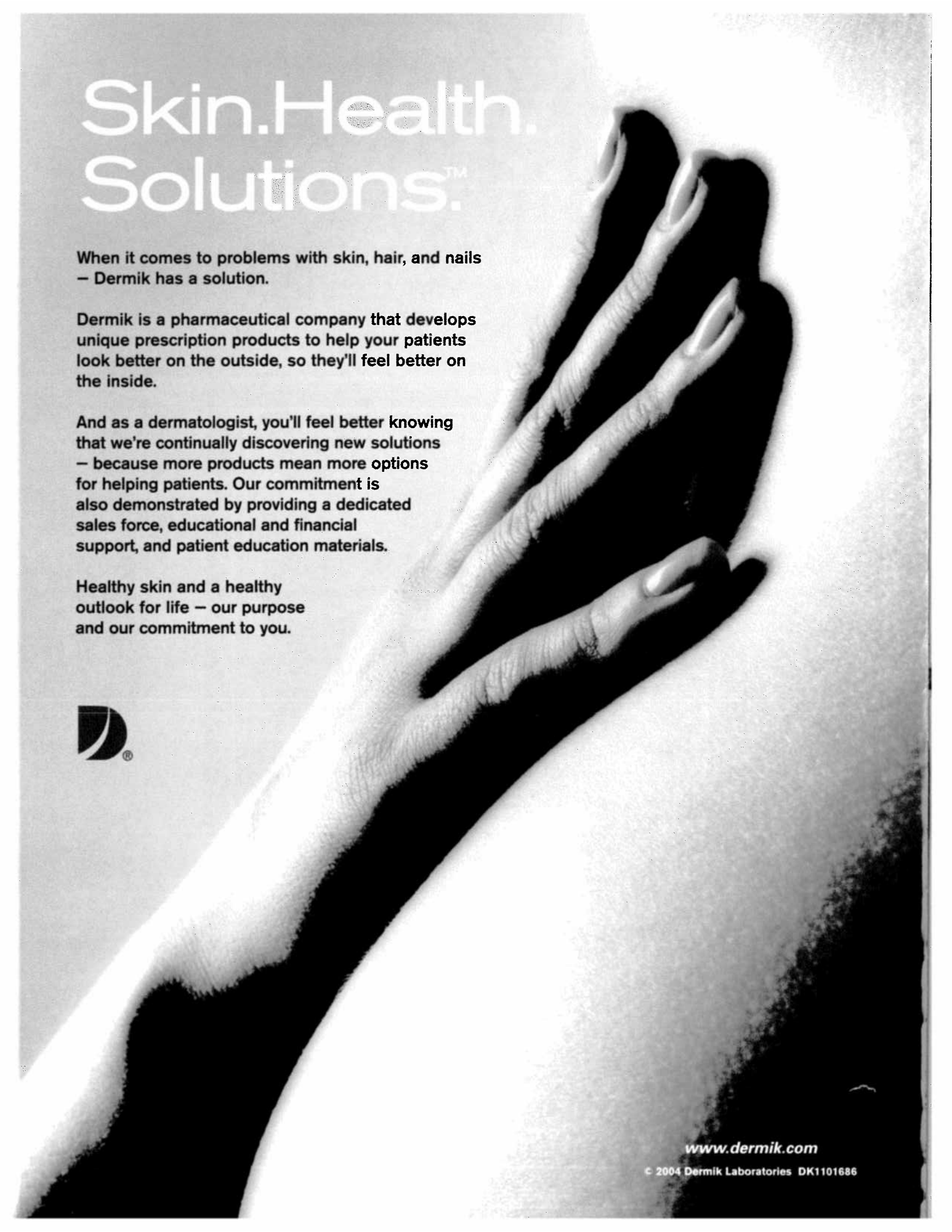
HAWAII MEDICAL JOURNAL

May 2004 Volume 63, No. 5 ISSN: 0017-8594


Skin.Health.
Solutions.™
When it comes to problems with skin, hair, and nails – Dermik has a solution.
Dermik is a pharmaceutical company that develops unique prescription products to help your patients look better on the outside, so they'll feel better on the inside.
And as a dermatologist, you'll feel better knowing that we're continually discovering new solutions – because more products mean more options for helping patients. Our commitment is also demonstrated by providing a dedicated sales force, educational and financial support, and patient education materials.
Healthy skin and a healthy outlook for life – our purpose and our commitment to you.
www.dermik.com
© 2004 Dermik Laboratories DK1101686

HAWAII MEDICAL JOURNAL
(USPS 237-640)

Published monthly by the
Hawaii Medical Association
Incorporated in 1856 under the Monarchy
1360 South Beretania, Suite 200
Honolulu, Hawaii 96814-1520
Phone (808) 536-7702; Fax (808) 528-2376

 The *Hawaii Medical Journal* (USPS 237640) is published monthly by the Hawaii Medical Association (ISSN 0017-8594), 1360 South Beretania Street, Suite 200, Honolulu, Hawaii 96814-1520.

Postmaster: Send address changes to the *Hawaii Medical Journal*, 1360 South Beretania Street, Suite 200, Honolulu, Hawaii 96814. Periodical postage paid at Honolulu, Hawaii.

Nonmember subscriptions are $25.

Contents

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

Mele Pō

Showing an ukulele player performing a "night song".

Editorial

Norman Goldstein MD
Editor, Hawaii Medical Journal

Robert A. Nordyke MD

July 14, 1919 - August 23, 1997

"I am Third"

This issue of the Hawaii Medical Journal contains a book review by Alfred Morris MD about "I am third, an American boy of depression years - Memoirs of Robert A. Nordyke MD"

For fellow physicians at the Straub Clinic and Hospital, and other physicians throughout Hawaii and indeed the world, the reading of Bob's memoirs and the viewing of family photos is a genuine pleasure.

I thought I knew Bob when I prepared the Festschrift honoring Fred Gilbert MD in the July 1997 issue of the Journal,[1] where I reviewed Bob's biography and his many awards and publications, and was reminded of our personal friendship over the years consulting with him about patients and Straub activities. But when I read Ellie Nordyke's compilation of his memoirs I really got to know Bob Nordyke.

The research work that was done by Bob Nordyke in the Fred Gilbert Festschrift is reproduced here:

Description of Research Work Done by Robert A. Nordyke MD

Dr. Robert A. Nordyke is an internationally recognized specialist in nuclear medicine and a pioneer in the field of medical informatics, recognized for his development of computer-based medical records, databases, and clinical studies of thyroid disease. Since establishing the Department of Nuclear Medicine at Straub Clinic and Hospital in 1960, Dr. Nordyke has built a uniquely large and complex thyroid disease database, which has helped uncover many new facts about these frequently under-diagnosed diseases and about their treatments. He has demonstrated the correlation between size of a goiter (thyroid gland enlargement) and increased thyroid function (hyperthyroidism); has shown how the cure rate for hypothyroidism is affected by various drug combinations and dosages; and most recently, determined what is the most cost effective sequence of thyroid function testing for general hospital laboratory use. Dr. Nordyke developed, in collaboration with Casimir A. Kulikowshi PhD, one of the earliest pattern recognition methods for computer decision support employing a combination of advanced statistical and logical reasoning techniques.

Dr. Nordyke's research, in collaboration with Dr. Fred Gilbert, led the research efforts on information systems for multi-specialty clinics, chronic disease clinics, and screening for breast cancer at the Pacific Health Research Institute (PHRI).

At a time when doctors kept patient records on 3x5 index cards and were viewing the computerization of medical records with suspicion, Dr. Nordyke recognized the power of computers as tools not just for keeping tidy notes, but for gathering and analyzing medical data in a way that would help direct doctors' diagnoses and treatments for patients. A visionary always bent on improving treatment for his patients, he was 30 years ahead of his time in realizing that the kinds of patients a doctor sees vary from practice to practice and that databases collected specifically for each practice improve the quality of patient care dramatically.

Bob Nordyke MD is a very special man, as indicated by George Chaplin, himself a very special man. Dr. Nordyke served as guest editor for the June 1995 Festschrift honoring Fred Gilbert MD. It was our largest and best Festschrift. Bob has received many accolades, accomplishments and awards – as described in his biography. Most recently he received a special recognition award from the Society of Nuclear Medicine, Hawaii Chapter.

Mahalo Nui Loa, Bob for the Fred Gilbert Festschrift, for your efforts to construct cabins at the YMCA Camp Erdman on Oahu's North Shore, for your years of research and administrative guidance at the Pacific Health Research Institute, for the many patients you have helped through the decades, and for your friendship.

Ellie Nordyke has received hundreds of letters from physicians, patients, and friends complimenting her and thanking her for completing the memoirs. As one of the many readers said, "if it's not blasphemy, he was first," referring to the subtitle "I am third. God is first, every one else is second, and I am third."

References

1. HMJ vol 56: 168 July 1997

From the Associate Editor

Fragments from Hawaii's Medical History

NHCOE'S 2004 Calendar

William W. Goodhue Jr. MD
Associate Editor, Hawaii Medical Journal

It's here! **Benjamin B. C. Young MD**, Executive Director and Principal Investigator at the John A. Burns School of Medicine (JABSOM)'s Native Hawaiian Center of Excellence (NHCOE) has added a splendid successor to his Division's annual *Hawaii Medical History Calendar*. Production of the 2004 calendar, *Fragments from Hawaii's Medical History*, was supported in part by a grant from the Department of Health and Human Resources.

This year's calendar provides a succession of vignettes of lives of twelve men and women whose legacy has molded today's Hawaii. Formatting includes glossy photographs of *kupuna* with succinct medically related texts, similar photographs and brief comments by *mo'opuna* (descendants), and appropriate third party quotations. The cover Seal of the Kingdom of Hawaii introduces the reader to a quotation on the following page which provides the calendar's theme: *I ulu no kaka lala i ke kumu*, roughly translated as *Without our ancestors we would not be here.*

Kupuna and *mo'opuna* honorees represent a broad slice of society in Hawaii over the past two centuries.

January introduces **High Chiefess Kino'ole o Liliha**, the granddaughter of King Kamehameha I's High Chief Kame'eiamoku. Her marriage to merchant Benjamin Pitman Sr produced many prominent descendants including today's **Diane Kino'ole Pitman Spieler** who treasures her heritage. *February* features **Miriam 'Auhea Kekauluohi**, *kuhina nui* for King Kamehameha III and mother of King Kamehameha IV (Lunalilo). Current Hawaii State Department of Health Director **Chiyomi Leina'ala Fukino MD** places the *alii*'s death from influenza in historical perspective. *March*'s **Abraham Fornander** championed preservation of all things Hawaiian and married Chiefess Alanakapu Kauapinao. He died of mouth cancer. Great-grandson and endocrinologist **Ralph Beddow MD** has maintained love for Hawaiian culture.

April's selection is **William Pitt Kalaho'olewa Leleliohoku**, brother of King Kalakaua and Queen Liliuokalani. On his death from pneumonia, Princess Bernice Pauahi Bishop became the next heir to the vast estate of his *hanai* mother, Princess Ruth Ke'elikolani. Waikiki Health Clinic Medical Director **Eliot Kalauawa MD** adds that pneumonia still causes 100 deaths a year in Hawaii. *May* highlights **Dr. William Joseph Arthur Goodhue**, Medical Director at Kalaupapa from 1902 to 1925, who married Christina Augusta Meyer. Her progenitor Rudolf Meyer had married Kalama Waha, Chiefess of Kalae, and was co-executor with Charles Reed Bishop of Princess Ruth's Molokai estate. Kalaupapa visitor Jack London wrote, "Dr. Goodhue...is a hero...". Grandson and Honolulu First Deputy Medical Examiner **William W. Goodhue, Jr. MD** (your Associate Editor!) is one of a long line of physicians in his family including his father, one of Kauai's last plantation doctors. *June*'s choice is **Archibald Scott Cleghorn**, first President of Queen's Hospital, husband of Princess Miriam Likelike, brother-in-law of King Kalakaua and Queen Liliuokalani, and Governor of Oahu. Child psychiatrist and APS Healthcare Executive and Medical Director **J. Kuhio Asam MD** values Cleghorn's many legacies to Hawaii.

King Kamehameha I appointed *July*'s **John Papa I'i** to train Liholiho. He helped draft the 1852 Constitution, was an associate justice of Hawaii's Supreme Court, and provided insights into health of the Hawaiian people in a series of articles collected into a book, *Fragments of Hawaiian History*. Architect **Kenny Brown FAIA** values his great-grandfather's insights. **William Hillebrand MD** (our December *Na Kauka o Hawaii* selectee) is *August*'s choice. He was physician to many of Hawaii's *alii*, first Medical Director of Queen's Hospital, and an expert botanist. Queen's Health System CEO and President **Gary Okamoto MD** maintains Hillebrand's commitment. *September* spotlights **Dr. Tai Heong Kong Li** who delivered over 6000 babies here in the 50 years after her arrival in 1896, including **Director Young**! Obstetrician-gynecologist **Gaylin Li MD** has followed in her great-grandmother's footsteps.

Paula Kaiulani Akana, television journalist, describes *October* honoree **Dr. C. T. Akana**'s work in searching for a Hansen's disease cure and her great-grandfather's expertise in treating diseases of men. *E hi'i i ke kapu!* (*Maintain the tradition!*) was the motto of *November*'s **Princess Miriam Likelike**. Sister of King Kalakaua

See NHCOE, p. 148

I'm Third

An American Boy of Depression Years

Memoirs of Robert A. Nordyke MD

Edited by Eleanor C. Nordyke and Aimee M. Grace
(privately published 2003)
Designed and Produced by Barbara Pope Book Design
Illustrated. Appendix. References. Index. 184 pp.
Available from the University of Hawaii Press Catalog,
Bookstores that carry University of Hawaii Press books,
Straub Clinic and Hospital Gift Shop,
Eleanor Nordyke, 2013 Kakela Drive, Honolulu HI 96822
Price $25

reviewed by:
Alfred D. Morris MD

It's difficult to write an objective, analytic review of a book which is so completely concerned with someone you have known and admired, a colleague of distinguished reputation and a member of a family for whom you have great aloha. Forgive me if I fail in the effort or allow my bias to have an inordinate influence. However, if the truth be known, reading this autobiographical collection of vignettes not previously known to me has greatly increased my feelings of admiration for and the loss of comradery on the passing of Bob Nordyke, the astute physician and gifted researcher that I knew.

Bob's style of writing is not grand. It is personal and just as the introduction promises tells remembered snippets of a lifetime as they were told to his children and family. Each taken individually is interesting, comic or sad, remarkable or mundane, but taken together expose not just the character of the individual but a cast of characters who are real people recording a vivid sense of a place and a time which spans a period of U.S. history which is I believe truly heroic–the roaring 20s, depression 30s, wartime 40s, post-war 50s and 60s. It is small town America, small time family and real live heroics of daily life. One of the readers states that he would rather read this book than *Huckleberry Finn*. I had the same feeling. Mark Twain captured a cross section of mid-America whereas Bob has related a longitudinal view of a life story, infant to grown man, that resulted in an exceptional physician.

This having been said I admonish you not to succumb to the temptation to thumb through this book looking for an interesting note or two here and there that happens to catch your eye. This type of work seems to invite such a reading. The remarkable thing is that the organization by chronological groupings, if read beginning to end, produces a wonderful account of the development of a child to adulthood. This is a portrait of a lively, adventurous, studious child who matures and grows, at times recklessly, at times responsibly, to adulthood. Every parent will recognize this process with a great feeling of concern and empathy.

I don't know if the compilers of the book or Bob himself meant this to be a study in what it is that makes one choose and succeed in a life dedicated to medicine or research. A multitude of studies at Johns Hopkins and elsewhere have tried to sort out what predicts whether a doctor will succeed in medical school and finally become the kind of physician our society desires. One such study found that the students who were most knowledgeable about bioethics were those of Jewish ethnicity, those who were older on entering medical school, and those who had had a broad experience outside of medicine. Bob certainly possessed the later two characteristics having entered medical school at age twenty-eight after serving as an instructor in the US Air Force during WWII. His stories of riding the rails, firefighting, working on a tuna fishing boat, narrow escapes while in the Air Force and adventures with entrepreneurship attest to a rich and often dangerous experience outside the medical world. I suspect that Bob would have succeeded at most anything he decided upon, or might have been forced into, and that he would have had the same ethics, life view and success. In a very brief conversation with his wife, Ellie told me that he was greatly influenced by his mother's strong character and morality. The other great influence she believes was his experience in the YMCA which at that time had a much stronger religious, moral aspect. What is striking to me is how many parallels there were in his life stories with those in my own. I suspect that many if not most physicians and their families will have the same reaction.

The Foreword by Bob's physician son Thomas and the Preface by his wife Ellie give a loving family assessment and explain the meaning of the title. The ten chapters group periods of Bob's life, each of which illustrates a stage of his development from infant to manhood and describes incidents which undoubtedly molded his beliefs and character. The Appendix compiles the scorecards of community opinion, patients' and colleagues' thoughts, scientific production and curriculum vitae, all of which give a grade of A+. If his medical career seems to have been slighted in the body of the book, it should be noted that Bob had outlined additional chapters

*See **I'm Third**, p. 148*

Commentary

Steven M. Moser MD

March 15, 2004

Last week the Hawaii House of Representatives passed across to the Senate a budget bill HB 1800 that includes a $11M cut in funding for the Hawaii Health Systems Corporation (HHSC). Once again, as it has done many times in the past, the legislature threatens to jeopardize the health and welfare of the people of Maui and our many visitors. As the outgoing Medical Director of our "safety net" hospital for the last two years, I can say categorically that if this funding is not reinstated, not only will we be unable to expand services as we have been planning to do, but we will need to cut some services and severely restrict others.

Historically, when the state took the hospital over from the county over 30 years ago, it assumed full responsibility for the health and welfare of the people of Maui in terms of hospital care. It was clearly not up to the job: because of the gross inefficiencies of trying to run local hospitals (ours is one of 12 state-run health care facilities) with a massive state bureaucracy, the legislature in 1996 established the HHSC as a quasi-public corporation to manage MMMC (along with the 11 other facilities). However, Act 296 was born bearing the seeds of failure: from the start the HHSC was underfunded to deal with the antiquated and dilapidated condition of many of its buildings; it maintained a Honolulu-centric civil service system of employment with collective bargaining done at a state level; it centralized budgetary and decision-making with the HHSC Board and CEO, with Maui Memorial still at their mercy.

Despite all of these problems, our hospital has continued to provide good service to our community. We have the 2nd busiest ER in the state. We handle all serious medical conditions except neonatal intensive care, interventional coronary procedures, transplantations and other highly specialized treatments. We have just opened the finest angiography unit in the state. We routinely do well in many outcome measures of performance when reviewed by national quality assurance organizations. We are in the process of redefining ourselves by establishing service lines for cardiology, oncology, surgery, and women's and children's services. We are restructuring our medical staff to improve efficiency and peer review, and are very close to starting construction on a new wing using a hard-fought $38M capital improvement bond. In short, we are on the verge of great things, and are trying to be progressive in a regressive time.

And yet, because of apparent political considerations, all the work we have done is in jeopardy. Like a house of cards, we on Maui are in danger of collapse as our operational underpinnings are being removed. There are many in the legislature who don't trust the leadership of the HHSC, and want to punish it by cutting it funding. They think that the HHSC is being "wasteful" with its expenditures, and apparently don't know how to read a financial statement, if we are to believe yesterday's article in which Mr. Driskill, CEO of the HHSC, points out that they mistakenly think HHSC has been "hiding" $15M. We need to remind these legislators, and the public, that MMMC does not, in and of itself, depend on state general funds. MMMC usually makes a small profit, ie, it collects enough money from third party insurances to pay for its operational and some CIP expenses, and is the only state hospital in Hawaii to do so. We would probably always be profitable were it not for the funds that we pay HHSC to administer us from Honolulu.

Why is the HHSC not more profitable? Because hospitals, MMMC included, do a lot of "free" care for the uninsured and under-insured; because reimbursements from Medicare and Medicaid, as well as HMSA are always being reduced; because we are mandated to pay salary increases for our union employees given by the legislature and for the recent market losses of their expensive pension plan without consideration for our ability to pay. Also, the practice of medicine is continually changing with the advent of new technologies, new equipment needs, and new drugs, not to speak of routine supplies which cost more and more. It is all expensive, but all necessary to maintain quality of care and stay current. Some of our facilities are 50 years old and should be replaced. This takes state moneys...it cannot come out of hospital revenues which barely keep up with day to day operations.

The legislators who dare to talk about their reasons for cutting us are under the false impression by "raising our special funding ceiling", they are somehow allowing us to spend more. They mistakenly assume that we can just raise our prices, charge more and collect more revenue. We can't...we are at the maximum reimbursements allowed by law. In fact, the cuts they propose will have the opposite effect: we will become rapidly less profitable as we lose business to Honolulu or encourage competing entities on Maui.

The cuts proposed by the legislature will have some or all of the following effects: loss of child and adult psychiatric inpatient services, loss of orthopedic inpatient services (and therefore trauma services), decreased staffing levels for all clinical services, inability to fund many projects in the works (such as ER renovations, upgrading endoscopic and inpatient dialysis services, upgrading information

technology systems, health and safety repairs and upgrades, etc), and cutting leadership positions. Service line development will be retarded. Recruitment of qualified staff and talented physicians to our hospital will be jeopardized. Good nurses and clinicians, unable to perform to their potential, will leave. And so will you, the patients...you will be flying to Honolulu to get the quality of care you need and deserve. From being the only profitable hospital in the system, we will lose market share and join the rest of the HHSC facilities swimming in red ink.

Thirty years ago, the state assumed the ongoing responsibility for assuring that our hospital care meets the minimum requirements of care. At this moment, the legislature, for reasons of political infighting, seems to have forgotten that cardinal responsibility. We are being "punished" along with the HHSC by the legislature. The legislators, some of whom are our own representatives, don't seem to understand how we operate, what we need to get the job done, and what effect their vindictiveness and short-sightedness (I can't believe they don't know how to read a balance sheet) will have on us here at the local level. Either they provide for us, or they should get out of the hospital business and allow this hospital to go on its own, or allow another to be built by private concerns. Or at least anesthetize us before they use the axe (when we run out of scalpels).

Why is this so hard? Is Hawaii really such poor state that we can't afford to give excellent health care to our residents and visitors? Vancouver charges a $10 exit fee to fund its airport. We could do the same for visitors leaving our airports and raise $40M a year to fund not just our hospital's crying needs, but other infrastructural necessities as well. An old idea to be sure, but isn't time to try something that would work?

Editor's Note:
Steven M. Moser, M.D. is a nephrologist on Maui and has served as Medical Director of the Maui Memorial Hospital. The name Moser should be very familiar to Hawaii physicians. His father Robert practiced internal medicine on Maui for many years and then became the Executive Director of the American College of Physicians. Bob Moser now lives in Green Valley, Arizona.

This commentary appeared as a column, "Island Voices" in the Honolulu Advertiser. Steve, mahalo for permitting us to reprint this in the Hawaii Medical Journal as a commentary. He can be reached at Moser@maui.net or at 135 S. Wakea Street, Suite 105, Kahului HI 96732.

NHCOE *from p. 145*

and Queen Liliuokalani and mother of Princess Kaiulani, she died of unknown causes. Pediatrician and NHCOE Fellow **Kelli-Ann Noelani Frank Voloch MD** emphasizes the importance of addressing spiritual and psychological, as well as physical, needs of patients. *December*'s choice, **Elizabeth Keawepo'ooleinamoku Sumner Achuck,** lady-in-waiting to Princess Likelike, composed the beloved song *Sanoe* with the future Queen Liliuokalani. She died of diabetic complications. Cultural expert **Nalani-Alua Olds** treasures her great-grandmother's legacy of musical talent and compositions.

NHCOE's 2004 *Hawaii Medical History Calendar*, like those in prior years, is a treasure trove for anyone interested in delving more into Hawaii's history. Perhaps next year's calendar will include a sketch of NHCOE Director **Benjamin B. C. Young MD**'s many contributions: he was crew member on the 1976 maiden voyage of the *Hokulea*, has recorded a CD of Irish folk songs, and is the first *kanaka maoli* to have become a psychiatrist! Mahalo, Ben, for this outstanding calendar!

Call NHCOE for further information about the calendar at (808) 956-5826, Facsimile (808) 956-6588.

I'm Third *from p. 146*

left uncompleted, a great loss to his readers. Although well known to his family, friends and colleagues we will not have his particular insight and literary statement of that period of his outstanding life. What we do have is a synopsis in the form of his retirement speech to the physicians of Straub Clinic June 26, 1995, a witty and insightful snapshot of medical practice at one of the premier clinics and hospitals of Honolulu, Hawaii.

I strongly recommend this book not only for a medically oriented reader but for a general readership. I am grateful for the family members who urged him to write down the stories that he had told them and for the fact that he did what they asked and for the editors who were responsible for making this delightful book available to us all.

AIR FORCE RESERVE Healthcare Careers

Take your career above and beyond as a healthcare professional in the Air Force Reserve.

When you join the Air Force Reserve, you're doing something for yourself and your country. As a physician or surgeon, you'll get benefits like paid CME credit and the opportunity to practice cutting edge medicine. You'll also get a paycheck and the respect that comes with an officer's rank. It's a part time commitment, yet what you get in return lasts a lifetime.

AIR FORCE RESERVE

ABOVE & BEYOND

For more information visit our website at www.afreserve.com/healthcare or call 800-257-1212.

Patient Characteristics, Health Status, and Health-related Behaviors Associated with Obesity

Deborah A. Taira ScD, Krista Gronley MPH, MBA, and Richard Chung MD

Deborah A. Taira ScD

Krista Gronley MPH, MBA

Richard Chung MD

Authors:
- Hawaii Medical Service Association (an independent licensee of the Blue Cross and Blue Shield Association) (D.A.T., K.G., R.C.)
- John A. Burns School of Medicine, University of Hawaii, Honolulu, HI (D.A.T., R.C.)

Correspondence to:
Deborah A. Taira ScD
HMSA (BCBS of Hawaii)
818 Keeaumoku St.
PO Box 860
Honolulu, HI 96808-0860
fax: (808) 948-6043

Abstract

The objective of this study was to identify factors associated with obesity and to examine the health habits of the obese and non-obese. In this study of over 44,000 insured individuals, obesity rates increased with age until age 65 and were highest among members of Samoan ancestry. Because the causes of obesity are multi-faceted, treatment approaches may need to address diet, exercise, pharmacotherapy, and management of comorbid conditions.

Introduction

Obesity, a complex, multi-faceted condition involving environmental, genetic, behavioral and psychological components, has been increasing in every state in the United States. According to self-reported height and weight information, in 2001, 20.9 percent of U.S. adults were obese (body mass index (BMI) ≥30), compared to 11.6 percent in 1990.[1] Although obesity rates were somewhat lower in Hawaii, a similar trend was observed, with prevalence climbing from 9.1 percent in 1990 to 17.6 percent in 2001.[2]

Obesity is the second leading cause of preventable death in the United States, resulting in approximately 300,000 excess deaths each year.[3] Obesity is also significantly associated with a number of co-morbid conditions. Adults with a BMI>40 (class 2 obesity) had an odds ratio of 7.4 for diagnosed diabetes, 6.4 for high blood pressure, 1.9 for high cholesterol, 2.7 for asthma, 4.4 for arthritis, and 4.2 for fair or poor health.[2,4]

Obesity and its associated health conditions contributed approximately $117 billion in healthcare costs in 2000 for American adults, compared to $99 billion in 1995, with a majority of the costs stemming from type 2 diabetes, coronary heart disease, and hypertension.[5,6]

Ethnic, gender, and age disparities in the prevalence of obesity have been observed at the national level, with obesity being more common among African American and Mexican American women than among Caucasian women.[7] The goals of this study were to identify disparities in the prevalence of obesity associated with age, gender, education level, and ethnicity in an insured population in Hawaii and to examine the association between obesity, health status, and health-related behaviors.

Methodology

Study population

The study population was comprised of 44,528 members enrolled in a Health Maintenance Organization (HMO (n=6,746)), a Fee-For-Service Organization (FFS (n=31,532)) or a Medicare cost contract (n=6,250) of a single health insurer, who responded to a 2002 member satisfaction survey. Of the 54,669 members who responded to the survey, 10,141 were excluded because they did not supply height and weight information. The survey was administered between May and July of 2002 and had an overall response rate of 45.3 percent. Females were more likely to respond than males (47% vs. 43%, respectively, $p<0.001$) and the mean age of respondents was older than that of non-respondents [59.6 vs. 50.7, respectively, $p<0.001$].

Measurement

Body mass index was calculated from the self-reported height and weight data. An individual with a body mass index of greater than 29.9 was categorized as obese. This cut-off point is consistent with the National Heart Lung and Blood Institute's Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults.[4]

The survey also asked members to self-report ethnicity, education, health-related behaviors, and health status. For ethnicity, members were asked to check all that apply from a list of 19 ethnic groups (Table 1). These categories were chosen to be consistent with the Hawaii Department of Health's Hawaii Health Surveillance Program. In most cases, members who marked more than one race or ethnicity were categorized as 'mixed.' The exceptions were that any member who marked Hawaiian was classified as Hawaiian and any members who marked both Portuguese and white or Puerto Rican and white were considered Portuguese and Puerto Rican, respectively. Hence, the 'mixed' category is actually 'mixed, non-Hawaiian'. Data were displayed for the 10 largest categories: Japanese

(n=16,705), white (n=7846), Part Hawaiian (n=5466), Filipino (n=4271), mixed (n=3900), Chinese (n=2966), Portuguese (n=1138), Korean (n=417), Puerto Rican (n=214), and Samoan (n=82).

Additional survey items asked about fruit and vegetable consumption and exercise (Table 1), and the impact of physician counseling. Health status was assessed using the Medical Outcome Study Short-Form 12 (SF-12).[8] Physical and mental health status summary scores were calculated from the SF-12 items.

Statistical analyses

For categorical variables, Pearson's χ^2 tests were used to compare the relation between demographic characteristics and obesity. For continuous variables, including physical and mental health scores, analysis of variance was used to determine whether there were significant differences related to obesity. Logistic regression was used to estimate the odds ratios of obesity for Japanese, Chinese, Filipino, Portuguese, Puerto Rican, Samoan, Korean, Hawaiian members, and members of mixed race or ethnicity, compared to whites. These analyses adjusted for age, gender, type of health plan, and education. T-tests were used to determine whether fruit and vegetable consumption and exercise differed for obese and non-obese members across all sub-groups defined by patient characteristics. All analyses were conducted in Stata V.7 (College Station, TX).

Results

Characteristics of the Study Population

Two percent of respondents were aged 18 to 24, 6.4 percent were aged 25 to 34, 12.1 percent were aged 35 to 44, 19.5 percent were aged 45 to 54, 20.3 percent were aged 55 to 64, and 39.6 percent were aged 65 and older. A total of 63 percent were female, and 86 percent had at least a high school education. The majority of members (70.8 percent) were enrolled in the FFS plan, 15.2 were enrolled in the Medicare cost contract, and 14.0 percent were enrolled in the HMO. Overall, 17.6 percent were white, 2.6 percent were Portuguese, 0.5 percent were Puerto Rican, 6.7 percent were Chinese, 9.6 percent were Filipino, 37.5 percent were Japanese, 1.6 percent were Korean, 12.3 percent were Hawaiian, 0.2 percent were Samoan, and 8.8 percent were mixed. In response to the overall health status item, 2.4 percent reported poor health, 14.6 percent reported fair health, 40.2 percent reported good health, 33.1 percent reported very good health, and 9.7 percent reported excellent health.

Patient Characteristics and Obesity

The overall obesity rate was 15.9 percent. Obesity varied by ethnic group (Figure 1). Compared to whites, Samoans, Hawaiians, Puerto Ricans, Portuguese, and individuals of mixed ethnicity were significantly more likely to be obese, while Asians (Koreans, Japanese, Filipinos, and Chinese) were significantly less likely. These ethnic disparities were consistent across gender.

After adjustment for other patient characteristics, obesity increased with age until age 64, after which the likelihood of obesity decreased (Table 2). Similarly, the likelihood of obesity was highest for members with mid-level education and some college relative to members with less than an 8th grade education. Females were significantly less likely to be obese than males. Type of coverage was not significantly associated with obesity.

Health-Related Behaviors

Rates of exercise (mean=2.6 times per week, SD 1.7) and fruit and vegetable consumption (mean =2.5 servings per day, SD 1.3) were below recommended levels (Table 3). Across all of the sub-groups defined by patient characteristics, non-obese members consumed more fruits and vegetables (0.1-0.4 more servings per day) and exercised more (0.4-0.7 more times per week) than obese members. Age was significantly associated with increased consumption of fruits and vegetables and increased exercise. Men tended to eat fewer fruits and vegetables than women, but exercised

Table 1.— Survey item content

Item	Response set
Member ethnicity (Please select ALL that apply to you)	Caucasian, African American, Mexican, Puerto Rican, Cuban, American Indian, Portuguese, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander, Other
How many servings of fruits or vegetables do you eat in a day?	0; 1; 2; 3; 4; 5 or more
How many times a week do you exercise for at least 30 minutes?	0; 1; 2; 3; 4; 5 or more
Which of the following has your doctor ever talked to you about?	Diet; exercise; smoking
Which of the following have you ever done because of your doctor's advice?	Changed your diet in any way; done more exercise; tried to cut down or quit smoking
Your height	____ Feet ____ inches
Your weight	____ lbs

Figure 1.— Odds ratio of obesity among adult health plan members in 2002 related to ethnicity, adjusted. All odds ratios are relative to non-Portuguese, non-Puerto Rican whites (n=7846) and adjusted for age, gender, education level, and type of coverage. All differences are statistically significant at the 0.05 level. The category 'Hawaiian' includes part-Hawaiian. Members that marked both Portuguese and white or Puerto Rican and white were considered Portuguese or Puerto Rican, respectively. All others who marked more than one group were categorized as 'mixed.'

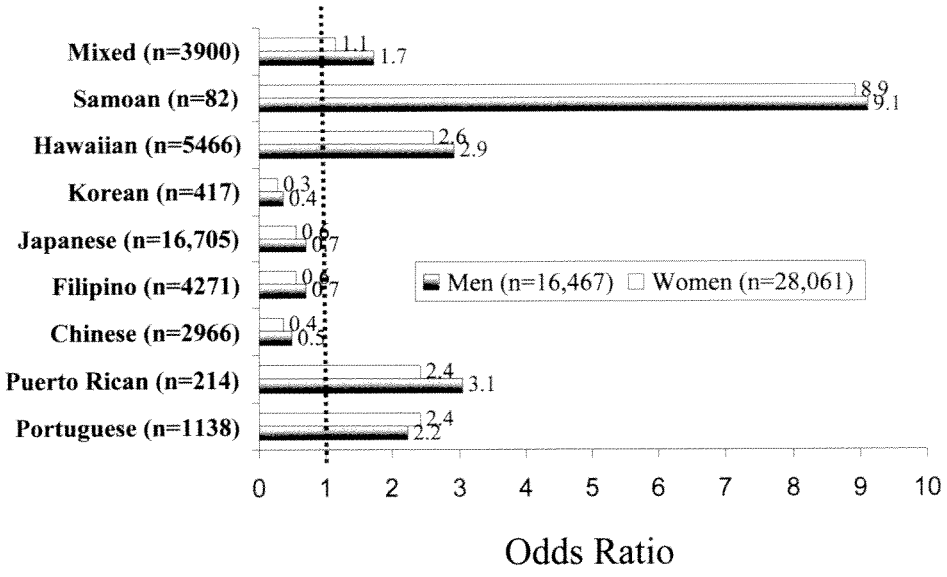


Table 2.— Likelihood of Obesity related to patient characteristics, adjusted*.

	Odds ratio of obesity	95% CI
Age		
18 to 24 (n=932)	1.0	
25 to 34 (n=2845)	2.0	1.6-2.6
35 to 44 (n=5393)	2.6	2.1-3.3
45 to 54 (n=8691)	2.8	2.3-3.5
55 to 64 (n=9019)	3.0	2.4-3.7
65 and older (n=17,648)	1.4	1.1-1.7
Gender		
Male (n=16,467)	1.0	
Female (n=28,061)	0.77	0.71-0.82
Education		
Less than 8th grade (n=2530)	1.0	
Some high school (n=2367)	1.1	0.95-1.3
High school graduate (n=11,429)	1.3	1.1-1.4
Some college (n=12,338)	1.2	1.1-1.4
College graduate (n=8464)	0.86	0.75-0.99
Post graduate education (n=6280)	0.82	0.71-0.94
Type of coverage		
Fee-for-Service (n=31,532)	1.0	
Health Maintenance Organization (n=6250)	1.1	0.96-1.23
Medicare cost contract (n=6746)	1.1	0.98-1.21

Adjusted for the factors listed above and member ethnicity (shown in Figure 1).

Table 3.— Mean consumption of fruits and vegetables per day and mean number of times of exercise per week related to patient characteristics and obesity.*

	Mean number of fruit and vegetables consumed per day			Mean number of times exercise ≥30 minutes per week		
	Non-Obese	Obese	t-test p-value	Non-Obese	Obese	t-test p-value
Age						
18 to 24 (n=932)	2.0	1.8	0.02	2.4	1.7	<0.001
25 to 34 (n=2845)	2.1	2.0	0.007	2.3	2.0	<0.001
35 to 44 (n=5393)	2.3	2.0	<0.001	2.4	2.0	<0.001
45 to 54 (n=8691)	2.5	2.2	<0.001	2.6	2.0	<0.001
55 to 64 (n=9019)	2.6	2.4	<0.001	2.7	2.2	<0.001
65 and older (n=17,648)	2.8	2.7	<0.001	2.9	2.4	<0.001
Gender						
Male (n=16,467)	2.4	2.1	<0.001	2.8	2.3	<0.001
Female (n=28,061)	2.7	2.4	<0.001	2.6	2.0	<0.001
Education						
Less than 8th grade (n=2530)	2.7	2.6	0.25	2.4	2.1	0.02
Some high school (n=2367)	2.7	2.4	<0.001	2.7	2.0	<0.001
High school graduate (n=11,429)	2.5	2.2	<0.001	2.6	2.1	<0.001
Some college (n=12,338)	2.4	2.2	<0.001	2.6	2.1	<0.001
College graduate (n=8464)	2.6	2.4	<0.001	2.7	2.2	<0.001
Post graduate education (n=6280)	3.0	2.7	<0.001	3.0	2.4	<0.001
Type of coverage						
Fee-for-Service (n=31,532)	2.6	2.3	<0.001	2.7	2.1	<0.001
Health Maintenance Organization (n=6,250)	2.4	2.2	<0.001	2.4	2.0	<0.001
Medicare cost contract (n=6,746)	2.8	2.7	0.07	2.8	2.4	<0.001
Ethnicity						
White (n=8547)	2.8	2.5	<0.001	2.9	2.2	<0.001
Portuguese (n=1138)	2.3	2.2	0.07	2.4	2.0	<0.001
Puerto Rican (n=214)	2.2	2.1	0.48	2.6	2.0	<0.001
Chinese (n=2966)	2.5	2.1	<0.001	2.6	2.0	<0.001
Filipino (n=4271)	2.4	2.2	<0.001	2.4	2.1	<0.001
Japanese (n=16,705)	2.5	2.2	<0.001	2.6	2.1	<0.001
Korean (n=47)	2.3	2.1	0.01	2.5	2.0	0.004
Hawaiian (n=5466)	2.3	2.2	0.001	2.6	2.1	<0.001
Samoan (n=82)	2.3	2.1	0.28	2.5	2.2	0.26
Mixed (n=3900)	2.3	2.2	<0.001	2.5	2.1	<0.001

*The mean number of fruit and vegetables was truncated at 5.

more. There wasn't a consistent trend relating education to fruit and vegetable consumption and exercise; however, individuals with post graduate education tended to have the healthiest behaviors. Exercise and fruit and vegetable consumption was highest for individuals covered by Medicare and lowest for HMO members. Obese or not, whites tended to exercise more and consume more fruits and vegetables than all other racial or ethnic groups.

When asked about physician impact on behavior change, obese members appeared to be more likely than non-obese members to change their behavior based on physician advice (data not shown in tables). Approximately 11.4% of obese members reported smoking less based on physician advice, compared to 8.2% of non-obese members. Similarly, 55.7% of obese members said they exercised more based on physician advice, compared to 43.6% of non-obese members, while 63.5% of obese members said they changed their diet based on physician advice, compared to 38.2% of non-obese members.

Impact of Obesity on Health Status

Overall, the physical health status score of respondents was slightly below the national norm (49 vs. 50), while the mental health status was above the national norm (52 vs. 50, data not shown in tables). Obese members had lower physical health status scores (47.4 and. 49.3, respectively) and mental health status scores (49.3 and 52.4, respectively) than non-obese members. After adjustment for patient characteristics, physical health scores of obese members were, on average, 2.6 points lower ($p<0.001$) than the scores of non-obese and mental health scores were 0.28 points lower ($p=0.002$).

Discussion

Healthy People 2010 identified obesity as one of ten high priority public health issues in the United States.[9] Also recognizing the need to attenuate the growing trend, the Surgeon General recently issued a call to action to combat the rising trend in obesity, stating that "Health problems resulting from overweight and obesity could reverse many of the health gains achieved in the U.S. in recent decades".[10] The goal of this manuscript was to examine the association between patient characteristics and obesity and to examine the health-related behaviors of the obese and non-obese in order to shed light on potential areas to target interventions.

In this study of over 44,000 insured individuals, we found that, after adjustment for other factors, the prevalence of obesity was significantly associated with age, gender, ethnicity, and education. After adjustment for other patient characteristics, obesity rates increased with age up until the age of 65 were highest for members of Samoan, Hawaiian, Puerto Rican, and Portuguese ancestry. Samoans stood out as having the highest obesity rates, with an odds ratio of obesity of 8.97 ($p<0.001$) compared to whites. The negative impact of obesity on health was documented in our finding that the physical functioning and mental health of obese members were significantly lower than that of non-obese members.

There are several limitations to this study. First, we know that respondents to the survey differed from non-respondents in that they were more likely to be female and older. This may bias our findings. For instance, we know that compared to women, men were less likely to respond to the survey yet more likely to be obese. This suggests that our overall estimate of obesity (15.9 percent) may be too low. Second, this study relied on patient reports of height and weight. Previous studies have documented a tendency among patients to under-report weight and over-report height.[11] One study suggested that this under-reporting was most common among individuals over age 70, who tend to underestimate their weight.[12] This, too, would result in our underestimating the prevalence of obesity, particularly among the oldest members.

Despite these limitations, this study provides useful information to support interventions to reduce obesity rates in Hawaii. Examining health habits, we found that females were less likely to exercise than males but more likely to consume fruits and vegetables. This suggests that an appropriate intervention for obese women might focus on exercise, while one for men might emphasize the need to consume more fruits and vegetables. Moreover, among obese members, all ethnic groups tended to consume fewer fruits and vegetables than whites and exercise less. For Samoans, the group most likely to be obese, their exercise rates were similar to those of whites, but their fruit and vegetable consumption was considerably less. Among all groups, obese individuals aged 18 to 24 had the least healthy behaviors. Given that their lifetime risk of an adverse event is highest, they represent a potential population to target for interventions.

While obese members were less likely to report exercising regularly and eating the recommended amount of fruit and vegetables, they were more likely than non-obese members to report changing their behavior (changing their diet, exercising more, smoking less) based on physician advice. This suggests that physicians may play an important role in informing patients of the health consequences of obesity and in recommending lifestyle changes. Moreover, the fact that the magnitude of the differences in exercise (<1 time per week) and fruit and vegetable consumption (< 1 serving per day) between obese and non-obese members suggests that small, persistent changes in diet and exercise may have an effect.

Because the causes of obesity are multi-faceted, treatment approaches may need to address diet, exercise, pharmacotherapy, and the treatment of comorbid conditions. The Task Force on Community Preventive Services strongly recommends: 1) large scale, visible community-wide campaigns to promote physical activity; 2) individually tailored programs to integrate physical activity in daily routines; 3) school-based physical education programs; 4) increased access to recreational areas.[13] The Department of Health, health plans, employers, hospitals, physicians, community health centers, and legislators need to work together to address this high priority public health issue.

References

1. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, 2000.
2. Mokdad AH, Ford ES, Bowman BA, Dietz WH, Vinicor F, Bales VS, Marks JS. Prevalence of obesity, diabetes, and obesity-related health risk factors, 2001. JAMA 2003 Jan 1:289(1):76-79.
3. Calle EE, Thun MJ, Petrelli HM, Rodriguez C, Health CW. Body mass index and mortality in a prospective cohort of U.S. adults. N Engl J Med 1999 Oct 7;341(15):1097-105.
4. National Institutes of Health, National Heart, Lung, and Blood Institute. Clinical guidelines on the identification, evaluation and treatment of overweight and obesity in adults. NIH Publication No. 98-4083; September 1998.
5. Wolf AM, Colditz GA. Current estimates of the economic cost of obesity in the United States. Obes Res 1998 Mar; 6(2):97-106.
6. Wolf AM. What is the economic case for treating obesity? Obes Res 1998;6(S1):2S-7S.
7. Eberhardt MS, Ingram DD, Makuc DM, et al. Urban and rural health chartbook. Health. United States, 2001. Hyattsville (MD):NCHS; 2001.
8. Ware JE, Kosinski M, Keller SD. A 12-item short form health survey: construction of scales and preliminary tests of reliability and validity. Medical Care 1996;32(3):220-233.
9. U.S. Department of Health and Human Services. Healthy People 2010, 2nd ed. With understanding and improving health and objectives for improving health. Washington (DC):GPO 2000. 2 vol.
10. U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. [Rockville, MD]: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; [2001]. Available from: US GPO, Washington.
11. Wang Z, Patterson CM, Hills AP. A comparison of self-reported and measured height, weight, and BMI in Australian adolescents. Aust NZ J Public Health. 2002;26(5):473-8.
12. Kuczmarski MF, Kuczmarski RJ, Najjar M. Effects of age on validity of self-reported height, weight, and body mass index: findings from the Third National Health and Nutrition Examination Survey, 1988-1994. J Am Diet Assoc 2001;101(1):28-34.
13. Task Force on Community Preventive Services. Increasing physical activity: a report on recommendations of the Task Force on Community Preventive Services. MMWR 2001;50(RR-18).

The successful treatment of end stage of heart failure associated with complete right bundle branch block with biventricular pacemaker placement

Eiji Hiraoka MD and Robert Hong MD

Abstract

Biventricular pacing has been used to treat patients with symptomatic heart failure, systolic left ventricular dysfunction and intraventricular conduction delays. This modality is usually reserved for the treatment of patients with a left bundle branch block pattern on electrocardiogram. We report the successful use of biventricular pacing in a patient with heart failure and a right bundle branch block conduction delay.

Introduction

Biventricular pacing (BiVP) or the simultaneous pacing of the left and right ventricle, has been used in the treatment of patients with severe left ventricular systolic dysfunction, intraventricular conduction delays and progressive heart failure.[1] This treatment may result in improved cardiac performance and functional status.[1] It is postulated that BiVP results in resynchronization of left ventricular contraction to allow coordinated contraction of the left ventricular septum and lateral wall. Left bundle branch block (LBBB) often causes asynergistic contraction between the septum and the left ventricular lateral wall.[2,3] Accordingly, BiVP has been predominantly used in patients with LBBB.[2,3] Although patients with right bundle branch block (RBBB) may also demonstrate intraventricular dysynchrony, the benefit of BiVP in patients with heart failure and RBBB has been less clearly established.[4] We report a case of a patient with nonischemic cardiomyopathy and RBBB in whom BiVP resulted in improved functional status and cardiac performance.

Case report

A 38-year old man presented to our institution with progressive heart failure and renal insufficiency. He had been diagnosed to have nonischemic cardiomyopathy at the age of 34. At that time, echocardiographic examination demonstrated dilated cardiomyopathy with left ventricular ejection fraction of 25%. Coronary angiography revealed the absence of significant coronary obstructive disease. The patient was treated with furosemide, valsartan, carvedilol and spironolactone. Three months prior to admission, the patient was diagnosed as having decompensated congestive heart failure. Outpatient diuretic therapy was attempted. The patient developed progressive worsening of dyspnea and was admitted to our institution.

On admission, the patient had overt congestive heart failure and a low output cardiac state. The blood pressure was 110/70 mm Hg and pulse was 102 beats per minute. On initial physical examination, the patient was documented as having elevated jugular venous filling pressure, pulmonary rales and a summation gallop. Laboratory studies showed normal blood count and electrolytes. Blood urea nitrogen and serum creatinine levels were elevated at 57 mg/dl and 2.8 mg/dl, respectively. A chest radiograph demonstrated congestive heart failure. An electrocardiogram (ECG) revealed the presence of sinus tachycardia, left axis deviation and RBBB with QRS duration of 190msec (Fig.1).

Right heart catheterization was performed. Hemodynamic pressure measurement showed a blood pressure 97/50 mmHg, a heart rate 109 beats/min, a right atrial pressure 18 mmHg, a pulmonary artery pressure 56/32 mmHg, a pulmonary artery wedge pressure 29 mmHg, and a cardiac index 2.0 L/min/m2 while on milrinone.

He was treated with intravenous diuretics, nesiritide and inotropic support with milrinone. However, he continued to manifest congestive heart failure and low cardiac output. Right heart pressure measurement documented right atrial pressure 24 mmHg, pulmonary artery pressure 61/40 mmHg, pulmonary artery wedge pressure 24 mmHg, and cardiac index 2.6 L/min/m2.

An echocardiography showed left ventricular enlargement, moderate to severe mitral insufficiency and global hypokinesis of the left ventricle with left ventricular ejection fraction of 10%. Septal contraction occurred 420 msec after the onset of the surface QRS complex and was 100 msec after contraction of the left ventricular lateral wall (Fig 2), demonstrating left ventricular dysynchroniza-

Authors:
- University of Hawaii Internal Medicine Residency Program, Honolulu, HI 96813 (E.H.)
- Department of Cardiology, Queen's Medical Center, Honolulu, HI 96813 (R.H.)

Correspondence to:
Eiji Hiraoka MD
University of Hawaii, Internal Medicine Residency Program
1356 Lusitana St., 7th Fl.,
Honolulu, HI 96813
Fax: 808-586-7486
email: hiraokae@aol.com

tion. Therefore, resynchronization treatment was considered. A biventricular pacemaker was placed. Ventricular leads were placed in the right ventricular apex and the posterolateral branch of the coronary sinus.

After placement of the biventricular pacing system, the patient had marked clinical improvement with a change in functional status from NYHA IV to II. Serum chemistries revealed a decrease in creatinine from 2.8 to 1.3 mg/dl. The echocardiography performed after pacemaker placement documented synchronous contraction of the septum and lateral wall and increase in left ventricular ejection fraction from 10 to 20%. It also showed significant decrease of mitral regurgitation.

He was discharged and has not required hospitalization for heart failure in nine months of follow-up. His functional status remains NYHA II.

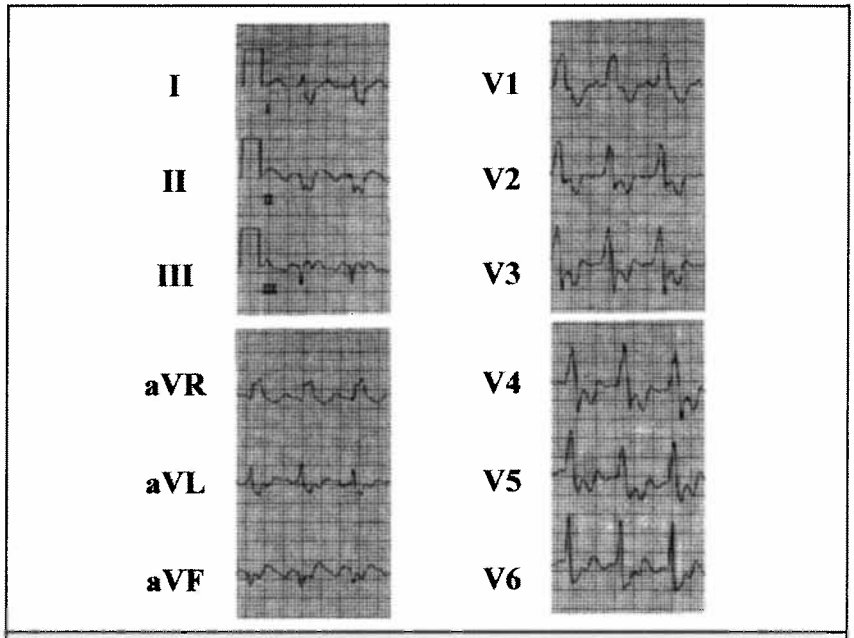


Figure 1.— A 12-lead surface electrocardiogram (25mm/s) on admission.

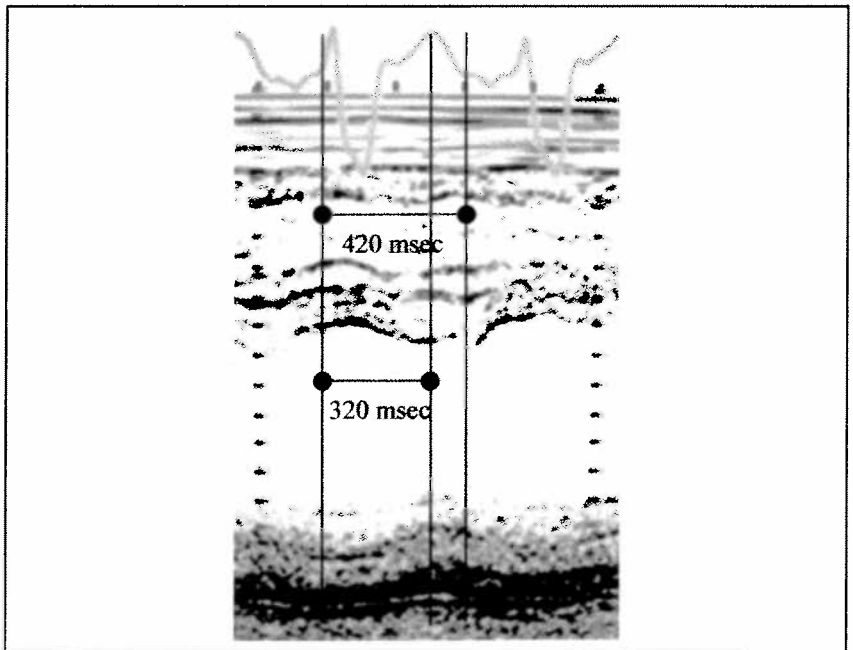


Figure 2.— M-mode echocardiographic view of the interventricular septum and posterolateral wall before biventricular pacemaker placement.

Discussion

Nearly 5 million persons living in the USA have heart failure, with 550,000 new patients diagnosed annually.[5] Despite substantial advances in drug therapy, heart failure was associated with 287,000 deaths and nearly 1 million hospital admissions in the USA in 1999.[6] A common finding in advanced heart failure is abnormal electrical activation of the ventricles or electrical ventricular dysynchrony, which is manifested in ECG as prolongation of QRS duration, often in the pattern of LBBB. This has been reported to be associated with diminished cardiac function[2,7] and increased mortality.[3] Recently, devices that make use of atrial-synchronized BiVP to coordinate right and left ventricular contraction have been developed. This device enhances cardiac function, reduces myocardial oxygen consumption, and improves exercise capacity, functional status, and quality of life. A meta-analysis of randomized controlled trial showed reduced mortality from heart failure.[8]

In the Multicenter InSync Randomized Clinical Evaluation (MIRACLE) study, 440 patients with marked functional limitations with NYHA functional class III or IV associated with an ejection fraction of 35% or less and a QRS interval of 130 msec or more were randomly assigned to BiVP or to a control group.[9] Patients treated with BiVP were noted to have improvement in functional class, increased exercise capacity and decreased rates of hospitalization. While improvement was noted in 66% of patients in this trial, a minority of patients did not improve. A hypothesis for failure to improve with BiVP was inclusion of patients with RBBB into the study population. This study included patients with both right and left bundle branch block as well as patients with nonspecific intraventricular conduction delay patterns.

We contend that improvement noted with BiVP in the treatment of patients with advanced heart failure and conduction abnormalities is not dependent upon the type of conduction abnormality but rather related to the extent of septal and left ventricular lateral wall asynergy. Despite the electrocardiographic finding in our patient of RBBB and therefore presumed isolated right ventricular asynergy, our patient demonstrated left ventricular dysynergy on echocardiographic studies. BiVP in our patient resulted in improved left ventricular contractile coordination and associated clinical status. We recommend that baseline echocardiographic testing be performed in patients with cardiomyopathies and conduction delays. BiVP should be considered in patients with conduction delays and associated left ventricular dysynergy.

See ***Successful Treatment****, p. 165*

Medical School Hotline

ePOI: electronic Pathways to Online Information

Facilitating Access to Hawaii's Online Library Resources

Steven E. Seifried PhD, Carolyn Ching MA, MLIS, Virginia Tanji MSLS, MEd and Paul Wermager MLIS, MPH

A web-accessible database of electronic biomedical reference materials has been developed by a consortium of science librarians and end-user organizations. Dependant upon license restrictions for each resource, a library visit, membership, card number or login/password may be required of the user. This tool is available to the public, researchers, students and health care professionals, and is available at http://epoi.hawaii.edu.

Introduction

The two major academic libraries that service the biomedical enterprise in Hawaii, Hawaii Medical Library (HML) and University of Hawaii Manoa Library (UHM) are steadily increasing the number of digital resources available to their patrons. Like many libraries throughout the nation, making these new resources easy to find and to access via the Internet is a major challenge. Web-based indices, search tools, and active links provide common solutions to this problem. The information environment in Hawaii offers an additional challenge since the two libraries have a complex overlapping set of patrons for whom recognizing available digital resources via the respective library is confusing.

Libraries and patrons are significantly challenged to possess current listings of what holdings are available to the patron. Online subscriptions are often bundled into collections of titles and ranges (dates of journal availability) by third-party subscription providers. These aggregate subscriptions are highly dynamic, and vary almost daily as specific agreements change between the aggregator and the originating publisher. Libraries must therefore subscribe to additional services that track the ever-changing availability. However, these reporting services do not provide searchable or reportable interfaces to the data for use by the end-user patron or the managing librarians.

Prior to the availability of the ePOI resource, the local end-user who wished access to an online biomedical journal was faced with several searches. First, the patron would determine whether they had privileges at HML or UHM. Several databases at those libraries would then be searched. Because of the dynamic nature of the holdings (see above), these in-house databases may not be complete or current. Having found the online availability, the user would then either go to the library to gain online access, or provide credentials (login) to remotely access the resource through the library's server.

In recognition of these factors that impede access to online biomedical journals, science librarians of University of Hawaii at Manoa, Hawaii Medial Library, Library Resource Center of John A. Burns School of Medicine, and a bioinformatician have developed an inter-institutional collaboration. The complex technical and administrative needs of the various entities were discussed and accommodated when possible through a series of planning and development meetings. A proposal to fund development of the required website and database was developed. The successful collaborative effort required the definition of compromise solutions that met the needs and goals of the various partners.

The National Library of Medicine (NLM) funded the proposal, submitted by a consortium of science librarians and end-user organizations, to develop a web-based mechanism for library patrons to search and access electronic resources from UHM Library and HML. These resources include electronic versions of research journals, databases, textbooks, and websites. This consortium of providers and user organizations has agreed to publicize and facilitate use of the ePOI resource through shared links on their organizational websites. Participating organizations include Cancer Research Center of Hawaii, Hawaii Area Health Education Center, Hawaii Health Systems Corp., Hawaii Pacific Health, Hawaii Residency Programs, Pacific Biomedical Research Center, University of Hawai'i School of Nursing and Dental Hygiene, University of Hawai'i at Manoa School of Social Work, Honolulu Shriners Hospital for Children, Spark A. Matsunaga Veterans Affairs Medical and Regional Office Center, and The Queen's Medical Center.

In summary, patrons and librarians had to check multiple places to figure out what was available and what was not, to whom and where; librarians were managing information about and access to these resources in multiple places. The ePOI project's goal is to create one place for access and management of online biomedical resources.

User Instructions

ePOI, Pathways to Online Information, provides a single searchable database of digital biomedical resources (subscription-based and free resources). These online resources are available via the University of Hawai'i Manoa Library (UHM) and Hawaii Medical Library (HML) to the biomedical research, education, community-based and healthcare organizations throughout Hawaii that are affiliated with the respective libraries. This database searches journal titles and holdings. Patrons must have identified a desired journal article citation before entering the ePOI resource.

The end-user enters http://epoi.hawaii.edu from any computer with access to the Internet, using an Internet browser of recent vintage. ePOI is used to browse or search through the extensive combined electronic resource collections of these libraries. Searches can be made by journal title, title abbreviation, keywords that describe the journal contents, alphabetic title search and more advanced Boolean searches based on title and keywords. ePOI includes the names of journals, databases, e-books, and websites. Searches for individual articles cannot be made. To search for the article citations, primary reading or reference database such as PubMed or ScienceDirect are extracted, the full text of the desired article is accessed through ePOI.

Off-campus access to many of the resources requires a valid, activated UHM Library or HML card. Resources indicate whether a valid, activated library card is required or if they are freely accessible. If a resource indicates "HML", then Hawaii Medical Library makes the resource available. The resource will be accessible directly from computers within HML and possibly from anywhere on the Queen's Medical Center campus. Remote access may be available via HML's proxy server with a valid HML Library card. For additional information HML's membership policy is available on HML website at http://hml.org/WWW/hmlmem.html.

If a resource indicates "UHM", then the resource is made available by the UHM Library. The resource will be accessible from any UHM Library computer. Out-of-library access to UHM resources requires a valid, activated UHM Library card or UHM username and password. For additional information UH Manoa Library's Electronic Resources User Guide at http://www.hawaii.edu/serials/guide.htm#remote is accessed.

Many resources included in ePOI have open access, which means they are available to everyone with or without affiliation with UHM or HML. These resources are indicated by a "Free" designation and often include an embargo period. For more information and access to free journals, the websites: http://www.freemedicaljournals.com/, http://highwire.stanford.edu/lists/freeart.dtl, and http://www.pubmedcentral.nih.gov/ can be checked.

Results

The technical implementation developed includes a Microsoft SQL Server database with ASP pages dynamically generated and served through Microsoft IIS. The result is a secure and private website; end users cannot see the code that is generated, thereby limiting possible malicious interference. The data is primarily generated from data sets provided by the participating libraries, via a third-party vendor (Serials Solutions). As Serials Solutions does not report all the required data, manual augmentation of the data is performed by the relevant library. The database is updated regularly. An additional outcome of this program is the population and activation of over 1300 LINKOUT buttons at PubMed; a feature that allows the user to click directly to the e-journal from the PubMed website (http://pubmed.gov).

Approximately 12,000 online title holdings are contained in the ePOI database, with approximately 76,000 individual holding records. The scope of the database is primarily defined as those listed in the Index Medicus or can be found at PubMed. The ePOI website has received more than 10,127 page hits since the beginning of the 2004 calendar year. 7,426 searches have resulted in 3,152 links to online resources; yet the website has had limited publicity to date. Use levels are expected to increase as students, researchers and health care professionals become more aware of the ePOI resource.

Library administrative reports and patron use research are additional outcomes of the ePOI project. Patron use data will provide the librarians with information of what journals patrons are either not finding by POI, or are not currently held in collections so that librarians can better build the collections. Supplemental administrative reporting and tracking functions are planned to improve the end-user experience and promote efficient and effective management of online biomedical journal resources.

Acknowledgements

This work is supported by grant LM007788-01 from the National Library of Medicine. Additional personnel involved in the development of this product include Lee Adams, Matthew Casamina, Pamela Casem, Jessica Hashimoto, Sarah Jansen, Jared Kuroiwa, and Quoc Le. Mahalo to beta-testers who gave comments.

Ethnopharmacology and Study of Medical Plants in the Pacific Islands

Will McClatchey PhD

Recently there has been a debate in Hawaii about bioprospecting plants as sources of new pharmaceuticals, and the roles of traditional knowledge. The issues are important, although poorly understood by advocates. Most people seem to think that the process proceeds by a researcher simply testing every plant to see what it is good for. However, the truth is that no molecules from plants have been discovered and marketed as pharmaceuticals in the United States in the last 30 years (a period of the most intensive search for drugs in history.) The myth that the next cure for cancer is to be found by searching in a rainforest should be set aside. However, we should not abandon study of traditional medicine, but instead be more realistic about the process and outcomes of research.

Modern pharmacology is built upon a set of observations and predictions about relationships between receptors (often proteins imbedded in membranes) and ligands (any drug or other chemical mediator). The interaction between receptor and ligand results in an event or effect. Pharmaceuticals are selected based upon their actions at this level and our abilities to distinguish positive effects in a range of assays from the molecular to the whole animal level. Therefore, when a drug is administered to a patient, we expect the drug to exert its effect through interactions at receptors (or other target molecules). Although there are drugs that do not work by this kind of mechanism, this is the general pattern of modern pharmacological thought. This causes us to look for a magic bullet with a one to one correspondence between remedy and efficacy.

For decades, the emphasis has been on simplistic collection of as many plants as possible, extraction of their chemical contents, and testing those contents in a wide range of biological assays. After much work, this has proved to be a poor method for identification of new drugs. A more efficient way is to look at how the plants are used by people in traditional communities. This is a difficult task for professionals; we tend to ignore comments of people when they do not correspond to our world view. For example, there are very few patients who enter and leave the doctor's office with a receptor-ligand mechanism of action in their heads. Over a 10-year period I worked as a pharmacist in a variety of settings. I do not recall any discussions with patients, wherein the receptor-ligand theory was articulated by the patient as a mechanism for the effects of drugs. Instead, patients consistently discussed ideas based upon simple assumptions such as can be seen in the following frequent comments: "if a medicine tastes good it must not be very strong (effective)"; "if a medicine tastes bad is must be strong (effective)"; "if a little bit is good, more must be better"; "I suffer from a chemical imbalance and this medicine balances my system"; "why do I need to take the medication if I feel fine"; and "my body is immune to that antibiotic". Each of these statements made perfect sense to the patient. Most professionals, however, would dismiss these statements as lacking real information. They find it uncomfortable to work with people who have a different world view, particularly if that view is as different as that of someone from another culture.

As it turns out, there are many different world views about drugs and drug-action in the human population. Commonly, these are articulated within the construct of languages, cultural groups, and religious and philosophical perspectives. Within each of these world views is included a set of logically consistent ideas about how and why people become ill and how to return to a healthy state, often with the assistance of plant-based medications. The study of the logical explanations for how medications work, as understood from a specific cultural perspective, is ethnopharmacology.

Ethnopharmacology

Ethnopharmacology is not the search for new drugs from cultural sources. Rather, it is the development of more clear understandings of how, when, where, and why people use their own pharmacopoeia. Ethnopharmacology reveals an entire system of which bioprospectors are unaware.

As a researcher, I have spent the last 15 years exploring the perspectives of professional healers from communities in the Solomon Islands, Fiji, Rotuma, Samoa, Marshall Islands, and Hawaii, trying to better understand the logic behind their selection of plant remedies and why and how they feel particular remedies work. I have learned that it is rare for the logic employed to be consistent with or even close to what I was taught in pharmacy school. However, healers are able to diagnose illnesses in patients, prescribe and administer remedies, and see positive results leading to healthy patients.

Medicinal Plants in the Laboratory

Although the pharmacological explanations for selection of a plant as a remedy are not the same across cultures, the effects of molecules within cells are the same. For instance, recent reviews of the roles of plants in the treatment of cancer (such as McClatchey & Stevens 2001) reveal that there is still an important role for plants as sources of ideas for development of pharmaceuticals. With cancer, there are even examples of molecules from plants that have been brought to market such as taxol, since its discovery more than 40 years ago. In order to follow new leads, researchers must first determine how to properly test the information that arrives in the laboratory from other cultures. This is not an easy task. With diseases such as cancer,

it is difficult to tell what is being considered as the same disease in another culture, and therefore, what remedies from other cultures might be useful for treatment of cancer.

A number of important problems are faced by laboratory researchers seeking to study plant medicines based upon observations of usage in other societies and the complexity of plant systems. These include:

- Complexity of traditional remedies (usually several plants, processed in complex ways).
- Identification of an appropriate evaluation assay when the logic for the efficacy is inconsistent with anything in modern medicine.
- Complexity of natural plant systems (usually several molecules work together to bring about an action.)
- Reactive molecules that are released from plant cells, thereby profoundly changing the chemical contents of a remedy.
- Differences between usage in humans and in-vitro or in-vivo lab assays. Effects of body processing include degradation of many constituents, binding of some to proteins or lipids, concentration of some constituents in specific tissues or fluids, activation of some constituents, and separation of some constituents from others in ways that may enhance activity only minimally identifiable in extracts of the plant.
- Even intellectual property rights and ownership of plant resources are important considerations.

Researchers tend to test a plant extract or fraction of a plant. This is consistent with the goal of identification of a single ligand that is active at one or more receptors. However, this is probably inconsistant with the logic of most other cultures, particularly for complex categories of disease such as cancer.

Cancer in Pacific Traditions

One of the questions I have been exploring is: Do traditional Pacific Island healers recognize cancer, and if so, how do they go about treating it? There are several problems with this question. 1. Pacific communities are typically very small and occurrence of any particular kind of cancer must be exceedingly rare. The chances of a healer seeing a particular cancer more than once in their lifetime is rare. Therefore, how would a healer be able to develop remedies? 2. Many kinds of cancer have few external symptoms until they are quite advanced. How would a healer diagnose a disease that does not manifest symptoms? 3. Assuming that a tumor/lesion could be recognized and treated, how would a healer know that the treatment was effective?

I cannot be certain that I have identified any traditional healers who are treating cancer. However, I have found individuals using plant remedies: to treat skin lesions that appear to be melanomas; to treat large lumps under the skin; and to remove polyp growths from mucosal tissues. In each of these, the treatments were described as making the diseased area shrink in size and then disappear. This description has been consistent across a range of cultures with fairly different world views and explanations for diseases. In one case, a tumor-like growth was determined to be caused by bad feelings that the patient was having about his brother-in-law. In another case, a skin lesion was determined to be caused by eating too many sweet foods. In a third case, a persistent lump in a breast was determined to be caused by an evil spirit that had been sent by an enemy. Although the logic in each cause is different, and the resolution of the problem was actually different, the resulting effect was described as the same (reduction and disappearance of the problem.)

What the healers are doing and how they use plants does not always make sense to us. However, as is illustrated below, this is more a matter of lack of understanding on the part of the researcher than on the part of the traditional practitioner.

Recent Research

One of the most important plants used by healers in tropical Pacific Islands is *Morinda citrofolia* (known as "noni" in Hawaii). The plant is used in combination with other plants to treat a wide range of illnesses including diabetes symptoms; healing of wounds, bruises, varicose veins; and treatment of lumps under the skin and skin lesions, headaches, fevers, and topical fungal infections (Dixon et al. 1999, McClatchey 2002). Most biologists would pass off such a broad list as not having any common thread, and therefore, not take the value of the plant seriously. However, recent research conducted at Louisiana State University by Hornick et al. has shown that noni juice (produced from fruit grown in Hawaii) inhibits the ability of breast cancer masses to develop new angiogenic growth and induces apoptosis in newly formed angiogenic masses. Noni may therefore be effective in the treatment of some kinds of tumors via reduction of blood supply to the cell mass and/or promotion of programmed cell death. With this perspective the same mechanisms could support other claims for noni such as the treatment of some vascular disorders and healing of wounds, varicose veins and bruises.

We are fortunate in the case of noni to gain insight from two world views in understanding its mechanism. In general we need to bring in more of the traditional knowledge by following more closely what a traditional healer would do. A model that more accurately follows would be to:

1. Have a healer prepare a fresh sample as it is intended for use in a human.
2. If the sample is swallowed, then treat the sample with a "digestion" process followed by filtration across a membrane that simulates the digestive tract filtering effects.
3. If the assay is intended to measure effects within a cell then a second filter should be used that simulates crossing a cell membrane.
4. The final product should then be suspended in a solution with appropriate pH and other characteristics to simulate cytosol of the target tissue and tested in an appropriate assay that is actually based upon the healer's logic rather than assumptions on the part of the researcher.

In our search for magic bullets that are highly specific, we may be overlooking genuine efficacy that is right in front of us. We need to listen carefully to traditional healers, especially because their message is complex and not easily understood from our world view.

For more information on the Cancer Research Center of Hawaii, please visit our website at www.crch.org.

References

1. Dixon, A.R., H. McMillen, Etkin, N.L. Ferment This: The transformation of Noni, a traditional Polynesian medicine (Morinda citrifolia, Rubiaceae). Econ Bot 1999; 53:51-68.
2. McClatchey, W. 2002. From Polynesian Healers to Health Food Stores: Changing Ethnopharmacology of Morinda citrifolia. Journal of Integrative Cancer Therapy. 1(2):110-120.
3. McClatchey, W. & Jodi Stevens. 2001. An Overview of Recent Developments in Bioprospecting and Pharmaceutical Development. Pp 17-45 in Development of Plant-Based Medicines: Conservation, Efficacy and Safety Edited by Praveen K. Saxena, Kluwer Academic Publishers, Dordracht, The Netherlands.

RSVP today!

2004 OLA PONO IKE

HEALTH IS KNOWLEDGE

Saturday, May 22, 2004
Sheraton Waikiki Ballroom
Honolulu, Hawaii

Tickets ~ $150
Tables of 10 ~ $1,500

No-Host Cocktails & Silent Auction Extraordinaire 6 p.m.
Gala Dinner Dance 7 p.m.

Keynote Speaker
Chris Ward
"Access to Healthcare"

Tort Reform and the Canadian Healthcare experience ~ What works ~ What doesn't

Chris Ward is a former Parliamentary Assistant to the Minister of Health, Canada
Today he testifies before legislators throughout the United States

REGISTRATION
Yes, I will attend!

( ) Individual seat(s)
$ 150 x _____=$_____

( ) Table(s) of 10
$1,500 x _____=$_____

I am unable to attend, please accept my contribution:
$_____

Total Enclosed
$_____

Yes, I will be a sponsor!
( ) Diamond Sponsor $25,000
( ) Ruby Sponsor $10,000
( ) Sapphire Sponsor $5,000
( ) Semi-Precious Sponsor $3,000
( ) Contact me to discuss my sponsorship benefits.

Name (Please Print) _____

Company/Practice _____

Street Address _____ Suite _____

City _____ State _____ Zip Code _____

Fax _____ Phone _____

Email address _____

Payment Information:

___Enclosed is my check payable to Hawaii Medical Association
___Please charge to ___Visa ___ MasterCard __AMEX

Name as it appears on the card _____

Account No. _____

Expiration Date _____ *Zip Code of billing statement* _____

Signature _____

A portion of the proceeds will be donated to **Hawaii Prescription Care**. Hawaii Prescription Care's mission is providing access to lifesaving medications for those who cannot afford them.

Thanks to Corporate Sponsors

Diamond Sponsor

PHYSICIANS EXCHANGE
of Honolulu Inc.

Voice Mail Hawaii
ANSWERING YOUR CALLS

Sapphire Sponsors

Honolulu
OPEN MEDICAL IMAGING

THE QUEEN'S HEALTH SYSTEMS

CITYBANK

First Hawaiian Bank

St.Francis Healthcare System of Hawaii

Semi-Precious Sponsors

Clinical Laboratories of Hawaii, LLP

PT Hawaii

Work Star
Occupational Health Systems

Hawaii Medical Association
1360 S. Beretania Street,
Suite 200
Honolulu, Hawaii 96814
(808) 536-7702
(808) 528-2376 fax
www.hmaonline.net

Hawaii Medical Association Highlights Member Benefit

A recent membership survey shows that many members are unaware of an important member benefit.

Hawaii Medical Association subscribed to HIPAA Readiness Collaborative (HRC) to allow access to a wealth of HIPAA implementation and sustainability resources from the Hawaii Health Information Corporation.

Your membership in the Hawaii Medical Association provides numerous benefits.

Here are just a few highlights:

♦ **HIPAA Resources:**

HMA subscribes to HIPAA Readiness Collaborative (HRC) to allow access to a wealth of HIPAA resources from the Hawaii Health Information Corporation (HHIC). This reflects a tremendous savings to members who would pay $4,500 if they purchased the service individually. This information is significantly different than other offerings because it been tailored to Hawaii with a $125,000 preemptive legal review to ensure that the materials, policies, and advice reflect Hawaii rules.

Through HMA's Affiliate Membership, HMA members have unlimited access to all HRC products and services in Microsoft Word, PowerPoint, or Excel format. Benefits include:

- **HRC sponsored Conferences and Workshops at no additional or minimal costs**
- **HIPA Hands-on Implementation Workshops**
- **HRC Presentations Material**
- **HRC Policies and procedures**
- **HRC Educational materials**
- **Participation in all HRC Sub-committees and collaborative efforts**
- **HRC Quarterly Meetings attendance.**

Sign up on line www.hmaonline.net or call 536-7702 Ext. 104 and we will fax the registration form to you.

HIPAA SOLUTIONS AND BEYOND:

Advanced HIPAA Implementation Summit

Thursday, June 24, 2004

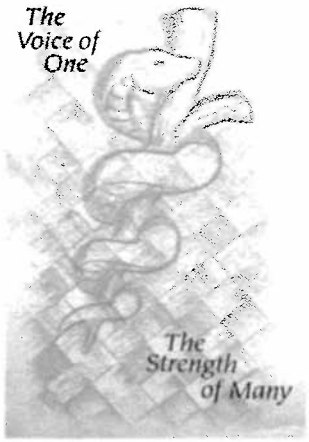
Presented by the HIPAA Readiness Collaborative (HRC)
and the Workgroup for Electronic Data Interchange (WEDI)

- Sessions include: Security: Implementing HIPAA Risk Analysis Requirements for Your Organization; Security: Understanding and Implementing Secure E-mail for Ongoing HIPAA Compliant Communications Experts; Transactions & Code Sets: National Provider Identifier (NPI) and Claims Attachment; and Update on Industry Transactions & Code Sets.
- Featured Faculty: Andrew Melczer, Ph.D., VP, Health Policy Research, Illinois State Medical Society; Carol Pratt, Ph.D. J.D., Associate, Davis Wright Tremaine, LLP, Portland, OR; Janice Caldwell, Staff Assistant in the Office of the Regional Administrator, Centers for Medicare & Medicaid Services; and Tom Hanks, CPHIMS,
- Registration is very limited. No onsite registrations or registrations after June 16 accepted. **Let them know you are an HMA member.**

Call Hawaii Health Information Corporation (808-534-0288) for more information or check the HMA website, www.hmaonline.net, for complete schedule and registration information.

Save the Date!

2004 Hawaii Medical Association Annual Meeting
September 2~5
Sheraton Waikiki
Honolulu, Hawaii



HMA Legislative Report Preview

What has the HMA done for you lately? The HMA is the only organization to represent physicians, regardless of specialty, at the State legislature. HMA's legislative priority for the 2004 session and for the future is meaningful tort reform for the State of Hawaii. In addition, the HMA was involved in many other health related legislative issues.

The following is a brief summary of some of the top issues the HMA actively advocated or opposed this year:

Tort Reform - HMA's bills were not heard this year, a clear indication that legislators do not appreciate the gravity of the problem and its impact on their constituents. In the words of one legislator, "I am not convinced that medical malpractice premiums are a cost driver in health care." HMA will continue to work with its healthcare partners to educate legislators about the need for immediate solutions.

Department of Commerce and Consumer Affairs Compliance Fund – Vetoed by the Governor, at press time, HMA is working to prevent an override of SB2525 that jeopardizes funding for the Medical Claim Conciliation Panel and its ability to adequately review medical malpractice claims. Should an override occur, the bill will undermine the effectiveness of the Panel, increasing Hawaii's vulnerability to a malpractice crisis similar to that confronting other states.

Optometrists Prescriptive Authority – At press time, HMA and the Hawaii Ophthalmological Society are working feverishly to secure legislative support to sustain Governor's Lingle's veto of this bill. The bill would permit optometrists to prescribe all medications except controlled substances without restriction and appropriate educational and training requirements.

Nurses Prescriptive Authority – HMA successfully averted an attempt by the Hawaii Nurses Association to replace BME authority with that of the Board of Nursing for determining APRN prescriptive authority contrary to a compromise agreement reached in 2002 between the HNA, HMA and Board of Medical Examiners.

Health Care Pricing – HMA successfully opposed a bill that would have prohibited physicians from collecting from uninsured or medically needy patients more than the cost of providing services, as well as require physicians to confirm that such patients do not qualify for coverage from government health programs.

HMA members can look forward to receiving the full report, which will also be available on our website at www.hmaonline.net.

Successful Treatment from p. 156

Reference

1. Serge C, Christopher L, Thomas L, et al: Effects of Multisite Biventricular Pacing in Patients with Heart Failure and Intraventricular Conduction Delay. N Eng J Med 2001; 344:873-880
2. CL Grines, TM Bashore, H Boudoulas, et al: Functional abnormalities in isolated left bundle branch block. The effect of interventricular asynchrony. Circulation 1989; 79: 845-853
3. Samuele B, Cristina O, Marco G, et al: Left bundle-branch block is associated with increased 1-year sudden and total mortality rate in 5517 outpatients with congestive heart failure: A report from the Italian network on congestive heart failure. Am Heart J 2002;143:398-405
4. Geraldo A, Paride G, Renato R, et al: Biventricular pacing in heart failure: back to basics in the pathophysiology of the left bundle branch block to reduce the number of nonresponders. Am J Cardiol 2003; 91:55-61
5. Mariell J, Susan BN: Heart failure: N Eng J Med 2003; 348:2007-2018
6. Eugene B, Michael RB: Congestive Heart Failure: Fifty Years of Progress. Circulation 2000; 102: suppl 4: IV 14-IV23
7. Rachel L.M, George D, Joseph AD, et al: A prolonged QRS duration on surface electrocardiogram is a specific indicator of left ventricular dysfunction. J Am Coll Cardiol 1998; 32:476-482
8. David JB, Elizabeth AB, Kenneth L.B, et al: Cardiac Resynchronization and Death From Progressive Heart Failure: A Meta-analysis of Randomized Controlled Trials. JAMA 2003; 289:730-740
9. William TA, Westby GF, Andrew LS, et al: Cardiac resynchronization in chronic heart failure. N Eng J Med 2002; 346:1845-1853

Classified Notices

To place a classified notice:

HMA members.–As a benefit of membership, HMA members may place a complimentary one-time classified ad in HMJ as space is available.

Nonmembers.–Rates are $1.50 a word with a minimum of 20 words or $30. Not commissionable.

Locum Tenens

LOCUM TENENS– FP, BOARD CERTIFIED. Available for short term locums. Dr. Vadim Braslavsky (913) 685-7494.

Insurance Problems?

INSURANCE PROBLEMS?– Experienced Attorney With Insurance Background Will Settle, Litigate, Or Appeal Any Claim. 521-0800. Stephen Shaw.

Office Space & Support Services

ALA MOANA BLDG.– PHYSICIAN WANTED to share space and support services. Interest in physical rehab. preferred. We have unique time-share arrangements starting at one half-day per week. Run your practice with no fixed overhead. Contact Dr. Speers, REHABILITATION ASSOCIATES, 955-7244.

The Weathervane Russell T. Stodd MD

Let's Win One For The "Duke."
Historically, doctors have steered clear of running for political office. The push, shove, compromise, double-dealing, broken promises and abiding frustration of politics are so far removed from medical science, that few physicians seek that milieu. It is much better suited to lawyers, educators and salespeople. Two active members of the Hawaii Medical Association, Fred Holschuh, a councilmen on the big island, and Duke Bainum, who has served for years on the Honolulu Council, are the exceptions. Now, Duke Bainum is running for Mayor of the City and County of Honolulu. The job comes with large powers of appointments to city and county boards and department managers, and also awards millions in vendor contracts. You merely have to read the newspapers to know about the outright corruption in some areas of Honolulu government. Duke is experienced; he is one of us; he is spending a lot of his own money, and running on a campaign of "honesty and integrity." He wants to clean up government, and he deserves our support. Get out the vote!

Ants, Savages and Viruses Put Strangers To Death.
A research team at the Center for Disease Control and Prevention in Atlanta, under very careful laboratory controls, is trying to recreate a deadly virus with scraps of material from an 85 year old hospital lab sample, and genetic material from a body buried in Alaska permafrost in 1918. The virus is the one that caused the great influenza pandemic of 1918-1919. In November 1918, almost the entire population of Brevig Mission, Alaska, where the corpse of the Inuit woman was buried, was wiped out. That disease claimed approximately 40 million lives worldwide, with deaths in the United States alone estimated at 675,000, about 3/4 of one percent of the entire population. Mortality rate was highest in 20 to 40 year-olds. Why try to recreate this? Specifically, to determine why the virus was so deadly, and how it killed so easily in just a matter of hours. This could solve a mystery and direct viral research. With the current mobility of people and disease (e.g.SARS), the issue is much more than academic.

Noise Is A Stench In The Ear. The Chief Product Of Civilization.
A study done at the Mayo Clinic affiliate St Mary's Hospital, published in the American Journal of Nursing, described a noise level well above that recommended by the Environmental Protection Agency. The chatter of nurses, rolling of portable x-ray machines, ringing telephones, rumble of generators, and the clatter of nighttime garbage pickup all serve to disturb sleep. A decibel level rivaling the sound of jack hammers, was highest at the seven A.M. shift change. Previous studies done by the Veterans Administration demonstrated that sleep deprived patients recovered more slowly than those who slept well. It ought to be obvious, but few hospitals give any attention to the noise level during sleeping hours. At Mayo's a training program stressed quiet speaking, reducing volume on the intercom system, keeping certain doors closed, turning down cardiac monitors and other simple common sense measures, which were found to make a marked difference.

It's Natural! It's Organic. The Wonder Drug — Coffee!
At last, a study that brings joy and comfort to the hearts of all us coffeeholics.. Previously reported in Lancet and Annals of Internal Medicine, now a new study from Finland (Finns are world champs in per capita coffee consumption) published in the Journal of the American Medical Association, has confirmed that imbibing coffee on a regular basis reduces the possibility of developing type II diabetes by 25 to 30%. For years studies have been conducted to implicate caffeine in heart disease, cancer, kidney disease, Alzheimer's, gall stones, hormonal changes, Parkinson's Disease, high blood pressure, erectile dysfunction, and even birth defects, all to no avail. The NCAA even has a rule limiting caffeine level for athletic competition, although no one really knows why. So, have a second cup, or even a third or fourth, and listen to to the gastric growling of borborygmi. No benefit accrues to decaf wimps.

The Reality Check Bounced.
Four and 1/2 years ago Bristol-Myers announced a study to prove their drug *Provachol* was equal to Pfizer's *Lipitor* in preventing deaths and heart attacks. Arrogance? Hubris? Overconfidence? Whatever wild cilia churning in the minds of leaders at Bristol-Myers Squibb that caused them to challenge Pfizer, it was a large mistake. Lipitor not only was found to be more effective in reducing serum cholesterol, the study showed that it was significantly better at reducing the risk of death, heart attack or other serious complications in patients with known heart disease. Bristol-Myers now has a serious marketing problem for Provachol while Pfizer was gifted a nice ad package. In addition, the study appears to indicate that the lower the cholesterol level, the better prognosis for heart disease patients. So, how low should it go? The consequence of a better cardiac outlook with a lower cholesterol due to stepped up drugs, will add more dollars to the already bulging wallets of pharmaceutical manufacturers. I am so happy for them. Not!

She's Selling What She Used To Give Away.
Geez! You can still get it free, but many are willing to buy bottled water at costs of 89 cents a pint and up. Not only are we supposed to buy *Perrier* and others, but each bottle has an expiration date!! New Jersey alone has a law that water venders must stamp dates on every bottle, but the reason is unknown. Coke's water, *Dasani*, has a one year shelf life before it should be pulled. *Poland Spring* and *Aquifina* are labeled to be consumed within two years. The Red Cross has even gotten into the loop, advising people to replace stored bottled water within six months. Crazy! There is no rationale and the practice is not health based, nor is there any evidence that drinking the water after expiration date has any impact at all. This year, Americans will buy more bottled water than beer and coffee. *Evian* spelled backwards is an appropriate adjective for the multitudes carrying a jug around as they stroll by drinking fountains. In the words of P.T. Barnum.....

Mr. Soloman, What The — Were You Thinking?!!
Only a lawyer could examine the law and decide that the F word was not in violation of broadcast decency standards. "Bono" the lead singer for the band U2, accepted a Golden Globe award for best original song for the movie *Gangs of New York*. Being a rock singer with a rudimentary vocabulary, Bono said, "This is really, really f—ing brilliant." Now, most of us might find that vulgar, crude, offensive, and unfit for prime time television, but David Solomon, counsel for the Federal Communications Commission, decided that the smutty speech was an "exclamative" adjective, and protected under principles of free speech. The public was somewhat angry with Bono and sent 234 complaints to the FCC, but they were really, really angry with Mr. Solomon and sent 237,215 letters protesting his ruling. One more log on the fire for Congress to consider in their hearings on media violence, vulgar language, and Janet Jackson's malfunctioning bra.

Another Thing That Ain't What Is Used To Be - The Older Generation.
Possibly nothing frightens Democrats and Republicans alike more about the November election than the age of the Justices of the Supreme Court of the United States. Chief Justice Rehnquist will be 80 years old in October, Justice John Stevens will be 84 in April, Justice Sandra Day O'Connor is 74, and all three have mentioned retirement, but made no commitment. The present court is nearly balanced between a liberal/conservative interpretation of the Constitution of the United States, and the man elected this fall will very likely have an opportunity to appoint from one to three judges, including a chief justice, during his term in office. Think of it – the new justice could be Ralph Nader, John Ashcroft, or Johnny Cochran, or maybe all three.

ADDENDA
- A surgeon-safari trip combines an African safari with your choice of a tummy-tuck, lipo-suction, or laser face resurfacing. One week packages start at $3800.
- On June 26, 1974, Wrigley's Juicy Fruit gum was the first commercial product bar code scanned at a supermarket check out counter.
- Interval ownership is the upscale phrase for time share.
- We need corporal punishment in our schools. Let's use it on the teachers.

Aloha and keep the faith —rts■

Contents of this column do not necessarily reflect the opinion or position of the Hawaii Ophthalmological Society and the Hawaii Medical Association. Editorial comment is strictly that of the writer.

THERE ARE MANY ADVANTAGES TO HAVING US AS A CORPORATE TRUSTEE.

TRUST IS JUST ONE OF THEM.

When you name First Hawaiian Bank as a trustee to manage the assets in your trust, you'll find yourself in the company of professionals with years of experience in everything from investments and tax planning to retirement plans and trust real estate management. Every member of our Trust Management Team is devoted to giving complete and objective attention to both your short- and long-term objectives. And we approach estate planning with an alternative perspective to ensure that your investments are always on track with your goals. Knowing that your corporate trustee will administer your trust in a thoughtful, caring and objective way and is backed by 140 years of financial and money management expertise can be very reassuring. So can the fact that First Hawaiian Bank trust services are far more affordable than you think.

First Hawaiian Bank®

THE power OF yes.

For a free consultation and to learn more about what our trust professionals can do for you, stop by our Trust & Investments Division or call 525-7134 (Oahu), 933-2252 (Hilo), 887-6000 (Kamuela), 873-2240 (Maui), or 245-7516 (Kauai).

INVESTMENTS ARE NOT FDIC INSURED • INVESTMENTS HAVE NO GUARANTEE • INVESTMENTS MAY LOSE VALUE

b.com