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Taro

Depicting the dietary staple of old Hawaii from which poi was made.
**Editorial**

**Watch the Wasabe – Revisited**

Severe Palmar Hyperhidrosis Treated with Sympathectomy instead of sympathectomy

Norman Goldstein MD
Editor, Hawaii Medical Journal

Americans spend more than half a billion dollars annually for sweat reducing products,1 usually to treat auxiliary hyperhidrosis. Not generally known is the fact that many of the over-the-counter products also help cases of mild to moderate palmar hyperhidrosis.

Mildly sweaty palms can be treated with OTC topical products, electric iontophoresis units, oral medication and more recently Botox injections (Botulinum A toxin) reviewed in the HMJ Editorial.2

Despite some adverse effects of Botox, including temporary burning and pain from 40 or 50 injections, this treatment affords relief to disabled, stoic patients.

Transthoracic Endoscopic Sympathectomy has become a popular procedure for the patient with severe, incapacitating palmar hyperhidrosis.

Formerly we referred these severe cases of palmar hyperhidrosis to the mainland for this procedure. We now have physicians in Hawaii who perform bilateral transthoracic endoscopic sympathectomies. This procedure, first reported in 1951,3 has now become the standard operation for severe cases of palmar hyperhidrosis.

Recently Atkinson & Fealey, neurosurgeons at the Mayo Clinic in Rochester, Minnesota started using sympathectomy for these cases of severe hyperhidrosis.3 The authors point out that complications of surgical sympathectomy include compensatory hyperhidrosis in other body parts (10-40%). Lau and associates report of sympathectomy for compensatory hyperhidrosis of the trunk in all cases, and two in the feet, but that it “appeared to be of little concern to their patients.”3

The sympathectomy procedure in Atkinson & Fealey’s 10 cases produced compensatory hyperhidrosis in 8, “all rated as mild.” The authors conclude that “Sympathectomy alone by disconnection of the T2 Ganglion input into the brachial plexus produces excellent results... and appears to lower the severity of postoperative compensatory hyperhidrosis.” We now have another, better surgical treatment for this disorder that disturbs the quality of life for many patients.

If the reader missed the May 2001 HMJ Editorial:

Why “Watch the Wasabe”? Most people in Hawaii, and indeed around the world, now know to watch the Wasabe and not to eat it all at once. In a letter to the editor “Horseradish Horrors: Sushi Syncope” in the Journal of the American Medical Association, a 63-year-old man ate the whole (glob) of wasabe at his first Japanese meal and had vasomotor near-collapse. Among his many symptoms was severe diaphoresis, not merely palmar hyperhidrosis.

References
2. Goldstein N. Watch the Wasabe. HMJ 2001; 56, 122, 129.
3. Lau WT, Lee JD, Dang CR, Lee L. Improvement in Quality of Life after Bilateral Transthoracic Endoscopic Sympathectomy for Palmar Hyperhidrosis. 2001 HMJ 60;125-7, 137.
Petroglyphs (petros = rock; glyph = carving) are man-made images that were pecked, scratched, incised, or abraded into stone. They date back thousands of years and are found all over the world. Petroglyphs were used by early man to record events and visions, and for story telling. They were produced using crude tools such as sticks, rocks, or bones. Such pictures convey ideas or meaning to the mind without the use of words, sounds, or other language forms. This primitive means of communication, known as pictography (picture-writing), forms the basis of the Chinese and Japanese characters used today. Like ancient Indians north of the Rio Grande, kanaka maoli of old had no written language. They sustained traditions and told stories by passing them down by word of mouth. Petroglyphs were helpful in aiding memory and communicating ideas from one generation to the next.

Hawaiian petroglyphs have a common character and occasional similarities to those found elsewhere, especially in Europe, North and South America, and India. Petroglyph sites here are widespread, and have been reported on all of our major islands. Most sites, about 70, are on the Big Island of Hawaii, which had the greatest population in the late 1700s. Other sites are on Lanai (23), Maui (18), Oahu (9), Kauai (9), Molokai (5), and Ni‘ihau (1). Petroglyphs have more recently been found on Kahoolawe. Hawaiian petroglyphs are most often clustered in groups, rather than as isolated units. Many are at wahi pana (strored places), at boundaries, along trails, and in caves. They commemorated events, marked boundaries, kept records, and depicted man’s interaction with the gods including ‘amakua (ancestral guardian gods) and ‘unipilii (another class of protective spirits). Cupules were also carved in rock for placement of the piko (umbilical cord stump) after childbirth.

Petroglyphs in Hawaii are most often found on five types of surfaces: pahoehoe (most on the Big Island), waterworn boulders (many on Lanai), cliff faces (most Maui sites), cave walls (lava tubes especially on the Big Island), and beach shelves (some Kauai and Oahu sites). Subjects of most petroglyphs are people, dots and circles of varying significance, and a few man-made objects and animals important to Hawaiians. Families, birth scenes, means of transportation (such as canoes, paddles, sails, and men marching), and supernatural beings often are readily identifiable. Surprisingly, other than a few turtles, crabs, and some other marine animals, there is relative paucity in our petroglyphs of sea life, and also of birds and houses.

Hawaiian petroglyphs may date from the first arrivals here some 1,200 years ago. Many appear to have been inscribed in the immediate Pre-Discovery Period, before 1778, when Captain James Cook’s arrival at Kealakekua Bay at makahiki was interpreted by kanaka maoli as the return of Lono, god of rain, thunder, agriculture, and fertility. Some petroglyphs depict the horses and guns introduced to the Kingdom by haole in 1798. Petroglyph activity virtually ceased by the 1860s, in conjunction with codification into writing of the Hawaiian language, ascendency of Christianity over Hawaiian pantheism, and accelerating dissolution of Hawaiian culture.

Excellent accounts detail the story of petroglyphs in Hawaii. The panoply of Hawaiian petroglyphs is well represented by illustrations in the collection of Merle Setser, Ph.D., Research Analyst, Honolulu Police Department, and maven of Hawaiian rock carvings. The Journal will, from time to time, print images from her collection in our pages. These will complement our cover art by the talented Dietrich Varez, and serve as a reminder that we are the Hawaii Medical Journal. Mahalo, Merle, for sharing!

References
Acute Compartment Syndrome Signs and Symptoms Described in Medical Textbooks

Jeanelle L. Kam, Meituck Hu, Liana L. Peiler, and Loren G. Yamamoto MD, MPH, MBA

Abstract

Objective: To evaluate the accuracy of commonly accessed medical textbooks in their description of the presenting signs/symptoms of acute compartment syndrome (ACS).

Methods: Textbooks in six different specialties were surveyed for information about ACS. Informational content was scored using a 0 to 4 point system.

Results: 67 textbooks (36 primary care, 31 specialty) were reviewed. Of the 36 primary care textbooks evaluated, 29 contained no information on ACS. Three of the remaining 7 primary care books provided inaccurate information (43%). Only 3 of the 31 specialty books scored 0. Four of the remaining 28 specialty books provided inaccurate information (14%). Overall, 23 of the 31 specialty books (74%) provided accurate information (score of 3 or 4), compared to only 2 of the 36 primary care books (6%) (p<0.001).

Conclusions: Some textbooks contain inaccurate information in the diagnosis of acute compartment syndrome, which may delay the diagnosis resulting in irreversible morbidity. In reality, there are only three P’s (pain, paresthesia, paresis) which are important.

Introduction

Acute compartment syndrome occurs whenever increased tissue pressure in an osteofascial compartment compromises blood flow to muscles and nerves within the compartment, resulting in tissue damage. The elevated compartment pressure, due to various origins such as hemorrhages, fractures, crush injuries, muscle edema and limb casts, leads to blockage of venous outflow and subsequent venous infarction. As the pressure within a compartment exceeds the venous outflow pressure, venous outflow ceases. Without venous outflow, net capillary flow ceases leading to ischemia and subsequent infarction. Intra-compartmental infarction results in death of neural tissue as well as rhabdomyolysis. Disability resulting from amputation or permanent limb dysfunction, may result if treatment is not initiated in time.

Because of the seriousness of this condition, prompt diagnosis is essential. It is common practice for compartment syndrome to be described by medical reference texts and resource materials as the 5 P’s, sometimes 6 P’s (Pain, Pallor, Pulselessness, Paresthesia, Paresis, Poikilothermia). In actuality, pulselessness and pallor are NOT presenting symptoms. These would be regarded as late findings (actually too late), indicating a poor prognosis. Pulselessness and pallor are acute signs of arterial embolization, rather than what occurs in an acute compartment syndrome (which is a venous outflow obstruction). Pallor is not usually seen initially due to continuous cutaneous perfusion originated from sources proximal to or outside the involved compartment. Pulselessness is an extremely late finding and is rare upon initial presentation. Arterial pulsation will still occur even if no forward flow occurs, making this a deceiving and dangerous phenomenon, because a clinician may fail to consider the possibility of a compartment syndrome just because pulsation is present. In fact, some textbooks have specifically listed “Pulsation Present” instead of “Pulselessness” as one of the P’s to emphasize this point and counter the misinformation that has been published in the past. Poikilothermia, which probably refers to the coolness of an extremity, is similarly a late sign of compartment syndrome.

Therefore, pallor and pulselessness are not considered reliable criteria for the diagnosis of acute compartment syndrome. Excruciating pain with increasing severity in conjunction with numbness/paresthesia and paresis are highly suspicious for an acute compartment syndrome. It is critical to recognize, diagnose, and treat acute compartment syndrome in a timely manner. Therefore it is crucial that medical references accessed by physicians, physicians-in-training, and other medical personnel are accurate in their description of acute compartment syndrome. Promoting the 5 or 6 P’s suggesting that pallor and pulselessness are signs/symptoms of acute compartment syndrome may contribute to a delay in diagnosis and treatment.

The purpose of this study is to evaluate the accuracy of commonly accessed medical textbooks in their description of the presenting signs/symptoms of acute compartment syndrome.

Methods

A review of medical textbooks was conducted at the Hawaii Medical Library using texts from both the reference and shelved section. Reference texts were exhausted first to ensure that all standard books were covered in our study. Each textbook (which had information on compartment syndrome) was reviewed by a team of three reviewers and assigned a score based on consensus.

Texts that provided no information on acute compartment syndrome were scored as a zero. A score of 1 was assigned if the textbook indicated that pallor or pulselessness are signs/symptoms of acute compartment syndrome. A score of 2 was assigned if only brief information about acute compartment syndrome was supplied, but
there was no information suggesting that pallor and pulselessness are signs/symptoms of acute compartment syndrome. A score of 3 was assigned if the text provided accurate information on signs and symptoms (i.e., that pallor and pulselessness are only late signs of acute compartment syndrome). A score of 4 was assigned if the text provided the correct information just as in the score of 3, but additionally, the text described a method to measure intracompartmental pressure. The categories can be summarized below:

0 = Compartment syndrome not covered.
1 = Incorrect information present.
2 = Minimal information present, but nothing which is incorrect.
3 = Correct information present.
4 = Correct information, plus instructions on how to measure the intracompartmental pressure is sufficiently described.

The content reviewed was focused on acute compartment syndrome. We did not consider chronic compartment syndrome, exercise induced compartment syndrome or abdominal compartment syndrome.

**Results**

We evaluated a total of 67 textbooks (see reference list) for the content and accuracy of their descriptions of acute compartment syndrome. This included 36 primary care textbooks (from pediatrics, family practice, and internal medicine) and 31 specialty references (from critical care, emergency medicine, orthopedics, and general surgery). Textbooks that earned a score of 0 were eliminated from the mean calculation.

Textbook scores are stratified by the specialty areas in table 1. Of the 36 primary care textbooks evaluated, 29 scored 0 (contained no information). Three of the remaining 7 primary care books had a score of 1 (50%), all from internal medicine. Only 3 of the 31 specialty books scored 0. Four of the remaining 28 specialty books had a score of 1 (14%) (p<0.05, Chi-square testing comparing the rate for primary care versus subspecialty textbooks)

Overall, 23 of the 31 specialty books (74%) scored well (3 or 4), compared to only 2 of the 36 primary care books (6%) which scored well (3 or 4) (p<0.001).

**Discussion**

The number of textbooks that incorrectly list pallor and pulselessness as signs/symptoms of acute compartment syndrome is smaller than we expected, but such textbooks with incorrect informational content on this topic, still exist. However, if a primary care physician decides to learn about acute compartment syndrome in a primary care textbook, they are not likely to find any information. Specialty textbooks are more likely to have useful information that is correct.

Mnemonics are commonly used in the education process to facilitate learning. However, in this case, the desire to add more P’s (to augment the mnemonic), has resulted in an educational disservice to physicians who have learned the 5 or 6 P’s. It is difficult to undo this, but future book editors and authors should be careful to avoid this pitfall. In reality, there are only three P’s (pain, paresthesia, paresis) that are important. The other P’s are too late.

**References**

2. Higashigawa KH, Yamasato LG. Forearm swelling, pain, and numbness following trauma. Radiology in Pediatric Emergency Medicine, 2003, Vol. 7, Case 7 (available online at: www.hawai.edu/mcmed/pediatrics/PEM/7C07t.html)

**Pediatrics books**


**Family Practice books**

Orthopedics books


Surgery books


Emergency Medicine books


Cancer Screening Among Vietnamese in Hawaii

Ly T. Nguyen MD, Kelley Withy MD, Michelle M. Nguyen MD, and Seiji Yamada MD, MPH

Abstract
Objectives: To determine the extent of utilization of cancer screening services by Vietnamese in Hawaii, who had sought medical care from 1996 through 2000.
Methods: A chart review of 952 adult Vietnamese patients was performed.
Results: Of all eligible women, 52% and 26% had Papanicolaou test and mammogram, respectively. Among men age 45 and over, 8.4% had prostate-specific antigen test and 3.4% had digital rectal exam. Flexible sigmoidoscopy and colonoscopy were not utilized by patients.
Conclusions: This is the first study to examine the use of cancer screening tests by Vietnamese immigrants in Hawaii. Our findings of lower utilization rates in cancer screening by both male and female strongly support efforts to educate and promote preventive health for this population.

Introduction
Vietnamese are one of the fastest growing Asian minority groups in the United States, projected to reach four million by the year 2030.1,2 Breast and cervical cancer are the most common cancers occurring in Vietnamese women in the United States. Vietnamese women are about one third as likely to develop invasive breast cancer, but nearly five times as likely to develop cervical cancer in comparison to white women in the United States.3 According to the Surveillance, Epidemiology, and End Results (SEER) data for the year 1988-1992, the average age-adjusted incidence rate for breast cancer is 37.5 per 100,000 for Vietnamese, compared with 111.8 per 100,000 for white women.4,5 Although Vietnamese women have low incidence of breast cancer, acculturation studies indicate that cancer rates for Asian-American Pacific Islanders will increase and begin to mirror the rates of their host country within 10 years of immigration.6

The incidence of cervical cancer in Vietnamese women is four to five times that of white women. The average age-adjusted incidence rate for cervical cancer is 43.0 per 100,000 for Vietnamese, compared with 8.7 per 100,000 for white women.6 Yet, Vietnamese women have the lowest cancer screening and early detection rates of all ethnic groups.3 In addition, they tend to present later with more advanced disease compared to Caucasian women. A study of cancer patterns in Los Angeles County revealed that proportional incidence ratios for cancers of the lung and rectum were higher for Vietnamese men than any other racial/ethnic groups.6 The authors were unable to find any other published epidemiological studies on cancer in Vietnamese men.

There are no published studies regarding rates of cancer screening such as Papanicolaou (Pap) smear, mammograms, digital rectal exam (DRE), prostate-specific antigen (PSA), flexible sigmoidoscopy, or colonoscopy for Vietnamese men and women in Hawaii. The goals of the present study are to determine the extent of preventive care utilization by Vietnamese in Hawaii and to examine factors that may influence screening practices. The study findings may provide insights to assist health care professionals to effectively promote preventive health for this growing population.

Methods
The study was determined to be exempt from Department of Health and Human Services regulations in October 1999 by the University of Hawaii Committee on Human Studies. The study was conducted at a private internal medicine office in Honolulu, Hawaii, selected because one of the physicians is of Vietnamese ethnicity, fluent in the language and culture, and attracts a large part of the Vietnamese population of Honolulu to his practice. Data were collected between January and February of 2000. Two thousand medical charts of Vietnamese patients were screened for eligibility. The charts of all patients, born on or before 1982 (over 18 years of age) in either Vietnam or United States with confirmed Vietnamese ethnicity, were included in the study. The first author trained and supervised three medical students and one graduate student from the University of Hawaii in the data collection process.

A data collection form was developed, based on the 1997 National Ambulatory Medical Care Survey of the 20 most common diagnoses in ambulatory care, recent literature, and Vital Statistics Report.7,8 The following information was recorded: Age, gender, address, profession, years in the U.S., type of medical insurance, year of last doctor visit, and health screening procedures/tests (Papanicolaou, mammogram, digital rectal exam, prostate-specific antigen, flexible sigmoidoscopy, and colonoscopy). Patient names were not recorded, patients were not contacted, and all information was collected from patients’ paper charts. Study data were analyzed using the SPSS (Statistical Program for Social Services) program.
The demographic characteristics of the Vietnamese study population are shown in Table 1. The study population consisted of 470 males (49.4%), 468 females (49.1%), and 14 subjects of unknown gender (1.5%). The mean age of the study population was 57 years old (range 18-82 years). The study participants arrived in the U.S. between 1970-1999, with a mean of 9.5 years ago (range 1-30 years). Approximately 48% of the study participants were employed, 2% of whom worked as food handlers, equipment cleaners, helpers, and/or laborers. The majority of the patients lived in the Honolulu area (86%). Fewer than half (43%) of the Vietnamese patients had Medicare or Medicaid insurance, and approximately 32% had private insurance. Patients in this study were seen by a physician between 1996 and 2000. The percentage of the study group who received cancer screening tests are summarized in Table 2. Of the 468 eligible females in the study population, more than half (51.7%) received a Papanicolaou test. Less than one-third (26%) of the eligible females over age 40 had a mammogram done. Among men over the age of 45, 8.4% received PSA and 3.4% had DRE. Flexible sigmoidoscopy and colonoscopy were not utilized by either gender.

The frequency of screening tests were higher in patients in the younger age group, 35.0% in the 18-44 years old, 34.5% in the 45-64 years old, compared to 30.6% in the 65+ age group. Similarly, patients who worked as handler/equipment cleaners and unemployed/students had higher rates of preventive care use (29% and 20% respectively) compared to those with other occupations (less than 10%). Also, patients who had Medicare and or Medicaid insurance were more likely to obtain at least one screening test (46%) compared to 34% in patients with private insurance. The utilization of screening services was not associated with the year of arrival in the U.S.

Discussion
In our study, Vietnamese in Hawaii generally had a lower utilization rate of cancer screening compared to Vietnamese in California, compared to Hawaii Asian/Pacific Islander populations, and compared to the general U.S. population. Healthy People 2000, objectives published by the U.S. Department of Health and Human Services, indicate that 95% of women 18 years old and older should be screened annually for cervical carcinoma. According to our study, the rate of cervical cancer screening for Vietnamese women in Hawaii is 51.7%, well below the Healthy People 2000 guideline. This rate is lower than that for Hawaii Asian/Pacific Islander population (84.2%) and the general U.S. population (84.8%). Vietnamese women in Hawaii, however, have a similar rate of receiving the Papanicolaou test to that of Vietnamese women in California (53%).

Healthy People 2000 also established a goal of 80% for mammography for all women over 40 years of age. Breast cancer screening received by Vietnamese women fall short of this national goal. Vietnamese women in Hawaii have lower rates of breast screening (26%) than Vietnamese women in California (30%). In addition, their mammography utilization rate is low compared to Hawaii Asian/Pacific Islander (80.7%) and the general U.S. population (73.7%).

In 2001, the American Cancer Society recommended that the PSA test and the DRE should be offered annually to men beginning at age 50 who have a life expectancy of at least 10 years. Vietnamese men in Hawaii have a very low utilization rate of the PSA test, only 8.4% in men over the age of 45. The utilization rate of DRE in Vietnamese men in Hawaii was 3.4% compared to Hawaii Asian/Pacific Islander (23.8%) and the U.S. general population (18.1%).

### Table 1. — Sociodemographic Characteristics of Vietnamese Patients

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>470 (50.1)</td>
</tr>
<tr>
<td>Female</td>
<td>468 (49.9)</td>
</tr>
<tr>
<td>No entry</td>
<td>14 (1.5)</td>
</tr>
<tr>
<td>Age Group</td>
<td></td>
</tr>
<tr>
<td>18-44</td>
<td>236 (24.9)</td>
</tr>
<tr>
<td>45-64</td>
<td>356 (37.6)</td>
</tr>
<tr>
<td>65+</td>
<td>355 (37.5)</td>
</tr>
<tr>
<td>Mean Years in U.S.</td>
<td>9.5</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>455 (47.8)</td>
</tr>
<tr>
<td>No</td>
<td>497 (52.2)</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
</tr>
<tr>
<td>Exec/Admin/Mgr</td>
<td>13 (2.3)</td>
</tr>
<tr>
<td>Professional Spec</td>
<td>11 (1.9)</td>
</tr>
<tr>
<td>Tech Support</td>
<td>20 (3.5)</td>
</tr>
<tr>
<td>Sales</td>
<td>48 (8.4)</td>
</tr>
<tr>
<td>Admin Sup/Clerical</td>
<td>14 (2.4)</td>
</tr>
<tr>
<td>Private household</td>
<td>6 (1.0)</td>
</tr>
<tr>
<td>Service</td>
<td>42 (7.5)</td>
</tr>
<tr>
<td>Farm/Forest/Fish</td>
<td>15 (2.6)</td>
</tr>
<tr>
<td>Prec Prod/Craft/Rep</td>
<td>47 (8.2)</td>
</tr>
<tr>
<td>Mach Op/Assem/Insp</td>
<td>8 (1.4)</td>
</tr>
<tr>
<td>Trans/Moving</td>
<td>82 (14)</td>
</tr>
<tr>
<td>Hand/Clean/Labor</td>
<td>146 (25.5)</td>
</tr>
<tr>
<td>Unemployed/St/Housewife</td>
<td>106 (18.5)</td>
</tr>
<tr>
<td>Retired</td>
<td>11 (1.9)</td>
</tr>
<tr>
<td>Other (not specified)</td>
<td>3 (0.5)</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
</tr>
<tr>
<td>Downtown Honolulu</td>
<td>99 (10.6)</td>
</tr>
<tr>
<td>East Honolulu</td>
<td>453 (48.5)</td>
</tr>
<tr>
<td>West Honolulu</td>
<td>282 (30.2)</td>
</tr>
<tr>
<td>Other Oahu</td>
<td>100 (10.7)</td>
</tr>
<tr>
<td>Health Insurance</td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>280 (32.0)</td>
</tr>
<tr>
<td>Medicare/Medicaid</td>
<td>379 (43.3)</td>
</tr>
<tr>
<td>Other/Unspecified</td>
<td>169 (19.3)</td>
</tr>
<tr>
<td>None/Don't know</td>
<td>48 (5.5)</td>
</tr>
</tbody>
</table>

### Table 2. — Cancer Screening Tests by Gender

<table>
<thead>
<tr>
<th>Screening Tests</th>
<th>No. of Female (%)</th>
<th>No. of Male (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papanicolaou</td>
<td>242 (51.7)</td>
<td>30 (8.4)</td>
</tr>
<tr>
<td>Mammogram</td>
<td>90 (26)</td>
<td>12 (3.4)</td>
</tr>
<tr>
<td>Prostate-specific antigen</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Digital rectal exam</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
The American Cancer Society also recommends colorectal cancer screening for men and women age 50 or older. Screening can consist of performing a fecal occult blood test annually with or without another associated test, flexible sigmoidoscopy every 5 years, or colonoscopy every 10 years. However, none of the Vietnamese men and women in this study received sigmoidoscopy or colonoscopy as screening tests compared to 40.7% of Asian/Pacific Islander in Hawaii and 30.1% of the U.S. general population.9

Our results concur with other studies in showing that Vietnamese have lower cancer screening rates compared to Asian/Pacific Islanders, the U.S. general population, and Vietnamese in California. A number of studies have examined behavioral factors influencing preventive service utilization. According to Kagawa-Singer and Pourat, education is a significant predictor of screening among Caucasian women.11 For the Papnicolaou test, 15% of Caucasian women with an elementary education never have the test compared with 5% with a high school education and 4% with a college education.12 Education also has similar effect on mammography utilization rate.12

According to McPhee et al., a factor that contributes to lack of medical awareness is age of the patient.10 Older Vietnamese immigrants are accustomed to episodic care for acute symptoms, a pattern that is common in Viet Nam.10 Their attitudes and knowledge about medical care are based on their previous experience in Viet Nam. As such, Vietnamese women have a history of lower rates of cancer screening because physicians in Viet Nam traditionally have not recommended the screening.10 Other barriers to receiving preventive care are long working hours, costs of the tests, unemployment, lack of medical insurance, and not having a regular primary care doctor. The lack of health insurance has a great effect on screening. Kagawa-Singer and Pourat showed that 24% of insured Asian-American Pacific Islander women never had a mammogram compared to 72% of uninsured; 20% of insured Caucasian women have never had a mammogram compared to 42% of uninsured Caucasian women.12 They also pointed out that the lack of access to or use of primary care also affects screening rates. Among Asian-American Pacific Islander women without a regular primary care physician, 50% never had a Papnicolaou test and 46% never underwent mammography compared with 14% and 19%, respectively, of those who have a regular primary care physician.12

The data presented here should alert the public health community to the cancer screening needs of the Vietnamese population living in Hawaii. In order to increase rate of screening tests performed, Vietnamese patients and physicians must be targeted. High priorities for the Vietnamese patients should include education about cancer risks and prevention. Physicians must also discuss the availability and use of screening tests. Cheek et al. interviewed 199 Vietnamese women and found that the family doctor is the most important source of information about Pap smears.13 The majority of the Vietnamese women reported that they would have Papanicolaou test if recommended by their physician.13

There are several limitations to this study. First, the study group was drawn from patients seen at a single primary care provider’s medical office. Therefore, the data are not representative of all Vietnamese adults living in Hawaii or in other areas of the country. However, the provider was chosen for his large population of Vietnamese patients, and in fact the study group represents almost one-third of the total Vietnamese population of Hawaii (7,867) as reported in the 2000 Census.14 This study is also limited by the assumption that all screening procedures were accurately recorded in the medical charts and were up-to-date. In addition, many disadvantaged Vietnamese patients may not purchase or qualify for medical insurance and therefore may not have visited this or any other primary care physician. Therefore, there may be a significant population of Vietnamese that do not receive any screening at all, leading us to overestimate the screening rate. Conversely, since this doctor is Vietnamese-speaking, he may be attracting a patient population of immigrants with poor English language skills. Other Vietnamese with adequate language skills being seen by other practitioners may have more positive attitudes toward screening and have higher rates. Lastly, recommendations for screening practices are always in flux, while our methods accessed data from a specific past period of time.

In light of these limitations, this is the first study on preventive screening practices by Vietnamese in Hawaii. Vietnamese men and women have very low screening rates for colon, prostate, breast, and cervical cancer, which may increase their risk of presenting at later stages of disease, with its attendant morbidity and mortality. Culturally sensitive educational interventions to increase screening test utilization should be implemented. Socioeconomic and barriers to access should be addressed in order to facilitate the early detection of cancers. Future research may include qualitative research to delineate the barriers to screening and intervention studies to determine if addressing the barriers will improve utilization rates. Furthermore, primary care physicians should play a vital role in increasing screening test utilization among Vietnamese patients. The importance of primary care physicians in initiating discussions with their Vietnamese patients regarding effective cancer screening measures cannot be emphasized enough.

Acknowledgments
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References
The aging of the population brings new challenges to medicine. In the last century, the U.S. population 65 and older grew from 4% to 12%, and is projected to reach 20% by the year 2030. The American Association of Medical Colleges estimates that 75% of all current medical students, regardless of the specialty selected, will have a substantial number of older people in their practice. Because of the growing number of older people who have substantial responsibility for the care of children, even pediatrics will need to be keenly aware of common problems in older people to help prevent unintentional abuse and neglect. The challenge of providing knowledgeable health care to older people has generated an accreditation requirement to teach geriatrics to all medical students.

While Geriatric Medicine is a specialty, the majority of primary care for older people will continue to be provided by family practitioners and internists. This is ideal because of the benefits of longitudinal care provided by a physician who knows the patient and family well. When the care needs exceed those that can be provided in primary care, a referral to a geriatrician for evaluation or long-term follow-up is in order. Geriatricians usually practice as part of an established interdisciplinary team capable of handling complex, overlapping medical and psychosocial issues.

Family Practitioners may choose to provide geriatric care as a part of a mixed age practice or may become specialist geriatricians. The educational goals in geriatrics of a 3-year core family practice or internal medicine residency is for its trainees to attain a high standard of excellence in the primary care of older people and to recognize when referral is needed.

It has been recommended that at least 25% of the 3-year Family Practice residency consist of geriatrics training. Currently, every residency program is far from that goal. The reasons for the gap are several, including the shortage of both academic geriatricians and organized clinical teaching services in geriatrics. Training programs in family practice and internal medicine are required to have a formal curriculum and clinical experience in geriatrics. Family Practice was the first to make geriatrics an accreditation requirement. This requirement is usually interpreted and best met by having a formal required clinical rotation in geriatrics.

Physicians may enter fellowships in Geriatric Medicine after completion of residency program in either Internal Medicine or Family Practice. After successful completion of a one-year accredited clinical fellowship, and if board certified in either Internal Medicine or Family Practice, physicians are eligible to take the examination for certification in added qualifications (CAQ) in Geriatric Medicine. Specialty geriatricians often focus on consulting, medical education, research, long-term care, medical direction and program development. Because of the low reimbursement for each outpatient primary care visit and the extra time needed to see older people in the office, a fee-for-service primary care practice of Geriatric Medicine is rare. Currently there are only about 100 fellows graduating from Geriatric Medicine fellowships every year in the United States. Geriatric Medicine is considered a critical shortage specialty.

A strong Geriatric Medicine curriculum is an important component of the JABSOM Family Practice residency program. The goals of the residency reflect an interest in developing family practice physicians for whom geriatrics will be an expanding part of their practice. In addition, the program assists the resident to improve their resident performance in geriatrics on both the Family Practice in-training examination and the American Board of Family Practice certifying examinations.

The Geriatric Medicine rotation in the Family Practice residency consists of a one-month block for third-year residents. Residents train at different sites, including, the Mililani Physician Clinic, Wahiawa General Hospital for acute care, the hospital’s 100-bed Skilled Nursing Facility and Rehabilitation Center, home visits, and a network of community resources. Patients are first seen by residents who then present them to an attending and supervising physician assigned to help them formulate management plans.

The curriculum developed for the Family Practice residency consists of both didactic and clinical experiences throughout the 3 years of residency. This rotation for third-year residents provides both integrated and longitudinal training.

**Integrated:** The geriatrics curriculum is integrated into an existing structure so that all faculty will include relevant aspects of geriatric medicine into existing rotations. For example, during a general medical ward rotation, residents will explore geriatric topics, such as pharmacology in the elderly, functional assessment, the differentiation between dementia and delirium, and methods to limit the use of restraints and indwelling bladder catheters.

**Longitudinal:** Residents will care for a panel of patients for a 24-48 months period in a community and in an institutional setting. There will be a conference series where each presentation builds upon the knowledge base previously attained. Longitudinal experiences will allow residents to follow patients long enough to see the results of their medical decision.

**Specific Clinical Experiences**

**Block rotation:** Residents will focus exclusively on Geriatric Medicine for at least 1 month. This permits trainees to master a significant amount of material and apply it throughout the rest of their training program.

**Multidisciplinary teams:** Practitioners in other disciplines will contribute to the residents’ knowledge about their patients. This will allow the residents to focus on clinical management, social and ethical problems, and functional issues.
Home visits: Residents will learn to assess and assist in keeping patients at home. In addition, they will also learn about the reasons for institutionalization and the current limitations of community-based home services. Finally, they will be able to examine the home environment and gather accurate nutritional and medication history. Home visits will be made to patients well known to residents, for example, people discharged from the resident’s acute medical service or their continuity clinic.

Consultations: Prompt and effective consultations will help to build the geriatrics educational program by focusing on difficult management issues or complicated patients. Common consultation problems will include comprehensive assessments before a decision is made related to institutionalization, altered mental status, multiple medical problems, or preoperative assessments.

Nursing Facility: Although the majority of older people do not reside in nursing homes, those who do present challenging care problems. Residents will learn how to practice and understand the differences in management and regulations that govern their care in an acute hospital and a nursing facility. The nursing home experience is longitudinal, with a resident following four to eight patients over several years. The role of the medical staff and the regulations that govern medical care in a nursing facility will be covered both in the block rotation in geriatrics and in the longitudinal experience. Residents will participate in case conferences with the families and with the other professionals involved in the resident’s plan of care.

Family Counseling: Family Practice deals with the care of the individual in the context of their family and social network. The intergenerational issues that form the background of a person’s health and well-being are important to the understanding of the individual. Family issues in geriatrics are important as elders consider their historical and financial legacy, and contemplate the value of their lives in a social and spiritual context. Residents will learn to handle the family dynamics of emotionally charged issues such as moving to an assisted-living facility, moving in with relatives, permanent placement in institutional care, naming a designated surrogate or power of attorney, and making advance directives. Serious unresolved sibling rivalries may resurface when siblings become involved in decisions regarding their parents.

Compassionate caregiving: Patients suffer not only physically but also emotionally and spiritually. The need to provide both care and compassion is the underpinning of the educational goals.

The new geriatrics curriculum in the Family Practice Residency Program consists of a well-defined curriculum delivered through didactic and clinical experiences, case discussions, problem-solving conferences, discharge planning rounds, interdisciplinary care, and meetings with community agency staff, such as visiting nurses and community social workers. A strong training experience in geriatrics will help Family Practice residents provide overall primary care to older patients.

References

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The Importance of Biostatistics to Cancer Research

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Overview. Statistics is defined by the Merriam-Webster Collegiate dictionary as “a branch of mathematics dealing with the collection, analysis, interpretation, and presentation of masses of numerical data.” In practice, statistics is multi-disciplinary, in that it uses the tools of mathematics and computing to answer questions in other fields. Statisticians are members of research teams, who must become knowledgeable about the field of application, in order to understand the data issues. Statisticians are committed to the scientific method, believing that well-designed research studies with good data collection techniques are essential for uncovering the truth. Statisticians are specialists in understanding the nature of uncertainty in data and accounting for it in the design and analysis of research studies. Biostatistics involves the development and application of statistical techniques specifically to scientific research in biological sciences and health-related fields, including medicine, epidemiology and public health.

Biostatisticians are involved in every step of a research project. They help formulate scientific questions to be answered, determine appropriate sampling techniques, coordinate data collection and management procedures, and carry out statistical analyses to answer the scientific questions. They ensure that the data meet the assumptions of the statistical model or test being used and develop new statistical techniques as needed. Biostatisticians use the tools of data base management and statistical programming.

Specific areas of study in cancer research that require statistics include clinical trials and group intervention trials, epidemiology, environmental science, genetics and molecular biology.

Clinical Trials and Group Intervention Trials. Clinical trials in cancer research are experimental studies where patients are, in general, randomly assigned to receive different cancer treatments. Commonly, a new treatment is compared against the standard care for the particular type of cancer under study. Researchers may hypothesize that a new therapy improves survival or is safer for the patient. Pharmaceutical companies use clinical trials to determine the effectiveness of new therapies, and the National Cancer Institute uses the results of national clinical trials to make recommendations on standard care for cancer patients. CRCH’s Clinical Trials Unit coordinates these national clinical trials for the patients in Hawai‘i. Statisticians are involved in the design and analysis of these experimental studies. Determining the appropriate sample size for clinical trials is very important, as a study that is too small will not be able to answer the question of interest. Also, a study that is larger than needed may expose more patients than necessary to an experimental therapy, before safety issues are adequately understood. Statisticians develop randomization schemes to help ensure that the treatment groups are similar in important prognosis factors, other than the therapy under study. If treatment groups differ on important prognosis factors, such as age, the question of which therapy is better will be more difficult to answer. Randomization to treatment generally results in groups that are similar in age. Adaptive randomization schemes have been developed for trials with multiple treatment doses to minimize the number of patients randomized to more toxic doses.

Statisticians plan and execute the analysis of clinical trials. The analysis generally involves determining the relationship between the outcome variable and the assigned treatment group. However, certain factors complicate the analysis. Clinical studies often recruit patients from multiple clinics and require multiple measures from patients over time. The analysis of the data must then account for the correlation structure between the data points. Also, patients may withdraw from longer studies. If the data collection mechanism that leads to missing data is related to the treatment or outcome, the analysis must account appropriately for the missing data to derive the correct result. For example, sicker patients may drop out of a study, resulting in the final outcome being available only for patients with a good prognosis. Comparing the treatments only for patients with final outcomes may not give an accurate picture of the benefits of the therapies. Biostatisticians have studied the effect of such missing data and have developed special analysis techniques for dealing with missing data.

Group intervention trials are studies that randomize communities or groups of individuals to an intervention under study. CRCH’s Social and Behavioral Science Program uses these studies to investigate ways to effect behavior change in smoking, diet and sun protection practices at the population level. Analysis of group intervention trials is complicated by the challenge of measuring behavioral change in the community and the fact that communities are randomized to interventions, but measurements are made at the individual level.

Epidemiology. Epidemiology is the study of the distribution and determinants of human disease. CRCH’s Epidemiology Program studies lifestyle and genetic risk factors for cancer in Hawai‘i’s multiethnic population.

In descriptive epidemiology, the extent of the disease problem is measured. The Hawai‘i Tumor Registry of the CRCH reports cancer incidence and mortality rates for the state by sex and ethnicity. Biostatisticians ensure the accuracy of these rates, by comparing the ways data, such as residency and ethnicity, are collected for the numerator and denominator, and making adjustments to ensure that the definitions are similar. Analytic epidemiology uses observational studies to answer scientific questions. Standard research designs are cross-sectional studies, case-control studies and cohort studies. All require appropriate choice of participants, so that the results can be generalized to the larger population that the participants are meant to represent. In observational studies, the relationship between exposures of interest and disease is studied. However, because individuals are not randomly assigned to the exposure, the analysis of these studies is complicated by potential confounding.
from other risk factors. Statistical techniques are used to control for the effect of other factors. For example, a researcher may study the possible protective role of vegetable consumption in the development of lung cancer. Cigarette smoking is known to be a strong risk factor for lung neoplasm, and it has been found that heavy smokers are less likely to eat vegetables. Therefore, careful controlling for tobacco exposure is needed to determine if vegetable consumption truly protects individuals from lung cancer, or is simply a surrogate measure for the extent of tobacco exposure. Another statistical challenge in observational, and even clinical studies, is that most exposures cannot be measured precisely. Most statistical models, however, assume that independent variables are measured without error. In the above example, the long-term consumption of vegetables and exposure to tobacco is usually self-reported by the study participants; this self-report is prone to error in recall. Statisticians determine the level of error in the measurement of exposures and its effect on the results. Special study designs and models have been developed to deal with measurement error in exposure variables.

Environmental Science. Environmental science uses statistics to characterize potential adverse health effects resulting from exposure to environmental hazards. Both the level of exposure present, and the relation between exposure and incidence of disease, are quantified. As an example, the Environmental Protection Agency monitors the level of pollutants in the air and water, and estimates the level of health risk posed. Measuring the level of exposure to environmental hazards in the general population is difficult. For instance, air pollution levels may vary by geographic features, such as proximity to mountains, and by time of day. Biostatisticians determine appropriate sampling methods to determine how best to measure overall exposure.

Genetics and Molecular Biology. Genetics and Molecular Biology are becoming an important component of cancer research. With advances in biotechnology, we can now study structures and functions of genes and particular DNA regions, and their organizations in the human genome. It is now known that certain regions of DNA in our genome play various regulatory roles in controlling human body functions by promoting or silencing the expression of genes. The understanding of DNA and the networks of genes in turn gives us important knowledge of the molecular nature of the development of many diseases such as cancer. Discovering exact functions of various regions of DNA and confirming the associations and/or causations between genetic variations and diseases are the challenges of the Human Genome Project. The completion of the human genome — the genetic blueprint of humankind — has provided researchers large amounts of DNA data. With about 3.1 billion units of DNA in the human genome being available as sequence data, the need to process the information, to reveal hidden patterns and to interpret encoded messages has created new problems that are mostly statistical in nature. A newly emerged science termed bioinformatics is dedicated to the development and application of mathematical, statistical and computational methods in genome research. It certainly falls within the realm of biostatistics, and has also been identified as a part of the field of statistical genetics in the Handbook of Statistical Genetics.

Genetics has already started to be incorporated in cancer research studies. In clinical studies, treatments are being targeted to patients based on gene expression profiles of their tumors. In epidemiology, the role in cancer risk of interactions between multiple genes and between genes and the environment are being investigated. There are a few genotypes that have been found to have a large effect on the risk of cancer, such as a mutation in the BRCA1 gene that has been linked to the development of breast and ovarian cancer. However, these genotypes are generally rare. Susceptibility genes, which affect an individual’s ability to activate or detoxify a carcinogen, are being investigated for their role in cancer development. Most genotypes under study are common and would presumably only affect cancer risk in the presence of a carcinogen.

Future challenges. Cancer research studies are becoming ever more complex, collecting data from multiple sources with varying accuracy. Aggregating and interpreting this data to provide an accurate picture of the underlying phenomenon will require well-trained specialists in biostatistics. In addition, these individuals will be needed to support the projected growth of biomedical research in Hawai’i. However, there is a nationwide shortage of biostatisticians as noted in The Seventh Report to the President and Congress on the Status of Health Personnel in the United States and Objectives for the Nation. The lack of any degree-granting biostatistics program in Hawai’i makes it especially difficult to find people with these skills. The reinstatement of the graduate program in biostatistics at the University of Hawai’i, as well as development of additional statistical training at the university level, would help meet this demand as well as provide a good career option for people in Hawai’i.

For more information, please visit the Cancer Research Center’s website at www.crch.org.
HMA Informed Consent Bill Passes!

Paula Arcena, Executive Director, Hawaii Medical Association

The Hawaii Medical Association, with strong support from many proponents, successfully gained passage of legislation during the 2003 legislative session resulting in a clear standard for the process of Informed Consent.

On May 31, the more than 600 guests of HMA’s Ola Pono Ile dinner dance program witnessed Governor Linda Lingle sign the bill into law. Representative Calvin Say, speaker of the House, and Senator Colleen Hanabusa, chair of the Senate Judiciary Committee, whose support was key to passage of the bill, participated in the bill signing along with approximately 20 other legislators and key participants.

Reform of Hawaii’s Informed Consent law is a critical first step for preventing the malpractice insurance crisis from hitting the shores of Hawaii and negatively impacting patient access to quality care.

Before HMA’s reform of Hawaii’s Informed Consent law, statutes required a physician to inform patients of every “possible” risk, complication and anticipated benefit of medical treatment or surgical procedure. The word “possible” created an impossible standard for any physician to meet and fertile ground for unfair lawsuits against physicians. In fact, suits against Hawaii physicians for informed consent have already resulted in million dollar verdicts. As a consequence, malpractice insurance premiums have increased by as much as 25 percent by MIEC this year.

Passage of the bill was not an easy task. The Hawaii Coalition for Health and the Consumer Lawyers Association made every effort to kill the bills. The Coalition, which represented to legislators that it speaks for 300-400 physicians, testified that changes to the law were unnecessary and physicians simply “resent” the time it takes to properly deliver information to their patients for effective informed consent. Fortunately, HMA’s legislation prevailed despite this opposition.

More work is necessary to ensure that reasonable standards for informed consent are reflected in regulations under the purview of the Board of Medical Examiners and cases heard by Hawaii’s judicial system. The HMA will continue to work in this regard.

Successful passage of Informed Consent legislation is the result of years of groundwork and building credibility with our government decision-makers. The Hawaii Medical Association is the only physician organization that advocates for physicians, regardless of specialty, and their patients, at the State legislature.

We thank those who have supported the bill: HMA members who submitted supportive testimony, MIEC, HAPI, Board of Medical Examiners, Kaiser Permanente, Hawaii Association of Osteopathic Physicians and Surgeons, Hawaii Association of Health Plans, HMSA, Kaiser Permanente, Art Roeca, Esq., Health care Association of Hawaii, Cancer Institute of Maui and Radiology Associates.

To see the bill go to: http://www.capitol.hawaii.gov/sessioncurrent/bills/hb651_sd1.htm

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What Lawyers Lack In Depth, They Make Up In Length.
And the beat goes on. In Massachusetts, a District Court judge overturned a jury verdict that had been found in favor of Alcon-Summit in the eximer laser patent rights complaint against Nidek. Judge Edward Harrington reviewed the jury’s verdict and determined that the evidence provided by Alcon to prove the claim of infringement, was insufficient. He stated that Alcon failed to confront the essential issue, and that there was considerable evidence to support Nidek. Naturally, Nidek is claiming victory and is now free to market its laser, and surgeons who own the device need not worry about being sued for using it. Of course, Alcon lawyers are planning an appeal. How many thousands of corporate dollars have swirled down the drain and into the hands of attorneys in this continuing saga?

God Created Man At The End Of The Week When He Was Tired.
An orthopedic surgeon in North Carolina implanted a device in his patient’s spine which had not been approved by the Food and Drug Administration (FDA). The patient filed a lawsuit claiming that because he had not been told that the FDA had not granted approval, the surgery was performed without his informed consent. The suit was dismissed. The trial court ruled, and it was later affirmed by the North Carolina Supreme Court, that informed consent only requires disclosure of the medical risks. Physicians need not discuss the actions or inactions of a government agency, nor any implications of such action or inactions by that agency.

What Does Viagra Have To Do With Dancing?
In an apparently (?) thoughtless action in August of 1997, the Food and Drug Administration (FDA) allowed TV and radio ads to be offered directly to consumers (DTC) without a detailed presentation of side effects or complications of the medication. “Ask your doctor.” A cynic might suggest that the change in ad regulations occurred because drug lobbyists manipulated the FDA. Whatever. Television drug advertising exploded to $2.7 billion in 2001. Forget the beer and auto ads, the DTC pharmaceutical people have become the big dogs in TV advertising. The drug people claim patients get educational benefits from DTC, but they are far outweighed by the difficulty for prescribing physicians, and the big bite it is putting in medical expenses. It is past time for the American Medical Association and specialty organizations to push for a return to the old FDA rules, as the New Zealand Medical Association has already done.

The Truth Shall Make You Free – And In This Case, Rich!
Now here is a story about early retirement. Two doctors blew the whistle on TAP Pharmaceutical Products for their alleged health-care fraud. TAP was pushing their drug Lupon, an injectable drug used primarily for treatment of advanced prostate cancer, in competition with Zolodex. TAP was controlling the drug price to Medicare, but cutting the price to providers. Moreover, to make it sweeter still, they were giving kickbacks and bribes with free samples, free consulting services, expensive trips to golf and ski resorts, and even “educational” grants. The freebies and kickbacks worked to ensure the prescription of Lupon. Gathering evidence after the whistle blew, the Department of Justice came a-tapping on TAP’s door, charged the company with health care fraud, and fine them $875 million. The award of 17% of the fine, a cool $95 million, goes to the two doctors who sounded the alarm, and that is much better than a consulting contract or a ski trip.

The Worst Thing In The World Next To Anarchy Is Government.
The 342 page Patriot Act was passed by Congress in a stampede, just one month after the September 11 terrorist attacks, giving the federal government unprecedented powers. Attorney General Ashcroft has used “national security letters” to require businesses to hand over electronic records on finances, telephone calls, e-mails and other personal data. His guidelines allow investigators to subpoena private books, records, papers, documents and other items. Librarians and bookstore owners have been forced to secretly hand over information about a patron’s reading and internet habits. And if this isn’t frightening enough, the proposed sequel to the Patriot Act, the “Domestic Security Enhancement Act” would give the feds the authority to wiretap any individual, collect a person’s DNA without court orders, detain people in secret, and revoke citizenship, among other powers!! Now, in an act of nonviolent disobedience, in Arcata, California, the City Council passed a resolution urging local law enforcement officials to refuse requests for cooperation under the Patriot Act if they believe the request violates an individual’s civil rights under the Constitution. Then, the City council went even further passing an ordinance that outlaws voluntary compliance with the Patriot Act. Council member David Meserve (campaign slogan, “The Federal Government Has Gone Stark Raving Mad”) was surprised when his resolution passed 4 to 1 with little debate. Moreover, the ordinance has had near-unanimous approval by the residents. To date, 89 cities have passed resolutions condemning the Patriot Act, and a dozen more are in the works. Here in Hawaii, with echoes of the government sins of 1941, Rep. Roy Takumi introduced a resolution to open discussion of the Patriot Act. It is time for our timid Congress to read over the Constitution and Bill of Rights, and remove many of the deplorable portions of the “Patriot Act” and the “Homeland Security Act.”

When You Game The System, Be Certain Of The Ground Rules.
Did the house staff do the work, or did the faculty physician? An audit of Medicare billing practices will now cause teaching institutions to correctly document faculty oversight. The federal bean-counters scanned the billings, and presented some sizeable bills. Johns Hopkins University paid the feds $800,000 in response to over-billing issues. But that is chump change compared with University of Pennsylvania Medical School which paid $30 million, University of California (five schools of medicine) coughed up $22.5 million, University of Pittsburgh gave back $17.3, and some others were Florida College of Medicine $8.6 million, Medical College of Wisconsin $8.9 million, Medical University of South Carolina $5.2 million. It is ever so true. Improper or lack of documentation can cause pain in any number of ways.

Alcohol: The Enemy Man Has Learned To Love.
Emergency rooms and ER physicians are required to manage trauma. At least 1/3 of injuries treated in the ER are from alcohol related auto crashes, and another large percentage are domestic violence and street brawls involving booze. There is a direct causal connection between excessive alcohol use and ER services. In California, last year alone, physicians lost $150 million in uncompensated medical care, and hospital ER’s, $390 million. Since 1990, sixty hospital emergency departments have shut down. Now in an effort to recoup losses from alcohol related crashes where the ER people end up holding the bag, California lawmakers want to place the burden where it belongs; the liquor industry. The Senate committee passed a bill that would collect a 5 cent fee per drink from wholesale distributors of distilled spirits, wine and beer sold in the state. If it becomes law, $700 million marked for uncompensated emergency services, would be added to the state budget. In a poll of over 1000 registered voters, nearly 80% were in favor of the tax.

ADDENDA
❖ A scallop has 35 eyes - all of them blue.
❖ Galileo went blind by studying the sun through telescopes.
❖ While Peter Jennings was doing the ABC news, a typewritten line of current events was running below the picture. Somebody with an unusual sense of humor, perhaps dyslexia, or maybe a Freudian slip, had written that Alan Greenspan had gone to the hospital for care of an enlarged prostate. Okay, there is nothing wrong with that. Aiding a portly lady of the night may be just as useful as worrying over the interest rate.
Aloha and keep the faith - rtst

Contents of this column do not necessarily reflect the opinion or position of the Hawaii Ophthalmological Society and the Hawaii Medical Association. Editorial comment is strictly that of the writer.
Fiercely Loyal Banking means providing our customers with the very best financial services. In this case, a portfolio management alternative for institutional investors and affluent individuals who appreciate working with professionals right here at home. It’s part of our company’s ever-expanding vision of delivering customer-focused and customer-loyal services. With nearly 100 years of combined experience in portfolio management, our new Asset Management Division is a bold addition to our proven Trust and Private Banking Divisions. Together, these three divisions now have enhanced capabilities to help you manage, grow and transfer your wealth.

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In uncertain times, seek the high ground

TIMES ARE TOUGH IN PROFESSIONAL LIABILITY INSURANCE—again. Insurers are restricting coverage, leaving the market and some have disappeared. MIEC was founded by doctors in similar turmoil in 1975.

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