared to present evidence on damages at the hearing. Although the panels have the right to split the hearing, entertaining the liability issues first, and then, if liability is found, entertaining evidence on damages, I have never, in my experience, had this happen. The panel's written decision finds either actionable negligence or no actionable negligence and, if there is actionable negligence, the panel will make a recommendation as to damages. No reasoning or basis for the decision is given. After the panel hearing, the panel members will often be willing to speak informally with you to discuss the basis for their decision. Occasionally, there will be a dissenting panel member, since only two out of three needs to agree.

According to H.R.S. § 671-15, the decision must be mailed to you 30 days following the completion of the hearing.

If you disagree with the MCCP panel, you may file suit. However, before filing in court, pursuant to H.R.S. § 671-16, you must file a written rejection of the panel's decision with the MCCP.

The MCCP, even though it proceeds in the same order as a trial, is an informal process and the rules of evidence are very loosely applied. Many panel hearings are concluded in half a day.

Both the claimant and health care provider or providers must attend the MCCP along with counsel, if any. If it is extremely onerous for my client to be present, I am usually granted permission to have my client excused. Generally, the panel requires claimants and health care providers to be present, even if they no longer live in Hawaii. The reasoning is that the purpose of the panel is conciliation and it is hard for this to occur if the parties are not present.

One side note, a Federal District Court of Hawaii decision in 1995, *Hum v. Dericks*,[2] has held that the MCCP requirement is procedural and does not apply to preclude malpractice actions brought in Federal Court on the basis of diversity jurisdiction where no MCCP claim has been filed.

Benefits versus Drawbacks of the MCCP

Although we never file until we have completely examined all the relevant medical records and have experts committed (unless the statute of limitations is imminent and it looks as though there is potentially a very good case), we invariably learn something new about the case during the panel process.

One of the most important reasons I take the process seriously is because the defense, to my knowledge without exception, takes it seriously. The two major carriers in this state are MIEC (Medical Insurance Exchange of California) and HAPI (Hawaii Association of Physicians Indemnification) and I know they feel the MCCP is a helpful process. I have found that a case is somewhat easier to resolve if there is a favorable panel result.

I know there are one or two people that represent claimants that do not put on a case at the MCCP. I am informed that they do this because they feel they are giving up too much information about their case without a sufficient quid pro quo. There may be strategic reasons for withholding certain parts of a claim, for instance, because the healthcare provider is not under oath, and it might be better to confront the healthcare provider with that information for the first time when the provider is under oath at his or her deposition. In general, I find that if I have a meritorious case, letting the defense know the basis of my claim at the panel is not a detriment, as I will usually then learn in advance of suit what their defenses are. In general, I believe if the panel is going to help, both sides should make an effort to present their case so that I, representing the claimant, can learn of any weaknesses which may not have been fully appreciated, and the defense can understand where they have problems in defending the case.

Although we will not go to the panel without the medical experts, except in the rare situation I mentioned earlier, there have been occasions when we have learned matters at the panel which have caused us to reconsider and not proceed further. I recall a case defended by Kenneth Robbins, Esq. a number of years ago where my clients' son was blinded at birth as a result of excessive oxygen. We had excellent experts telling us that the defense had breached the standard of care, but Mr. Robbins presented videotapes at the MCCP from two experts demonstrating that there were two legitimate schools of thought on how to handle this infant's problem. As a result of his presentation, we felt that our odds of prevailing were very slim, and we did not proceed past the MCCP.

If you do not present a case at the MCCP, the 1993 Legislature passed a bill giving the MCCP power to assess costs of the hearing, including the costs of expert witnesses and panel stipends, for such non-cooperation.[3] This assessment of costs may be appealed to the Circuit Court.

I think many of us representing plaintiffs have the concern that the doctor on the panel almost invariably, particularly if he or she is in the same field, knows the respondent doctor. Although there have been occasional decisions where I am afraid that friendship has maybe colored the outcome, I would say that more often than not, doctor members of the panel have tried to make an objective assessment of the medical facts. In almost all cases, the doctor's opinion will carry the day on whether there is or is not actionable negligence found. It is not easy for the panel chairpersons to obtain doctors to sit in the panels, but I have found that, if there is a physician on the panel that we feel will not be open-minded, that both the panel chairs and Rod Maile have been receptive to our concerns.

A legitimate concern for claimants regarding the panel is the time that is added to the process of bringing a malpractice action to finality. Against that delay has to be weighed how many cases are actually resolved at the panel (which I will cover later) and other factors such as costs. To bring even the more routine medical malpractice case through trial costs many tens of thousands of dollars. If you can have a case resolved at the panel level or learn

something at the panel level which leads you not to pursue the case further, the cost to your client, and in many cases, ultimately you as the claimant's attorney, is significantly reduced. I have also found that counsel for respondent doctors have told me that their doctors were totally against settlement and then, having been presented with the claimant's case at the MCCP, have agreed to authorize settlement. In almost all medical malpractice insurance contracts, although there are a few that I know do not require this, the doctor must consent to settlement. So, although you obviously will have to convince the doctor's lawyer that your case has merit, you will also need to have the doctor himself convinced of that fact.

I have found more recently that even though H.R.S. § 671-19 states that as part of the cooperation both parties should have authority to negotiate a settlement, the defense often does not come to the panel with that in mind. I would urge that counsel representing health care providers let their carriers know that they should arrive at the panel, in a case where they have exposure, prepared to discuss resolution. The attorneys representing the insurance carriers are experienced medical malpractice attorneys, and it would be a rare case where they were not able to fairly accurately evaluate their exposure before the start of the MCCP.

In summary, I believe the benefits of the MCCP far outweigh the two potential drawbacks, those two being the delay of cases and informing the defense of the theory of your case.

As stated earlier, the MCCP findings are confidential. I personally am in favor of this confidentiality requirement. Several years ago, I was asked to handle a case in Arizona where, at the time, the result of the finding of that panel, negligence or no negligence, was able to be used as the equivalent of an expert opinion. In my view, this turned what should have been a fact-finding and conciliation hearing into a mini trial with the attendant expense and trial-like posturing. In my view, the procedure as it then existed in Arizona (which is no longer the case), really was not a beneficial process, and added to delay of the case.

A Few thoughts on How to Make the MCCP Process Meaningful

Before you file your claim letter, you should: a) know the medical records; b) know your client's story; c) have spoken to a doctor or doctors in the appropriate medical fields – that you know will be candid in his or her opinions; and d) have obtained a written report or reports from the healthcare providers that you have retained. We often find that the story the client provides at the initial interview varies dramatically from what is contained in the medical records. Although we sometimes wonder about the accuracy of the medical records, we rarely find that we are able to prove that they were altered.

At the panel hearing itself, you should: a) establish the respondent's position as to the essential medical facts; b) have the respondent explain any differences in his or her opinions from what is contained in the medical records; c) have the respondent explain why any critical facts are omitted from the medical records; d) examine other critical healthcare personnel, such as nurses, to see if they differ on important issues from the respondent; e) have the respondent explain how his or her position can be supported in contrast to your own experts' opinions; and f) observe carefully the demeanor of the respondent – a likeable doctor can sometimes make the difference in whether an otherwise close case is won or lost.

MCCP Statistics

In 1999, there were 144 claims filed, which is very similar to the numbers filed in the preceding two years, although slightly less than the numbers filed in 1995 and 1996. Interestingly, if we go back 15 years, the number of cases that were filed in 1985 were essentially the same as filed last year. The 144 cases filed in 1999 involved 265 claimants and 375 respondents. No claimant filed more than one claim in 1999; however, the 375 respondents were not all different healthcare professionals and facilities. In fact, of the 375 healthcare professionals named, 26 of these claims were against one particular group of respondents.[4]

In 1999, the MCCP panels heard 129 cases that involved a total of 240 claimants and 489 respondents. In 20 of those cases, the claimants were prose. In only one of the cases in which the claimant did not have an attorney was there a finding of actionable negligence. The panels found actionable negligence on the part of all or some of the respondents in 47 of the 129 cases and rendered advisory determinations of damages raging from $25,000 to $3.2 million. In one case, the panel found actionable negligence but was not able to make a damages determination.[5]

In summary, as to the claims heard in 1999, actionable negligence was found in 33%, no actionable negligence in 61%, 2% were dismissed by the panel, and in cases with multiple respondents, at least one was found negligent and at least one non-negligent in 4% of cases. Thirty-seven claims were closed without hearings for various reasons such as withdrawal, settlement prior to hearing, dismissal by stipulation, termination, and lapse of the tolling period. Over the years, the percentage of cases in which negligence is found has varied roughly between 20% and 33%.[6] There has not been any dramatic change in the approximately 25 years since the MCCP has been in operation.

In my opinion, the statistics showing a two to one or as much as four to one ratio of losses versus wins by claimants at the MCCP is somewhat skewed. I know that some claimants' lawyers will go to the panel to give their client his or her "day in court." There is also the occasional claimant's attorney who does not present a case at the panel and, of course, that case will likely result in a finding of no negligence. Therefore, it has been my experience that even though local doctors, who will probably know the respondent doctor, sit on the panel, if the plaintiff presents his or her case fully with expert reports, the claimants will win as many cases as they lose.

In conclusion, the MCCP process is the law. I think we should utilize it, so as to provide the most possible benefit to clients.

1. 1976 Haw. Sess. L. Act 219; Hawaii Revised Statutes Chapter 671.
2. 162 F.R.D. 628 (D.C. Haw. 1995).
3. For examples, see H.R.S. § 671-19.
4. MCCP DCCA Annual Report to the 200 Legislature.
5. *Id.*
6. *Id.*

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Medical School Hotline

Indigenous Ways of Healing Guinea Worm by the Sonninke Culture in Mauritania, West Africa

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John A. Burns School of Medicine,
University of Hawaii,
and Deborah Miller, Documentary Film Maker,
Honolulu, Hawaii

Editor's Note by Dr. Satoru Izutsu, Editor of the Medical School Hotline: *Scott Hickman is a second year student at the John A. Burns School of Medicine. He was accepted for admission to the School in the Fall of 1998; at his request, he was granted a one-year "delayed matriculation" to participate in completing a film documentary on the Dracunculiasis medinesis in Mauritania, West Africa. He began his medical studies in 1999. This article is an example of the rich diversity that students bring with them in becoming physicians...*

Introduction

Dracunculiasis medinesis is a nematode that will hopefully soon share the distinction with smallpox of being completely eradicated from the face of the earth. In 1986 there were an estimated 3.2 million cases worldwide. After being targeted by the WHO, the Carter Center, and various other organizations, this number has now dropped 97% to only 78,557 cases in 1998.[1] Although its days may now be numbered, it has a very long and insidious past with humanity. The two to three foot worms have been found on the radiograph of a mummified Egyptian girl who died in 1000 B.C.,[2] and a treatment of the disease appears in *Papyrus Ebers* from 1550 B.C.[3] Some think that when Moses was fleeing Egypt, the "fiery serpents" that afflicted them on the Red Sea were Guinea worm. The ancient as well as modern way of healing someone afflicted with the disease, by wrapping the worm on a piece of wood and slowly pulling it out, has been hypothesized to be the symbol of modern medicine.[4] (Figures 1 & 2) Alexander the Great brought it with him to modern day India in 300 B.C., and it was the trans-Atlantic slave trade that brought it to the New World.[3] It received its popular name, Guinea worm, from European travelers who in the 17th century witnessed the disease on the Guinea Coast (West Africa).[5] Its scientific name, *Dracunculiasis medinesis*, or the "Little Dragon of Medina" comes from being considered historically the scourge of the Islamic pilgrimage.[6]

My first introduction to the disease came as a Peace Corps Volunteer in Mauritania, West Africa from 1993-1995. I had left the village I was living in, Hassi Chaggar, right before the rainy season with its typical health problems of malaria and diarrhea abundant. I returned one month later to find hundreds of people in the village who could not walk more than 10 feet at a time, with small white worms coming out of their skin and large secondary bacterial infections accompanying the worm. A few weeks after my arrival, the regional health director was giving me a ride in his air-condi-

Figure 1.— Persian surgeons extracting Guinea worm. This plate is from a monograph about Guinea worm written by a European physician in the 17th century. *"Exercitatio de Vena Medinesi, ad Mentem Ebnsinae sive de Dracunculis Veterum. Specimen Exhibens Novae Versionis ex Arabico, cum Commnetario Uberiori, cui Accedit Altera de Vermiculus Capillaribus Infantium. Augusta Vindelicorum. Imprensis Theophili Goebelli,"* Georg Hieronymus Welsch, 1674, 303. Plate taken from: Kean BH, Mott KE, and Adair RJ, *Tropical Medicine and Parasitology Clinical Investigations*, Vol. 2, 1978, Cornell University Press, New York, New York, 413-414.

Figure 2.— The modern symbol of medicine. One of many hypotheses to its origin is that it comes from the technique of wrapping Guinea worm on a stick to extract it.

tioned car (nice rides are prized by Peace Corps Volunteers more than pizza and ice cream in Nouakchott [pronounced "new ox shot"], the capital of Mauritania) and he suggested I do a survey of the whole village to get an accurate idea of how many had fallen to the disease. After three days of canvassing the village, I counted 247 out of 5000 people in Hassi Chaggar had been afflicted, the highest rate at the time in Mauritania. While walking in the stifling heat, (on my last trip there it got up to 138° F by 10:30 A.M. and I did not have the guts to check it at the hottest part of the day) I also saw how indigenous healers cured people with the disease. This technique was much different from what I and modern medicine were teaching them to do.

The Sonninke are mostly farmers in the Sahel region of West Africa, and the vast majority are Muslims. With only 50-100 miles separating them from the great sand dunes of the Sahara desert, food and water supplies are at a premium. Being able to work in the fields is critical for a family during the three to four months of the rainy season, for it is only during this time that millet, their staple crop, can be planted and harvested. Unfortunately, this is when Guinea worm strikes, afflicting the able-bodied so that they cannot farm. Children are dually affected, by being inflicted themselves or pulled out of school to work in the fields to take the place of a parent with the disease, causing a significant loss of time in school.[7] Guinea worm does not just affect the health of a community, but has an impact on the economic and nutritional status of a village as well.

Overview of the Life Cycle

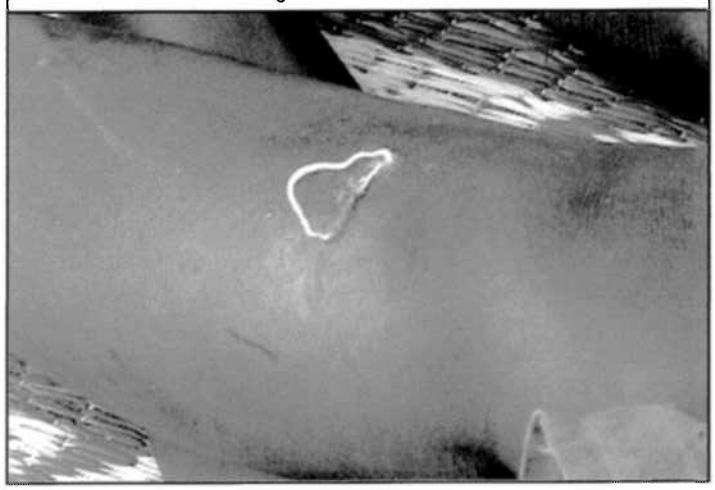
Dracunculiasis is contracted by drinking water contaminated with small crustaceans *(Cyclops)* infected by the larval stage of the nematode. (No. 3 & 4 in Figure 6) After ingestion (No. 5 in Figure 6), the Guinea worm larvae penetrate through the stomach and small intestine and enter the retroperitoneal cavity where they mature. The female mates and develops, and then makes her way painlessly mainly to the lower extremities moving through connective and lymphatic tissue.[8] The female's full size is about 1 meter in length, (almost all of it uterus to carry its million of larvae) and 0.2 cm in diameter.[9] About one year after initially ingesting the larvae, when the rains come again, a very painful blister is formed by the female worm (No. 8 in Figure 6). Although the worm usually is found in the lower extremities, it can be found anywhere on the body such as the scalp, eyes, scrotum, vagina, spinal cord, etc. Multiple infections are common, and some people may contain from 15 to 30 worms.[6] When the blister is placed in water, which helps in reducing the pain, it bursts and the female deposits thousands of larvae into the water (No. 1 & 2 in Figure 6). The *Cyclops* again ingest the larvae, and the larval-infected *Cyclops* are then swallowed by humans continuing the life cycle.

Humans are the only host for Guinea worm, making its eradication feasible. Simply by filtering the water with a cloth will capture the *Cyclops* so that ingestion does not take place. Under the leadership of the regional health director and UNICEF and in conjunction with local leaders, my main job in the Peace Corps was teaching how the life cycle of the disease to the Sonninke and the preventative technique of filtration. Throughout the world this has been a very efficient means of prevention, and in 1998 when I was last in Mauritania there were only 12 cases of the disease in Hassi Chaggar.

Figure 3.— Carrying water to the house from a well in Hassi Chaggar. During the times when water is scarce, some must walk upwards of one mile several times each day from the well to their house carrying water on their head.

Figure 4.— Guinea worm coming out of the leg of a small child, with a string attached to the worm and the leg to keep it stable. The worm is about 10 cm out of the leg.

Figure 5.— A worm coming out just below the knee. This worm was one of five infecting this woman.



Indigenous Healing Methods

There is no cure for the infection, and most patients are incapacitated for 10 - 11 weeks due to the pain and secondary infections.[1] (Figure 7) The way taught to the villagers by the local health authorities and myself involved wrapping the worm around a matchstick and pulling it out about 2-3 cm per day while keeping the wound clean. The Sonninke claim to have developed a way of turning this long time of disability to less than one week, so that they can quickly be out in the fields working. It was to research this method that the author and Deborah Miller, a documentary film maker now based Honolulu, went to Mauritania in 1998 to make a film on the indigenous ways of curing the disease.

The process begins by inducing a bacterial infection by making 10-30 superficial cuts around the general vicinity where the worm is found. (Figure 8) Sometimes the lesion formed by the worm itself produces such an infection so that this step is not needed. The wound is initially left open, and then covered with leaves such as from the Neem tree. Once there is a sufficient amount of infection, pus, and edema, a hot-metal poker is used to puncture the wound while 5-6 people hold the patient. (Figures 9 & 10) The patient is then encouraged to immediately get up and walk around. Once the pus drains from the wound, the worm is more easily pulled out, probably by losing its adhesions with the connective tissue destroyed by the bacterial infection.

We followed one patient who had the procedure done in the above figures. She was about an 18 year old married woman with 5 worms in her lower extremities. For weeks before she underwent the procedure, she could walk no more than 20 feet at a time and was confined to her house due to her severe pain, especially due to an infection in her left foot. Under the urging of the relatives in her compound, she visited an indigenous healer, or *jarandanna*, and underwent the procedure. She stood up almost immediately after being lanced on her foot in obvious severe pain but walked home. The next day she appeared to be in much better spirits and in much less pain, with most of the original edema gone but the worm still in place. On the second day after the procedure we went back to interview her again, but her relatives told us she had gone to the fields to work and the worm was gone.

I became interested in the Sonninke way of healing Guinea worm because it has been developed to enable one to go back to work more quickly than what Western medicine could do in such a place. It was incredibly horrific to see this done to someone, as well as appearing very dangerous. But, it was indeed just as amazing when these very same people who before could take no more than a couple steps before visiting the healer were out farming only 2 days afterwards. Modern medicine has made incredible strides to help the health of humanity, but here a local means of healing was preferred by many in the village, not only for its economic benefit of allowing people to go back to work quicker, but for its thereaupetic effects as well.

The healers understand the danger of systemic infections, contractures, and frozen joints, and have told me of deaths that occurred due to secondary infections by people who did not wish to undergo the procedure. Their lancing they say is a quick way of finally ending a Guinea worm infection as well as draining the secondary infection. The disease was often explained to me analogous to a fight. If you did nothing, sat around in pain, and were afraid of undergoing the procedure, the worm and its infection would eat you and get the best of you and your family. But if you were brave and lanced it and immediately walked around, you could beat the worm and go back to work. While sipping tea one night in Hassi

Figure 6.— The Life Cycle of Guinea Worm. From reference 6.

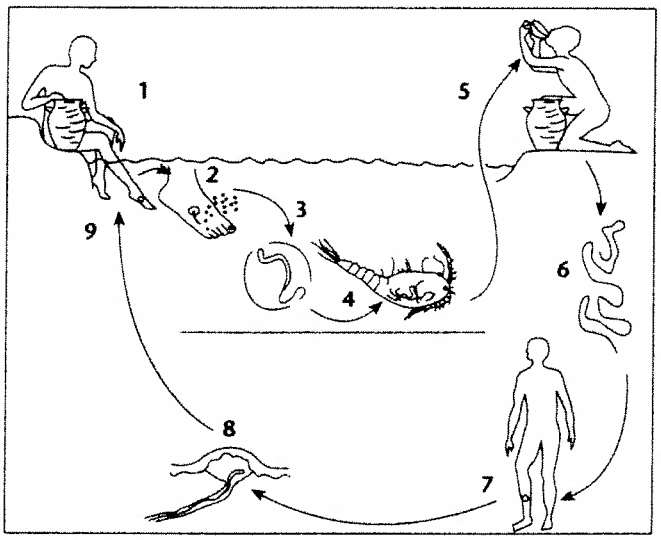


Figure 7.— Using a cane to walk due to the pain of a Guinea worm infection.

Figure 8.— Cutting the skin in the area of the worm. The worm at this point can be palpated under the skin but has not yet bore its way through. Cutting will induce a secondary bacterial infection that probably breaks down connective tissues that the worm normally adheres to.

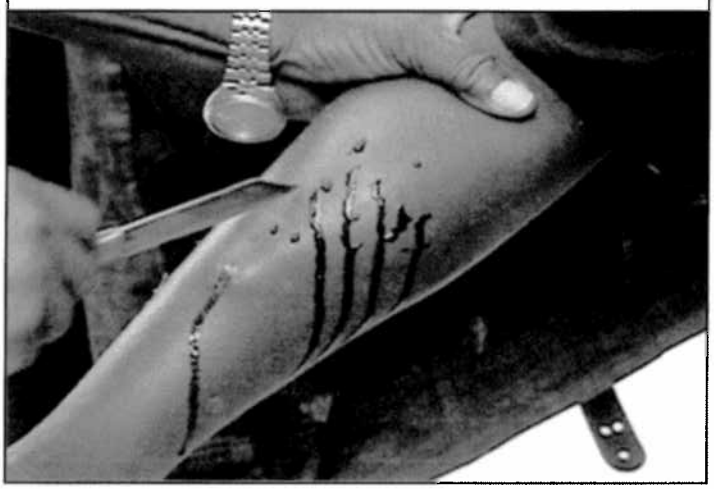


Figure 9.— No anesthetic is used when lancing the infected area with a red-hot metal poker, so the patient needs to be held down during the process. Lancing the infected area will drain the wound, which the Sonninke claim makes it easier for the worm to come out.

Figure 10.— Lancing the infected area. The poker is in the left hand of the man in the striped shirt, with the coals seen under his left arm. The Guinea worm infection is on the left foot.

Chaggar under the African stars and enjoying the cool of the evening, a Sonninke friend of mine told me that both the available Western and Sonninke methods of extracting the worm were inadequate. One was too slow and the other too dangerous, and both were extremely painful. It makes the final eradication of Guinea worm all that more welcome.

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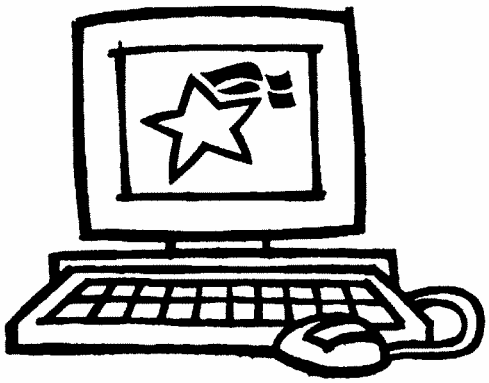

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Box jellyfish (*Carybdea alata*) in Waikiki:

Their influx cycle plus the analgesic effect of hot and cold packs on their stings to swimmers at the beach: A randomized, placebo-controlled, clinical trial.

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

Abstract

The study measured the analgesic effect of hot and cold packs on box jellyfish (Carybdea alata) stings to Waikiki swimmers at the beach. Analysis of data showed a minimal trend toward pain relief 10 minutes after the application of hot packs, particularly when the initial pain was mild to moderate. Cold packs showed no clinically significant relief of pain, compared to the control. Date tracking shows that most box jellyfish appear in Waikiki waters on the 9th or 10th day after the full moon.

Introduction

Box jellyfish (*Carybdea* species) annually inflict hundreds of painful stings to Hawaii ocean-goers.[1] On July 29, 1997, over 800 people were stung at Waikiki Beach alone.[2] Worldwide, thousands more people are stung annually by these and other box jellyfish species. Box jellyfish belong to the jellyfish class Cubomedusae, found only in tropical and subtropical waters. Cubomedusae have transparent, almost perfectly square bells. Their bottom edges are straight rather than scalloped, and tentacles hang from each of the bell's four corners.

In the middle of each of the four, flat sides of a box jellyfish bell lay the animal's sensory organs including elaborate, well-developed eyes. In darkness, a box jellyfish can detect light from a match 4 or 5 feet away and will swim toward it. These creatures appear to be sensitive to bright sunlight and most apparently retreat to deep water at midday. Because of this, most stings occur to swimmers in the morning.

Box jellyfish are strong, fast swimmers, some cruising up to about 2 miles per hour. These creatures feed mainly on shrimp and fish, stinging them with cells called nematocysts, abundant on the trailing tentacles. When a human comes in contact with these nematocysts, they sting exposed skin.

Two kinds of stinging, but non-lethal, box jellyfish appear periodically in Hawaii's bays and shorelines. These are *Carybdea alata*, about 3 to 4 inches high and about 2 inches wide, and *Carybdea rastoni*, about 1 inch square. Both have pinkish tentacles trailing from the four corners of the square. The tentacles of the larger species can be up to 2.5 feet long.

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The box jellyfish called sea wasps (*Chironex fleckeri*) are infamous in Australia and surrounding areas for their sometimes-fatal stings. This species does not inhabit Hawaiian waters.

No confirmed deaths have occurred in Hawaii from box jellyfish stings but the pain they inflict can be severe. The pain and marks from box jellyfish stings is nearly always self-limited, usually disappearing with no treatment from 20 minutes to one day. Some victims suffer persistent pain and/or recurring rash.

Therapies to minimize box jellyfish pain have not been studied in controlled, clinical trials. Some remedies, such as application of ice packs or heat in the form of hot showers or hot water soaks are common at home and in Hawaii's emergency rooms but are unproven. Additionally, chemical hot packs and chemical cold packs are a significant expense to the City and County of Honolulu since lifeguards sometimes use these to treat the pain of jellyfish stings at the beach.

This study was undertaken to determine whether applying hot or cold packs at the beach significantly relieves pain from box jellyfish (*Carybdea alata*) stings.

Box jellyfish have been in Hawaii at least since 1906 and a swarm of *Carybdea alata* was reported appearing on Waikiki Beach in June, 1951.[3] According to Honolulu City and County lifeguards, however, box jellyfish began occurring in Waikiki waters and on Waikiki beaches on a regular basis and in large numbers in the late 1980s. The first of these influxes was noted in December of 1988, followed by influxes in April, May, June and July of 1989.[4] In May of 1989, daily Waikiki swimmer Minoru Yoneshige noticed that box jellyfish seemed to be appearing in Waikiki waters on a regular basis. He recorded influx dates for 4 years and discovered that box jellyfish usually appeared there two days after the last quarter moon. He notified one of the authors (S.S.) and lifeguards of his findings.

Lifeguards also began recording influx dates and counting individual jellyfish found in the area of Waikiki Beach near tower 2C, a place where box jellyfish were often highly concentrated. From their unpublished data, it was confirmed that the highest influxes occurred on the 9th and 10th days after the full moon (another way of saying two days after the last quarter moon). The authors believe that compiling and publishing the dates of box jellyfish influxes in Waikiki over the last three years is of value to lifeguards, heath care workers and the public in general since box jellyfish sometimes cause painful and fearful experiences for people recreating in Waikiki waters.

Methods

This study is one part of an ongoing, larger study examining the efficacy of different temperatures and solutions in treating the pain of box jellyfish and Portuguese man-of-war stings in Hawaii. The University of Hawaii's human subjects committee has approved all portions of this on-going study.

The main study sites for applying hot and cold packs to box jellyfish stings were at Waikiki Beach at the lifeguard towers marked 2C and 2D. These sites were chosen for their high number of box jellyfish sting incidents compared to other leeward beaches. This increased incidence is likely due to the trapping of box jellyfish inside nearby concrete breakwaters.

The study was conducted from January 1997 through December 1999. During this time, any adult or child who came to the lifeguard tower complaining of a sting was assessed immediately for the possible need of ambulance assistance. Criteria for such assistance were respiratory distress, altered consciousness, uncontrollable pain, widespread rash, stings to eyes or victim request. Five victims needed ambulance transport. Two had a hot pack applied to their stings, two had a cold pack applied and one had a control pack applied, all before ambulance arrival.

Those victims not requiring ambulance assistance, and who likely had box jellyfish stings as indicated by the lunar cycle and wind direction, had their sting areas immediately doused with vinegar. Vinegar is currently the recommended method of neutralizing undischarged nematocysts in box jellyfish stings.[5] This treatment is not purported to relieve pain, but prevents additional stings. Following this dousing, a worker applied one of three temperature variants to the sting: a chemical hot pack, a chemical cold pack or an air temperature pack (control). The worker selected the type of pack applied in a random manner by reaching into a box containing an approximately equal number of the three types of packs and choosing the first one at hand. This method of providing randomized treatment is not flawless but proved a practical method of randomization at the beach. Also, blinding the researcher as to whether he or she was using hot, cold or air-temperature packs was difficult since as soon as the pack was activated, its temperature change, or lack thereof, was noticeable instantly by touch.

The chemical hot packs (Kwik-Heat) reached a maximum temperature of 110 degrees F. soon after being activated by squeezing the bag. The cold packs (Kwik-Kold) soon reached a minimum temperature of 42 degrees after being activated in the same manner. Control packs were depleted hot or cold packs. At 0 (immediately after the vinegar dousing), 5, 10 and 15 minutes, victims 7 years of age and older made a single mark, or told the field researcher where to make a mark, through a standard 100-mm visual analog scale (VAS), with 0 being no pain and 100 being severe pain.

Results

Sample and Data Analysis

The dataset contained information on 133 individuals. However, two (both in the cold group) dropped out before the vinegar dousing, and three more (one in the hot group, two in the cold group) dropped out before the 5-minute pain score was recorded. Another participant had a final pain score of 0 after the vinegar dousing. The sample size for the analysis of pain score at 5 minutes after the vinegar dousing is therefore 127. More serious sample attrition begins after the 5-minute mark. Only 100 participants gave complete data at 10 minutes, and only 43 at 15 minutes. Thus, the most reliable results are those from the pain score at 5 minutes. After that, two different analytic methods were used, one which considered only the data actually collected (method 1), and another method in which missing pain scores were imputed with the last pain score recorded (method 2). Both methods give results that are limited in comparison to the results from the pain score at 5 minutes. The former method does not take into account any treatment effect on dropping out and the latter relies heavily on imputed pain scores.

The pain scores were analyzed as both continuous and binary outcomes. Graphical analyses indicated the pain scores were somewhat skewed, so a square root transformation was used for the analysis of covariance. The results were similar to those with the untransformed data, however, so the latter are presented here for ease of interpretation. Nonparametric statistical tests also corroborated the results obtained with the untransformed data. The analysis of covariance described the inter-treatment differences in the mean pain scores at 0, 5, 10 and 15 minutes, with statistical control for the pain score at 0 minutes for the last 3 outcomes. A binary outcome was also constructed, depending on whether the participant experienced complete cessation of pain or not over the 15 minute testing period. However, only 7 of the 127 participants reported a final pain score of "0", 5 in the hot group and 2 in the cold group. (Three other participants reported 0 after 5 minutes, but re-elevated pain scores after 10 and 15 minutes.) Since there were no participants in the neutral group (the reference group) who reported a final score of 0, the definition of cessation of pain was widened to include a final pain score of 10. A logistical regression model was used to analyze the odds of the cessation of pain across the treatment groups, while controlling for initial (after vinegar dousing) levels of pain.

Records of the dates of appearance and box jellyfish counts at Waikiki Beach near lifeguard tower 2C since 1998 were collected and recorded in tables and graphs.

Estimation of pain scores at 5, 10 and 15 minutes by treatment group.

Results are summarized in the following table, including both of the above-described analytic techniques for pain scores at 10 and 15 minutes after vinegar dousing. The basic model was: pain score at 5-, 10- and 15-minute intervals (after vinegar dousing) = intercept + baseline pain score (after vinegar dousing) + treatment effect.

At 5 minutes, both the cold and hot treatment groups had significantly lower average pain scores than the neutral group. The estimated difference was approximately 5 points for the cold group and 6 points for the hot group. This is shown graphically in the figure below (Graph 1). There is some suggestion of an interaction with the effect of the hot group in that the difference between the hot and neutral group was greater among those participants with lower initial pain scores, compared to those with higher initial pain scores. This interaction was not statistically significant, however. The decrement associated with the cold group was fairly constant across the range of initial pain scores (no interaction).

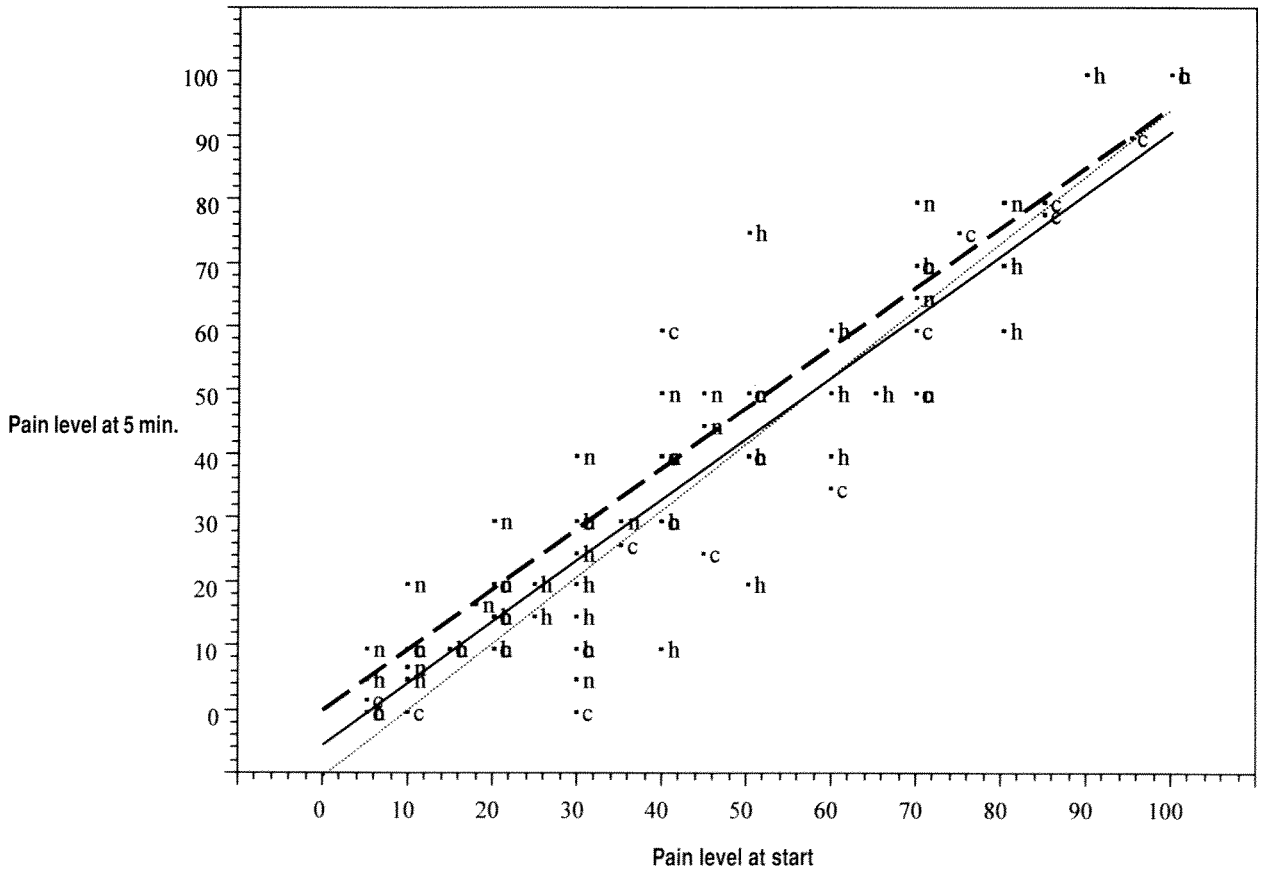
At 10 minutes, participants in the hot treatment group had significantly lower pain scores compared to the cold and neutral groups, between which there were no longer differences (Table 1). This was true for both methods 1 and 2.

Table 1. — Estimated* average pain scores, by 5-minute intervals and treatment group.

		Method 1[1]					Method 2[2]	
Group	time:	0 min.	5 min.	10 min.	15 min.		10 min.	15 min.
Cold	n	42	42	31	17		42	42
	pain score	38.3[a]	32.8[a]	36.2[a]	45.0[a]		33.2[a]	33.9[a]
	standard error of pain score	3.9	1.4		2.4	4.3	2.0	2.2
Hot	n	44	44	35	12		44	44
	pain score	42.3[a]	31.3[a]	27.5[b]	34.1[a]		26.0[b]	23.8[b]
	standard error of pain score	3.8	1.4		2.3	5.2	2.0	2.2
Neutral	n	41	41	34	14		41	41
	pain score	38.6[a]	37.7[b]	38.2[a]	37.3[a]		35.0[a]	33.4[a]
	standard error of pain score	3.9	1.4	2.3	4.8		2.0	2.3

*Estimates at 5, 10 and 15 minutes are adjusted for pain level after vinegar dousing (0 minutes).
[1]Method 1 utilized only non-missing data in estimation of average pain scores.
[2]Method 2 imputed missing values after 5 minutes, using the last recorded pain level for all subsequent missing values. (Note that the sample sizes for each treatment group remain constant in Method 2.)
Significance tests between treatment groups (within 5 minute intervals): groups with same letter are not significantly different ($p \geq 0.05$).

Graph 1. — Prediction of pain at 5 minutes by treatment group.



(Fitted lines: Neutral group indicated by dashed line, hot group by dotted line, and cold group by solid line.)
(Data points: Neutral group indicated by "n", hot group by "h", and cold group by "c".)

Prediction of the cessation of pain by treatment group. The proportion of participants who experienced the cessation of pain within the study period was highest in the hot treatment group (41%) and lowest in the neutral group (29%). After adjustment for initial pain scores, participants in the hot group were estimated to be 5 times more likely to experience cessation of pain, compared to those in the neutral group. While this estimate was statistically significant (p=0.02), note the wide confidence interval, ranging from roughly 1 to 23. In fact, exploratory data analysis indicated the odds estimate was substantially decreased by artificially changing the status of 1 or 2 participants in the hot group. There was no statistical difference in the odds of pain cessation between those in the cold group and the neutral group (p=0.4).

Table 2.—Odds of cessation of pain*, by treatment group.

Treatment group	Cessation of pain? yes (%)	no	Odds ratio (95% confidence interval)
cold	14 (33%)	28	0.5 (0.1 - 2.1)
hot	18 (41%)	26	5.2 (1.3 - 22.8)
neutral (reference)	12 (29%)	29	1.0

*Cessation of pain is defined as a final pain score of 10 or less. All estimates are adjusted for initial pain scores.

Box jellyfish appeared on Waikiki Beach at tower 2C nearly always between the 8th day and 12th day after the full moon. In the 1998 graph, a 13th day column was added because of the unusually high influx of jellyfish on the 12th day in March. The counts near tower 2C on all other dates were zero or near zero. Analysis of the dates of box jellyfish influxes in Waikiki for the past three years confirms that these jellyfish most often appear on and near the beach in the highest numbers on the 9th and 10th days after a full moon.

Recent research suggests that the synchronous arrivals of box jellyfish in Waikiki are monthly spawning aggregations. Box jellyfish start to arrive on the beaches of Waikiki approximately one hour before the high tide on the ninth and tenth days after the full moon. The first individuals to arrive are usually mature spawning males. Approximately one hour later, mature spawning females arrive.[6] It is unknown why this occurs only on the leeward shore of Oahu.

Discussion

Our data analysis shows that after 5 minutes of holding packs on a box jellyfish sting, both the cold and hot treatment groups had lower pain scores (less pain) on average than the control group: cold was approximately 5 points lower than neutral; hot approximately 6 points lower. It is doubtful, however, that such small differences are clinically significant. One study examining the significance of this visual analog scale (VAS) model reports that in acute traumatic pain in an emergency department, less than a 13-mm change in pain severity, although statistically significant, may have no clinical importance.[7] Another emergency department study on VAS pain scores found the minimum clinically significant difference in VAS pain scores to be 9 mm.[8] From these studies the authors conclude that the 5 or 6 point VAS difference in hot and cold pack treatment at 5 minutes is not clinically significant.

At 10 minutes, there is neither a statistically nor clinically significant difference between the cold packs and neutral packs (in both methods 1 and 2), thus in this study, cold packs were ineffective in relieving jellyfish sting pain 10 minutes after application.

At 10 minutes, hot pack victims are lower (less pain) than the control in both statistical methods. In Method 1, the decrease was approximately 11 points; Method 2, approximately 9 points. This difference is clinically significant according to one VAS study and not clinically significant according to the other. In Method 1, the average pain score estimates in the cold and hot groups increase at the 15-minute mark, compared to the 5-minute mark. (Actually at 10 minutes in the case of the cold group.) There are at least three possible explanations for this. One is that there is less potential for late pain relief among those in the hot and cold groups, since they experienced a greater decrease of pain earlier. Another possibility is that people in the hot and cold treatment groups are dropping out earlier than those in the control group because of lessened pain. A third option is that both the hot and cold packs used tended to lose their maximum temperatures after 10 to 15 minutes, therefore, their efficacy diminished with time.

One uncontrolled and possibly significant variable in this study was the time elapsed between the time the victim was stung and the time he or she sought help. Often, victims continued surfing or swimming for a while, took freshwater showers at the beach or treated the stings with their own remedies before coming to the lifeguard. Considering this is a self-limited affliction, it's possible that this unmeasured variable skewed study results.

Some clinicians in Hawaii's emergency rooms instruct their box jellyfish victims to take hot showers. Anecdotal reports indicate that victims who do this say they feel an immediate relief of pain. The pain of jellyfish stings, however, is self-limited, often disappearing on its own from 20 minutes to a day, thus any intervention often appears to work. The analgesic effect of hot showers should be studied with a control, examining the effects of fresh water, water pressure from the showerhead, water temperature and elapsed time. Similarly, ice packs used at home or in the emergency room need a controlled clinical trial to examine their effectiveness as do cool fresh water showers at the beach. Such studies, however, are extremely difficult to conduct. Studying late interventions is problematic in self-limited injuries plus few victims (fortunately) are seen in emergency rooms for jellyfish stings in Hawaii.

Based on the findings of this study, and the results of other studies regarding clinical significance in VAS scores, the authors conclude that there is a trend toward relief of box jellyfish pain with hot packs 10 minutes after application particularly if the initial pain was mild to moderate. The clinical significance of this trend, however, is borderline and thus makes it unlikely that noticeable relief of pain from Hawaii's box jellyfish stings is achieved with the application of hot packs at the beach. Applying cold packs at the beach does not appear to be effective in relieving the pain of these box jellyfish stings. Because of these results, the authors recommend that all box jellyfish stings be sprayed liberally with vinegar, but that neither hot nor cold packs be applied routinely.

Because box jellyfish influxes occur with relative regularity, lifeguards should continue to monitor Waikiki beaches in the early mornings on the 8th through 13th, and particularly on the 9th and 10th, days after the full moon and post jellyfish warnings to swimmers as warranted.

Graph 2

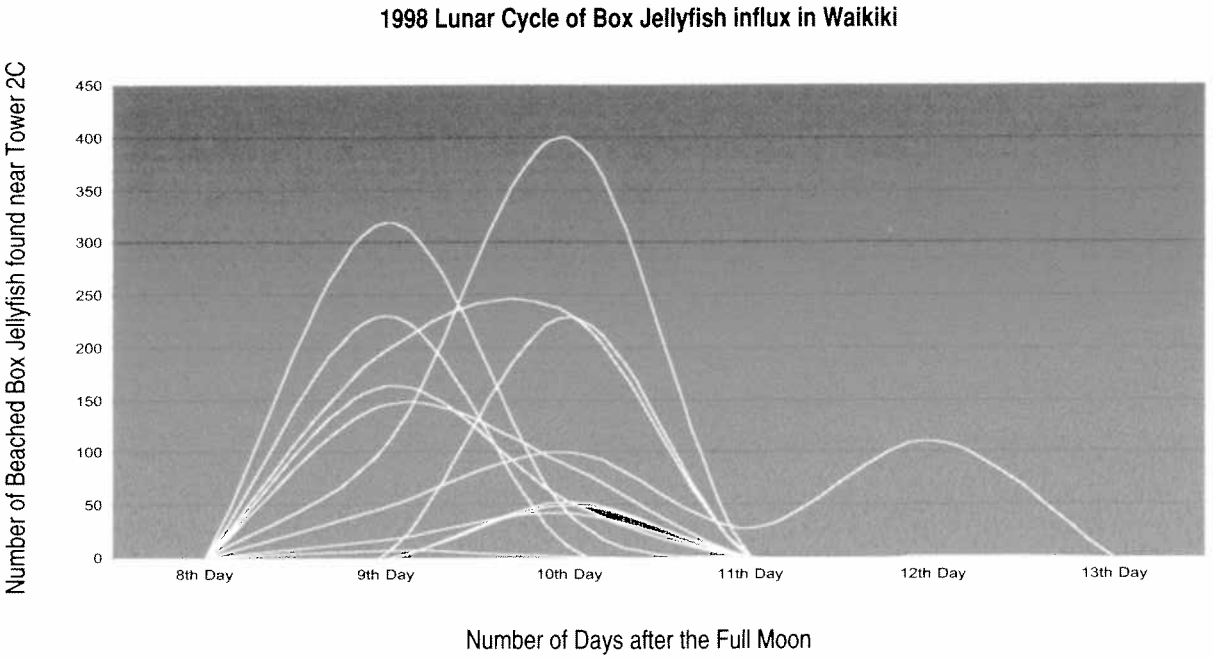


Table 3

Month	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13
January	0	18	43	0	0	0
February	0	147	88	0	2	0
March	0	49	100	28	111	0
April	0	108	400	1	1	0
May	0	165	53	0	1	0
June	0	4	230	0	0	0
July	0	0	50	1	0	0
August	0	0	54	0	0	0
September	0	231	10	0	0	0
October	0	320	42	0	0	0
November	0	198	232	1	0	0
December	0	7	1	0	0	0

Graph 3

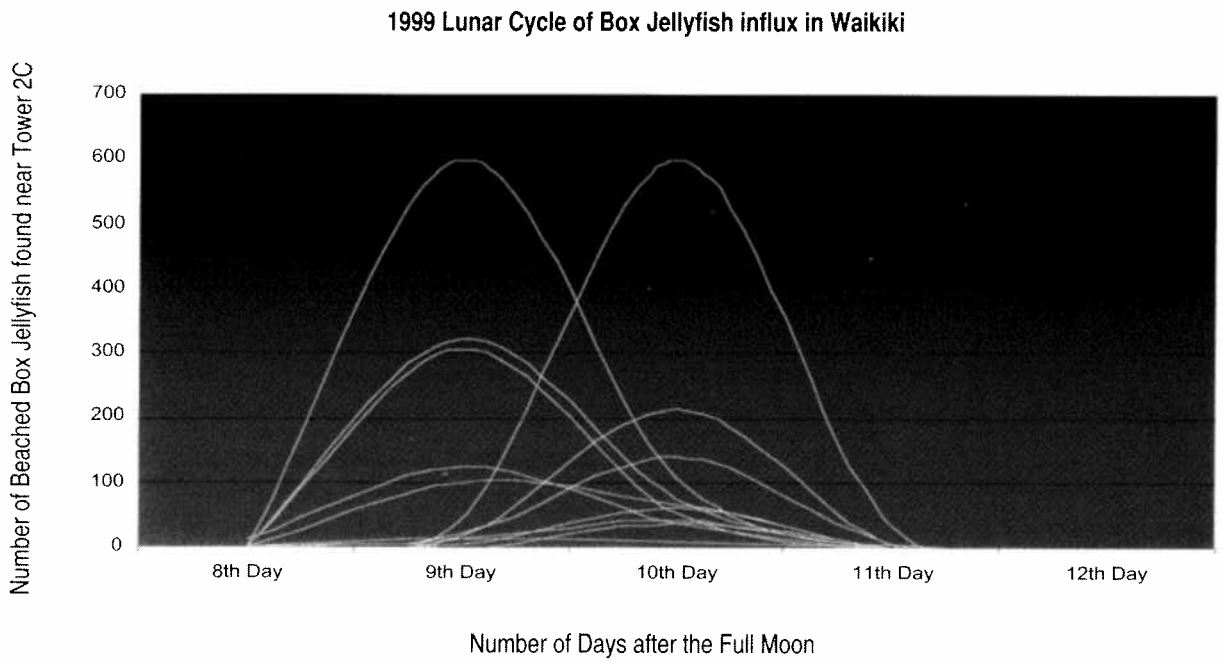


Table 4

Month	Day 8	Day 9	Day 10	Day 11	Day 12
January	0	20	141	7	1
February	2	324	76	0	0
March	0	45	600	36	0
April	0	14	43	0	0
May	0	100	70	1	0
June	0	1	39	4	0
July	1	18	216	4	0
August	0	16	11	0	0
September	0	5	61	3	0
October	13	127	38	0	0
November	0	307	54	0	0
December	1	600	108	0	0

Graph 4

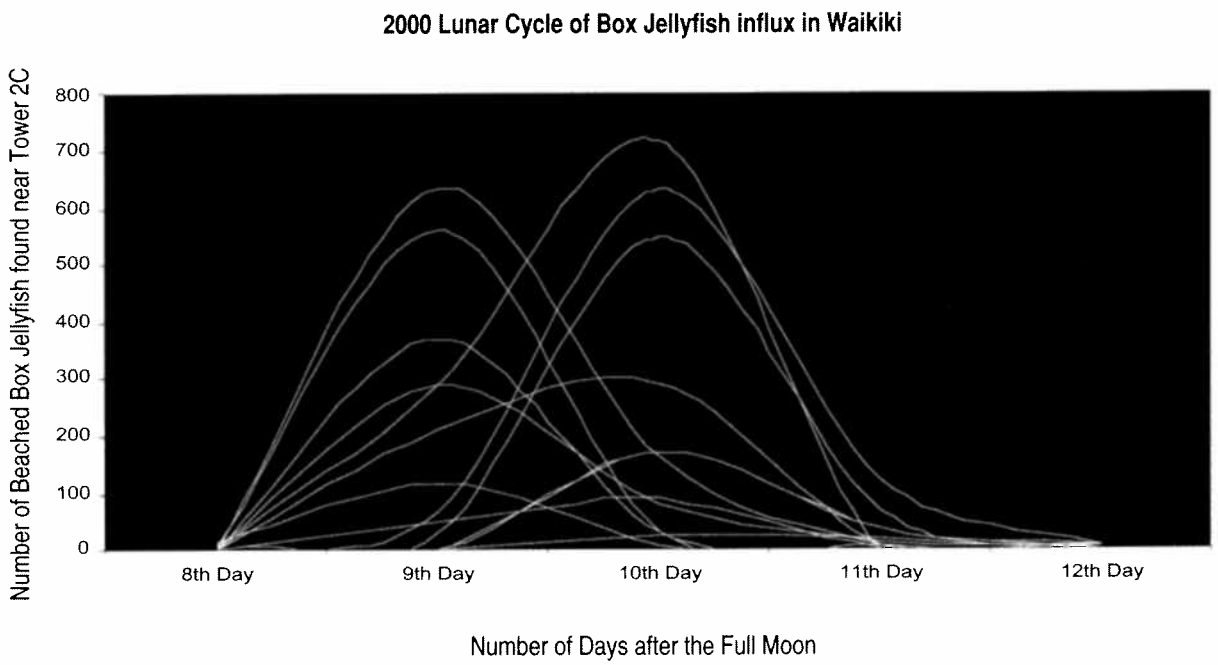


Table 5

Month	8th Day	9th Day	10th Day	11th Day	12th Day
Dec/Jan	15	117	8	1	5
January	7	288	79	14	5
February	7	560	31	5	0
March	0	210	292	8	0
April	0	372	28	0	0
May	0	3	171	36	7
June	0	0	22	18	0
July	3	29	550	67	1
August	0	1	168	35	2
September	0	47	87	3	1
October	0	67	630	122	5
November	0	634	162	9	3
December	0	0	22	18	0

The authors stress that their recommendations do not pertain to Portuguese man-of wars (*Physalia physalis* and *Physalia utriculus*), two other stinging marine species that also sometimes plague Hawaii's ocean goers. Portuguese man-of–wars' nematocysts (stinging cells) are different from one another and from those of box jellyfish, and therefore, need to be studied separately.[9]

Acknowledgements

The authors gratefully acknowledge Honolulu lifeguard Landy Blair for his outstanding contributions to this study. For years, Mr. Blair worked hard collecting data, collaborating with researchers and helping beachgoers cope with painful box jellyfish stings. Without him, this study would not have been possible.

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Case Report
Pseudo Pseudothrombocytopenia

Robert T.S. Jim MD

Abstract

An 82 year old Caucasian male minister presented with thrombocytopenia and platelet clumping on the blood smear thought to have pseudo thrombocytopenia. However, the platelet clumping was due to delay in making the blood smear rarther than clumping due to EDTA anticoagulant. This factitious or artificial platelet clumping (pseudo pseudothrombocytopenia) should not be confused with pseudo thrombocytopenia.

An 82 year old Caucasian male minister was seen for thrombocytopenia (platelet count 85,000 cmm. The rest of the Complete Blood Count was normal). His past history revealed essential hypertension and coronary artery bypass X 4. His medications taken included Quinapril HC1, Cimetidine, Procainamide HC1 and ASA.

Examination of the blood smear revealed numerous clumps of platelets. Pseudothrombocytopenia (PT) or drug induced thrombocytopenia was considered. A repeat platelet count with EDTA anticoagulant revealed a count of 101,000 cmm and with citrate anticoagulant a count of 101,000 cmm.

Blood smears from the EDTA and citrate anticoagulant blood revealed no platelet clumping.

A blood smear made from the patient's freshly drawn venipuncture revealed no platelet clumping.

A blood smear made from the patient after allowing the drop on the slide to sit 3 minutes delay revealed striking platelet clumping.

Discussion

Pseudothrombocytopenia (PT) is a laboratory-induced artifact where an unknown serum factor in normal or ill patients reacts with the EDTA anticoagulant used to collect blood resulting in platelet clumping.[1] Spurious low platelet counts by electronic Coulter machine results. Examination of the blood EDTA collected blood reveals clumping of platelets. If citrate or oxalate is substituted for EDTA, platelet clumping is not seen and normal platelet counts are seen.

In this case report, platelet clumping was not seen with the EDTA anticoagulant, as would be found in PT and PT was thus excluded.

It was observed that simple delay of 3 minutes in making the blood smear from freshly drawn venipuncture blood revealed marked platelet clumping.

In the patient reported, PT was excluded, The most likely cause for this thrombocytopenia was his medications.

Clinicians should be aware of this laboratory-induced factitious platelet clumping due to a delay in making a blood smear.

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Cancer Research Center Hotline

Your Link to Cancer Information: The Cancer Information Service of Hawaii

Brian Issell MD, and Hali Robinett MPH

Explaining what a diagnosis of cancer means for a patient is a challenging and time consuming process. The complexities of the disease and its management, along with fear evoked by hearing the word cancer often result in considerable distress for patients, family and providers as they negotiate optimal treatment decision making and care. Treatment recommendations may rapidly change as a result of new findings from the largest disease related research enterprise in existence.

As the foremost source for cancer information, the Cancer Information Service (CIS) was established in 1975 by the National Cancer Institute (NCI) to meet the information needs of cancer patients and their families, health professionals, and the public. CIS applies a unique health communications model to communicate the latest research findings about cancer detection, treatment, supportive care and prevention, to its users. At the University of Hawaii's Cancer Research Center, the Cancer Information Service has served as the NCI's link to the public by providing critical cancer information to Hawaii's patients and their families, health professionals, and the public since 1983. In its long history, CIS has evolved considerably from a program that began as a telephone service, to one that now includes a Partnership Program and research initiative.

Long considered a mainstay of the program, the CIS toll-free information service - 1-800-4-CANCER - has expanded to provide callers with several options. In addition to speaking with an Information Specialist, callers can opt to listen to recorded messages 24 hours a day, 7 days a week; connect to one of the CIS smoking cessation or Spanish call centers; or order publications through the CIS Publications Ordering Service. Although the 1-800 service is no longer operated at the University of Hawaii Cancer Research Center, CIS Information Specialists at the Fred Hutchinson Cancer Research Center (FHCRC) in Seattle, Washington, continue to provide thorough and personalized attention to each caller from Hawaii. CIS Hawaii staff assist the FHCRC staff in this regard by providing regular training specific to Hawaii culture, geography, communication styles, cancer problems, and resources. In addition, frequent communication between the Hawaii and Seattle offices helps the phone staff remain up to date with island events and services.

With 45% of today's Internet users searching for health related information, most seeking information about cancer, the CIS recognizes the need to make cancer information readily available via the Internet. To meet the new demands of today's consumers, the CIS provides a vast array of information through the NCI's website (http://cancer.gov). At cancer.gov, users can find the latest, scientifically-based cancer information regarding treatment options including clinical trials (http://cancertrials.nci.nih.gov), cancer risks, complementary and alternative medicine, and other related topics. In addition, users can order NCI publications online through the NCI's Publications Locator Service. An online instant messaging service for users who need help finding and understanding NCI information is also being piloted.

To reach those who do not traditionally seek health information, or those who may have access difficulties due to cultural, educational, financial, or language barriers, CIS Hawaii works in partnership with national, state, and local organizations to address the cancer information needs of minority and medically underserved audiences in Hawaii. Partnership Program staff provide expertise and information to these partners, strengthening their ability to educate and communicate about cancer. CIS Hawaii staff provide an array of services to meet the distinct needs of each organization, offering expertise in the areas of promotions, training, materials development, and new technology. CIS Hawaii staff work with partners to increase knowledge in breast and cervical cancer education, clinical trials, and tobacco control - those areas with the greatest potential to lessen the cancer burden in Hawaii.

Recognizing that Native Hawaiians have the highest cancer mortality rate of the five largest ethnic groups in the islands and the third largest mortality rate in the nation, CIS Hawaii staff strive to decrease this disparity by collaborating with organizations reaching the Native Hawaiian population. In addition, the Partnership Program actively seeks new partnerships with organizations focused on reaching other medically underserved populations in Hawaii.

In supporting the mission of both the Cancer Research Center of Hawaii and the National Cancer Institute, the CIS plays an important role in research by studying ways to promote healthy behaviors and communicate cancer information effectively. In addressing research priorities, CIS Hawaii networks with researchers at both community and academic levels, interested in studying better ways to communicate cancer messages. CIS supports research studies that test strategies and technologies within the broad span of research fields - cancer control, behavioral research, social psychology, informatics, nursing and others - to determine how best to communicate about cancer. CIS works with research partners to recruit participants; test telephone or Internet-based protocols; and test strategies designed to meet the needs of underserved populations.

The CIS is here to help you and your patients. Please do not hesitate to use or encourage your patients to call the toll free information service at 1-800-4-CANCER. You may reach our Honolulu office at (808) 586-5853, visit us at the Cancer Research Center of Hawaii located at 1236 Lauhala Street, or visit our website at http://cis.nci.nih.gov.

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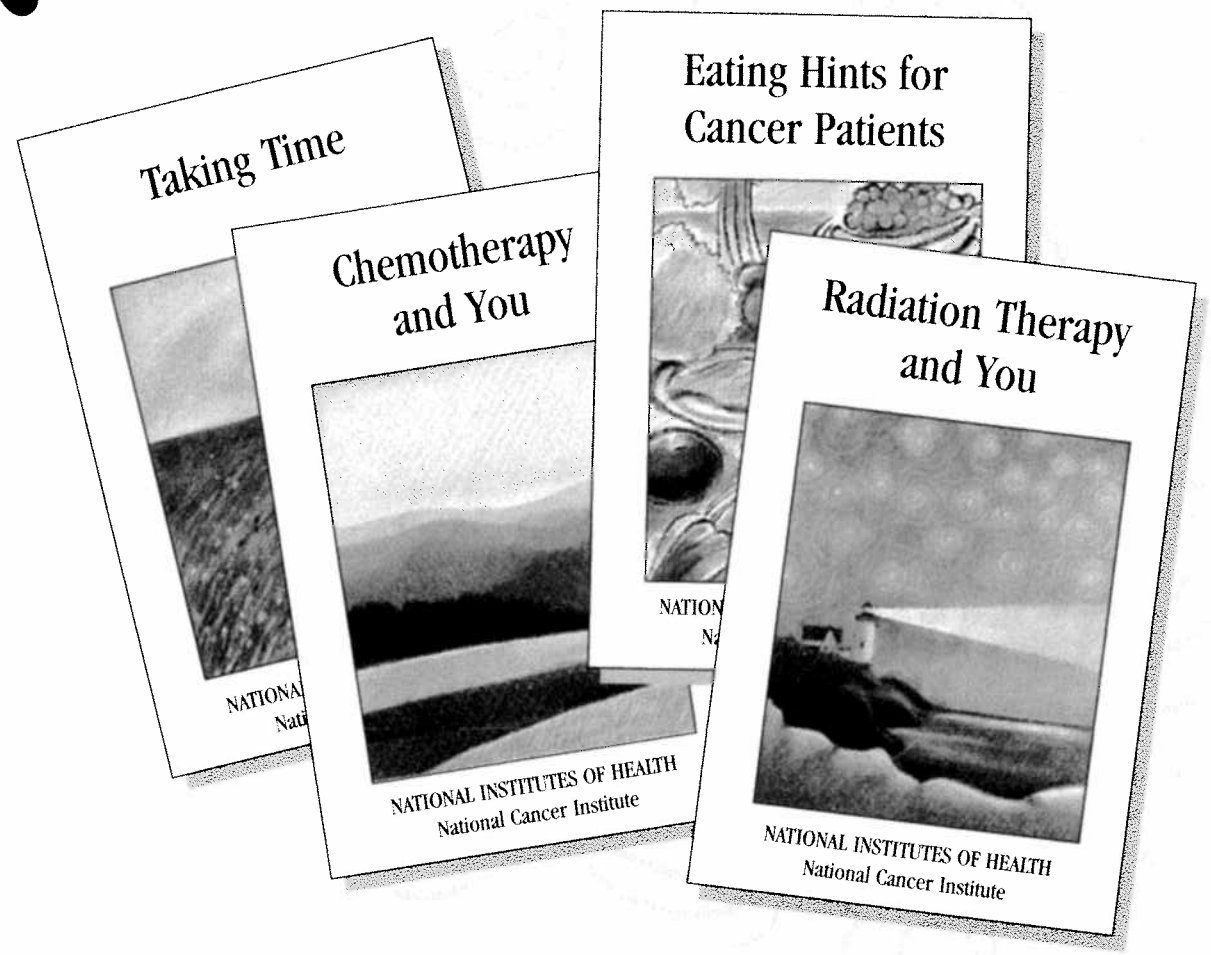

To order these and other materials, call the Cancer Information Service, a program of the National Cancer Institute, at

1-800-4-CANCER

(1-800-422-6237)

Persons with TTY equipment, dial 1-800-332-8615.

These and other cancer publications are also available on NCI's Website at: http://rex.nci.nih.gov

News and Notes Henry N. Yokoyama MD

Potpourri I

Seems a 70 year old gent and his 67 year old baby doll made an appointment with a doctor, went to his office and said they were having certain problems, and would he please watch them do some smooching.

The doctor looked puzzled, but agreed. When the couple had finished, the doctor said:"Looked OK to me. I didn't see anything wrong." He charged them $32.

This happened several weeks in a row. The couple would make an appointment, smooch, pay the doctor and leave. Finally, the doctor, thoroughly puzzled, asked, "Exactly what are you trying to find out."

The old gent said, "We are not trying to find out anything. She's married so we can't go to her house. I'm married and we can't go home. The Holiday Inn charges $60, the Hilton charges $78. We do it here for $32 and I get a $28 refund from Medicare."

(Muriel M. Muraoka, former nurse for Harry Arnold Jr. sent us this joke she received from Harry Arnold Jr. in 1991... Thanks Muriel, it revived many pleasant memories of HHA2...)

Potpourri II

Another busy day in my small town, Nova Scotia practice and I'd seen my share of colds, rashes and Paps that morning...Just before lunch, a young mother came in for her new baby boy checkup... The little fellow had a rather unusual name... I asked why they'd chosen his name. The new mother laughed and said, "He's named for where he was conceived..."Dakota"...I knew the father was in the military, so thinking he must have been stationed in the States, I replied, "Oh, is that North or South?"

Stunned silence... Pause..."No, a Dodge Dakota."

Dr. Lana Beth Barkhouse

Potpourri III

The Birds & The Bees:

A female patient in her 30's mentioned she'd never had a Pap smear...I rescheduled her and she returned a month later...Before the Pap, I tried to elicit some sexual history... I asked her if she had any "partners"...I asked her if her partners used condoms...She replied "no." I asked if she was trying to conceive. She stared at me blankly...

I asked her if she understood that with regular sexual activity without birth control she could certainly become pregnant...She replied that she never realized she was at risk of getting pregnant and wondered how it was possible...

I asked her why she thought she couldn't get pregnant, hoping she'd give me the answer to this confusing picture. She did when she replied: "You do understand I have a female partner."

Potpourri IV

Dream On:

I used to work for McKellar Hospital as a general pediatrician and covered the neonatal care unit...One day, I found a group of student nurses and their supervisors around a newborn baby with significant priapism...I was about to give the students a lecture about this natural event and asked "What do you think priapism is? A female family doctor who was passing by exclaimed quite loudly without missing a beat..."Every woman's dream."

Dr. Antonio Belda, Ontario

A gentleman on a train who suffers from absent mindedness, carefully searched thru his pockets while the conductor waited patiently. Finally he said, "This is terrible. I know I have a ticket, but for the life of me, I can't remember what I did with it."

The conductor said, "All is not lost, sir. You can pay me directly. Then when you find the ticket. You can return it and get your money back."

"But that's not the point," said the man in agony..."I don't remember where it is I'm going."

Like A Summer Breeze:

Over 40 years ago when I practiced in northern Ontario, one of my patients was a delightfully straight forward lady whose English was better than my French...

She wasn't a frequent visitor to our office, but when she did have a complaint, it was very specific and readily pointed to a treatable diagnosis...

My aide took her to the examining room and when I entered, she had removed her dress and slip and crawled up on exam table and pulled the linen sheet over her abdomen...

When I asked about her problem, she lowered the sheet and put her hand on her abdomen and said, "Doctor, it's de gas" "When I get in bed at night, she starts to move." And she moved her hand in a clockwise motion over her abdomen.

"I reach down and part the cheeks," and she put her hands on her buttocks. "And de wind she blow the bed sheets...It's just like a summer breeze...It's not like a fart at all."

So we had the surgeon remove a gall bladder full of stones and her problem was solved...

Dr. J.W. Marlone, Ontario

IRRITABLE BOWEL SYNDROME

Visiting Professor Lin Chan from UCLA - QMC

Incidence of IBS: Primary care: 12%; GI Setting 28%

Epidemiology: 15% of population; Women oftener than men...

Evaluation: ↑ sigmoid contraction c̄ IBS; visceral hypersensitivity...

↑ ↗
→ EMS (Emotional Motor Syndrome)
↙ ↓ ↘

Diagnosis of IBS:

Rome II Criteria:
- 12 weeks (past 12 mos)
- Abdominal pain: Relieved by defecation
- 3 stools/d

Ddx:
a. Dietary factor
b. Infection
c. Inflammatory bowel syndrome
d. Anxiety?

Red Flags: alternative dx
- Anemia
- Fever
- Severe constipation

Diagnostic Test:
Age <50:CBC, electrolytes;liver enzymes, sigmoidoscope
Age >50: BE; colonoscopy
Symptoms: constipation; diarrhea; pain/bloating

Management IBS:
a. Education, reassurance, etc.
b. Dietary modification
c. Fiber
d. Symptomatic Rx
e. Psychological: Behavoral options
f. Realistic goals
g. Psychological: Behavoral options
h. Realistic goals

Therapy: Management of pain, diarrhea, constipation c̄ antispasmotics, ↑ fiber, and opioid like agents

Drugs: Laxatives & bulking agents (laxatives; MOM; Psyllium)

Commentary:
- Placebo response (70-80%)
- Antispasmodics: not effective
- Antidiarrheal Rx: Imiperal etc.
- Tricyclic antidepressants & SSRI's

Tricyclic Antidepressants & SSRI's:

- Low dose effective for pain: Start c̄ 10mg → 50mg
- Amitriptyline:
- SSRI's: Adjunctive Rx

LOTRONEX (Alosetron HCl) NEM approved for IBS; Rationale:
↓ Serotonin (5HT)
Serotonin role: ↑ 5HT in IBS
Alosetron: 1mg bid most effective; relaxes colon → relief
1mg bid for 2 weeks as clinical trial;
12 weeks treatment;
Adverse effect: 5% constipation; Pt should have < 78% diarrhea. Caution: Don't use in pt with constipation.

LOTRONEX: Adverse Effects:
a. Constipation;
b. Ischemic colitis;
c. ↑ liver enzymes
Treatment dose: 1 mg bid with or without food.

Visiting Professor John Speer Schrader, Queen's Friday, Sept. 25, 2000

John Speer Schroeder MD
Division of Cariovascular Medicine
Falk Cardiovascular Research Center
Stanford University School of Medicine
300 Pastour Drive
Stanford, CA 94305

NEW TARGETS FOR HYPERTENSION, DIABETES AND HYPERLIPIDEMIA/CAD

New Targets for Hypertension
- SBP 130; 140 in elderly
- DBP 80
- Use: ACE I quinapril (Accupril) ramipril (Altace)
  ARB if cough telmesartan (Micardis) losartan (Cozaar)
  or dihydropyridine amlodipine (Norvasc)
  Add 12.5 HCTZ Hydrodiuril or triamterene/HCTZ (dyazide or maxide)
  Start with CCB if angina/IHD: Diltiazem CD
- Add ARB to ACE I in difficult to control HTN. Consider adding carvedilol (Coreg) which does not ↑ insulin resistance
- For ISH in elderly:
  Amlodipine 2.5 → 5
  Add HCTZ 12.5

New Targets for DM
Control BS/HbAlc: HbAlc< 6%
Use Insulin sensitizers:
metformin (Glucophage) 500 bid → 1000 bid if CR<2
pioglitazone (Actos) 7.5 → 15 → 30 → 45
rosiglitazone (Avandia) 2 → 4 → 8
- Add glipizide (Glucotrol XL) 5-10 qd or bid
- Avoid diuretics/BB which ↑ insulin resistance
- Tight WT and BP control

New Targets for CAD/Hyperlipidemia
Known CAD/vascular disease
TC 150 (down to TC 125 probably safe)
LDL 60-80
Use atorvastatin (Lipitor) or simvastatin (Zocor) up to 80 mg qd or qhs
Diet < 20 mg SR
Avoid diuretics
Avoid BB unless post Q MI or CHF
Primary prevention
TC < 200
LDL < 100
Aggresive lowering as risk factors ↑ such as family Hx, smoker, sedentary, postmenopausal, HTN
Diet < 25 grams SF

Use Multifactorial RF Reducton for Both Primary and Secondary Prevention
- Exercise 30 min every day
- ASA 80 mg EC if CAD or > 50 yrs old
- Fish oil (omega - 3 oil) 1G
- Vit E 400 IU
- Vit C 500 mg
- Calcium carbonate 1G (1.5G post menopausal)
- Folic acid 400-800 µgm
- Multivit with B
- HRT (Use caution if recent CV event)
- B-13 catradio/norgestimate (Ortho-prefest®)
- Or B estradiol/norethindrone (Fem HRT®)

Evolving
- Consider tissue ACE I quinipril (Accupril®), ramipril (Actace®) in all patients with vascular disease regardless of hypertension status

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Quotable Quotes

A generalist is someone who learns less and less about more and more until he knows nothing about everything...
A specialist is someone who learns more and more about less and less until he knows everything about nothing...

Anonymous

Varicose Veins are the result of improper selection of grand parents...

William Osler

Ratner's Law: Beepers work better if you turn them on.

Thomas Sydenhome

Bennett's Axiom on lab tests: "If you get a lab test to reassure a patient, the result will always be abnormal...

Corollary No. 1: Unexpected lab results will not correct themselves no matter how often you look at the chart...

To err is human. To forgive is against departmental policy...
A drug is a substance that when given to a patient produces the side effect you forgot to mention...

Howard Bennett

After two days in the hospital, I took a turn for the nurse...

W.C. Fields

ASSISTANT PROFESSOR OF GERIATRIC MEDICINE, Position Nos. 88915T and 88927T, M3, Geriatric Medicine Program, John A. Burns School of Medicine, F/T, to begin approx. July 2001 for one-year, non-tenurable. Duties: Develop academic career in geriatrics, supervise residents and fellows in the care of older patients, participate in research, and education, develop research/medical education grant-funded projects. MQS: MD degree; board eligible or board certified, fellowship in Geriatric Medicine, Certified (or eligible for certification) in Geriatric Medicine, eligible for Hawaii license and demonstrated ability in teaching. Min. Annual Sal: $78,924. Send updated c.v., bibliography, and 5 names of reference to Patricia Lanoie Blanchette, MD, MPH, Geriatric Medicine Program, John A. Burns School of Medicine, University of Hawaii, 347 No. Kuakini St., HPM-9, Honolulu, HI 96817. Closing date: May 1, 2001. An EEO/AA Institution.

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The Weathervane Russell T. Stodd MD

When Sammy Davis Kissed His Girl, Do You Think He Closed His Bad Eye?
A study at the Mayo Clinic in Rochester, Minnesota, was conducted with laser pointers. Three patients whose eyes were going to be enucleated for uveal melanoma agreed to the research. Laser pointers were directed at retinas which were exposed for durations up to fifteen minutes. The eyes were examined at intervals from 24 hours up to 15 days, and at post enucleation. Other than transient afterimages, investigators were unable to document any functional, ophthalmoscopic, fluorescein angiographic or histologic evidence of damage to the eye. On the basis of this study, the risk to the human eye from class 3A laser pointers with powers of 1,2, and 5 mW, was believed to be negligible. How sad for plaintiffs' attorneys.

There Is Much To Be Said For Failure. It's More Interesting Than Success.
What a surprise! The Government Accounting Office (GAO) has assessed the National Practioners Data Bank (NPDB) and brought some heavy criticism. The GAO reported to Congress that "the National Practitioner Data Bank contains sets of data that are incomplete, inappropriate, inconsistent and inaccurate." The GAO found that nearly all the malpractice records reviewed were incomplete, and that one-third contained patients' names (a reporting violation). The intent of the NPDB is to keep a record and track problem physicians, but instead the bank collects a lot of useless data which does nothing to assess the quality of any doctor in question. In typical governmental officious denial, the deputy administrator, Thomas Morford, objected to the GAO findings. "We think the data are accurate." A much more useful monitoring device is through physician profiling systems within state run data banks, a system presently working in about half the states. But facts do not deter bureaucrats, and despite protests from the American Medical Association and others that the bank fails to do what Congress intended, bureaucrats have persisted. Very possibly, like any other failing government program, they will expand it.

Snap Judgements Are Easily Unfastened.
Across the country the question of medical marijuana has been one of controversy and confusion. In California, voters passed proposition 215 legalizing medical use of marijuana, and the Oakland Cooperative was established for medical distribution of the drug. However, the Controlled Substances Act of 1974 makes it illegal to distribute or manufacture marijuana. Government lawyers say that Congress has decided there is no accepted medical use of marijuana. Ergo, the federal government filed a lawsuit asking a judge to ban the Oakland Cooperative from supplying marijuana, and now the case has percolated up to the Supreme Court of the United States. The same nine souls who untied (?) the knot in the Florida presidential election have decided to rule on the medical use of marijuana. There can be no doubt that if the Supreme Court rules in favor of the medical use of marijuana, state laws will change across the nation. Already, nine states, including Hawaii, have passed laws permitting the use of cannabis for medical reasons. Many doctors claim that for sick patients there is no other lawful drug alternative that helps chemotherapy patients stave off nausea, or that helps AIDS patients stimulate their appetite. The Court expects to hear arguments in the spring.

I Regard Golf As An Expensive Way Of Playing Marbles.
The high court, on a somewhat less momentous issue, will decide the fate of professional golfer, Casey Martin. Mr. Martin, who suffers from a degenerative circulatory disorder that makes walking painful, is citing the Americans with Disabilities Act, and demanding that the Professional Golfers Association (PGA) grant him the right to ride in a golf cart. The rules state that the participants in competition must walk, and the PGA has denied his request. Their attorney contends that golfers must walk as much as 20 miles during a four day, 72 hole sponsored event. Walking the terrain in the heat and humidity is an important and challenging part of the game. Justices Ruth Bader Ginsburg, Sandra Day O'Connor, and John Paul Stevens are golf enthusiasts. Justices Anthony Kennedy and David Souter offered that perhaps the courts should defer to the PGA's rules. So, okay, it's not Roe v. Wade, or Brown v. Bd. of Education, still, to golfers the matter is really, really important. Previously, the Court has viewed the ADA with narrow definition.

Some Days You're The Dog, Some Days You're The Fire Hydrant.
Like a simmering pot that moves from the back to the front of the stove, the medical liability issue is heating up once more. The relative calm we have enjoyed through the 1990s is about to end, and clouds are gathering. In Hawaii, underwriters have suffered increased losses in recent years, dividends are disappearing, and holding the line on premiums is becoming problematic. Still, the worst direction is to have the state involved. In Pennsylvania, physicians must purchase malpractice insurance and then pay a surcharge to underwrite the state's Medical Professional Liability Catastrophe Loss Fund. In 1995 when the fund faced a shortfall, it imposed a surcharge on top of a surcharge. Last year (2000) a heavy flood of payouts from the CAT fund means that the state needs an additional $25 million to cover losses. And where will that money come from? As in 1995, doctors and hospitals, of course. Depending on specialty, Pennsylvania physicians will pay from 7 to 56% more in 2001.

By The Time You Understand The Disease, Your Brain Implodes.
Mad-Cow fever is gripping Europe, and calls are now being made for precautions in the United States. Advisers to the Food and Drug Administration are recommending that blood donors who have lived in Europe or the United Kingdom for six months (Red Cross is asking for three months) or longer in the years 1980 to 1996, should not be allowed to contribute blood or blood products During that time tens of thousands of animals infected with mad-cow disease were eaten in the U.K. according to Ermias Belay, epidemiologist with the Centers for Disease Control and Prevention. Creutzfeldt-Jakob Disease (CJD), the fatal brain-wasting human disease, is believed to be transmitted by eating animals infected with mad-cow disease, but no cases of mad-cow disease have been found in the U.S. There is no evidence that it has been passed between humans through a blood transfusion, but studies in sheep have found that a variant of CJD can be so transmitted. In the U.S. the Agriculture Department is examining brain tissue of sick animals to rule out the disease. Also, the U.S. prohibits importation of cattle, sheep and goats from Europe, as well as their biological products, without a special permit for research.

He May Be A Genius. The Contrary, Of Course, Is More Likely.
According to the military, at any time, forces may be deployed to areas of the world with risks of biological warfare. Hence, anthrax vaccine is now being included for troops. Captain John Buck, M.D. an Air Force physician, has decided he doesn't like the idea, and has refused the vaccine. Dr. Buck views it as an investigational vaccine being used in an off-label fashion even though it has been in use for over 30 years. He faces court martial. Apparently Dr. Buck forgot that when he took the oath with the Air Force, he thereby relinquished his right to determine which orders he would obey. Going back to the days of the Roman military, "there's the right way, the wrong way and the Army way."

Count The Towels, Silver And Furniture, Martha. Elvis Is Leaving.
Any final traces of respect for the Clinton presidential years, disappeared with the departure of Bubba from the White House. Creative word definitions, draft evasion, property scams, adultery, estrangement, the Lincoln Room $$$ motel, a new use and flavor of cigars, blatant perjury, trading military secrets for Chinese campaign fund contributions, topped off by unbelievable monetary pardons of slimey bottom feeding criminals. What a guy! Leaving at Andrews Air Force Base to a self-aggrandizing speech and inspection while his successor was being inaugurated, could not be more typical, nor more lacking in class. Meanwhile his teen-age-mentality staff was moving out of the White House by removing keys from typewriters and computer boards, gluing file cabinets closed, scribbling graffiti and vulgar cartoons on the wall, and even pilfering silverware. Many of us won't miss him, but the late night comedians are in mourning. What a tribute to our mighty constitution and our republic that the country survives.

ADDENDA
❖ The average age of widowhood in the United States is 56.
Aloha and keep the faith —rts■

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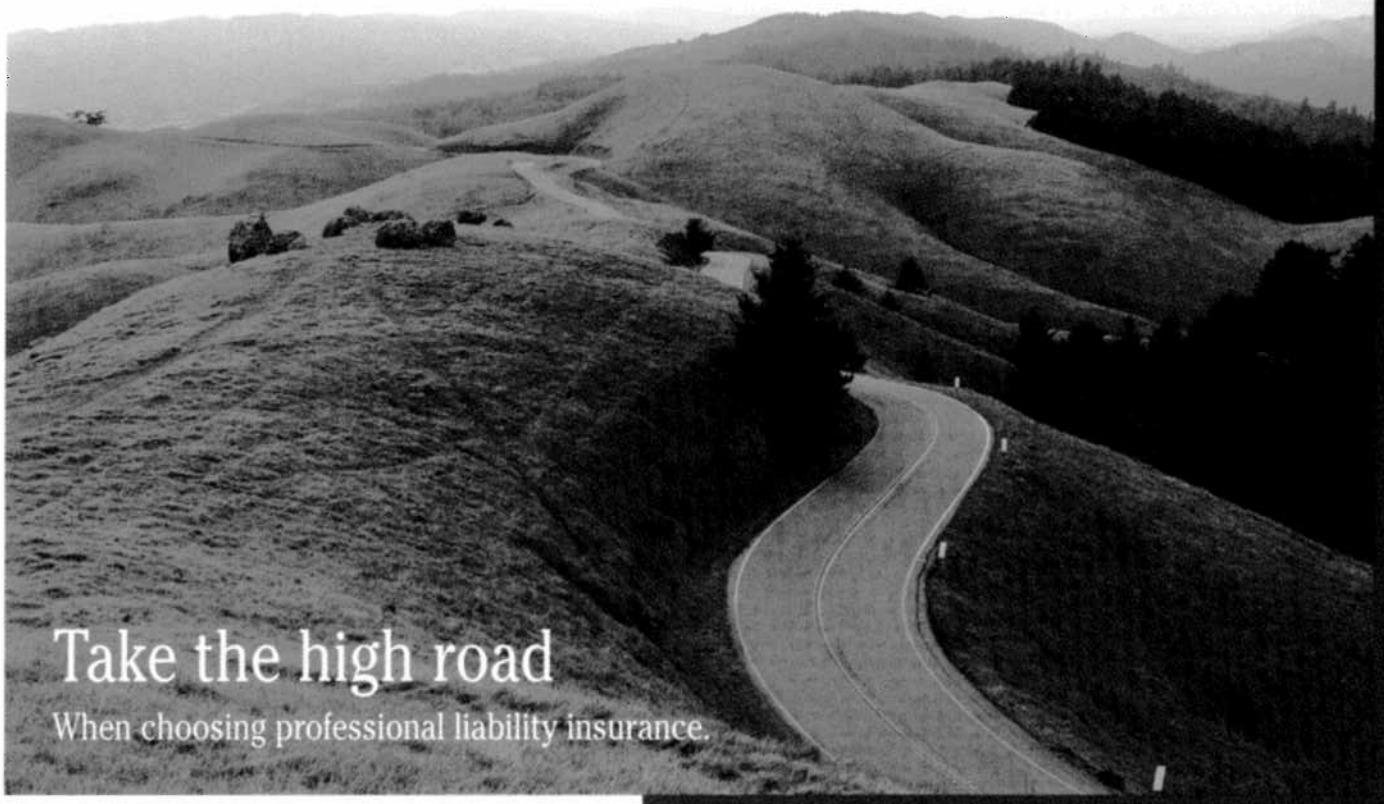

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