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Ulana

Ulana means to “weave” in Hawaiian. Shown here is a basket being made of pandanus leaves.
MESSAGE FROM LIEUTENANT GOVERNOR MAZIE K. HIRONO
Hawaii Medical Journal
Women’s Health Month 1999

As Honorary Chair of Women’s Health Month 1999, I invite you to join me, health care providers across the state, The Department of Health, The Hawaii State Commission on the Status of Women and all our participants in celebrating Women’s Health Month this September. Throughout Hawaii numerous events will inform, educate and help to focus public attention on the issues that impact women’s health.

This month-long public awareness campaign allows professionals from many fields to share knowledge through interactive, informative and entertaining events. Our goal is to increase understanding of women’s health related issues and to provide access to the many resources available. We look forward to further collaboration with all of you.

Mahalo to all the past and present participants for their support of the women of Hawaii. We encourage all of you to become involved in Women’s Health Month 1999 and share in this important community effort.

Aloha,

MAZIE K. HIRONO
Aloha! I am pleased to be participating in this special women’s health issue of the Hawaii Medical Journal.

As a surgeon for many years specializing in breast cancer, women’s health is a primary concern to me. Women’s health is enjoying unprecedented attention and we are beginning to see long overdue improvements. Yet, we still have a long way to go to fully appreciate and improve the entire spectrum of women’s health issues. The articles in this issue of the Hawaii Medical Journal highlight just a few of the broad array of issues affecting women’s health.

Why is women’s health so important? In addition, to having their own unique health needs, women frequently respond differently than men to treatments for health problems which they share with men. Outcomes from medical research on men are not always applicable to women. Also, in spite of the expanding number of career women, women are still the predominant caregivers in the family and make eighty percent of the health care decisions in families.

Preventive health has always been important to me. With my new role in the State Department of Health, I am even more aware of the power of preventive health in the overall public health of all of the people of Hawaii. Unhealthy habits and lifestyles account for the majority of health problems which all of you treat every day.

September is Women’s Health Month. It is a time for women. It is also a time for physicians and the entire health care industry to recognize the unique health care needs of women and ensure that women have fair and equal access to top quality, affordable health care services. This includes attention to counseling our patients on healthy lifestyles. In spite of the increasing autonomy and empowerment of women, women still respect the advice of their physician. Let us accept the challenge.

Virginia Morriss Pressler, M.D., M.B.A.
Deputy Director for Health Resources
Hawaii State Department of Health
Welcome Dr. Ricketson and Dr. Sato to the Big Island community. Hilo Medical Center can now provide on-site and on-island emergent and elective neuro and spinal surgical services. Through these expanded services, Hilo Medical Center continues to care for its community.

Robert Ricketson, MD
Spinal Surgery

Ken Sato, MD
Neurosurgery

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Hawaii Laborers Health & Welfare Trust Fund
Aloha Care Quest
Kaiser Quest
Kapiolani Health Hawaii Quest
Straub Care Quantum
Veteran's Administration
HMAA
Worker's Compensation

HAWAII EMERGENCY PHYSICIANS ASSOCIATED, INC.
and
HILO MEDICAL CENTER

Hilo Medical Center
We Care for Our Community

Robert Ricketson, MD
Spinal Surgery

Ken Sato, MD
Neurosurgery

HAWAII EMERGENCY PHYSICIANS ASSOCIATED INC.
P.O. Box 1266 • Kailua, HI 96734 • (808) 261-3326 • Fax: (808) 262-0514
The Hyperbaric Treatment Center (HTC) at Kuakini Medical Center is a vital service that meets the needs of SCUBA divers not only in the State of Hawaii but throughout the Pacific. The center is one of the University of Hawaii John A. Burns School of Medicine (JABSOM) direct links to the community which provides essential patient care. HTC also provides training for residents in a unique field of medicine. These residents learn to treat decompression illnesses (DCI) and to administer Hyperbaric Oxygen Treatments (HBO) for a broad range of ailments. HTC not only meets the needs of divers and teaches physicians the clinical skills needed to treat DCI but also offers the Medical School opportunities for research.

Hyperbaric Medicine was first used in the 19th century, when compressed air was used to help facilitate the construction of tunnels and bridge piers. This new technology was later adopted by the medical community to hyperoxigenate the blood. Hyperbaric Oxygen has continued to evolve since the 19th century into a research based tool, not only to treat Decompression Sickness but also for other medical problems.

During the early 1980’s the then governor of the State of Hawaii, George Ariyoshi, was notified by the US Navy (USN) that they could no longer provide humanitarian treatment of civilian divers. The Navy had provided this care for divers in the State since the introduction of self contained underwater breathing apparatus (SCUBA) gear in the early 1950’s. The Governor identified JABSOM as a source of expert medical advisors and requested that the School provide him with an opinion on the most prudent course of action to provide for care to injured divers. The Dean of the School of Medicine convened a group of interested faculty members and appointed the Chairman and Professor of Pathology, Dr. John Hardman, to lead the group. The Committee produced an extensive report informally titled as the Hardman Report. It provided recommendations on the establishment of a center, the equipment that should be purchased, and other details. With that effort, the foundation for the involvement of the John A. Burns School of Medicine with the Hyperbaric Treatment Center was established.

The most important and critical contribution that the School of Medicine provided the Hyperbaric Treatment Center was the talent, energy and background in academic diving medicine of Dr. Edward L. Beckman, Professor of Physiology. Dr. Beckman, an ex-Navy Captain, had been involved in diving and aerospace research throughout his entire career. To this day, the HTC utilizes treatment tables developed specifically for divers in Hawaii by Dr. Beckman. He was one of six (6) founding members of the Undersea Medical Society, now known as the Undersea & Hyperbaric Medical Society (UHMS). The UHMS is the professional society of clinicians and research scientists who work and study in the field of diving and hyperbaric medicine.

Dr. Beckman served as HTC’s Medical Director and provided the Center with not only his expertise and clinical treatment skills but continued his research, experiments and studies. He established an interest group of faculty members, community physicians, Navy Medical Officers and the HTC Medical Staff named the Research Advisory Committee (later known as the Medical Advisory Committee). Through its quarterly meetings this group provided information on current diving medicine research and clinical cases presented to the HTC. The meeting provided the HTC medical staff experience in the academic and scientific environments. It was an impetus to bring the most talented, interested members of the community together. Dr. Beckman encouraged continually academic curiosity and high research standards.

Dr. Robert Overlock, HTC’s current Medical Director, initiated a collaboration with JABSOM’s Residency Program to provide all residents an elective in hyperbaric medicine. This elective permits the residents to join the HTC’s staff for one month to study the clinical aspects of diving accident management and hyperbaric oxygen therapy. Since diving is popular year round in Hawaii, the residents are exposed to divers who suffer from DCI. Without this elective, the residents are not likely to be exposed to any type of Hyperbaric Medicine. Many residents come from the mainland to train in an academic and clinical setting that would otherwise not be possible. Through this elective the residents utilize Problem Based Learning (PBL) format.

Dr. Overlock also provides a monthly Diving Medicine course geared mainly for emergency medicine residents and other medical professionals. This course includes an overview of physics, physiology, dive accident management and hyperbaric oxygen therapy (HBO) and provides an overview of how treatment can relieve the symptoms of DCI and how hyperbaric oxygen therapy can be an adjunctive therapy to many health problems. Hyperbaric oxygen therapy is generally approved for select medical indications including: carbon monoxide poisoning, acute smoke inhalation, crush injuries, compartment syndrome, exceptional blood loss, gas gangrene, chronic refractory osteomyelitis, radiation necrosis, prevention of compromised skin grafts, moderate or severe thermal burns and necrotizing fasciitis.

Hyperbaric oxygen is 100% oxygen delivered at greater than atmospheric pressure. Except for its proven efficacy in treating DCI, HBO was not taken seriously as a treatment modality until the 1950’s. It was then investigated for treatment of carbon monoxide poisoning, support of oxygenation during cardiac surgery, and treatment of anaerobic infections. Today HBO treatments are used as an adjunctive therapy for the various health problems noted above. The beneficial effects of HBO include: stimulating blood vessel growth, reducing edema, and improving the host response to fight infection. Routine HBO treatments last for a total of 2 hours and 8 minutes at a maximum depth of 47 feet. Currently, the HTC at Kuakini administers HBO treatments daily. The usual regimen for a patient is 30 to 60 treatments.

Dr. Overlock comments, “Our treatments work extremely well for the majority of patients referred to us. There are a few whose illness does not respond as well as we would like, but they are in the minority. The best way to find out if HBO treatments will work for an individual is to have your physician call us for a consultation.”

DCS or what is commonly known as “the bends” afflicts a small percentage of divers but can be a life threatening illness. When breathing compressed air at depth, divers accumulate excess nitrogen in their body tissues. The normal air mixture is 80 percent nitrogen and 20 percent oxygen. When divers follow the dive tables there is not likely to be any ill effect from the nitrogen build up. Problems occur when safe diving recommendations are overlooked or the individual is predisposed to DCS. The build up of nitrogen produces millions of bubbles in the body’s tissues upon ascent. As the diver reaches the surface these bubbles can cause pain and other symptoms. In the severe cases the bubbles can form in the brain or spinal cord and can result in paralysis or even death.

The HTC at Kuakini is the only facility of its kind which utilizes a maximum treatment depth of 280 feet. Through the center’s own research, this prescription is suggested as more effective, and produces results more quickly than treatments at other centers. HTC meets the specific needs of Hawaii due to the popularity of diving in Hawaii, it is not simply an asset, but a necessity to the Islands. Services are available 24 hours a day seven days a week for any emergency DCS cases. Beyond the HTC’s impact upon the Hawaiian Islands, the Center treats patients from the farthest reaches of the Pacific. HTC provides information to the Divers Alert Network (DAN), a national agency for divers, which studies DCS and symptoms to provide an increased knowledge base for all recreational, commercial and Navy divers.

The University of Hawaii JABSOM supports this effort with both the vital connection to talented, academic leaders and an avenue for an organizational structure for further development and provide an essential service to divers on the islands and throughout the Pacific Basin. In return the HTC represents the John A. Burns School of Medicine with a direct link to the community. It also continues the School of Medicine’s research mission and serves as a unique and valuable training environment for residents.
 Millions of dollars are spent each year on research to prevent and treat cardiovascular disease, cancer, and other diseases in order to improve health outcomes for women in the United States. The impact of this research on longevity and quality of life is significant. However, it pales in comparison to the potential impact of a single known preventable cause of most of these diseases - tobacco use. Cigarette smoking is by far the number one preventable cause of death in both men and women. While the death rate for tobacco related disease for men has leveled off, rates among women continue to rise. More than 140,000 women in the United States die each year as a result of smoking related diseases, including cardiovascular disease; lung cancer; chronic lung disease; pancreatic, oral, esophageal, laryngeal, urinary, and cervical cancers; and lower respiratory infections.

Cardiovascular Disease

Cardiovascular disease, particularly coronary heart disease and stroke, is the major cause of death among women in the United States and in most developed countries. Cigarette smoking is the leading preventable risk factor for CVD in women, with more than 50% of myocardial infarctions among middle-aged women attributed to tobacco. Carbon monoxide, which inhibits oxygen transfer to the blood, and nicotine, which increases the heart rate and blood pressure, are just two of the multiple factors in smoking that increase the risk of myocardial infarction. Women smokers who also take oral contraceptives have a 10-fold increased risk of myocardial infarction compared to nonsmoking women.

Cancer

Tobacco use accounts for nearly one third of all cancer deaths, and more than 80% of lung cancer can be directly attributed to cigarette smoking. Between 1960 and 1990, the lung cancer death rate among women increased by more than 50%, and the rate is continuing to rise. While much recent attention and funding have been targeted to breast cancer, mortality from breast cancer is declining by 1-2% annually. Less known is the alarming fact that lung cancer surpassed breast cancer in 1987 as the number one cause of cancer death in women. (Figure 1.) The American Cancer Society estimates that in 1999, lung cancer will kill 68,000 women and breast cancer will kill 43,300 women.

Recent studies have discovered an interesting phenomenon demonstrated by an unusual increase in lung adenocarcinoma; nearly 17-fold in women and nearly 10-fold in men. Lung adenocarcinoma has replaced squamous cell carcinoma as the most common histologic subtype of lung cancer. Since such changes in cancer type are rarely observed, scientists have found this perplexing for years. Researchers now attribute this change in histopathology to the manufacturer's modification in cigarette composition and gender selection choices. High-tar, nonfiltered cigarettes, generally preferred by men, are perceived as too toxic and harsh for smokers to inhale deeply. The inhalation of such high-tar cigarettes tends to deposit the carcinogenic agents in the more central regions of the lung leading to the development of squamous cell tumors. In contrast, smokers of filtered low-yield cigarettes (advertised as light, mild, low tar/nicotine, etc.) inhale more deeply and develop adenocarcinomas at the lung's periphery. This hypothesis is offered to explain why women, who have historically smoked filtered low-yield cigarettes, are having a higher prevalence of adenocarcinoma.

Tobacco use is also a major risk factor in cancers of the mouth, throat, esophagus, kidney, pancreas, bladder and cervix.

Figure 1. In 1987 Lung Cancer surpassed Breast Cancer as Number One cause of Cancer Death in Women

Source: American Cancer Society.
*Rates are adjusted to the 1970 census population.
Respiratory Diseases

In addition to cancer, tobacco smoking is responsible for non-neoplastic bronchopulmonary disorders and increased frequency of respiratory symptoms and illnesses. The death rate due to chronic obstructive pulmonary disease among women who smoke is also on the rise. Nearly 80% of persons with emphysema are current or former smokers. The prevalence of chronic bronchitis, chronic cough and sputum production varies directly with the number of cigarettes smoked daily.9

Environmental tobacco smoke causes lower respiratory tract infections in adult women as well as chronic middle ear disease, reduced lung function, exacerbation of existing asthma, and increased risk of new cases of asthma among children.10 Every year in the U.S. between 8,000 and 26,000 children are diagnosed with asthma attributed to mothers who smoke at least 10 cigarettes a day. Between 200,000 and 1 million asthmatic children have their condition worsened by exposure to second hand smoke.11

Reproductive Health

Women of reproductive age face increased adverse consequences of smoking. The irony is that smoking rates are highest among women at the height of their childbearing years (age 25-44). Several epidemiologic studies have suggested that smoking decreases fecundity in women. The probability of conceiving per cycle is reduced by one-third.12,13,14 Smoking is further associated with premature menopause. Women smokers experience menopause from one to three years earlier than nonsmokers.12,15

Smoking during pregnancy is causally linked to intrauterine growth retardation, fetal loss, low birthweight infants, respiratory distress syndrome and other respiratory conditions of the newborn, and sudden infant death syndrome (SIDS).16,17,18 The risk of SIDS is twice as high for infants born to women who smoked during pregnancy and higher yet among infants exposed to postnatal smoking.14

Approximately 18%-20% of pregnant women in the United States smoke during pregnancy.19 Data reveal that although one-third of women who smoke at the beginning of pregnancy will quit smoking for the duration of the pregnancy, 60% of these women relapse within the first 6 months postpartum, and 80%-90% will return to smoking by 12 months postpartum.20 Women who smoke expose their infants to tobacco in the postnatal period. This exposure increases respiratory diseases in newborns, infants, and children. Children of smoking mothers are also more likely to become smokers themselves.21

Despite the known health risks, women continue to smoke at high rates. In the United States, 22% of women are smokers.22 In Hawaii, 17% of women over 18 years of age are current smokers,23 but the statistics for adolescent girls are particularly alarming. Thirty-one percent of high school girls in Hawaii are frequent smokers compared to 27% of high school boys. The level rises to 38% of 12th grade girls who report frequent smoking.24

What can physicians do?

Women initiate smoking for many reasons including social accept-
tance, body image and weight control. The tobacco industry has done an outstanding job of appealing to the insecurities of adolescence and equating smoking to emancipation, success, beauty, and

---

**Figure 2. Smoking Intervention Model**

<table>
<thead>
<tr>
<th><strong>ASK About Smoking at Every Visit</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Document by vital signs stamp, progress notes, computerized record, or chart stickers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ADVISE All Smokers to Quit</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Advice should be clear, strong and personalized.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ASSIST Smokers in Quitting</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Assess motivation to make a quit attempt:</td>
</tr>
<tr>
<td>Ready to Quit Now:</td>
</tr>
<tr>
<td>✓ Identify reasons for wanting to quit.</td>
</tr>
<tr>
<td>✓ Develop a quit plan:</td>
</tr>
<tr>
<td>● set quit date within 2 weeks</td>
</tr>
<tr>
<td>● review previous quit attempts</td>
</tr>
<tr>
<td>● identify smoking triggers and anticipated challenges</td>
</tr>
<tr>
<td>● brainstorm strategies</td>
</tr>
<tr>
<td>✓ inform family, friends and coworkers</td>
</tr>
<tr>
<td>✓ Provide self-help materials and referrals.</td>
</tr>
<tr>
<td>✓ Encourage nicotine replacement therapy (patch, gum, nasal spray, inhaler) or non-NRT (bupropion-SR) unless contraindicated.</td>
</tr>
<tr>
<td>✓ Give advice on successful quitting: total abstinence; avoid alcohol; have a plan for dealing with smokers in the house.</td>
</tr>
<tr>
<td>Not Ready to Quit Now:</td>
</tr>
<tr>
<td>✓ Use the 4Rs to enhance motivation to quit:</td>
</tr>
<tr>
<td>● Relevance- Provide patient-specific information.</td>
</tr>
<tr>
<td>● Risks- Ask Patient to identify the negative consequences of smoking.</td>
</tr>
<tr>
<td>● Rewards- Ask patient to identify benefits of quitting.</td>
</tr>
<tr>
<td>● Repetition- Repeat every visit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ARRANGE Follow-up</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>If Quit (Relapse Prevention):</td>
</tr>
<tr>
<td>✓ Congratulate, encourage maintenance.</td>
</tr>
<tr>
<td>✓ Review benefits from cessation.</td>
</tr>
<tr>
<td>✓ Review problems encountered, offer possible solutions.</td>
</tr>
<tr>
<td>✓ Anticipate problems or threats to maintenance (weight gain, depression, prolonged withdrawal, lack of support).</td>
</tr>
<tr>
<td>✓ Timing: Contact soon after quit date, preferably during first week, and within first month; further follow-up as needed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If Quit Attempt unsuccessful:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Ask for recommittment to total abstinence.</td>
</tr>
<tr>
<td>✓ Remind patient to use lapse as a learning experience.</td>
</tr>
<tr>
<td>✓ Review circumstances that caused lapse.</td>
</tr>
<tr>
<td>✓ Develop new plan with patient.</td>
</tr>
<tr>
<td>✓ Timing: Contact soon after NEW quit date, preferably during first week; further contacts as needed based on new quit plan.</td>
</tr>
</tbody>
</table>

Center for Tobacco Prevention and Control Preventive & Behavioral Medicine University of Massachusetts Medical School

In Partnership with the Massachusetts Tobacco Control Program

"It's Time We Made Smoking History"
other desirable characteristics. Adolescents are unaware that they are being manipulated by the clever and seductive marketing.

Physicians play a key role in affecting smoking behavior. Over 70% of adult female patients want to stop smoking, but only half of them have been urged to quit by their physician or other health care provider. Physician advice has been shown to be the most important factor in getting patients to initiate smoking cessation.

Recommendations on smoking cessation from the Agency for Health Care Policy and Research (AHCPR) are summarized in a Smoking Intervention Model (Figure 2.) provided by the Center for Tobacco Prevention and Control, Preventive & Behavioral Medicine at the University of Massachusetts Medical School. Copies of the full report, Clinical Practice Guideline on Smoking Cessation, and guideline products are available by calling AHCPR Publications Clearinghouse toll-free at 800-358-9295 or writing: AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907.

Pharmacotherapy using nicotine replacement and/or bupropion has expanded effective treatment options for physicians. Combining pharmacotherapy with intensive behavior interventions further increases abstinence rates.

Physicians who deal with women’s health can contribute more to health care outcomes by advising women to stop smoking than by any other single intervention. When we put the entire spectrum of women’s health in perspective, tobacco is a real lady killer!

References
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A Review of Male Violence Against Women in Hawaii

Deborah A. Goebert MS

Abstract
This review attempts to emphasize the urgency in addressing issues of violence against women in Hawaii. It demonstrates that violence against women is a significant, challenging, and often overwhelming and overlooked public health problem. While attention to this problem has dramatically increased, more needs to be done to end violence against women and improve the well-being of women and our society as a whole.

Introduction
Acts of violence are everyday events in the lives of women in Hawaii, impacting all women whether or not they directly experience violence. Violence occurs in the home, at the workplace, and in the community. It is most typically perpetrated by a man known to the woman with at least one in ten women experiencing violence any given year and as many as four in five women experiencing violence at some time during their lifespan. This equates to one woman every nine seconds. However, these figures are extremely suspect, and most likely conservative, due to the high degree of under-reporting. Violence against women is, therefore, a significant public health issue in Hawaii.

The direct health consequences of violence against women are multiple. Health implications include, but are not limited to, physical injuries, rape, suicide attempts, substance abuse, miscarriage, gynecological symptoms, psychosomatic complaints (head aches, muscle aches, sleep disturbances, and eating disorders), and psychiatric illness. However, these health consequences represent only the most linear effects of violence. Violence against women impacts many other lives. For example, disturbances in social and emotional development, long-term psychological sequela and an increased propensity for aggression have been identified among children that witness violence. Studies also indicate that the abuse of women in the home begins before the abuse of children. As a result of sexual assault, marriages, jobs, and family and social networks may be jeopardized. Additionally, violence against women can threaten and shape every woman’s life, even when she herself is not a victim. Its affects can be seen in the choices women make—where they choose or are allowed to work; what events they feel safe attending; when and where they walk; what they say and do at home.

However, it was not until 1971 that research efforts focused on violence against women as distinct from child abuse or psychiatric studies. Perhaps even more startling is that the United Nations has only recently recognized it as a fundamental abuse of women’s rights and passed the declaration on the elimination of violence against women regardless of custom, tradition or religious consideration. Women from the Pacific nations were the first to express strong regional concern about violence against women, stating that fear of male violence is the worst aspect of being female as early as 1988. In Hawaii, early efforts are documented by the first spousal abuse law in 1972 (HRS Section 709-906, Abuse of Family and Household Members). Since then, efforts to prevent and intervene have dramatically increased. However, major gaps remain.

This review article describes the epidemiology of violence against women in Hawaii and the difficulties in estimating the extent of the problem. It also highlights implications and strategies for health care providers.

Epidemiology
Estimates provided in this article are based on local data, when available. However, there are only a few studies that have been conducted locally. This information is accentuated by national and international surveys from populations deemed comparative to Hawaii’s based on inclusion of indigenous, immigrant and dominant cultures. Unfortunately, all of these sources provide discrepant estimates. Accurately estimating rates of violence against women is hindered by the lack of data. There are no epidemiologic, periodic, nor standardized databases from which to reliably estimate the extent of violence against women. There is sufficient literature to suggest that under-reporting is a problem and, as a result incidence and prevalence estimates are low, for example, see 11,13-15

While crime statistics and clinical studies indicate a serious problem, they are gross underestimates when compared with epidemiological surveys. The following information demonstrates that violence against women in the home, the work place and the community clearly poses a serious threat to the health and safety of women in Hawaii, even when glaringly undercounted.

Violence in the Home
The most frequent type of violence against women is abuse of women by their current or former intimate male partners, a form of violence in the home or domestic violence. Estimates of women abused by their partners vary from 10% in the last year to as much
as 80% over the course of their lifetime. However, Hawaii’s lifetime estimate, extrapolated from a Kauai survey, is only 14% with an additional 6% of women who reported the abuse to no one. This seemingly low figure equates to nearly 50,000 women in the State of Hawaii. Additionally, more than one third of women studied stated that they knew someone who had been hit, kicked or beaten up by someone in the household. This discrepancy whereby a greater percentage of respondents have personally known an abused woman than admit to being abused themselves has been found in other studies of non-metropolitan areas. It is considered to be a more accurate estimate.

Data from police records provide an even lower estimate of the incidence of violence in the home in Hawaii. There were approximately 7,000 police reports of misdemeanor domestic violence and over 4,000 arrests in Hawaii during 1994. Of these, only 3,000 misdemeanor cases and a few hundred of other felony abuse cases were referred to the prosecuting attorneys’ offices. The discrepancy between incidents reported to police departments and those referred to prosecuting attorneys’ offices discoursages women from reporting. While nearly all of the incidents took place in the home, police incident reports reveal that neighbors were most likely to call and report escalating domestic disputes.

The majority of women murdered are killed by present or former partners. Locally, from 1989 to 1992, nearly 100 women were killed by men in Hawaii—and most of the killers were partners, family members, or acquaintances. The risk of being killed by one’s significant other 1.3 times higher for women than for men. In a similar Hawaii study conducted by the Attorney General’s Office using crime statistics from 1985-1994, 29% of all homicides were the result of domestic violence. Of these, women were victims in the majority of cases (63%) and men were the offenders in 87% of cases. While the absolute number of murders in Hawaii have remained relatively stable, the percentage of women murders has almost doubled, primarily as a result of spousal homicide.

Homicides between intimates, regardless of whether the victim is male or female, are often preceded by a history of physical and emotional abuse directed at women. In most domestic violence situations, the violence increases in both severity and frequency over time. Most victims are killed when they try to flee from their abusers. Of those women killed by their partners in Hawaii, 60% were killed after they had left the relationship. When a woman kills her partner, it is usually in self-defense.

Additionally, violence in the home is often a precipitating factor for suicides and suicide attempts by women. Abuse may be the single most important precipitant for suicide attempts by women yet identified. In Hawaii, partner conflict in the form of verbal or physical abuse preceded most suicide attempts by women. Violence, either an actual assault or fear of it, is inferred in many suicides, accounting for 41% of female suicides in Fiji. Attempted suicide, particularly repeated attempts, is a sequela of abuse among women that affects one abused woman in ten.

The extent of violence against women in the home can also be estimated from service utilization records. Victim assistance programs in Hawaii provided services for over 6,300 women who were victims of domestic violence in 1994. Additionally, the four largest domestic violence shelters provided a safe haven to over 1,400 victims who were forced to flee their homes in order to survive. Questionnaires were completed by 311 victims of domestic violence that had accessed services around the state in the Statewide Domestic Violence Survey. Respondents reported escalating violence, frequently with more than one type of violence such as beating, sexual assault and/or verbal abuse and the use of a weapon including guns, knives, household object, and vehicles.

**Work-related Violence**

Violence is pervasive in the workplace. Historically, work-related violence has been narrowly defined to include only physical assault and homicide that occurs at the workplace and that is associated with work activities. Recently, the definition has been broadened to include forms of aggression such as verbal threats, abuse, harassment and any assault or threat that produces psychological harm. Although reporting to the Hawaii Department of Labor is required by OSHA standards, there are no published documents with local data for violence against women in workplace.

Homicides are a major cause of death among workers. However, only 6% of all people killed at work are females. While the overall occupational injury death rate for men is 12 times higher than the rate for women (9.9 versus 0.8 per 100,000 workers), the male to female ratio of occupational death rates is the lowest for homicide at only 3 to 1. Among women, the leading cause death in the workplace is murder, accounting for 40%.

The impact and cost of work place homicide are far outweighed by the prevalence of physical assaults, abusive behavior and threats of violence at work, much of which remains unreported and unrecognized. While few studies have documented non-fatal events associated with physical assault, their findings are consistent. Unlike workplace homicides, the majority of non-fatal assaults that involved lost time from work occurred to women. Women had an assault rate of nearly twice that of men (51 versus 26 per 100,000 workers), with the highest assault rates among those employed in health and social services.

Sexual assault in the workplace has not been well studied. Utilizing workers compensation claims from Washington State from 1980-1989, 63 cases of work-related sexual assault were identified during this period. The occupations of sexual assault victims were similar to occupations identified for other intentional injuries, primarily health and social services, and the incidents were characterized by isolation from the public and coworkers.

A considerable proportion of threats and harassment in the workplace are perpetrated by co-workers and supervisors (37% and 86%, respectively). Data from a nationwide survey using a random, representative sample of 600 civilian workers shows that 19% of respondents reported being harassed in the last 12 months, 10% reported being afraid of becoming a victim and 13% reported having been threatened in the past five years while on the job. While there were no difference in fear and threats between men and women in the workplace, women were more than 1.7 times more likely to report being victims of harassment than men. Harassment was more prevalent when workers reported low levels of group harmony and co-worker support and increased layoffs in the organization.

**Violence Against Women in the Community**

Women in Hawaii are increasingly at risk from violent and abusive behavior. A 1997 crime victim study by the Department
of the Attorney General indicates that the average crime victim in this state is female, under age 45, and living on Oahu. This annual survey found that 10.1% of women in Hawaii, or nearly 50,000 women, reported being victims of violent crimes. Sixty-six percent of these violent attacks were committed by a person well-known to them and 25% by strangers or casual acquaintances. (The remaining 17% is committed by a family member and constitutes violence in the home.) Less than 1% of women were assaulted with a weapon and 2.1% of women had been beaten. Women were more likely than men to be beaten (60.0% versus 40.0%).

Two percent of women were forced to have sex in the last year. In fact, rape and sexual assault are the only violent crimes in Hawaii that have increased over the past few years. Rape is considered by the FBI to be the second most serious crime, following murder. Only 37.5% of those arrested for rape were convicted for felony sex offenses. The majority of assaults that lead to an arrest take place between victims and alleged offenders who are either acquaintances or members of the same family. Generally, these assaults occur in private residences (59.7%), although not necessarily the victim’s home (32.1%). Approximately 90% of victims were female. These findings are similar to other research that reports more than 90% of adult rape victims are women and 78% of child sexual abuse involves girls.

A University of Hawaii study found that one out of every three female students identified themselves as having been victims of sexual or attempted sexual assault. Thirty-five percent of males responding to a different survey at the University of Hawaii admitted to committing acts which are legally classified as sexual assault. The Honolulu Police Department reported the majority of calls regarding sexual assault on Oahu come from the University area. A similar study of college women in New Zealand found that 25% had been victims of rape or attempted rape.

**Health Care Interventions**

Utilization of services by women who are victims of violence appears to be high. Given the breadth and magnitude of health effects, it is not surprising that between 22% and 54% of all visits to the hospital emergency departments are estimated to be made by victims of emotional or physical abuse. A recent study among women seeking routine care in a Native American health care facility found similar rates. While women seek help for as few as one in five assaults, between 40% and 80% of all victims of violence are likely to turn to health workers for assistance at some stage. In a national study, 68% of women who experienced severe violence had sought help at least once. In a more recent study, Hutchinson and Hirschtel found that 98% of abused women interviewed had sought help from formal sources and 65% seeking some kind of social assistance.

Yet only 5% of all battered women who seek medical care are identified. Rodriguez and colleagues conducted a qualitative study of abused Latina and Asian women examining barriers to discussing abuse with health care providers. Several participants discussed the difficulty of disclosing abuse and asking for help, particularly where providers did not bring up the topic. Participants expressed a desire and expectation for providers to initiate discussions about abuse. Participants also indicated that they would be more willing to get help from their primary care physician, gynecologist or pediatrician. These findings suggest that women are not only willing to seek help for abuse but frequently do seek help for abuse. The onus is placed on the provider to ask personal questions. However, the role of the provider represents only one of many barriers to help seeking behaviors for abuse.

There are many reasons women do not report their experiences to police or health care providers. Victims of violence are stigmatized, thus, by acknowledging their status, they incur some level of devaluation. Qualitative research on women that are abused has found that women are often reluctant to identify themselves because they feel ashamed. Additionally, female victims of violence are seen as instigators or even participants in crime unless strong resistance in the form of serious physical injury can be demonstrated. The two leading problems with the system reported by female victims surveyed in Hawaii were “people made me feel like it was my fault” and “people made me feel like they didn’t believe me”. The social consequences of help seeking may be one reason that women are also likely to refrain from mentioning the cause of their injuries.

The reporting behavior of victims has a number of important health implications. Women who do not report violence may not be notified about nor qualify for public-supported health care. Women that present with multiple injuries to health care providers and are not identified as victims of violence may fail to receive appropriate treatment for the nonphysical effects of these events. Psychological abuse is likely to be much more prevalent and less likely to be identified. Additionally, public funding for services is based on incidence estimates from reporting. There are numerous examples that demonstrate an incongruence between reporting and need for services. For example, funding for shelter in Hawaii are based on incidence estimates using police and survey data. However, Hawaii has insufficient shelter space. As new shelters open or existing shelters expand, they soon fill to maximum capacity.

There is a proliferation of literature on recommendations for improving detection and screening of violence against women, providing training protocols and instruments. McCleer and Anwar found that, after staff training and the introduction of an identification protocol, the percentage of women identified as being battered in the emergency department increased nearly six-fold from 5.6% to 30%. Yet the implementation of hospital and medical protocol for victims of domestic and sexual violence in Hawaii are inconsistent at best. Few personnel are appropriately trained and available to properly interact with victims in need of medical care or to conduct forensic exams. This is particularly true for the neighbor islands. Additionally, protocols have primarily been developed for emergency departments. In the Kauai study, 59% of women reported they would seek help from an agency if beaten or sexually abused but only four percent of injured women reported seeking treatment in the emergency department after such an incident. All providers need to be prepared to interact with patients that have been victims of violence.

**Conclusion**

Violence against women is endemic. Acts of violence are everyday events in the lives of women, impacting all women whether or not they directly experience violence. Violence against women is occurring in the home, at the workplace and in the community. This
wide-spread problem has serious and long-term consequences for women, their children and families and their communities. Health care workers are often reluctant or even prepared to become involved in cases of violence against women. Providers must become trained and comfortable asking stressful and personal questions in a nonjudgemental manner. Health care workers have an obligation to identify, treat and provide appropriate resources to victims of violence.

Acknowledgements
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References
Non-Competition and Restrictive Covenants in the Practice of Medicine: Has Their Time Passed?

Notwithstanding the fact that the A.M.A.’s Counsel on Ethical and Judicial Affairs discourages any agreement which, upon the termination of employment, restricts the right of a physician to practice medicine within a specified time period and/or geographic area, non-competition clauses and restrictive covenants can still be found in some physician employment agreements in Hawaii. Whether such covenants are legally enforceable in Hawaii is often uncertain. The answer may depend on a case-by-case analysis of multiple factual considerations. Any analysis is made difficult by the absence of any clear legal guidelines or bright-line tests. The following is a brief synopsis and discussion of factors which can be relevant to the issue.

The enforceability of restrictive covenants in physician employment agreements varies widely from state to state. The courts in some states, such as Massachusetts, reject outright any attempt to restrict a physicians’ ability to practice medicine upon the termination of an employment agreement. They view such restrictions as impermissible restraints on trade. Courts in other states engage in a case-by-case balancing of a number of factors in order to determine the reasonableness (and therefore the enforceability) of the actual restrictions, often coupled with a consideration whether the particular covenant is reasonable in light of the business activity of the employer and physician.

Typically restrictive covenants in physician employment agreements contain temporal and/or geographic competition limitations. As a general rule, the longer the time period of the limitation, the less likely its enforceability. There is some thinking that any covenant not to compete which exceeds two years might be automatically unenforceable, although there is no hard and fast rule in Hawaii.

Geographic restrictions on practice are more problematic. Often a restrictive covenant contains a “radius” clause stating that the departing physician may not practice within a five, ten or twenty mile radius of the former employer. Courts have struggled with what a “radius” means and how a “radius” distance should be measured. Some courts have been particularly reluctant to enforce “radius” clauses which aren’t supported by any legitimate business interest of the employer. For example, assume the (a) a physician currently employed in Kailua wishes to leave his employer and practice in downtown Honolulu, (b) the physician is subject to a restrictive covenant with a ten mile “radius” clause, (c) the physician desires to start a new practice in downtown Honolulu, and (d) the distance from downtown to Kailua is slightly less than ten miles. At first glance, the chances of the physician avoiding the restrictive covenant might appear slim. However, if it is further assumed that (a) the bulk of the patients treated at the employer’s facility in Kailua reside within five miles of the facility, and (b) the bulk of the Kailua patient population receive their medical care in Kailua, then the physician might be able to successfully attach the ten mile “radius” clause as overly broad, having no rational relationship to the protection of the employer’s actual market area, and therefore constituting an impermissible restraint. Note: the fact that the employer markets its medical services within the entire designated radius does not necessarily mean that the employer is entitled to an enforcement of the covenant within the entire area.

Some restrictive covenants also contain what are commonly called “liquidated damages” clauses. For example, a physician’s employment agreement may specify that, if the physician decides that he/she will “test” the enforceability of the restrictive covenant by competing within the prohibited radius during the prohibited time period, then the physician must pay to the employer a specified sum. Such “liquidated damages” are inserted into employment agreements by employers hoping to avoid the difficulty inherent in proving the amount of actual damages sustained as a result of the departed physician’s competition within the restricted radius and time period. As a general rule, in order to be enforceable, the stated amount of “liquidated damages” must constitute a reasonable estimation of the actual damages that the employer would be expected to sustain as a result of the departing physician’s competing practice, as judged at the time when the employment agreement was made. Conversely, if the stated amount of “liquidated damages” is either exorbitant or lacking in any rationale basis, the employer is exposed to the argument that the “liquidated damages” were in excess of any reasonable estimation of actual damages and/or speculative in nature and therefore unenforceable.

Some courts have questioned whether the literal enforcement of a restrictive covenant might actually work an undue hardship on the physician. For instance, some courts have balanced an employer’s right to enforce a contractual agreement against the fact that (a) a “radius” clause might effectively preclude the departing physician from using a hospital which contains certain equipment of facilities necessary for the safe practice of his specialty, or (b) a lack of patient base outside the prohibited area might effectively deprive the physician of an opportunity to make a living. In essence, any potential harm to the employer brought about by the new “competition” is weighed against any burden placed on the physician in adhering to the terms of the restrictive covenant.

In order to be enforceable, covenants not to compete must also be supported by valid consideration. Where a physician sells his practice, receiving money and an employment agreement from buyer in return, most courts assume that the consideration test has been met. However, where a fixed period of employment is not stated in the employment agreement, where the employment agreement can be terminated without cause, or where a restrictive covenant has been forced upon a physician as a condition of employment after the commencement of employment, it has been held on occasion that there is no valid consideration to support the restrictive covenant and it is therefore unenforceable.

A few courts have shown a willingness to essentially rewrite non-competition agreements so as to make them reasonable in time and geographic scope. However, upon a finding of unreasonable, most courts have simply declared the covenant in question null and void. Recently, the New Hampshire Supreme Court ruled that physician covenants not to compete apply only with respect to patients treated by the physician when he was under the employment, but not apply to new patients treated for the first time after the physician’s independent practice is established.

Another potential (and sometimes controversial) consideration is whether enforcement of the particular restrictive covenant might run counter to the best interests of the patients in the affected community. When the “public interest” becomes part of the equation, the scope of the analysis broadens substantially, factors such as the concentration of physicians in particular geographic area and the demand for service in a particular specialty area of practice become potentially relevant. Finally, in defending an employer’s attempt to enforce a restrictive covenant, the departing physician may be able to successfully assert that the employer made material misrepresentations in connection with the formation of the employment agreement, thus excusing any obligation of the physician to comply with the terms of the restrictive covenant contained in the agreement. Potential grounds for such defense include an employer’s misrepresentation as to (a) the conditions of employment, (b) the employer’s financial position, and/or (c) the physician’s potential or projected income.

In summary, physician non-competition agreements and restrictive covenants are generally controversial and subject to close scrutiny by the courts. How individual agreements and covenants will be interpreted in Hawaii courts, and whether they will be literally enforced, remains to be seen. Any physician interested in challenging the enforceability of a restrictive covenant should understand that the issues involved are often complex and the outcome may be unpredictable. In such an important area, where a physician’s livelihood is directly impacted, any challenge to a restrictive covenant or a non-competition clause should be preceded by a careful legal and factual analysis.

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Genetics: The Future of Medicine

Genetic disease was once thought to be limited to a few rare pediatric conditions. It is now known to affect everyone. After years of promise, the field of genetics is finally coming to fruition and will increasingly impact the delivery of health care services. Every disease has, in addition to environmental influences, genetic components that collectively determine (1) the likelihood of a specific disease; (2) age of onset; and (3) severity. While the “single gene defect” model of inherited disorders was instrumental in developing our understanding of genetic disease, it clearly is insufficient to explain the more complex inheritance patterns of more common diseases. It is our basic understanding of genetics, along with technological advances, that has allowed us to begin to fulfill our quest for better detection and treatment of disease.

We are increasing our ability to predict who will develop cancer, heart disease, diabetes and Alzheimer’s disease, and assist in prevention. Reflecting back on our ancestors in the early 1900’s when the major cause of death was infectious disease, we can see parallels with genetic diagnosis as we enter the 21st century. Understanding genetic mechanisms helps us to appreciate patterns of disease and how these patterns relate to our current medical dilemmas.

The causes of human morbidity and mortality have changed with the times. Evolution has allowed for the “survival of the fittest” through adaptation of our genes to an ever-changing environment. Unfortunately, it takes many generations before we appreciate the benefit of gene alterations, and many more to rid ourselves of altered genes that no longer provide a survival advantage. Every individual carries four to five potentially deleterious genes related to our ethnic background and ancestral environment. We now have the ability to identify many of these gene alterations. Our understanding of gene function and interaction with other genes, as well as our environment, has led us toward a clearer appreciation of the physiological disease process.

An example of adaptation is thalassemia. This is a recessively inherited (Continued on page 2.)

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Identification of hereditary predispositions can enhance medical management and lead to prevention and early detection of disease.
Genetics: The Future of Medicine

(formatted from page 1.)

form of anemia which affords carriers improved survival (fitness) against malaria. This disease is caused by abnormalities in the beta and alpha globin genes leading to a quicker turnover of red blood cells, thus preventing the normal life-cycle of the malaria parasite. Populations from Southern China, Southeast Asia, the Philippines and the Mediterranean (all malaria endemic regions), exhibit carrier frequencies of 1/10-1/20. Although the mutation has improved survival of these ethnic groups, in today's environment, the mutation can be detrimental. A carrier couple has a 25% chance with each pregnancy of having a child with either transfusion dependent anemia (in the case of beta thalassemia major), or a fetal or neonatal demise as the result of non-immune hydrops (alpha thalassemia). Individuals living in malaria-free climates are now hampered by this mutation with increasing frequency. Identification of carriers allows tailored medical care, including reproductive options.

Populations originating from the Celts and Nordics are at a higher risk of developing iron overload as a result of hereditary hemochromatosis (HH). The HFE gene controls iron absorption through the duodenum. Carriers of a specific gene mutation absorb excess iron. In times of poor diet, obstetrical complications and bloody battle, individuals with HH were afforded a survival advantage. In modern times with increasing longevity, reduction of obstetrical complications, war and improved diet, the morbidity of this disorder is evident. Iron deposits in the heart, pancreas, liver and testis can cause diabetes, cirrhosis, heart failure and impotence. Symptoms typically appear in males after the age of 40. Females exhibit later onset because of menstruation. If the disease is presymptomatically diagnosed prior to organ damage, therapy through phlebotomy can be life-saving. Population studies have estimated the carrier frequency in the Caucasian population as 1/8 with a disease frequency of 1/200 with ranges from 1/65 in the Irish to 1/500 in the Spanish.

Gene mutations causing thrombopathias provided an advantage against excessive blood loss. Today 50% of venous thrombosis cases have an identified genetic basis. It is estimated that 6-8% of Caucasians carry at least one predisposing genetic risk factor for venous thrombosis. Identification of these individuals allows for prophylaxis in high risk situations (pregnancy, surgery, prolonged immobility) as well as avoidance of exacerbating agents such as oral contraceptives.

In each population, there is at least one major gene mutation which predisposes to disease. These mutations have become increasingly prevalent as carriers survive and reproduce. As death rates from infectious disease has decreased, we have observed an increase in genetic disease.

Currently, cancer affects 35-50% of the population. Genetic risk assessment provides guidance for cost-effective medical management, decreasing morbidity and mortality.

Hematologic disorders, such as thalassemia and hemochromatosis, affect 10-20% (carrier frequencies) of the population in Hawai'i.
Cardiovascular disease is becoming amenable to risk assessment and genetic testing, and predisposition to diabetes is forthcoming.

Neuropreventive strategies are in the making for neurodegenerative diseases for which genetic testing is already available. It is expected that similar pathological mechanisms exist for a variety of these disorders, raising hope that there will be neuroprevention for common diseases such as Alzheimer's and Parkinson's.

Current genetic services can reduce the morbidity and mortality from diseases and conditions with a genetic component. This is accomplished by working with health care providers to assess genetic risk, diagnose and appropriately manage individuals and their families.

The Future of Medical Genetics
We can now appreciate our differences.

Some of us are (1) sensitive to certain drugs; (2) prone to allergies; or are (3) subject to behavioral difficulties. We know that many genes have an additive effect on our health and we are now for the first time able to ascertain these differences on a molecular level. The amount of this information however, is overwhelming. We currently have the resources to understand, detect and predict many genetic traits and diseases. However, we are currently limited to those which are influenced by only a handful of genes apiece.

Breakthroughs in technology, brought about by the Human Genome Project, permits us to handle large amounts of data. This new field of "informatics" will enable us to determine (1) whether a drug has adverse effects on a patient; (2) what therapies will likely be most successful for a patient with a specific disease; (3) the identity of high-risk diseases and; (4) the identity of low-risk diseases for that patient.

Integration of Genetic Services into Routine Patient Care
The effective delivery of genetic services requires integration with existing services, thereby enhancing medical care. The Queen's Medical Center has long recognized the importance of integrating modern Genetics services with clinical medicine. As of May 1st, The Queen's Medical Center has brought together clinical specialists to expand services in a much needed niche for the State of Hawaii and the Pacific Basin. The Queen's Comprehensive Genetics Center is available to help physicians in identifying patients who are at high-risk for a wide variety of disorders with genetic components. Specifically, the Center can help to (1) identify patients who would benefit from genetic counseling and/or testing; (2) determine if clinical tests are available for a condition with a genetic component; (3) provide genetic testing for disorders that are common in the population of Hawaii; (4) identify laboratories that can provide testing for other genetic disorders; and (5) interpret test results so that a physician and/or patient can adequately understand them to make meaningful and helpful decisions regarding their health care.

The Queen's Genetics Center is a part of Business Planning and Development Department under Dan Jessop, Vice President. Plans to expand services to include addition of a full-service genetics laboratory. We have realized that we are moving from the identification/treatment stage to the prediction/prevention/cure end-point. Application of individual genotypes will revolutionize health care. We will all benefit from increased efficiency and reduced pain and suffering from diseases with a genetic component.

The Queen's Genetics Center is a family-centered organization committed to the prevention, diagnosis, treatment and management of conditions with a genetic component. The foundation of our care is offered in the spirit of aloha as guided by the mission and ideals of our founders.
Genetics Center Professional Staff

Berkley Powell, MD  
**Medical Director**
Medical Director for The Queen’s Genetics Center, Dr. Powell provides a genetics diagnostic service. Dr. Powell received his MD from the Medical College of Virginia in 1973, subsequently completing his Pediatric and Genetics residency at Oregon Health Sciences University. He is Board Certified in Clinical Genetics by the American Board of Medical Genetics and has practiced at the University of Nevada School of Medicine and Kapiolani Medical Center. In addition to being on staff at The Queen’s Medical Center, he is also an Associate Professor of Pediatrics, Genetics and Cell and Molecular Biology at the John A. Burns School of Medicine. He is involved in several on-going clinical research projects and lectures frequently in the community on genetic topics.

Mark Bogart, PhD  
**Cytogenetics Laboratory Director**
Dr. Bogart will direct the future cytogenetics laboratory, primarily providing prenatal, pediatric and cancer chromosome analysis. He received his PhD in Biology from San Diego State University in 1988 and went on to a two-year fellowship in Human Genetics at The University of California, San Diego. He is Board Certified in Clinical Cytogenetics by the American Board of Medical Genetics. Dr. Bogart was Assistant Director of Cytogenetics at UCSD, and for the past five years, has served as Director of Mid-Pacific Genetics. In the near future, he will be employed by Queen’s as Cytogenetics Laboratory Director.

Timothy Donlon, PhD  
**Molecular Genetics Laboratory Director**
Dr. Donlon is responsible for developing and directing the future Molecular Genetics Laboratory providing DNA analysis for prognostic and diagnostic purposes. He received his PhD in Medical Genetics from Oregon Health Sciences University in 1984 and did a two-year Human Genetics fellowship at Boston Children’s Hospital. Dr. Donlon is one of a few individuals internationally that is certified in PhD Medical Genetics, Clinical Molecular Genetics and Clinical Cytogenetics by the American Board of Medical Genetics. He founded and directed the Molecular and Cytogenetics Laboratory at Stanford Medical Center and directed the laboratory at Kapiolani Medical Center. He is Chairman of chromosome 15 for the Human Genome Organization and Associate Professor of Genetics and Cell & Molecular Biology at The Cancer Research Center, the University of Hawaii. Dr. Donlon is also an Associate Researcher at the Center.

Deborah Schmidt, MS, RN  
**Advanced Practice Genetics Nurse, Coordinator of Reproductive Genetics**
Ms. Schmidt provides general genetic counseling specializing in Reproductive Genetics. She received her diploma in nursing from the Buffalo General Hospital School of Nursing. She earned her BSN from Incarnate Word College and her MS in nursing from Texas Woman’s University. Ms. Schmidt has worked in nursing for 26 years including 11 years in the field of genetics. She was the program coordinator for the Baylor College of Medicine Prenatal Screening Program prior to moving to Hawaii. An Associate Clinical Professor at the University of Hawaii School of Nursing, she has provided prenatal, pediatric and adult genetic counseling at Queen’s for the past 6 years.

Susan Seto Donlon, MS, PhD  
**Certified Genetic Counselor, Coordinator of Adult Genetic Services**
Ms. Donlon provides general genetic counseling and risk assessment, specializing in adult onset disease. She received her Masters in Genetic Counseling from the University of California at Berkeley in 1986. Since that time, she has coordinated genetics clinics and provided prenatal, pediatric and adult genetic counseling at the University of California, San Francisco, Stanford Medical Center and Kapiolani Medical Center. She is Board Certified in Genetic Counseling by the American Board of Medical Genetics and the American Board of Genetic Counseling. Ms. Donlon is on staff at The Queen’s Medical Center and is a referral source for The National Cancer Institute and an American Society of Clinical Oncologists (ASCO) Trainer.

Janet Brumblay MS, RN  
**Advanced Practice Genetics Nurse, Coordinator of Pediatric Genetics**
Ms. Brumblay earned her BS in Nursing and her MS in Genetics from University of Hawaii. For the past five years, she served as office manager and case coordinator for Pediatric and Adult Genetics at Kapiolani Medical Center. Ms. Brumblay, who also has a social work background, serves as case coordinator for diagnostic services and will assist patients in obtaining necessary genetic testing and follow-up medical services in the community. In addition to being on staff at Queen’s, she is a PhD candidate in genetics at the University of Hawaii.
LOPROX (CICLOPIROX) REDEFINES THE SCOPE OF BROAD-SPECTRUM TOPICAL ANTI-FUNGAL TREATMENT.

Its unique mode of action makes LOPROX effective against a wide range of cutaneous mycoses. LOPROX has demonstrated activity against both dermatophytes and yeasts as well as the proliferative and nonproliferative phases of fungal organisms. This sporicidal activity may reduce the possibility of recurrent infection. LOPROX is active against both gram-positive and gram-negative bacteria, making it ideally suited for mixed infections. In addition, LOPROX has anti-inflammatory activity equivalent to a mild steroid.

So, you have a choice. You can either let cutaneous mycoses off lightly. Or, you can prescribe LOPROX and send them to their death.

The incidence of adverse reactions with LOPROX Cream and Lotion was low. Reactions included pruritis and burning at the site of application. See full prescribing information for further information.
FULL PRESCRIBING INFORMATION
FOR DERMATOLOGIC USE ONLY.
NOT FOR USE IN EYES.

DESCRIPTION
LOPROX (ciclopirox) Cream 0.77% and lotion 0.77% are for topical use. Each gram of Loprox Cream contains 7.5 mg ciclopirox (as ciclopirox olamine) in a water receptive vanishing cream base consisting of purified water USP, octyldodecanol NF, mineral oil USP, stearol alcohol NF, steryl alcohol NF, cocamide DEA, polyethylene 60 NF, myristyl alcohol NF, sorbitan monoacetate NF, lactic acid USP, and benzyl alcohol NF (1%) as preservative. Each gram of Loprox Lotion contains 7.5 mg ciclopirox (as ciclopirox olamine) in a water receptive lotion base consisting of purified water USP, cocamide DEA, octyldodecanol NF, mineral oil USP, stearol alcohol NF, steryl alcohol NF, polyethylene 60 NF, myristyl alcohol NF, sorbitan monoacetate NF, lactic acid USP, and benzyl alcohol NF (1%) as preservative.

LOPROX Cream and Lotion contain a synthetic, broad-spectrum, antifungal agent ciclopirox (as ciclopirox olamine). The chemical name is C6H4(OH)2CH2NCH2CH(OMe)2.1H2O.

The CAS Registry Number is 141021-49-2. The chemical structure is:

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LOPROX Cream 1% and Lotion 1% have a pH of 7.

CLINICAL PHARMACOLOGY
Ciclopirox is a broad-spectrum, antifungal agent that inhibits the growth of pathogenic dermatophytes, yeasts, and Malassezia furfur. Ciclopirox exhibits fungicidal activity in vitro against isolates of Trichophyton rubrum, Trichophyton mentagrophytes, Epidermophyton floccosum, Microsporum canis, and Candida albicans.

Pharmacokinetic studies in men with tagged ciclopirox solution in polyethylene glycol 400 showed an average of 1.3% absorption of the dose when it was applied topically to 750 cm² on the back followed by occlusion for 6 hours. The biological half-life was 1.7 hours and excretion occurred via the kidney. Two days after application, only 0.01% of the dose applied could be found in the urine. Fecal excretion was negligible.

Penetration studies in human cadaveric skin from the back, with Loprox (ciclopirox) Cream with tagged ciclopirox showed the presence of 0.8 to 1.6% of the dose in the stratum corneum 1.5 to 6 hours after application. The levels in the dermis were still 10 to 15 times above the minimum inhibitory concentrations.

 Autoradiographic studies in human cadaveric skin showed that ciclopirox penetrates into the hair and through the epidermis and hair follicles into the sebaceous glands and dermis, while a portion of the drug remains in the stratum corneum.

Drager Human Sensitivity Assay, 24-Hour Cumulative Irritation Study, Phototoxicity study, and Photo-Draize study conducted in the total of 142 healthy male subjects showed no contact sensitization of the delayed hypersensitivity type, no irritation, no phototoxicity, and no photo-contact sensitization due to Loprox Cream.

In vitro penetration studies in freeze or fresh exuded human cadaver and pig skin indicated that the penetration of Loprox (ciclopirox) Lotion is equivalent to that of Loprox Cream. Therapeutic equivalence of cream and lotion formulations also was indicated by studies of experimentally induced guinea pig and human tinea trichophytosis.

INDICATIONS AND USAGE
Loprox Cream and Lotion are indicated for the topical treatment of the following dermatological infections: tinea pedis, tinea corporis and tinea cruris due to Trichophyton rubrum, Trichophyton mentagrophytes, Epidermophyton floccosum, and Microsporum canis; candidiasis (moniliasis) due to Candida albicans; and tinea (tinea) versicolor due to Malassezia furfur.

CONTRAINdications
Loprox Cream and Lotion are contraindicated in individuals who have shown hypersensitivity to any of their components.

WARNINGS
General: Loprox (ciclopirox) Cream and Lotion are not for opthalmic use.

PRECAUTIONS
If a reaction suggesting sensitivity or chemical irritation should occur with the use of Loprox Cream or Lotion, treatment should be discontinued and appropriate therapy instituted.

References:
Local and Gay: Addressing the Health Needs of Asian and Pacific Islander American (A/PIA) Lesbians and Gay Men in Hawaii

Valli K. Kanuha PhD

Abstract
Asian and Pacific Islander American lesbianns and gay men, who are “local” born and raised in Hawaii face conflicting personal and social expectations due to factors including prejudicial attitudes about homosexuality, A/PIA racial/ethnic traditions, and the unique cultural milieu of Hawaii. Based on anecdotal and research reports of this Hawaii population, health and social needs are discussed with implications for professional health practice.

In December, 1996 Circuit Court Judge Kevin S. C. Chang ruled that the Hawaii statute regarding marriage was unconstitutional and that the state could not deny persons of the same sex the right to obtain marriage licenses solely because of their sex. Judge Chang’s ruling opened the way for an amendment to the Hawaii State Constitution defining “marriage as between one man and one woman.” The 1998 vote on the same-sex marriage amendment became one of the most heated and controversial local campaigns in recent memory. Lost in the politics, however, was concern with the impact of prejudice and discrimination upon the health and mental health of lesbians and gay men in Hawaii. For whatever we think about homosexuality, gay men, or lesbians, they live and work among us in Ewa, Kohala, and upcountry Maui. They are our cousins, fathers, aunts, and sisters. They teach our children, nurse our kūpuna, and work at the local drive-in. Most important, and contrary to how most media accounts depict gay men and lesbians in Hawaii, they are also “local,” born and raised in the islands who are part-Hawaiians, Filipinos, Portuguese, Chinese-Japanese and from the many Asian and Pacific Islander American (A/PIA) groups who reside in the state.

This article will describe some of the challenges and conflicts that local gay men and lesbians face in Hawaii. Based on anecdotal reports and studies of “local” lesbians and gay men of Asian American and Pacific Islander descent in Hawaii, relevant health and social concerns for medical providers will be discussed.

Overview of Homosexuality
Beginning with Kinsey’s linear framework of human sexuality in the 1950s, social scientists have been engaged in analyses to delineate the precise nature and typology of sexual identity development for decades.1-2 With regard to homosexuality in particular, the longstanding claim that 10% of the population is gay has often been critiqued due to Kinsey’s emphasis on self-reports of sexual behavior without consideration of contextual factors such as psychological commitment or evidence of other practices associated with gay life (such as gay social support, engagement in gay activities, etc.). In addition, most of the study cohorts in this pioneering research were White gay men.3-4

One of the most enduring interests with regard to sexuality, and homosexuality in particular has been the question of its biological versus social origins. While many social constructivists3,5 believe that sexuality (sexual orientation, sexual preference) is largely formed by the environment in which people live, in the last decade gay researchers Hamer and LeVay,6,7 and Bailey and Paillard in their twin studies8 have focused their psycho-biological inquiries on finding a genetic basis to homosexuality. At this point, however, most theorists believe that sexual orientation may be both a fact of one’s genetic or biological make-up as well as social influence.4,9,10

In addition, there are methodological conundrums regarding the differences between sexual behavior, which focuses on conduct; sexual orientation, referring to emotional, sexual, and erotic attraction; and sexual identity or self-labeling of all meaningful aspects of conduct, orientation, and lifestyle. That is, should estimates of gay life be based on counts of persons engaged in homosexual behavior? What about persons who self-identify as lesbian but are not engaged in sexual conduct? And how do we account for the many persons who discretely engage in same-sex conduct but are also married with children? Therefore, given the highly stigmatizing nature of homosexuality, it is improbable that we will ever have an accurate estimate of either homosexual behavior or gay/lesbian sexual orientation in the general population.

It was less than 30 years ago that the American Psychiatric Association removed “homosexuality” as a psychopathological disease from the Diagnostic and Statistical Manual of Mental Disorders. Prior to that period, medical and psychiatric professionals as well as society-at-large viewed “homosexuality” not only as deviant but as an illness that could be treated and cured by psychoanalysis, aversion therapies, shock treatment, and as recently as 1951, surgical techniques such as lobotomies.11 While changes in social mores and public policy regarding lesbians and gay men in the United States have been slow in coming, the past decade has seen significant changes in the United States such as the approval of gay marriage in Hawaii.
States have educated health practitioners to be more responsive to the needs of this population, growing religious and conservative influences in American life have resulted in a resurgence of what is known as “reparation” or “conversion” therapy intended to change the sexual orientation/identity of gay men and lesbians. However, these therapeutic interventions are generally unsuccessful which attests to the highly resistant and perhaps ingrained nature of sexual orientation.12, 15

**Sexual Diversity in Asian and Pacific Island American (A/PIA) Populations**

Most Asian and Pacific Island cultures have documented the existence of same-sex behavior and relationships for centuries. In the Philippines, bakla refers to a man who assumes a female gender role and sometimes same-sex roles and behaviors, similar to the mahu in Native Hawaiian or Kanaka Māoli (indigenous people of Hawaii) culture.14-16 During Captain Cook’s early voyages to Hawaii, members of his crew chronicled the importance of aikane, who were male consorts of the male ruling class of Kanaka Māoli.17 There are also accounts of same-sex roles and practices in Samoa with the fa’afafine, the Tongan fakaleti, and in Korea, Japan, and China.14, 18-22

For Asian and Pacific Island peoples who have either been colonized in their own homelands (such as Hawaii or Samoa) or have emigrated to the United States, some suggest that the influence of Western religiosity, social norms, and acculturation/assimilation patterns have altered once-acceptable variations in values and practices regarding sexuality.23 In addition, the contemporary portrayal of gay men and lesbians as Caucasian contributes to the perception of many A/PIA populations that homosexuality is a White phenomenon, thereby disavowing the existence of gay men and lesbians in their own A/PIA communities.24-26

**A/PIA Gay Men and Lesbians in Hawaii**

The scarcity of studies about lesbian and gay life among “local” A/PIA communities in Hawaii can be explained by a number of factors. First, many of our “local” cultures value the maintenance of social order and are careful to protect and uphold the collective well-being of the family from anything that will bring public humiliation upon them. As Alexander Nakatani, Maui-born father of two sons who died of AIDS recalls about his upbringing, “I knew how important it was to keep shame from visiting our family...Honor and shame...I think they live in the walls of every Japanese house.”27 While many European American cultures reinforce social norms through guilt, the collective and public nature of shame in Japanese, Chinese, Filipino and other “local” A/PIA cultures is linked to the loss of “face” that results from conducting oneself in a socially unacceptable manner. Having a gay or lesbian family member is considered deviant in most A/PIA populations who reside in Hawaii regardless of the extent of their acculturation to American norms and beliefs.

In addition, traditional A/PIA values about the privacy of intimate matters such as sexuality preclude discussion about such topics among “local” families or in other settings throughout Hawaii including schools, churches, and doctor’s offices. Finally, the relatively insular nature of island life discourages many people from sharing information that is perceived to be discrediting or embarrassing - such as the existence of gay or lesbian family members - for fear that in the “small town” character of Hawaii it is likely that a co-worker, neighbor, or acquaintance will find out.

For lesbians and gay men in Hawaii who are also “local,” learning to develop and enact their lesbian/gay identities requires a delicate balance of personal needs and social obligations.

**Conflicting Loyalties to Family and Self**

One study of sexual and racial/ethnic identity among Hawaii-born, “local” lesbians and gay men suggests that the inherent tension of adhering to “local” A/PIA values regarding loyalty to one’s family while simultaneously developing an autonomous sexual identity is a significant stressor.28 As a part-Hawaiian gay man stated, “As long as I don’t talk about ‘it’ my parents and I get along.” In other reports of “local” A/PIA gay and bisexual men in Hawaii, participants reported that while their families of origin (parents, siblings, aunts, uncles, grandparents) were important social supports, the family relationship was also the source of greatest internal conflict.16-28 Many “local” gay men and lesbians state that they are reluctant to either disclose or non-discretely enact their homosexuality for fear of losing the connection to their families. As a “local” Japanese-American lesbian stated:

I thought, I can’t possibly do this [be a lesbian]. My family will hate me...because family and the notion of family was so important in Hawaii.29 p. 231

A common reaction of A/PIA parents when they discover they have a gay son or lesbian daughter is, “What will people in the community think?” Because the concept of “saving face” is an important aspect of many Asian American cultures, one study found that A/PIA gay men and lesbians who choose to remain closeted with their parents also do so in the A/PIA community for fear of being socially stigmatized.30 As argued by Wong, et. al., “a stronger value (is) placed on loyalty to family roles than on the expression of one’s own sexual desires.”

**Social Distancing Linked to Social Stigmatization**

In a study of gay and lesbian youth in Hawaii initiated by the 1990 Hawaii State Legislature, many young people and service providers reported acts of harassment and discrimination such as ridicule, taunting, and physical assault from peers and strangers.31 More disturbingly, many of these incidents occur in the presence of authorities such as teachers, counselors, or youth workers who either do not intervene or sometimes are responsible for precipitating them. These situations result in many local lesbians and gay males isolating themselves from others, becoming more secretive about their sexual conduct, and engaging in risk behaviors such as unsafe sex, drug use, and running away from home.

In addition, “local” A/PIA gay men and lesbians commonly report that they purposely leave home to attend school or take jobs on the Mainland where they will feel more comfortable “coming out.” A part-Hawaiian lesbian who grew up on Molokai and now resides in California recounts that she originally went to the Mainland to “try to get ahead”:

I came here for an education to work my way home and here I am after twenty something years! My mom said to stay here because the job situation at home wasn’t very good. I think another reason why I stayed here was I wasn’t out.32 p. 88
In one study, local Japanese, part-Hawaiian, and Hawaiian-Puerto Rican lesbians mention that they were more likely to be public about being gay on the Mainland than at home in Hawaii because as one noted “there was no family and I could start fresh. I could hold hands in public and not have to think about it, and nobody in my family knew.” 29 p. 230

Finally many “local” A/PIA lesbians and gay men report trying to balance pride and comfort in privately being gay while preserving their familial relationships by publicly not “acting” gay. Wong, et. al. 14 suggest that this private - public tension is not necessarily incongruent as long as one’s private behavior does not interfere with one’s social behavior. So for example, if a local gay man engages in a same-sex relationship that is discrete and private, while maintaining his social role as a fun-loving (heterosexually-seeming) guy at the baby luau, he may find such an enactment acceptable not only to himself internally but externally to his family. However one significant consequence of this compromise is that many must live what A/PIA lesbian activist Michiyo Cornell 33 calls “the great lie” which dissociates them from parts of themselves, but also from their families and communities.

Health and Mental Health Consequences

Most of the health and mental health effects documented among lesbians and gay men are due almost exclusively to societal denigration known as homophobia, which is the fear and hatred of gay men, lesbians, and anyone perceived to be other than heterosexual. Bidwell’s study of gay and lesbian youth in Hawaii reported that many young people in this population who choose to be more self-accepting and perhaps public about their gay/lesbian identity risk harassment, rejection, and sometimes peer violence. National studies of gay and lesbian youth document the prevalence of homelessness, truancy and sexual exploitation among this vulnerable population. 34 35

A 1989 study by the U. S. Department of Health and Human Services estimated that gay and lesbian youth are 3-5 times more likely to consider, attempt, and perhaps complete suicide than other adolescents in the U. S. 36 Bidwell found repeated accounts of suicidal ideation and attempts in his interviews with Hawaii youth providers, parents, and young people themselves. A worker at the Queen Liliuokalani Children’s Center estimated that five gay/lesbian teenagers who received services at the program had attempted suicide during Bidwell’s study period.

“Local” gay men and lesbians throughout Hawaii report histories of drug abuse, depression, and anxiety associated with issues including: confusion regarding their sexuality; stress in balancing their gay and family relationships; and lack of peer and social support. In addition, “local” lesbians and gay men may delay or forego health care because of past experiences with homophobic providers, with whom they are ashamed of talking about sex-related problems such as STDs/HIV especially related to same-sex conduct.

However, the most pressing health concern involving this population in Hawaii is the rate of HIV/AIDS among “local,” A/PIA gay men. In Hawaii the largest proportion of AIDS cases is among men who have sex with men. 37 While Caucasians represent the largest ethnic group in the category of men with AIDS in Hawaii, the number of White men diagnosed with AIDS is generally decreasing while there is a significant upward trend of HIV infection among the second highest ethnic population in the men who have sex with men category, which are Asian and Pacific Islanders.

Therefore, while the proportion of reported AIDS cases in Hawaii due to men who have sex with men has decreased over time, there has been an increase particularly among Native Hawaiian and Filipino gay and bisexual men who reside in the State. It is argued that the difficulty in reaching “local” gay men with HIV/AIDS prevention messages is that many are ashamed to acknowledge their sexual identity for fear of rejection; the lack of social networks and support that incorporate the cultural needs of non-Caucasian gay men in Hawaii; and, “local” gay men are engaging in HIV risk behavior such as unsafe sex and intravenous drug use in discrete settings where their public identities as gay and “local” will not be exposed.

Implications for Health Care Providers

For Asian and Pacific Islander, “local” gay men and lesbians, the enduring stigmatization associated with homosexuality coupled with “local” values and attitudes about the importance of family and maintaining social relationships has resulted in covert and overt acts of discrimination against them. The particular manner of dealing with this issue is described by one A/PIA researcher as, “don’t ask, don’t tell, don’t know.” 38

In order to work more effectively with this population there are a number of practice implications for physicians, nurses, allied health providers, mental health clinicians and other health professionals in Hawaii. First and foremost, health professionals have a responsibility to become educated about the unique and challenging issues of being “local” and gay in Hawaii. There is a prevalent misconception that “the gay problem” is a “Haole” matter, and that there are no or few “local” gay men or lesbians. It should be self-evident that homosexuality - as with heterosexuality - is found cross-culturally including throughout all parts of the State of Hawaii. Denying that “local” gay men and lesbians actually live and walk among us in Hawaii is probably the major barrier to health care for this group.

Gynecologists and other women’s health providers must not assume that every local Japanese woman who comes in for a PAP smear is having sex with men. Physicians, nurses, and allied health professionals need to sensitize their interactions with clients and patients by attaining knowledge of and skills to address sexuality, homosexuality, and same-sex intimacy in the context of our “local” Hawaii and traditional A/PIA cultures, and to do so in a non-judgmental manner.

Due to the “small town” nature of life in Hawaii, many gay men and lesbians need to be reassured about the importance of confidentiality in the provider-patient relationship. The fact that local gay men from the Neighbor Islands will sometimes fly to Oahu for HIV testing or other health care is evidence of the effects of social stigma that many are trying to avoid.

Finally, individual health providers and health professional associations must advocate for increased training and continuing education for medical and health practitioners on sexuality, gay and lesbian health issues, and the unique needs of “local” sexual minorities in Hawaii.
References

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W. Mitchell Sams, Jr.’s Open Letter to His Son:

Dear Hunter: Now that you have completed the first three years of medical school and are increasingly excited about patient contacts and your future role as a physician, I’d like to take this opportunity to pass on to you some thoughts that I have developed over many years of practice and that, if followed, are certain to make your own professional life more rewarding and your patients more satisfied.

* Don’t forget to smile as you enter the patient’s room. Such a simple gesture is terribly important and puts the patient immediately at ease.
* Remember that a patient often is frightened and lonely. Take the time and expend the effort to sit down with that patient, relax and just talk and listen, rather than standing as though you are in a hurry to leave the room.
* Write your notes about the patient and your prescription in the patient’s room. It is much more meaningful to them and permits you to spend more time with the patient. They may think of other questions important to them when you are relaxed.
* Touch the patient, even if just lightly on the arm. This shows you are not afraid of catching whatever they have (whether skin diseases or not), but also conveys concern and understanding. It can be a magnificently important gesture.
* Learn some “nonessential” information about the patient, such as hobbies, recent trips, children’s achievements and ambitions. Then make a note of this in the chart and bring up the subject again on the next visit. You will be amazed at how impressed the patient is with your “memory” for these events.
* It is o.k. to express confidence in helping the patient that may not be totally justified by the options. The patient’s confidence in you and in the real possibility of improving his or her condition can enhance the healing process.
* At the same time, tell the truth. If the disease is not curable (such as psoriasis or atopic dermatitis), say so, but quickly add that it can be controlled with appropriate therapy. I liken psoriasis to arthritis or diabetes, neither is curable but both are usually controllable. Patients seem to understand and accept that better.
* If you are running behind schedule, apologize to the patient as you enter the room. It puts them off guard if they were planning to complain and lets them know you are aware that their time is important.
* Express your appreciation often and sincerely to the people who help you be what you are — your colleagues, your nurses, your residents, your receptionists. You will not be a success without them. Be sure you let them know that.

(Miscellany)

There is the story of the computer that was ordered to translate a common English phrase into Russian and then translate the Russian back to English...What went in was “Out of Sight, Out of Mind.” What came out was “Invisible Insanity.”

(Potpouri)

A Big Help....

One day a patient came in and breathlessly described what sounded like a truly ghastly car accident that she’d witnessed at her corner. “There was blood everywhere,” she panted, “and cries and groans for help.”

“I was very proud of myself, Doctor. I remembered all my first aid course work — I took a deep breath, put my head between my knees and didn’t faint!”

Dr. Marion Rogers, Vancouver Stitches, Aug 99

Just Perfect...

A friend was applying for immigration into Canada and submitted himself for the required physical exam. The examining physician was young and obviously a recent medical graduate. As he finished, he explained, with an apology, that he was required to perform a rectal exam. He was as embarrassed at having to do this as my friend was at having to submit to it.

After the examination, the physician said, “I am sorry I had to do that, but you know, only perfect assholes are allowed into Canada!”

Dr. Michael Golbev, Kelowna, B.C.

Also from Stitches...

Conference Notes...”Angina and Silent Ischemia”

VP William Parmley, Prof of Medicine, UCSF...

7-15 Fri Am Conference, Kam Aud, GMC

Discussion:

Silent Myocardial Ischemia (SMI): Incidence: 4% of population...Angina and SMI: 3/4 of episodes are silent...SMI is not benign...

Prognostic implication of SMI with stable angina: Risk of death or adverse outcome...

SMI with Unstable Angina: Increased risk 3-4 times of adverse outcome...SMI plus risk factors increases potential of death...

SMI is marker of more severe disease.

Post MI: Increased risk with SMI.

* SMI diagnosis c Treadmill...

CAST Study:

CABG vs Medical therapy: Neg treadmill = better prognosis than positive treadmill. Adverse prognostic sign when ischemia occurs without pt perception viz SMI...

(Smoking: acute risk factor which is reversible)

Framingham Follow Up:

% of silent MI’s: men = 28%; women = 35%; elderly women even higher

Summary:

MI = Imbalance of oxygen supply & demand:

a. HR + BP = Rate/Pressure gradient
b. Reduced demand c BB (Beta Blockers)
c. Reduced supply 2° to: vasoin 
briction + stenosis + blood flow: a little constriction = MI.

Rx Demand (HR & BP) vs Supply (vaso constriction)

Rx: a) ↓demand + b) ↓vasoconstriction

Re Demand: a Circadian rhythm...MI’s occur Monday mornings (getting up to go to work)

Re Sudden Cardiac Death: Less MI’s c ASA qd (Physician MI Study) viz platelet aggregation factor

Why AM? Surge in BP, HR, catechola mine=plaque rupture; stickier platelets...

Therapy: Ischemic Heart Disease....

1. Variant Angina: a. Ca CB (eg amlodipine...every CaCB works)
   + b. Nitrates
2. Stable Angina: a. Beta blockers: Rx of choice; Betablockers > nitrates
3. Vasoconstriction: a. CaCB + nitrates ie combination Rx

Re Beta Blockers (BB): effective in post MI; HR = most important; ↓mortality

BB Role in Circadian Rhythm:

a. Reduces AM surge (eg c aenolol)
   b. BB works best in AM hours...

CaCB Role: Niphepine GITS (Procardia XL) (long acting CaCB) Uniform 24° level. But with Niphepine GITS: no difference in ischemic events; whereas BB reduces AM ischemic events...

**SMI Therapy(may be worthwhile...Should we pursue RX?)

In Stable Angina: Revascularization group has best results. If SMI shows *High Risk Ischemia by quantification c : ETT; ECHO MUGA; Perfusion; AEM etc and if all these tests are positive, revascularization is indicated in SMI...

HAWAII MEDICAL JOURNAL, VOL 58, SEPTEMBER 1999
Cigarette Smoking and Atherosclerosis: Fatty streaks and fibrous plaques found in teen agers and young adults who smoke...

"If you change a man, that's only one man...if you change a woman, you change the whole family."

Prof Wu Qing...

Exposure to passive smoke: Second hand smoke raises mortality by 30% Hypertension & CAD: 43 million cases of HTN in US...

a. NHANES III: Systolic hypertension common in Age 60 plus...31% of hypertensives don't know...Only 1/2 of hypertensives are controlled...

b. VA Cooperative Study (1962-1970): Reduced death and cardiovascular events with HTN control...Even mild HTN treated aggressively reduces events...HTN treated even in 80 yr olds reduces events and CHF...50% reduction in CHF e HTN therapy...11% reduction in events by treating moderate HTN...

Physician Health Study: 40% of MD's did not know they had HTN...22% mortality with untreated Systolic HTN...

Re Pharmacological Therapy: a. Beta blockers: As good as placebo...Not the way to go...Diuretics are better than BB...In older pts, be careful e BB...Beta blockers cause fatigue, sexual dysfunction...

e. E.D. (erectile dysfunction) Ask questions with partner present...Men have difficulty admitting E.D.

The worst thing in HTN is not to control BP properly"

HOT Trial (19,900 pts in 3 groups): Ideal diastolic pressure: 80 and systolic pressure: 130-135...

SYS-EUR Trial: Av diastolic pressure 80: Fatal and non fatal MI reduced but not as much as CVA...

How Many Drugs? (HOT Trial)

Diastole 80
Feldopine 79
ACE 45
Beta Blocker 32
Diuretic 24

Should we use multiple drugs in older patients?

General principle: Try treating once a day with a single drug...Better control with one pill...

PRAISE-1: Amlodipine improved survival in patients with HTN, Angina and LV systolic dysfunction...

Older patients c HTN and Diabetes: CaCB reduces mortality

SYS-EUR Trial: CaCB more effective than diuretics in older patients with HTN and Diabetes...

Choice of Drugs:

1. Systolic HTN in Older Patients:
   a. CaCB
   b. Diuretic
c. ACE

2. HTN & Angina:
   a. CaCB
   b. Beta blockers

3. HTN & Diabetes:
   a. CaCB
   b. Diuretic
c. ACE

4. HTN & ANGINA & LV Systolic Dysfunction:
   a. Amlodipine
   b. ACE
d. Digitalis

Re CHOLESTEROL: Framingham Study: No such thing as ideal HDL...Exercise plus diet...

HMG CoA Reductase Inhibitors for 2° protection and 1° prevention

Atorvastin (Liptor): 160% in LDL ↓60% in triglycerides

Postmenopausal women: Statin plus HRT (Hormone replacement)

Atorvastin is cheapest and fastest...Simvastatin and Lovastin take longer to catch up...

Only 30% of post MI pts are on HMG therapy...

Recommended LDL level: 100

POTPOURRI II

A senior citizen was driving down the freeway when his car phone rang. His wife was on the line. “Herman,” she said, “I just heard on the news that there’s a car going the wrong way on 280. Please be careful!” “Hell!” Herman replied, “It’s not just one car. There are hundreds of them!”

"I woke up this morning feeling so bad," one fellow told another, “that I tried to kill myself by taking a thousand aspirins.”

“Oh really? What happened?” “After the first two,” he said, “I feel better.”

Years after giving up on the idea of motherhood, a 65 year old woman had a baby with the help of a fertility specialist. All her relatives came to visit. When they asked to see the baby, the mother held them off with “Please, not yet.” A little later, they asked again and they were again put off with “Not yet!”

An hour passed and they became impatient. “When can we see the baby?” “When the baby cries,” she said.

"Why do we have to wait till she cries?" “Because,” the mother explained, “I forgot where I put her.”
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David Bergqvist, Sweden
Kevin Burnand, UK
Philip Coleridge Smith, UK
Anthony Comerota, USA
Andrew Cragg, USA
Jawed Fareed, USA
Peter Gloviczki, USA
Shunichi Hoshino, Japan
Russell Hull, Canada
Reginald Lord, Australia
Gregory Moneta, USA
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MEDICAL TIDBITS...

The carpal-tunnel syndrome occurs in as many as 1 in 5 people complaining of tingling in their fingers...

Babies of HIV positive mothers have a 30% chance of contracting the virus during labor. The inexpensive commonly used anti-viral drug NEVIRAPINE reduces the incidence to 13%. One pill for the mother during labor and a few drops for the baby within 3 days of birth.

Italian researchers have found that 1/3 of hepatitis C patients also harbored hepatitis B virus though it didn’t show up on a standard blood test. TIME, Jul 26 ’99

Two studies in the NEJM reported that mitral valve prolapse (MVP) may not be as prevalent or dangerous as believed (however the more severe forms can still be life threatening). Lisa Freed and her colleagues examined a broad cross section of adults in the Framingham Heart Study found only 2.4% with mitral valve prolapse and that half were less harmful variations of normal cardiac design.

Robert Levine, cardiologist at Massachusetts General Hospital, co author of the NEJM articles discovered 10 years ago that in ultra sound scans, the front back view was more valuable than the side to side view in determining the actual presence of prolapse.

MEDICAL TIDBITS...

Safer Sizzling: Barbecuing produces carcinogens, but researchers report that marinating beef with Hawaiian teriyaki and Indian marinades can reduce carcinogens by 65%.

Are Cigars Safe? The NEJM in June reported that cigar smoking boosts the risk of heart disease 56%. Smoking cigars regularly increases your risk of emphysema and cancers of the lip, lung, throat and esophagus. Kaiser Permanente researchers funded by the National Cancer Institute combed their computerized medical records for Northern California and found 16,228 men who never smoked cigarettes or cigars and another 1,546 who smoked only cigars (1971-1995). Results of the study: a) Less than 5 cigars/d had a 34% greater risk for lung cancer.

b) Men who smoked 5 or more cigars/d: 620% greater risk of lung cancer; 220% greater risk of lung cancer.

POTPOURRI III

A young couple on the brink of divorce visited a marriage counselor. The counselor asked the wife about the problem.

"My husband suffers from premature ejaculation," she said.

"Is that true?" the counselor asked, turning to the husband.

"Well, not exactly," he replied. "She's the one who suffers, not me."

What do the Dirt Devil and Viagra have in common? They both put the power of upright in the palm of your hand.

A store manager, in an effort to inspire efficiency, placed a sign directly above the men's room sink: "THINK!"

The next day someone had carefully lettered another sign just above the soap dispenser: "THOAP!"

(From Playboy Party Jokes)

Anti-Aging Therapies—(Cleaned from the May '99 issue of Mayo Clinic Health Letter)

The search for the fountain of youth: an update... Researchers have found that aging is an intricate and complex process... Its unlikely that a single pill or potion can be a cure all... Researchers have found certain strategies that do work:

a) Exercise with a healthful diet, and regular mental activity...
b) Women: ERT keeps bones strong, reduces cardiovascular disease, restores vaginal lubrication, improves skin elasticity and maintains mental function.

Re Anti-oxidants:

a) Vit E (400 I.U.): most promising of all the antioxidants...protects against cardiovascular disease, Alzheimer's and Parkinson's.

b) Vit A and Betacarotene (which is converted to Vit A) offers no protection against heart disease. Also two studies have shown that smokers taking Betacarotene have more lung cancer.
c) Vit C: Diets high in Vit C prevent cancer and heart disease (but no proof that Vit C pills do the same)
d) Selenium: Antioxidant mineral (esp in sea food and liver) may prevent cancer. Excessive amounts cause hair and nail loss.

c) Coenzyme Q10: Unproven that it slows aging and stops cancer spread. Has promise in treatment of CHF.

Re Hormones:

a) DHEA (Dihydroepiandrosterone): DHEA converts to estrogen and testosterone (Banned in 1985 by FDA)... Proponents feel DHEA slows aging, increases muscle and bone strength, burns fat, improves cognition, boosts immunity, and protects against chronic diseases (As yet, no proof) Side effects: cause liver damage, certain cancers and heart disease.

b) Testosterone: Low testosterone levels lead to loss of sex drive and energy...High testosterone levels: improve energy levels and sex drive... (but cause prostate problems, elevated cholesterol levels and infertility)

c) Melatonin: Hormone produced by the brain...Regulates sleep; may slow aging, prevent aging and increase sex drive.

d) HGH (Human growth hormone): Promotes growth spurt in children...Proponents: burns fat, builds muscle and renews energy; some studies suggest benefits; side effects: fluid retention, joint pain, diabetes and hypertension.
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A HERO IS A MAN WHO FOUGHT VALIANTLY FOR OUR CAUSE.

Our lives and our medical ranks are diminished by the sudden death of John Zelko, M.D. of Hilo. John served long and honestly in the field of eye surgery, bridging the generation of pre-microscopic ocular surgery long before the lens implant, on through the advent of laser refractive surgery. Always kind, ever careful and with a puckish and wry wit, John was a delight to be around and to work with. In 1995, Dr. Zelko was attacked by the drug enforcement agency for writing a simple prescription for an appetite suppressant for a friend. It was a cruel and seemingly malicious attack that was never adequately explained, and it threatened every physician who would prescribe a drug outside of his immediate area of practice. Of course, he had done nothing wrong, and was supported by virtually the entire medical community. His sterling reputation was maintained despite the adverse media attention generated by the DEA. Ultimately, the complaint was dropped with a paltry apology. John Zelko, M.D. was truly one of a kind, a kind that will be sorely missed and long remembered.

NO GOOD DEED SHOULD GO UNPUNISHED.

Since 1985 the American Academy of Ophthalmology promoted the National Eye Care Project (NECP) to provide eye examinations without charge for eligible people over age 65. 7,000 participating AAO fellows and members cared for the patients and waived the co-payment and deductibles. This highly successful program has been acclaimed by many including the American Medical Association, as a demonstrable effort to provide care for needy elderly patients. However, when Congress passed the Health Insurance Portability and Accountability Act the NECP was essentially destroyed. The fraud and abuse provisions of the act require the NECP to perform a financial need analysis before patients can be referred! Thomas Hutchinson, M.D. NECP chairman is working with the Health and Human Services in an attempt to circumvent the restrictive provisions. Bureaucracy strikes again.

THE AMERICAN MEDICAL ASSOCIATION JOINS THE TEAMSTERS —— NOT!

The media has made a major news story out of the AMA House of Delegates action to assist employed physicians and some residents to form an affiliated labor organization to deal with HMOs in regard to matters of patient care. Big Deal! None of the hoopla represents any change in the basic fact that independent physicians are not allowed to organize to negotiate with third parties in regard to insurance abuses, arbitrary changes in reimbursement, contracting, or medical definitions. The National Labor Relations Board has ruled that doctors who are employees can act in concert, but the great rank and file of partnerships, associated groups and independents remain locked out of collective bargaining. Moreover, as long as the Republicans continue to answer to the insurance money, the current Senate bill to loosen the NLRB rule has little chance.

REALLY IMPORTANT PEOPLE WHO DON'T KNOW WHAT THEY ARE DOING!

A more vital item of AMA business was a report by the Council on Ethical and Judicial Affairs which would require physicians to be responsible for reporting impaired patients to their state department of motor vehicles. The House of Delegates initially approved the report, but the ophthalmology team sustained in winning reconsideration; a truly rare parliamentary event. On second discussion, the House recognized the breach of patient confidentiality and the liability risk for physicians, and voted the report down. Congratulations to team leader Ruth Williams, M.D. and the eye surgeons in the House.

THE AIR BAG - ANOTHER NADER MAKE-WORK PROJECT FOR TRIAL ATTORNEYS.

The driver of the new pick-up truck ran a red light with his two-year-old child in a rear facing child-carrier belted in the passenger seat. A crash occurred, and the air bags deployed which killed the baby. This tragic event was compounded when a judge found the driver guilty of vehicular homicide because he had not used the air bag cutoff switch! Now 3.2 million such vehicles are equipped with a switch which will deactivate the air bags. The judge sentenced the father to two days in jail; one to be served on his dead son’s birthday and the other on the anniversary of the fatal accident. Also, he ordered that the driver make public-service announcements regarding air bag safety. What a compassionate fellow that judge! The National Highway Traffic Safety Administration (NHTSA) has conducted their original research using 170 lb. unbelted dummies, and claimed that 31% of lives would be saved by air bags in head-on crashes. However, it was soon learned that the exploding bag at 200 mph can be lethal for short people and small children, not to mention the 300,000 “minor injuries” that ranged from broken bones to shattered eardrums. Never admitting that air bags might be a bad idea, of course, the NHTSA has come out with a set of guidelines that read like gun safety: (1) seatbelts must be fastened, (2) do not sit close to the dash board, (3) little people and children under 12 should not sit up front, (4) don’t reach for something in the glove box when leaving a parking spot (broken neck), (5) do not drive with your hands in the classic ten-to-two position (broken arms), (6) point the tilting steering wheel toward the chest not the face. Why cannot NHTSA merely do the logical thing and admit that seat belts save lives, but air bags do not.

THE TRUTH IS THE DOG TRAINED PAVLOV TO RING THE BELL WHEN IT WAS HUNGRY

You have to admire those creative busybodies on the American Board of Medical Specialties. The board re-certification revision has hardly had time to become active, yet now the ABMS hopes to scrutinize diplomas and assess their actual performance rather than merely test cognitive skills. ABMS Executive Vice President Stephen H. Miller, M.D. states that “maintenance of certification” would include evaluating patient outcomes, quality improvement initiatives, and lifelong education in the certification process. What a quagmire of data that would produce! At the present time, the American Medical Association Accreditation Program provides an ongoing quality evaluation, and the ABMS action is seen as a competitive attempt to capture exclusive purview over specialists. Is this trip really necessary?

ADDENDA —

† In Holland, the government will not attempt to prosecute euthanasia cases since the law is now too vague. Anyone for a slippery slope?
† Metallic body parts - heart of gold, nerves of steel, will of iron, balls of brass.
Aloha and keep the faith —rts
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