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“TARO”

Depicting taro, the mainstay staple food of old Hawai‘i from which poi is made.
In every Journal, I enjoy every word of The Weathervane. Since 1988, when it first appeared, it has proven to be the most well-read page in Journal history.

Some of our newer readers may not know the man behind the popular monthly column. Dr. Russell T. Stodd was born in 1930, received his medical degree from Oregon University, served his residency in ophthalmology at Gorgas Hospital in the Canal Zone, and in 1974 began private practice in Kahului, Maui. That same year Dr. Stodd became president of the Maui County Medical Society. In 1983, under the auspices of the U.S. Agency for International Development, Dr. Stodd shared his ophthalmologic expertise in a Sudanese clinic, and in 1984 purchased the first ophthalmology laser on Maui, permitting qualified Fellows use of this high-tech instrument. The following year, Dr. Stodd became president of the Hawai‘i Medical Association. Today, he serves as the medical director of the Aloha Surgical Center on Maui.

I don’t know where he gets his material, but the breadth of his subject matter is astounding. In the August issue, the Weathervane lead item “Life is uncertain; eat dessert first” had me laughing out loud. It reminded me of dinner with Arthur Murray – dance industry entrepreneur, art collector, tennis whiz, and quick wit well into his 8th decade. “I always have dessert first,” Arthur declared, “It’s my favorite part and, at my age, I’m not sure if I’ll make it through the meal!” But, I digress.

Of course, the Hawai‘i Medical Journal contributes a wealth of well-written scientific studies to physicians in Hawai‘i, as it has for 65 years, but contributing editor Russ Stodd injects well-reasoned diversity. Doctors nationwide could use a healthy dose of Dr. Stodd’s insight. Let’s syndicate The Weathervane.
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524-2575
The 2006 annual meeting of the Hawai‘i Medical Association, celebrating HMA’s 150th Anniversary, was held at the Hawai‘i Convention Center in Honolulu, October 20, 21, and 22. It was superlative in every way but, like so many of our annual meetings, was enjoyed by too few members. The meeting combined an excellent education program, a meeting of the House of Delegates, and a marvelous Ola Pono Ike inauguration dinner program.

The Ola Pono Ike dinner party featured a speech by mountaineer Lou Whittaker, plus a warm address from the outgoing HMA President Patricia Blanchette MD and an entertaining slide presentation by incoming President Linda Rasmussen MD. We were honored by a visit from American Medical Association President William Pleased III MD who provided the honors for the swearing-in ceremony. The festivities included a wine tasting party and silent auction. Thomas Kosasa MD was recognized as physician of the year for his tireless efforts for the Hawai‘i Medical Association as well as his volunteer activities in the community, including service as a pilot for emergency medical flights. Orthopedic surgeon John Smith MD was given the President’s award for his long and faithful service to the medical community. All in all, it was a marvelous evening.

The education planning committee co-chairpersons, Kalani Brady MD and Myron Shirasu MD, and their 10 co-workers, constructed an excellent three-day educational program, entitled “Leading the Way...Building on 150 Years of Leadership”. Each session was nicely complemented by a luncheon or light breakfast, beverages, and snacks. Additionally, the generous participation of exhibitors made each day very satisfying. The organization committee and HMA staff deserve a powerful thank you for putting on such a marvelous show.

The kick-off was a pre-conference presentation on “New Horizons in Addiction Medicine” that featured Edwin A. Salsitz MD, FASAM, medical director of office-based opioid therapy, Department of Medicine, Beth Israel Medical Center, New York City; Lynn R. Webster MD, FACPM, FASAM, medical director, Lifetree Clinical Research and Pain Clinic, Utah; Christopher Linden MD, family practitioner from the Big Island; and Gerald McKenna MD, medical director of Ke Ala Pono Recovery Center, Kauai. The educational intent was to explain and understand the neuro-biology of addiction, varying degrees of vulnerability to addictive disease, and the pharmacology of addiction. The prevalence of prescription drug abuse was discussed, including patient risk factors. Dr. McKenna noted that addiction is the only medical disease for which a patient can be incarcerated. Points of intervention were presented with newer pharmacological agents available for use in addictive disease, especially in the treatment of alcoholism.

The Saturday morning, October 21 program featured a dynamite oration by AMA President William Pleased III MD, and a supporting speech by J.P. Schmidt, Esq. Hawai‘i insurance commissioner. The issue was tort reform and how a MICRA law for Hawai‘i can predict malpractice premiums to protect physicians and preserve access to care for patients. After that opening, Danial Bucsko MBA, assistant vice president for Doctor’s Company; Judith Huerta MA, of Medical Insurance Exchange of California; and Norm Slausas, Executive Vice President for HAPI, discussed how to minimize the risk of being sued. They all emphasized that the best defense for a physician in a malpractice complaint is a careful and well-documented medical record. Recording phone calls when away from the office, messages, lab reports, call coverage, etc., are all part of necessary documentation.

Also in the Saturday morning program was a new system of health care financing presented by Stephen Foreman PhD, JD, MPA. His primary point was that first dollar coverage offered by so many plans virtually ensures that patients will overutilize. He emphasized that employer provided insurance coverage removes individual responsibility. He described the need to write medical coverage that will take care of catastrophic medical expenses, but give patients the option to buy a cheaper plan with a significant deductible. By allowing individual decisions for first dollar expense, utilization will be realistic. In essence, he endorsed the medical insurance savings plans which have been pushed by the AMA for several years.

Luncheon on Saturday featured the ABCs of chronic kidney disease with management pearls for the primary care physician presented by Ramona Wong MD, medical director of the National Kidney Foundation of Hawai‘i. The speaker emphasized the need for increased awareness of co-morbidities, especially cardiovascular risk and mortality. Local resources are available to help primary care doctors achieve optimal management of chronic kidney disease.

Richard Whitten MD, FACP, contract medical director for Medicare part B for Hawai‘i; Richard Chung MD, senior VP for HMSA; and Eric Z. Matayoshi MD, FACS, chief of general surgery at Kaiser Permanente Hawai‘i, combined to explain the P4P (pay for performance) plan which will impact physicians in Hawai‘i. This will prove to be a headache for all in private practice until the system becomes functional, and even then the variables will cause concern. How does one define good performance—number of patients cared for? Dollar performance? Medical/surgical outcomes?

Electronic medical records (EMR) are looming on the horizon so Dan Heslinga MD, director of the Bridging the Adoption Gap Project, presented a program of getting started with EMRs. He
described how preventative services and disease management can be improved, and noted that the office practice will become more efficient, but there are difficulties to surmount when implementing a system. In addition, he cautioned against signing an EMR services contract before giving it careful scrutiny and consideration. Naive physicians can be easily exploited.

The final offering for the Saturday session was a discussion of the benefits of information technology. Dale Glenn MD, Straub Kailua Family Health Center; Grant Okawa MD, Kaiser Permanente; plus Richard Whitten MD and Dan Heslinga MD combined on a panel to relate the value of EMRs as an important tool in providing quality health care. Ease of obtaining patient history and profiles, even for patients not known, can be expedient and safe. A question and answer session followed.

Strengthening the safety net and caring for the uninsured and under-insured was detailed by Hawai‘i Health Director Chiome Fukino MD and Human Services Director Lillian B. Koller, Esq. as the initial presentation on Sunday morning. In particular, the role of the community health clinics and the Hawai‘i Health Systems Corporation facilities were presented. The financial limitations due to low reimbursement force a constant appeal to the Hawai‘i legislature to provide appropriate subsidies in order to maintain the staff and keep the doors open.

A blue ribbon collection of hospital chiefs followed featuring Danelo Canete MD, President and CEO Hawai‘i Medical Center (St. Francis); Arthur A. Ushijma, President and CEO Queen’s Medical Center; Raymond P Vara, Jr. EVP and CEO operations Hawai‘i Pacific Health; and Gary K. Kajiwara, President and CEO Kuakini Medical Center. They each discussed their current roles and challenges in the medical community, emphasizing past and especially future expectations.

The final portion of the program was devoted to Integrative and Complementary Medicine (CAM), featuring Roseanne Harrigan EdD, APRN, Chair, Complementary and Alternative Medicine Department, University of Hawai‘i; Thanh V. Huynh MD, University of Hawai‘i Cancer Research Center; Ira D. Zunin MD, Medical Director, Hawai‘i Consortium for Integrative Health; and Carolyn Gotay PhD, Director, Prevention and Control Program, University of Hawai‘i Cancer Research Center. These speakers outlined the rapid evolution of this fascinating and emerging area of medicine, including therapies for cancer patients. The National Institutes of Health has allocated $300 million per year for studies in integrative medicine. The impact and effectiveness of CAM is increasingly recognized and being melded into conventional medical care.

So, to anyone who took the time to read this far, this is but a scratch on the surface to describe an excellent program of continuing medical education. It was a great effort by the staff and members of the Hawai‘i Medical Association and visiting faculty.
Pattern of Birth Defects Delivered to Non-Residents in Hawai‘i, 1986-2002

Mathias B. Forrester BS and Ruth D. Merz MS

Abstract
Using birth defects registry data, this study examined whether deliveries to residents and non-residents differed. The non-resident rate was significantly higher among those infants/fetuses with more than one major birth defect, pregnancy outcomes that did not result in live births, multiple births, deliveries in the City and County of Honolulu, and pregnancies where prenatal diagnostic procedures had been performed.

Introduction
There is tremendous variation in the operations and activities among birth defects registries in the United States. For example, of the 45-50 state birth defects registries reported to be in existence in 2004, only around 12 appear to include deliveries within the state to non-residents. Although inclusion of non-resident deliveries are not essential for such birth defects registry activities as calculation of baseline rates and cluster and environmental investigations, they may be important for such activities as planning, referral, and utilization of services, prevention, education, economic impact evaluations, and clinical research.

In spite of the potential importance of non-resident births to birth defects registries, there is limited information on such deliveries. Review of the literature identified only one article that briefly discussed the topic, and this was by the current authors. The intent of the current investigation was to describe in more detail the patterns of non-resident deliveries included by a birth defects registry.

Methods
This was a retrospective study using data from the Hawai‘i Birth Defects Program (HBDP). The HBDP is a population-based birth defects registry with inclusion criteria consisting of all infants and fetuses of any pregnancy outcome (live birth, fetal death, elective termination) of any gestational age where a birth defect was diagnosed between conception and one year after delivery and the delivery occurred in Hawai‘i. Thus the HBDP includes in-state deliveries to state residents and non-residents; the HBDP does not include out-of-state deliveries to state residents.

HBDP staff identify eligible subjects and collect data through a multiple-source ascertainment system that involves review of logs and medical records at all delivery and tertiary care hospitals, facilities that perform elective terminations secondary to prenatal diagnosis of birth defects, genetic counseling offices, cytogenetic laboratories, and all but one of the prenatal ultrasound facilities in Hawai‘i. Among the information collected is the address of the mother’s residence at the time of delivery. For most subjects, this information is obtained from the birth or fetal death certificate. For those subjects where such certificates are not available, the address is obtained from the medical record, primarily the admission sheet at the time of delivery.

Other variables may also be found in both the medical record and birth or fetal death certificates. If a variable differs between the two sources, the information in the birth or fetal death certificate is recorded, except in those situations where the information in the medical record is obviously more accurate. For instance, if the birth certificate states that the mother did not smoke while the prenatal care records in the medical record make repeated mention of the mother smoking, the HBDP will record that the mother smoked.

Cases were all infants and fetuses with major birth defects delivered during 1986-2002 where the residence at delivery was known. Major birth defects are those birth defects the Centers for Disease Control and Prevention recommends always be collected by birth defects registries. The proportion of cases that were resident and non-resident deliveries was determined. Using data from the Hawai‘i Department of Health Office of Health Status Monitoring, the total number of live births delivered to residents and non-residents was used to calculate the total birth defect rate for the two categories. The distribution of non-resident delivery cases by state or country of residence was described. The reason a non-resident delivered in Hawai‘i was not systematically collected by the HBDP; however, for those cases where the reason for delivery in Hawai‘i was known, the proportions that were intentional and unintentional Hawai‘i deliveries were determined.

The non-resident delivery rates were assessed for selected variables relating to the infant/fetus (number of major birth defects, pregnancy outcome, sex, plurality), mother (race/ethnicity, age, number of prior...
Table 1.—Deliveries of infants/fetuses with birth defects to non-residents by various infant/fetus factors, Hawai‘i, 1986-2002

<table>
<thead>
<tr>
<th>Infant/fetus factor</th>
<th>Total No.</th>
<th>Non-residents No. (%)</th>
<th>Rate ratio</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of major birth defects</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>8,330</td>
<td>64 (0.77)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2,688</td>
<td>47 (1.75)</td>
<td>2.28</td>
<td>[1.53,3.37]</td>
</tr>
<tr>
<td>3</td>
<td>1,357</td>
<td>25 (1.84)</td>
<td>2.40</td>
<td>[1.45,3.86]</td>
</tr>
<tr>
<td>4</td>
<td>761</td>
<td>15 (1.97)</td>
<td>2.57</td>
<td>[1.36,4.55]</td>
</tr>
<tr>
<td>5</td>
<td>394</td>
<td>9 (2.28)</td>
<td>2.97</td>
<td>[1.30,6.00]</td>
</tr>
<tr>
<td>&gt;5</td>
<td>805</td>
<td>22 (2.73)</td>
<td>3.56</td>
<td>[2.09,5.85]</td>
</tr>
<tr>
<td>Pregnancy outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live birth (survived to one year)</td>
<td>12,450</td>
<td>126 (1.01)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>Live birth (expired within one year)</td>
<td>726</td>
<td>26 (3.58)</td>
<td>3.54</td>
<td>[2.23,5.43]</td>
</tr>
<tr>
<td>Fetal death</td>
<td>502</td>
<td>16 (3.19)</td>
<td>3.15</td>
<td>[1.75,5.32]</td>
</tr>
<tr>
<td>Elective termination</td>
<td>654</td>
<td>14 (2.14)</td>
<td>2.12</td>
<td>[1.12,3.68]</td>
</tr>
<tr>
<td>Infant/fetus sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boy</td>
<td>8,497</td>
<td>93 (1.09)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>Girl</td>
<td>5,718</td>
<td>85 (1.49)</td>
<td>1.36</td>
<td>[1.00,1.84]</td>
</tr>
<tr>
<td>Plurality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Singleton</td>
<td>13,687</td>
<td>169 (1.23)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>Multiple birth</td>
<td>532</td>
<td>13 (2.44)</td>
<td>1.98</td>
<td>[1.03,3.48]</td>
</tr>
</tbody>
</table>

Results

The HBDP identified 14,335 infants/fetuses with major birth defects and known delivery residence among 1986-2002 deliveries. Hawai‘i residents accounted for 14,153 (98.73%) of these cases and non-residents for 182 (1.27%) of these cases. During the same time period, there was a total of 315,313 live births delivered to residents and 1,195 live births delivered to non-residents. Thus the birth defect rate was 15.23% for non-residents and 4.49% for residents (rate ratio 3.39, 95% CI 2.92,3.93).

Among the deliveries to non-residents, 93 (51.10%) were to US-residents from 23 different states and territories. The most frequently represented states and territories were Guam (n=32) and California (n=23). Seventy-four (40.66%) of the non-resident deliveries were to residents of other countries, the most common being Japan (n=32), Marshall Islands (n=11), and Korea (n=10). The remaining 15 (8.24%) deliveries to non-residents had military addresses; thus it was unclear whether their residence was in the United States outside of Hawai‘i or in another country.

The reason for delivery in Hawai‘i was known for 78 (42.86%) of the non-residents. In 22 (28.21%) of these cases, the mother had been visiting Hawai‘i when she had gone into labor and delivered. In 56 (71.79%) of these cases, the mother had specifically been transported to Hawai‘i to deliver.

Table 1 illustrates the non-resident rates for selected infant/fetus variables. The non-resident rate was significantly higher among those cases where more than one major birth defect had been diagnosed. Moreover, the non-resident rate increased with the number of major birth defects. When pregnancy outcome was examined, the non-resident rate was substantially greater among those pregnancy outcomes that did not result in live births that were known to be alive after one year of age. Although the non-resident rate was higher among girls than boys, the difference was not statistically significant. The non-resident rate was substantially higher among multiple births.

Table 2 presents the non-resident rate for maternal factors. When compared to whites, the non-resident rate was substantially lower for Hispanics, Asians, and Pacific Islanders. However, when one specific subgroup of Pacific Islander was examined, the non-resident rate among Guamanians was significantly greater than that among whites. Non-resident rates tended to be greater with increasing maternal age; however, the trend was not statistically significant (p=0.056). The non-resident rates tended to be lower among women who had had one or more prior pregnancies, and to increase with maternal education, but these patterns were not statistically significant.

Table 3 contains the non-resident rates for various delivery and diagnostic factors. The non-resident rates were substantially higher for deliveries in hospitals in the City and County of Honolulu when compared to the other three counties. The non-resident rate was greater among women who had had no reported prenatal care, although this difference was not significant. In contrast, the non-resident rates were substantially higher among those cases where prenatal diagnostic procedures had been performed, a birth defect had been prenatally diagnosed, or cytogenetic analysis of the infant/fetus had been attempted.

Table 4 compares the non-resident rate for 54 specific birth defects to the rate among all birth defects. The
non-resident rate varied from 0.00% to 10.81%. The rate was higher than the general rate for 32 (59.26%) of the specific birth defects and significantly higher for eight of the specific birth defects (spina bifida, hydrocephaly, small intestinal atresia and stenosis, renal agenesis and hypoplasia, cystic kidney, obstructive genitourinary defect, situs inversus, trisomy 18).

Discussion
This investigation described the non-resident deliveries with birth defects identified by a population-based birth defects registry in Hawai‘i over a seventeen-year period. Review of the literature failed to identify any similar studies. Most birth defects registries in the United States do not appear to include non-resident deliveries in their ascertainment criteria in spite of the observation that non-resident deliveries may be important to some of the activities the registries may want to perform. The present study may provide some indication of the potential impact of inclusion of non-resident deliveries on various registry activities.

The primary limitation of this application is its applicability to other states. Hawai‘i is unlike other states in that it is isolated with no borders with other states or countries. Only similar studies by other states will determine whether the results of this study may be transferable to other states.

Another limitation is the manner in which variables such as the residence at delivery was determined as outlined in the Methods. The purpose of a given variable may differ between the medical record and birth or fetal death certificates. However, in the interest of efficiency, the HBDP records only one value for a given variable.

This study found that only slightly more than 1% of all identified deliveries involving birth defects in Hawai‘i were to non-residents. This would suggest that overall the inclusion or exclusion of non-resident deliveries would have little impact on the potential activities of the HBDP. However, the non-resident rate was higher for particular subgroups. Thus, non-resident deliveries may need to be considered if these subgroups are pertinent to particular birth defects activities. For example, 5% of spina bifida deliveries in Hawai‘i were to non-residents. A woman who has had an infant or fetus affected by a neural tube defect (NTD) such as spina bifida is at increased risk of having a subsequent infant or fetus with a NTD.\(^3\) As a result of studies suggesting that periconceptional use of folic acid by women reduces the risk of having infants and fetuses with NTDDs, it has been recommended that women who have had a prior infant or fetus with a NTD should take folic acid.\(^4\) If NTD recurrence education and prevention activities in Hawai‘i were provided solely to those spina bifida deliveries to Hawai‘i residents, then one out of every twenty spina bifida deliveries would be excluded from these activities.

Half of the non-resident deliveries involving birth defects in Hawai‘i were to residents of other US states and territories, and two-fifths were residents of other countries. This pattern is likely due to Hawai‘i being a tourist destination for residents from all over the United States as well as other countries all over the world. Moreover, Hawai‘i has a unique position in the middle of the Pacific Ocean where it is closer to US territories such as Guam and other countries such as Japan and Korea than are other states. Thus, if it were decided that a woman in the western Pacific needed to deliver in the United States, then Hawai‘i may be a primary choice of delivery location.

A portion of birth defects deliveries in Hawai‘i to non-residents were unintentional, i.e., the woman happened to be in Hawai‘i when she delivered. However, in the majority of non-resident deliveries involving birth defects with known intent, the mother was deliberately transferred to Hawai‘i for the delivery. This would indicate that in the majority of instances the pregnancy was known to be at risk for an adverse outcome. The anticipated adverse outcome may not necessarily have been a birth defect; other prenatal conditions such as

<table>
<thead>
<tr>
<th>Maternal factor</th>
<th>Total No.</th>
<th>Non-residents No. (%)</th>
<th>Rate ratio</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal race/ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>3,787</td>
<td>92 (2.43)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>530</td>
<td>16 (3.02)</td>
<td>1.24</td>
<td>[0.68,2.13]</td>
</tr>
<tr>
<td>Hispanic</td>
<td>348</td>
<td>1 (0.29)</td>
<td>0.12</td>
<td>[0.00,0.68]</td>
</tr>
<tr>
<td>Native American</td>
<td>139</td>
<td>3 (2.16)</td>
<td>0.89</td>
<td>[0.18,2.68]</td>
</tr>
<tr>
<td>Asian</td>
<td>5,109</td>
<td>34 (0.67)</td>
<td>0.27</td>
<td>[0.18,0.41]</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>4,268</td>
<td>28 (0.66)</td>
<td>0.27</td>
<td>[0.17,0.42]</td>
</tr>
<tr>
<td>Guamanian</td>
<td>41</td>
<td>11 (26.83)</td>
<td>11.04</td>
<td>[5.33,20.70]</td>
</tr>
<tr>
<td>Maternal age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤19</td>
<td>1,470</td>
<td>14 (0.95)</td>
<td>0.74</td>
<td>[0.37,1.36]</td>
</tr>
<tr>
<td>20-24</td>
<td>3,596</td>
<td>43 (1.20)</td>
<td>0.92</td>
<td>[0.60,1.42]</td>
</tr>
<tr>
<td>25-29</td>
<td>3,705</td>
<td>48 (1.30)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>30-34</td>
<td>3,106</td>
<td>36 (1.16)</td>
<td>0.90</td>
<td>[0.56,1.41]</td>
</tr>
<tr>
<td>35-39</td>
<td>1,921</td>
<td>26 (1.35)</td>
<td>1.05</td>
<td>[0.62,1.72]</td>
</tr>
<tr>
<td>≥40</td>
<td>532</td>
<td>14 (2.63)</td>
<td>2.03</td>
<td>[1.03,3.75]</td>
</tr>
<tr>
<td>&lt;35</td>
<td>11,877</td>
<td>141 (1.19)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>≥35</td>
<td>2,453</td>
<td>40 (1.63)</td>
<td>1.37</td>
<td>[0.94,1.96]</td>
</tr>
<tr>
<td>Number of prior pregnancies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>4,128</td>
<td>58 (1.41)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>3,710</td>
<td>46 (1.24)</td>
<td>0.88</td>
<td>[0.59,1.32]</td>
</tr>
<tr>
<td>&gt;1</td>
<td>6,241</td>
<td>76 (1.22)</td>
<td>0.87</td>
<td>[0.61,1.24]</td>
</tr>
<tr>
<td>Maternal education (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;12</td>
<td>1,488</td>
<td>6 (0.40)</td>
<td>0.51</td>
<td>[0.18,1.22]</td>
</tr>
<tr>
<td>12</td>
<td>5,088</td>
<td>40 (0.79)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>&gt;12</td>
<td>4,913</td>
<td>46 (0.94)</td>
<td>1.19</td>
<td>[0.76,1.87]</td>
</tr>
</tbody>
</table>
Table 3.— Deliveries of infants/fetuses with birth defects to non-residents by delivery and diagnostic factors, Hawai‘i, 1986-2002

<table>
<thead>
<tr>
<th>Delivery or diagnostic factor</th>
<th>Total No.</th>
<th>Non-residents No. (%)</th>
<th>Rate ratio</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>County of birth hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honolulu</td>
<td>11,711</td>
<td>170 (1.45)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>Hawai‘i</td>
<td>1,105</td>
<td>6 (0.54)</td>
<td>0.37</td>
<td>[0.14, 0.85]</td>
</tr>
<tr>
<td>Maui</td>
<td>926</td>
<td>3 (0.32)</td>
<td>0.22</td>
<td>[0.05, 0.66]</td>
</tr>
<tr>
<td>Kaua‘i</td>
<td>511</td>
<td>2 (0.39)</td>
<td>0.27</td>
<td>[0.03, 0.99]</td>
</tr>
<tr>
<td>Prenatal care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13,783</td>
<td>174 (1.26)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>252</td>
<td>5 (1.98)</td>
<td>1.57</td>
<td>[0.50, 3.74]</td>
</tr>
<tr>
<td>Prenatal diagnostic procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>10,868</td>
<td>154 (1.42)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>3,467</td>
<td>28 (0.81)</td>
<td>0.57</td>
<td>[0.37, 0.86]</td>
</tr>
<tr>
<td>Prenatal diagnosis of a defect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2,261</td>
<td>85 (3.76)</td>
<td>4.68</td>
<td>[3.46, 6.33]</td>
</tr>
<tr>
<td>No</td>
<td>12,074</td>
<td>97 (0.80)</td>
<td>reference</td>
<td></td>
</tr>
<tr>
<td>Cytogenetic analysis attempted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3,497</td>
<td>86 (2.46)</td>
<td>2.89</td>
<td>[2.12, 3.94]</td>
</tr>
<tr>
<td>No</td>
<td>10,342</td>
<td>88 (0.85)</td>
<td>reference</td>
<td></td>
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</tbody>
</table>

Table 4.— Deliveries of infants/fetuses with birth defects to non-residents by type of birth defect, Hawai‘i, 1986-2002

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Total No.</th>
<th>Non-residents No. (%)</th>
<th>Rate ratio</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anencephaly</td>
<td>118</td>
<td>1 (0.85)</td>
<td>0.67</td>
<td>[0.02, 3.77]</td>
</tr>
<tr>
<td>Spina bifida</td>
<td>153</td>
<td>8 (5.23)</td>
<td>4.12</td>
<td>[1.75, 8.29]</td>
</tr>
<tr>
<td>Encephalocele</td>
<td>67</td>
<td>0 (0.00)</td>
<td>0.00</td>
<td>[0.00, 4.38]</td>
</tr>
<tr>
<td>Holoprosencephaly</td>
<td>41</td>
<td>1 (2.44)</td>
<td>1.92</td>
<td>[0.05, 10.84]</td>
</tr>
<tr>
<td>Hydrocephaly</td>
<td>367</td>
<td>15 (4.09)</td>
<td>3.22</td>
<td>[1.77, 5.45]</td>
</tr>
<tr>
<td>Microcephaly</td>
<td>327</td>
<td>3 (0.92)</td>
<td>0.72</td>
<td>[0.15, 2.15]</td>
</tr>
<tr>
<td>Anophthalmia/ Microphthalmia</td>
<td>102</td>
<td>4 (3.92)</td>
<td>3.09</td>
<td>[0.83, 8.05]</td>
</tr>
<tr>
<td>Cataract</td>
<td>39</td>
<td>2 (5.13)</td>
<td>4.04</td>
<td>[0.49, 14.80]</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>11</td>
<td>0 (0.00)</td>
<td>0.00</td>
<td>[0.00, 26.68]</td>
</tr>
<tr>
<td>Atonia/Microtia</td>
<td>140</td>
<td>1 (0.71)</td>
<td>0.56</td>
<td>[0.01, 3.17]</td>
</tr>
<tr>
<td>Truncus arteriosus</td>
<td>24</td>
<td>1 (4.17)</td>
<td>3.28</td>
<td>[0.08, 18.52]</td>
</tr>
<tr>
<td>Transposition of great arteries</td>
<td>138</td>
<td>3 (2.17)</td>
<td>1.71</td>
<td>[0.35, 3.05]</td>
</tr>
<tr>
<td>Tetralogy of Fallot</td>
<td>124</td>
<td>2 (1.61)</td>
<td>1.27</td>
<td>[0.15, 4.66]</td>
</tr>
<tr>
<td>Single ventricle</td>
<td>28</td>
<td>0 (0.00)</td>
<td>0.00</td>
<td>[0.00, 10.48]</td>
</tr>
<tr>
<td>Ventricular septal defect</td>
<td>1,338</td>
<td>17 (1.27)</td>
<td>1.00</td>
<td>[0.57, 1.65]</td>
</tr>
<tr>
<td>Atrial septal defect</td>
<td>704</td>
<td>12 (1.70)</td>
<td>1.34</td>
<td>[0.68, 2.40]</td>
</tr>
<tr>
<td>Endocardial cushion defect</td>
<td>76</td>
<td>2 (2.63)</td>
<td>2.07</td>
<td>[0.25, 7.60]</td>
</tr>
<tr>
<td>Pulmonary valve atresia and stenosis</td>
<td>311</td>
<td>6 (1.93)</td>
<td>1.52</td>
<td>[0.55, 3.37]</td>
</tr>
</tbody>
</table>

hypertension, obesity, and diabetes may increase infant morbidity and mortality without necessarily resulting in birth defects. However the high birth defect rate among non-resident deliveries suggests this is one of the primary reasons for transfer to Hawai‘i for delivery. If this is true, then the presence of a birth defect must have been known or suspected prior to transfer. This assertion is supported by the observations of significantly higher rates of non-resident deliveries with use of prenatal diagnostic procedures and prenatal diagnosis of a defect. But not only must a birth defect have been known or suspected, but it must have been believed that the birth defect placed the fetus or infant at increased risk of morbidity and mortality or required specialized treatment. This contention is corroborated by the substantially increased non-resident rates among pregnancy outcomes associated with fetal and infant death, higher numbers of diagnosed major birth defects, and attempted cytogenetic analysis. Moreover, the eight birth defects with significantly higher non-resident rates can all be prenatally diagnosed and are associated with increased morbidity and mortality or may require specialized treatment.

The non-resident delivery rates varied among the racial/ethnic groups studied. This is likely related to the racial/ethnic composition of the states and countries from which the mothers originated. Of particular note was the very high non-resident delivery rate among Guamanians. This should not be surprising considering that the highest number of infants/fetuses with birth defects born to non-residents from US states and territories involved mothers who came from Guam.

The non-resident delivery rate was also higher with increased maternal age but lower number of prior pregnancies. This pattern is unusual because of the observation that maternal age is associated with increased gravidity and that older women are at increased risk of adverse pregnancy outcomes.

The non-resident delivery rate among women with more education may be a consequence of more highly educated women being more likely to use prenatal care and prenatal diagnostic procedures.

The non-resident delivery rate was substantially higher in the City and County of Honolulu than compared to the other counties in Hawaii. This observation is not surprising considering that most of the genetic counseling and pediatric tertiary care facilities in the state are in the City and County of Honolulu.

The non-resident rates varied greatly by specific type of birth defect but were higher than the general rate for three-fifths of the specific birth defects studied. Thus the impact of inclusion or exclusion of non-resident deliveries may depend on the type of birth defect of interest. As noted previously, those birth defects with significantly higher non-resident rates tended to be birth defects that can be prenatally diagnosed and can impact morbidity and mortality. However, it should be noted that other birth defects such as anencephaly and trisomy 13 that can be prenatally diagnosed and impact morbidity and mortality had lower non-resident rates.
In conclusion, this study found that only slightly more than 1% of deliveries in Hawai‘i of infants and fetuses with birth defects were to non-residents. The majority of non-resident deliveries with known reason for delivering in Hawai‘i were intentional. Higher non-resident rates were found with selected birth defects, increasing number of diagnosed birth defects, fetal or infant death, multiple births, older maternal age, lower number of prior pregnancies, higher maternal education, prenatal diagnosis, and attempted cytogenetic analysis. Since the applicability of these results to other US birth defects registries is unknown, similar studies by other registries are recommended.

Acknowledgements
We wish to thank Edward R. Diaz for his computer assistance, A. Michelle Weaver and Amy M. Yamamoto for their data collection activities, and the 34 participating Hawai‘i health facilities who allowed us access to their patient data.

References

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Total No.</th>
<th>Non-residents No. (%)</th>
<th>Rate Ratio</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tricuspid valve atresia and stenosis</td>
<td>55</td>
<td>2 (3.64)</td>
<td>2.86</td>
<td>[0.34,10.50]</td>
</tr>
<tr>
<td>Ebstein’s anomaly</td>
<td>16</td>
<td>0 (0.00)</td>
<td>0.00</td>
<td>[0.00,18.35]</td>
</tr>
<tr>
<td>Aortic valve stenosis</td>
<td>40</td>
<td>1 (2.50)</td>
<td>1.97</td>
<td>[0.05,11.11]</td>
</tr>
<tr>
<td>Hypoplastic left heart syndrome</td>
<td>56</td>
<td>1 (1.79)</td>
<td>1.41</td>
<td>[0.04,7.94]</td>
</tr>
<tr>
<td>Coarctation of aorta</td>
<td>77</td>
<td>0 (0.00)</td>
<td>0.00</td>
<td>[0.00,3.81]</td>
</tr>
<tr>
<td>Interrupted aortic arch</td>
<td>15</td>
<td>1 (6.67)</td>
<td>5.25</td>
<td>[0.13,29.63]</td>
</tr>
<tr>
<td>Anomalous pulmonary venous return</td>
<td>43</td>
<td>1 (2.33)</td>
<td>1.83</td>
<td>[0.05,10.34]</td>
</tr>
<tr>
<td>Choanal atresia and stenosis</td>
<td>41</td>
<td>0 (0.00)</td>
<td>0.00</td>
<td>[0.00,7.16]</td>
</tr>
<tr>
<td>Cleft palate</td>
<td>237</td>
<td>3 (1.27)</td>
<td>1.00</td>
<td>[0.20,2.96]</td>
</tr>
<tr>
<td>Cleft lip with or without cleft palate</td>
<td>411</td>
<td>5 (1.22)</td>
<td>0.96</td>
<td>[0.31,2.28]</td>
</tr>
<tr>
<td>Esophageal atresia and/or tracheoesophageal fistula</td>
<td>70</td>
<td>0 (0.00)</td>
<td>0.00</td>
<td>[0.00,4.19]</td>
</tr>
<tr>
<td>Pyloric stenosis</td>
<td>254</td>
<td>1 (0.39)</td>
<td>0.31</td>
<td>[0.01,1.75]</td>
</tr>
<tr>
<td>Small intestinal atresia and stenosis</td>
<td>90</td>
<td>5 (5.56)</td>
<td>4.38</td>
<td>[1.40,10.40]</td>
</tr>
<tr>
<td>Rectal and large intestinal atresia and stenosis</td>
<td>163</td>
<td>3 (1.84)</td>
<td>1.45</td>
<td>[0.30,4.30]</td>
</tr>
<tr>
<td>Hirschsprung’s disease</td>
<td>69</td>
<td>0 (0.00)</td>
<td>0.00</td>
<td>[0.00,4.25]</td>
</tr>
<tr>
<td>Biliary atresia</td>
<td>33</td>
<td>1 (3.03)</td>
<td>2.39</td>
<td>[0.06,13.47]</td>
</tr>
<tr>
<td>Malrotation of intestines</td>
<td>91</td>
<td>4 (4.40)</td>
<td>3.46</td>
<td>[0.93,9.02]</td>
</tr>
<tr>
<td>Hypospadias and epispadias</td>
<td>867</td>
<td>10 (1.15)</td>
<td>0.91</td>
<td>[0.43,1.71]</td>
</tr>
<tr>
<td>Renal agenesis and hypoplasia</td>
<td>151</td>
<td>6 (3.97)</td>
<td>3.13</td>
<td>[1.13,6.95]</td>
</tr>
<tr>
<td>Cystic kidney</td>
<td>145</td>
<td>8 (5.52)</td>
<td>4.35</td>
<td>[1.85,8.75]</td>
</tr>
<tr>
<td>Obstructive genitourinary defect</td>
<td>464</td>
<td>13 (2.80)</td>
<td>2.21</td>
<td>[1.15,3.87]</td>
</tr>
<tr>
<td>Bladder exstrophy</td>
<td>10</td>
<td>0 (0.00)</td>
<td>0.00</td>
<td>[0.00,29.35]</td>
</tr>
<tr>
<td>Persistent cloaca</td>
<td>5</td>
<td>0 (0.00)</td>
<td>0.00</td>
<td>[0.00,58.70]</td>
</tr>
<tr>
<td>Congenital hip dislocation</td>
<td>313</td>
<td>1 (0.32)</td>
<td>0.25</td>
<td>[0.01,1.42]</td>
</tr>
<tr>
<td>Polydactyly</td>
<td>562</td>
<td>4 (0.71)</td>
<td>0.56</td>
<td>[0.15,1.46]</td>
</tr>
<tr>
<td>Syndactyly</td>
<td>278</td>
<td>4 (1.44)</td>
<td>1.13</td>
<td>[0.31,2.95]</td>
</tr>
<tr>
<td>Reduction deformity of upper limbs</td>
<td>117</td>
<td>2 (1.71)</td>
<td>1.35</td>
<td>[0.16,4.93]</td>
</tr>
<tr>
<td>Reduction deformity of lower limbs</td>
<td>48</td>
<td>0 (0.00)</td>
<td>0.00</td>
<td>[0.00,6.12]</td>
</tr>
<tr>
<td>Craniosynostosis</td>
<td>162</td>
<td>2 (1.23)</td>
<td>0.97</td>
<td>[0.12,3.56]</td>
</tr>
<tr>
<td>Diaphragmatic hernia</td>
<td>81</td>
<td>3 (3.70)</td>
<td>2.92</td>
<td>[0.60,8.66]</td>
</tr>
<tr>
<td>Omphalocele</td>
<td>93</td>
<td>4 (4.30)</td>
<td>3.39</td>
<td>[0.91,8.82]</td>
</tr>
<tr>
<td>Gastrochisis</td>
<td>110</td>
<td>2 (1.82)</td>
<td>1.43</td>
<td>[0.17,5.25]</td>
</tr>
<tr>
<td>Situs inversus</td>
<td>37</td>
<td>4 (10.81)</td>
<td>8.51</td>
<td>[2.30,22.18]</td>
</tr>
<tr>
<td>Trisomy 21</td>
<td>481</td>
<td>9 (1.87)</td>
<td>1.47</td>
<td>[0.06,2.86]</td>
</tr>
<tr>
<td>Trisomy 13</td>
<td>62</td>
<td>1 (1.61)</td>
<td>1.27</td>
<td>[0.03,7.17]</td>
</tr>
<tr>
<td>Trisomy 18</td>
<td>154</td>
<td>6 (3.90)</td>
<td>3.07</td>
<td>[1.11,6.81]</td>
</tr>
<tr>
<td>Total</td>
<td>14,335</td>
<td>182 (1.27)</td>
<td>reference</td>
<td></td>
</tr>
</tbody>
</table>
Excessive Sweepstakes Participation in Patients with Dementia in Hawai‘i: A Case Series

Bruce K. Tamura MD, Warren F. Wong MD, Banu Sezginsoy MD, and Kamal H. Masaki MD

Abstract
We report a case series of 11 patients with excessive sweepstakes participation on initial geriatric consultation in Honolulu. Ten of these patients had dementia, mostly Alzheimer’s disease, with Folstein MiniMental Status Exam scores ranging from 17-29/30. Money lost ranged from $6,600 to $200,000-$400,000. Physicians need to have a high index of suspicion and the public needs to be educated about simple preventive strategies.

Introduction
Participation in sweepstakes can have severe financial consequences for people. The Federal Bureau of Investigation estimates fraudulent telemarketers represent 10% of the industry.1 What’s more, a lot of sweepstakes organizations target the elderly. The American Association of Retired Persons (AARP) estimates annual U.S. losses from telemarketing fraud at 40 billion dollars.2 Under the unfair- or deceptive-practice law, fraudulent telemarketing is a crime. If convicted, a person in Hawai‘i can be fined up to $10,000 per violation. The penalty is doubled if the victim is a senior citizen.1 There are no good statistics to measure the scope of the problem in Hawai‘i, but in 1997 the Office of Consumer Protection received 100 telemarketing complaints, which was felt to be the tip of the iceberg.2 The AARP released a survey of 2000 Hawai‘i members that showed perhaps 25% have been victimized by fraud. The national average is estimated to be somewhat less, approximately 20%. In that same survey only one in six filed complaints with the state.3 Avoiding large losses of money requires intact judgment. People with dementia have impairment of judgment and therefore are at greater risk.

This is a case series of 11 patients with dementia who had participated excessively in sweepstakes and had lost substantial savings.

Methods
This is a retrospective chart review study of 11 patients from the Kaiser Permanente of Hawai‘i Outpatient Clinic and the Geriatrics Clinic at Kuakini Medical Center, who were noted to have lost substantial amounts of money on sweepstakes during geriatric consultation. Characteristics of each patient were recorded including age, sex, ethnicity, marital status, other household members, dementia type, stage of dementia, MMSE score, dollar amount lost, and if sweepstakes participation was the presenting sign. All chart reviews were performed by a single physician (lead author).

Institutional Review Board approval was obtained from Kaiser Permanente and Kuakini Medical Center. Since this was a retrospective chart review study, informed consent was not obtained from subjects.

Results
Demographic and medical characteristics of the cases in our series are reported in table 1. Six of 11 subjects (55% of the population) were female. Subjects were of several ethnic backgrounds including Caucasian (3/11, 27%), Asian/Pacific Islander (7/11, 64%), and mixed descent (1/11, 9%). Regarding marital status, 4/11 (36%) were married, 2/11 (18%) were divorced, and 5/11 (45%) were widowed. The majority of patients (7/11, 64%) lived with family members; however two of these patients did not receive supervision. Of the remainder 3/11 (27%) lived alone, and 1/11 (9%) lived in a care home. Ten of the 11 patients had a diagnosis of dementia, 8/11 (73%) had Alzheimer’s disease, and 2/11 (18%) had fronto-temporal dementia. One person had an initial diagnosis of depression, and no follow-up, so it is unknown if she developed dementia at a later time. Scores on the MMSE ranged from 17/30 to 29/30 with the mean score being 25/30. Dollar amount lost ranged from $6,600 to $200,000-$400,000. Some patients did not have an exact dollar amount lost listed on the chart. For example, the chart noted that one person lost so much that “she was evicted from her condominium and was assisted by catholic charities to find public housing.” In 8/11 (73%) of cases, sweepstakes participation was one of the presenting symptoms of dementia, in 2/11 (18%) there was a prior diagnosis of dementia, and in 1/11 (9%) it was unclear.

Discussion
There is very little literature available on this subject. The authors did a literature search through medline,
Table 1.— Demographic and Medical Characteristics of Cases

<table>
<thead>
<tr>
<th>Pt #</th>
<th>M/F</th>
<th>Race</th>
<th>Marital Status</th>
<th>Living Situation</th>
<th>Diagnosis</th>
<th>MMSE Score</th>
<th>Amount of Money Lost</th>
<th>Medications Started</th>
<th>Was sweepstakes presenting sign?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>Caucasian</td>
<td>Divorced</td>
<td>By herself</td>
<td>AD</td>
<td>26/30</td>
<td>Doesn’t say. “Evicted from condo”</td>
<td>Donepezil</td>
<td>Doesn’t say. Seems disorganization and memory loss were first.</td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>Hawaiian</td>
<td>Married</td>
<td>Wife &amp; daughter</td>
<td>AD</td>
<td>22/30</td>
<td>$39,000</td>
<td>Donepezil</td>
<td>Yes. 10 yrs prior to consult.</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>Caucasian</td>
<td>Married</td>
<td>Wife, but on separate floors</td>
<td>AD</td>
<td>26/30</td>
<td>$40,000</td>
<td>Diversity for hypomania</td>
<td>No. 5 yrs prior to consult. Memory impairment and repetition. 2 yrs. prior to consult sweepstakes started.</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>Caucasian/African</td>
<td>Married</td>
<td>Wife</td>
<td>FTD</td>
<td>25/30</td>
<td>$200,000-$400,000</td>
<td>Divalproex, Donepezil</td>
<td>No. 5 yrs prior to consult. Memory impairment and repetition. 2 yrs. prior to consult sweepstakes started.</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>Hawaiian</td>
<td>Widowed</td>
<td>Son &amp; daughter</td>
<td>AD</td>
<td>17/30</td>
<td>“Large amounts”</td>
<td>Haloperidol for behavior</td>
<td>Yes. In addition to memory impairment 3-4 yrs prior to consult.</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>Japanese</td>
<td>Married</td>
<td>By herself</td>
<td>AD</td>
<td>25/30</td>
<td></td>
<td>Donepezil</td>
<td>Yes. In addition to memory impairment 5 yrs prior to consult.</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>Chinese</td>
<td>Widowed</td>
<td>Daughter &amp; granddaughter</td>
<td>AD</td>
<td>23/30</td>
<td>“Several thousands”</td>
<td>Paroxetine and Donepezil</td>
<td>Yes. “several yrs” prior to consult in addition to memory problems.</td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>Japanese</td>
<td>Married</td>
<td>Wife who has dementia, daughter, granddaughter</td>
<td>AD</td>
<td>23/30</td>
<td>?</td>
<td>Considering Donepezil</td>
<td>Yes. In addition to memory impairment 3 yrs prior to consult.</td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>Finnish</td>
<td>Widowed</td>
<td>Pohainani Care Home</td>
<td>Depression, FTD</td>
<td>29/30</td>
<td>$12,000</td>
<td>Sertraline for depression</td>
<td>Yes. In addition to short term memory loss, 1 yr prior to consult.</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>Japanese</td>
<td>Widowed</td>
<td>Grandson, but does not supervise</td>
<td>AD</td>
<td>27/30</td>
<td>$6600 documented</td>
<td>None</td>
<td>Not sure. 3 yrs prior to consult had memory impairment; on “recent review” found sweepstakes, so could have been.</td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>Japanese</td>
<td>Widowed</td>
<td>Herself, until 1997</td>
<td>Depression</td>
<td>29/30</td>
<td>$30,000</td>
<td>Continue Fluoxetine</td>
<td>Yes. 3 yrs prior to consult. Was first sign.</td>
</tr>
</tbody>
</table>

AD: Alzheimer’s Disease. FTD: Frontotemporal Dementia

PubMed, and used key words “sweepstakes,” “gambling,” and “dementia.” Only one article was found titled “Excessive Sweepstakes Participation by Persons with Dementia” by Mendez et al.4 In this letter to the editor, they evaluated three patients with excessive sweepstakes participation as the presenting symptom of vascular dementia. Patient number one had an MMSE of 24/30, had multiple hyperintensities on MRI, and was treated with olanzapine, trazadone, and behavioral therapy. Patient number two had an MMSE of 23/30, had multiple hyperintensities on MRI, and was treated with haloperidol. Patient number three had an MMSE of 22/30, had multiple hyperintensities on MRI, and was treated with olanzapine, trazadone, and behavioral therapy. There were many differences between their letter and our report. All three of their patients were diagnosed with vascular dementia, while 8/11 or 73% of this study’s patients were diagnosed with Alzheimer’s disease. Their patients’ MMSE scores ranged from 22/30-24/30, while this study’s had a wide range of anywhere from 17/30 to 29/30 with a mean score of 25/30. Lastly, all three of their patients had paranoid delusions on presentation while only one out of eleven of this study’s patients had paranoid delusions. This case series demonstrates that excessive sweepstakes participation can be seen in patients with any type of dementia.

What can be done to help this situation? First of all, physicians should listen to the family. More than a few families specifically stated that the patient would have never succumbed in this fashion if they were not cognitively impaired. For example, one patient’s family stated that he would have never done these kinds of activities before in his life as he was an analytical thinker, and would have known that there was little chance of winning in that form of sweepstakes. Thirdly, physicians should not assume that because there are other family members in the house, that it would prevent this from happening, since 64% of these subjects lived with one or more other persons in the house.

These are some educational tips that need to be relayed to the public: (1) be suspicious if you are told you have won a free gift, vacation, or prize, but you need to pay for postage, handling, taxes or anything else; (2) be suspicious if you must send money, give credit card numbers or bank account numbers, or have a check picked up by courier before you have had a chance to consider the offer carefully or if you are told you can’t miss this “high profit” or “no risk” offer; and (3) If you have really won a prize, you would not receive word via bulk mail postage. Notification would be through registered, certified, or first class mail.

There are some general rules which should be relayed to patients: (1) don’t buy by phone from unfamiliar companies. Always ask and wait for written material on any offer, charity, or expensive investment; (2) take time to make decisions. Legitimate companies shouldn’t pressure you; (3) never send money or give credit card or bank account numbers to unfamiliar companies; and (4) you can
always contact the Better Business Bureau if you have questions. There are advising lines to check for tips on prizes, contests, and sweepstakes offers.

Once a physician has identified that a patient has been a victim, these are some possible strategies to offer the patient and family: (1) change to an unlisted phone number; (2) limit credit cards to only small amounts, i.e. several hundred dollars; (3) limit the amount in checking accounts; (4) have joint accounts and/or require 2 signatures on checks; (5) review credit card and bank statements monthly for unusual charges; (6) family members should interrupt suspicious calls tactfully; and (7) purchase a Post Office Box for mail deliveries.

Patients and families can contact the Office of Consumer Protection or the Better Business Bureau to report problems and warn others. The Office of Consumer Protection website is www.hawaii.gov/dcca/ocp. Call and write to these organizations to take names off the respective mailing lists:

Mail Preference Service
Direct Marketing Association, P.O. Box 9008
Farmingdale, NY 11735-9008

Telephone Preference Service
Direct Marketing Association, P.O. Box 9018
Farmingdale, NY 11735-9014

However, only organizations that participate with these groups will be affected. One can tell telemarketers not to call; the federal trade commission states it is illegal for a company to call asked to stop. Lastly, physicians should contact Adult Protective Services if they feel a patient is a target. In Hawai’i and many other states, physicians are mandated to report such cases of suspected elder abuse.

Acknowledgements
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References
On August 4, 2006, at the “While Coat Ceremony”, sixty-two students were inducted into the medical school. At the ceremony, alumni from the Class of 1981 placed on each in-coming student’s shoulder a white coat, “cloak of compassion”, and, in unison, students and all physicians present stood to recite the Hippocratic Oath.

The newly admitted students, 31 men and 31 women, were selected from a total of 1, 629 applicants from Hawai‘i (219) and through out the mainland and Canada (1410). Of the total number, 173 non-residents and 164 residents passed the academic screen and qualified to be interviewed.

Of the 62 in-comings, 13 are re-applicants. Fifty-seven are residents of Hawai‘i. Median age is 23. Self-declared ethnicity are: 16 Native Hawaiian and Other, 13 Mixed Asians, 8 Whites, 6 Japanese, 4 Chinese, 4 Filipino/Other, 3 Koreans, 2 Japanese/Other, 1 in each of the following: Guamanian/Chomorro, Korean/White, Thai/White, Samoan, Vietnamese, and 1 declined to respond.

Thirty-eight are graduates of private high schools and 24 are from public high schools. Forty-one completed their undergraduate college on the mainland U.S., 20 are from Hawai‘i (2 Hawai‘i Pacific University and 18 from the University of Hawai‘i System), and one from the University of Guam. The mainland college represented are: Stanford University, University of Washington, Brigham Young University-Utah, Harvard University, Tufts University, University of California (UC)-Irvine, Baylor University, Brown University, Colgate University, Creighton University, Dartmouth College, Duke University, Eastern Washington University, Gonzaga University, Loyola Marymount University, MIT, Pepperdine University, St. Cloud State University, St. Mary’s College of California, Santa Clara University, Seattle University, UC-Berkeley, UC-Davis, UCLA, UC-Santa Cruz, University of Southern Main, Washington University in St. Louis, Washington University, Wellesley College, Willamette University, and Yale University.

All students earned their Bachelor of Arts and/or Sciences Degrees. In addition, eight have their Masters Degrees. The largest number (19) are majors in Biology/Biological Sciences. Regardless of college majors that range from emphasis in subjects such as Chemistry, English, Real Estate, to Nursing, all students fulfilled the pre-medicine requirements as delineated in the website: http://jabsom.hawaii.edu/.

The academic credentials of the entering class are: Medians, Cumulative GPA, 3.62; Science GPA, 3.51; MCAT components, Verbal Reasoning, 9; Physical Sciences, 10; Writing Sample, Q; and, Biological Sciences, 10.

Seventy Interviewers, regular and clinical faculty, and fourth-year medical students conducted interviews on a one on one basis from September 2005 to March 2006. Each interviewer received an orientation conducted by the Chair of the Admissions Committee prior to seeing the first applicant. Interviewers were assigned 8-10 candidates and furnished with documents that included: personal history statement that the applicant wrote for the American Medical Colleges Admissions Service (AMCAS) and essays that addressed, “Why Medicine as a career choice” and “Why the John A. Burns School of Medicine.” Interviewers had no knowledge of scores or personal data. The “bottom line” for interviewers was to advise the Admissions Committee as to whether the applicants will “make a physician.” The interviewers explored, with each applicants, issues such as: leadership skills, interpersonal relationships, compassion to help others, and the strength and stamina to go through eight years of medical education and training. The interviewers’ final recommendations included her/his selection of a category: “strongly recommend”, “recommend with reservation”, “recommend”, or “do not recommend”, accompanied by a confidential written explanation of why a specific recommendation was selected.

The documents from the Interviewers were submitted to the twelve-member Admissions Committee, 6 men and 6 women, 9 of whom are clinicians, two basic scientists, and one social scientist. They represented the major ethnic groups in Hawai‘i as well as various age levels. In twenty-one meetings the Committee processed 337 qualified applicants.

Prior to each Admissions Committee’s meeting, the Registrar assigned randomly the dossier to be discussed by a committee member. Members go on line, with a pre-assigned password to review the web-based AMCAS applications. The dossier includes: AMCAS application, MCAT scores, GPA scores and transcripts, letters of recommendations, interviews reports, and essays written by the applicants. Highlights of each section of the folder are reported sequentially to the Admissions Committee, after which there is a period for questions/answers and discussion. The Chair will call for a secret rating of 1-10 for each applicant reviewed. The confidential ratings are submitted to the Registrar. Three hundred thirty-seven (337) applicants were ranked. The top 53 were offered admission. Nine from the Imi Ho’Ola post-baccalaureate program joined to complete the roster of 62.

At the White Coat Ceremony of the Class of 2010, Dr. Damon Sakai, the keynote speaker, as he addressed the importance of professionalism, excellence in science, compassion and honor, reminded the class, “While compassion for ourselves and those we love enrich our lives, first and foremost, as physicians, we must nurture and protect the compassion we have for our patients. For when all is said and done, what they’ll remember about us is our compassion.”

With those words, the 62 were inducted into the profession of medicine as MS1 (first year medical students) in the John A. Burns School of Medicine, University of Hawai‘i. A rewarding future awaits them.

Reference
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for over 28 years

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2. The majority of new members saved 30% and more on their medical malpractice coverage costs upon changing their coverage to HAPI.

3. Actively practicing physicians could save $20,000/year and more, depending on specialty.

4. There is no profit motive at HAPI. Savings are passed on to the members.

5. Established in 1977, HAPI is Hawaii’s first, physician-owned medical malpractice coverage plan in the State of Hawaii.

6. For almost three decades, HAPI has maintained a financially secure, affordable plan for Hawaii’s physicians.

7. As a physician-owned company, all members have a say in the plan.

8. HAPI settles claims only with our member’s consent.

9. The majority of members who joined HAPI in the beginning have stayed with us throughout their career.

10. In four separate surveys conducted in 1998, 2002, 2004, and 2005, we asked our members if they would refer a colleague to HAPI. In all four surveys, 100% of our members said, “Yes.”

“What prompted me to search for a new malpractice insurance provider was the steep increase in premiums. I am a strong believer that you get what you pay for, but also want value. Malpractice insurance companies should provide good legal support if that fateful day arrives. In addition, I was concerned that certain companies would not have enough reserves to handle large or multiple claims. I checked with the insurance commissioner and researched the integrity of the attorneys and felt that HAPI has the support that I need at an affordable price. Now, that’s value!”
Lance M. Kurata, M.D., Internist

“The cost savings with HAPI was a consideration to some degree, but more importantly, physicians that I greatly respect recommended HAPI to me. Since becoming a member, I’ve realized that being a local company, there is a very personal, family environment to membership. I was especially impressed by the internal review process, to qualify for membership. We are all in this together, and I’m grateful to belong to an organization that cares about my well being.”
M. Barbera Honnehier, M.D., Ph.D., Plastic Surgeon

“I initially changed my malpractice carrier to HAPI due to the rising costs of my previous carrier, where premiums had increased to nearly twice that of HAPI’s rates. But since being a member, I have been so impressed with my ability to pick up the phone and ask my questions to a live, experienced person… no time zones, no voice recordings! Their service is always professional, courteous, and seamless.”
Kathleen Mah, M.D., General Surgeon

“After converting my coverage to HAPI, I was pleased with the cost savings but even more impressed with their immediate attention to my concerns. It is very reassuring to know that HAPI is highly accessible if there is a concern. I’ve experienced excellent customer service since day one.”
Art Wong, M.D., Pediatrician

For an in-person or telephone consultation, call Jovanka Ijacie, HAPI’s Membership Development Specialist.

HAPI’s Physicians’ Indemnity Plan, 735 Bishop Street, Suite 311, Honolulu, HI 96813
Ph: 808-538-1908, Fax: 808-528-0123, www.hapihawaii.com
Cancer is a major public health concern with over 564,000 cancer deaths predicted in the United States in 2006. Most of these cancer deaths are preventable. The American Cancer Society estimates that in 2006, 170,000 cancer deaths are expected to be caused by tobacco use and an additional 188,000 caused by physical inactivity, poor nutrition, and overweight or obesity. Immoderate sun exposure, heavy alcohol use, and sexually transmitted diseases also all contribute to the cancer burden in the United States.

To address this burden, population-based strategies are needed to alter human behaviors to reduce cancer risk. To impact the population, an intervention must not only be effective but must have substantial reach into the population. For instance, a smoking cessation clinic with a quit rate of 85% that reaches 2,000 smokers per year results in a smaller impact than a social marketing campaign with a quit rate of 5% and a reach of 500,000 smokers. However, despite their promise, population-based mass media approaches alone have had little impact on health behaviors.

In 1986, the first international conference on health promotion was held in Ottawa, Ontario, Canada. At this meeting, the Ottawa Charter for Health Promotion was developed. The Ottawa Charter expands the definition of health promotion to include creating supportive environments, building healthy public policy, strengthening community action, developing personal skills, and reorienting health services to promote health. Out of this broader focus of health promotion and in reaction to a victim blame ideology of personal responsibility for health and illness, the Social-Ecological model was developed. The Social-Ecological Model is a theoretical model that takes a broad view of behavior and works from the premise that human behavior is determined by a combination of individual skills, abilities and psychosocial constructs as well as factors in the social and physical environment. This ecological perspective highlights the need for approaching public health challenges on multiple levels and stresses interaction and integration of factors within and across levels. The levels of influence within the social-ecological model include:

1. **Public Policy**: local, state, and federal government policies, regulations and laws
2. **Community**: social networks, norms, standards and practices
3. **Institutional/Organizational**: rules, policies, procedures, environment, and informal structures within an organization or system
4. **Interpersonal**: family, friends, peers who provide social support and identity
5. **Individual**: awareness, knowledge, values, beliefs, attitudes, preferences

Research has shown that behavior change is more likely to endure when both the individual and the environment undergo change simultaneously. Community programs to increase physical activity and healthy eating will be more effective when the environment and public policies are in place that provide safe places to walk and healthy food choices. Together, the multilevel approaches create synergy and have a far greater influence on individuals, organizations, communities, and society as a whole, than either individual or environmental strategies could alone.

An excellent case example of the social ecological model is tobacco control efforts over the past 20 years. National as well as state and local efforts have reduced the adult prevalence of tobacco from 42.4% in 1965, to 30.1% in 1985 to 20.9% in 2004. This reduction is due in part to a three pronged strategy focusing prevention initiation among youth, helping smokers to quit, and protecting non-smokers from second-hand smoke. This effort has focused on each level of the social ecological model including public policy (i.e. cigarette taxes), community (i.e. enforcement of no tobacco sales to minors, tobacco quit lines), institutional/organizations (i.e. smoke-free workplaces), interpersonal (i.e. quit groups, youth anti-tobacco movements) and the individual (i.e. social marketing campaigns). The levels also work synergistically. Longitudinal research has shown that after the implementation of smoke-free workplace regulations, workers are more likely to support further legislation and are less likely to smoke.

In Hawai‘i, the social-ecological model has been used to address physical inactivity and poor nutrition through the Healthy Hawai‘i Initiative. The tobacco settlement provided a unique opportunity for Hawai‘i to address the problems of physical inactivity and poor nutrition. In 1999, the state legislature passed legislation mandating that the Hawai‘i Department of Health (DOH) allocate 25% of the State’s tobacco settlement money for disease prevention programs targeting tobacco, physical activity, and nutrition. The state used these funds to create the Healthy Hawai‘i Initiative (HHI), a partnership between the DOH, the University of Hawai‘i, Department of Public Health Sciences, and the Department of Education.

Continued on p. 352
QUESTION: During her hospital stay, an elderly patient noticed burn marks and abrasions on her extremities. She believed they resulted from the use of wrist and ankle restraints but could not prove it.

A. This is a case of res ipsa loquitur or ‘the thing speaks for itself,’ analogous to the leaving of surgical instruments in the abdomen.

B. If an unexpected adverse event occurs in the hospital, a good case of res ipsa can be made because the hospital team is in full control of the patient.

C. This is not a case of res ipsa, as the injuries may have resulted from excessive rubbing on the bed-sheets.

D. Res ipsa is good circumstantial evidence and the plaintiff will no longer need a medical expert to win her case.

E. The hospital cannot be liable because restraints were necessary to prevent the patient from thrashing around and posing a risk to herself and others.

ANSWER: Only C is correct. For res ipsa to be applicable, three conditions must be met: 1) the injury would not have occurred in the absence of someone’s negligence, 2) the plaintiff was not at fault, and 3) the defendant had total control of the instrumentality that led to the injury. In some jurisdictions, res ipsa shifts the burden of proof to the defendant (normally the plaintiff has the burden of proof), and plaintiff will not need an expert witness to testify that there has been a breach of the standard of care. However, in most jurisdictions, res ipsa is considered mere circumstantial evidence that is rebuttable, and plaintiff will need an expert to prove causation and damages. D is therefore incorrect. The facts here are insufficient to constitute a clear case of res ipsa, making A and B incorrect.

Medical mishaps in the hospital occur under complex circumstances, which is why most courts are reluctant to invoke the res ipsa doctrine except in very special situations, e.g., sponge left in peritoneal cavity.

Answer E is also incorrect. Use of patient restraints, either physical or chemical, is taboo under current JCAHO standards. Pleading this line of defense is therefore unlikely to prevail. Studies indicate that injuries are more, not less, apt to occur with restraints, which literally deprive patients of their physical freedom. Other means of treating the patient must be found, e.g., baby-sitters.

The best answer is C. So long as defendant’s negligence cannot be confidently assumed to be the cause of injury, invoking res ipsa will fail.

Res Ipsa Loquitur

The doctrine of common knowledge, more technically called res ipsa loquitur or ‘the thing speaks for itself,’ holds that where “the plaintiff’s evidence of injury creates a probability so strong that a lay juror can form a reasonable belief,” a plaintiff may be entitled to a waiver of the requirement of expert testimony. This doctrine is invoked rarely, usually in obvious examples of medical injuries such as amputation of the wrong limb, lung puncture following routine shoulder injection, or removal of the wrong vertebral disc. In one not so obvious example, the court allowed the case to go to the jury without benefit of expert testimony on the basis of common knowledge. The case involved the severance of a patient’s ureter during a complicated hysterectomy. The res ipsa doctrine was also allowed in a case where the plaintiff sustained injuries to the peroneal and tibial nerves after knee surgery. On the other hand, an Illinois court disallowed a plaintiff from claiming that it was common knowledge that someone should be referred to a cardiologist for a heart condition.

Res ipsa had its genesis in the classic 1863 English case where a barrel of flour fell upon the plaintiff from a window above a shop. Despite no other evidence, the court ruled for the plaintiff, opining that the circumstances constituted prima facie evidence of negligence (A prima facie case means the plaintiff has met the burden of going forward with evidence on the legal issue):

“I think it apparent that the barrel was in the custody of the defendant who occupied the premises, and who is responsible for the acts of his servants who had control of it; and in my opinion the fact of its falling is prima facie evidence of negligence . . .”

The res ipsa doctrine is most useful when the plaintiff has insufficient evidence of what caused the negligent act, but circumstances clearly indicate that the defendant was negligent. It is applicable only when three conditions are met:

1. The event, under the circumstances of the case, ordinarily does not occur in the absence of someone’s negligence
2. The event must be caused by a means within the exclusive control of the defendant
3. The plaintiff did not contribute to the event

In most jurisdictions, res ipsa permits the jury to infer that a negligent act had taken place, but the defense may still be able to rebut the evidence. Courts are usually hostile to the use of the res
ipsa doctrine to prove medical malpractice, unless the circumstances clearly warrant the application of the doctrine. Even a case of dysuria in association with a deformed penis was deemed insufficient evidence to indicate negligent circumcision.

In the well-known California case of *Ybarra v. Spangard*, the court permitted the use of the *res ipsa* doctrine against multiple defendants in the operating room after the plaintiff developed shoulder injuries following an appendectomy. Since the plaintiff was unconscious, the court felt it was appropriate to place the burden on defendants to explain how the shoulder injury occurred.

Courtroom eloquence concerning *res ipsa* was at its best in *Cassidy v. Ministry of Health*, an English case from the 1950s. In *Cassidy*, a patient suffered significant deformity of his hand following surgery for Dupuytren’s contracture. His attorney asserted: “At the outset, only two of the plaintiff’s fingers were affected; all four are now useless. There must have been negligence — *res ipsa*.” The Court of Appeal agreed, Lord Denning taking the position that it raised a *prima facie* case against the hospital. However, Lord Denning also indicated that the doctrine could only be invoked against a doctor in extreme cases.

The use of *res ipsa* is governed by statutes in some states. Georgia and North Dakota, for example, disallow the use of *res ipsa* in medical negligence cases.

This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is excerpted from the author’s book, “Medical Malpractice: Understanding the Law, Managing the Risk” published in 2006 by World Scientific Publishing Co. You may contact the author, S.Y. Tan MD, JD, at email: siang@hawaii.edu or call (808) 526-9784 for more information.

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The second page of the manuscript should include an abstract no longer than 60 words that highlights for the reader the essence of the authors’ work. It should focus on facts rather than descriptions and should emphasize the importance of the findings and briefly list the approach used for gathering data and the conclusions drawn.

**Style**

Use JAMA style or consult the AMA Manual of Style. Use the objective case, such as “the team determined” or “the study involved,” not I or we, and avoid medical jargon. Use generic drug names unless citing a brand name relevant to your findings. Do not use abbreviations in the title and limit their use in the text. Use human terms, i.e. “men” and “women” instead of “males” and “females.” Also place a comma before “and” in a series.

Please consult the JAMA website at: [http://jama.ama-assn.org](http://jama.ama-assn.org) for JAMA style.

**Text**

HMJ recommends that articles be divided into sections with headings:

**Introduction.** — The purpose of the article and rationale for the study. Do not review the subject extensively.

**Methods.** — Describe the patients or experimental animals clearly. Identify the methods, apparatus, and procedures in sufficient detail to allow other physicians to reproduce the results.

**Results.** — Present the results in logical sequence in the tables, illustrations, and tables. Do not repeat all of the data in the text, summarize important observations.

**Discussion.** — Emphasize the new and important aspects of the study and conclusions taken from them. Do not repeat data in Results section. State new hypotheses when warranted, but clearly label them as such. Recommendations may be included.

**Illustrations, Tables, Graphs and Figures**

Tables and graphs must be prepared in Microsoft Word or Excel. Numerical data should accompany graphs. Please limit the number of illustrations, tables, graphs, and figures.

Each figure or illustration should have a label pasted on the back indicating the figure number, name of authors, and the top of the figure. Do not write on the back, or scratch or mar them with paper-clips.

Illustrations must be clear, distinct, and unmounted.

Figures should be done on a computer or professionally drawn and photographed.

Type legends for illustrations starting on a separate page with arabic numbers corresponding to the illustrations. When symbols, arrows, numbers or letters are used to identify parts of the illustration, identify and explain each one clearly in the legend. Explain internal scale and identify method of shining in the photographs.

**References**

All references must be cited in the text and should be arranged in the order in which they are cited—not alphabetically. Please use the JAMA style for the references:


**Footnotes**

Place footnotes outside of punctuation marks. (e.g. These include diabetes, hypertension, orthopedic complications, asthma, sleep apnea, eating disorders and psychosocial problems.)
Acknowledgments
Acknowledge only persons who have made substantial contributions to the study. Authors are responsible for obtaining written permission from everyone acknowledged by name; readers might believe those acknowledged are endorsing the study and conclusions.

Reprints
Authors may order article reprints for a fee; however, a copy of the Journal will be sent to each author from which photo-copies may be made.

Synopsis-Abstract
In this age of electronic data retrieval, a well-written synopsis-abstract has become increasingly important in directing readers to articles of potential clinical and research value. The synopsis-abstract summarizes the main points of an article: (1) the purpose of the study, (2) the basic procedures followed, (3) the main findings, and (4) the principal conclusions. Expressions such as “X is described,” “Y is discussed,” “Z is also reviewed” should be avoided in favor of a concise (limited to 135 or 150 words in AMA’s journals) statement. A few specific guidelines to consider in preparing a synopsis-abstract follow:

- Do not begin the abstract with repetition of the title.
- Omit P values.
- Cite no references.
- Avoid abbreviations.
- Use the salt or ester of a drug at first mention.
- If an isotope is mentioned, when first used spell out the name of the element and then, on line, give the isotope number.
- Avoid the use of trademarks or manufacturers’ names unless they are essential to the study.
- Include major terms in the abstract, since the abstract can be text searched in many data retrieval systems. This will enable the article to be retrieved when relevant.

Table 1.— Age Structure of the Study Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Ebeye CHC Study Population</th>
<th>%</th>
<th>Ebeye Census</th>
<th>%</th>
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</thead>
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<td>302</td>
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<tr>
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<td>40</td>
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<tr>
<td>Total</td>
<td>692</td>
<td></td>
<td>2694</td>
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</tr>
</tbody>
</table>

Comparison of age structure of study population with age structure of residents of Ebeye as recorded in 1999 Census.

References to Books
Complete Data—A complete reference to a book includes (1) authors’ surnames and initials; (2) surname and initials of editor or translator, or both, if any; (3) title of book and subtitle, if any; (4) number of editions after the first; (5) place of publication; (6) name of publisher; (7) year of publication; (8) volume number, if there is more than one volume; and (9) page numbers, if specific pages are cited.

Example:

References to Website Example

For assistance with tables, figures, charts, and graphs you may contact Drake Chinen, at (808) 383-6627.

Figure Sample

Figure 1.— Incidence of Invasive Colorectal Cancer, Hawaii 1996-2000 (Age-adjusted to the US 2000 Population)
<table>
<thead>
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<th>Date</th>
<th>Specialty</th>
<th>Sponsor</th>
<th>Location</th>
<th>Meeting Topic</th>
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<td>1/17-1/22</td>
<td>D</td>
<td>American Academy of Dermatology</td>
<td>Wailea Beach Marriott Resort &amp; Spa, Wailea, Maui</td>
<td>3rd Annual Advances in Cosmetic &amp; Medical Dermatology</td>
<td>Tel: (312) 321-0150&lt;br&gt;Web: <a href="http://www.acmd-derm-hawaii.com">www.acmd-derm-hawaii.com</a></td>
</tr>
<tr>
<td>1/19-1/20</td>
<td>Multi</td>
<td>Queen’s Medical Center</td>
<td>Hilton Waikiki Prince Kuhio Hotel</td>
<td>Surf the Neuro Challenge 2</td>
<td>Tel: (808) 547-4731</td>
</tr>
<tr>
<td>1/20-1/24</td>
<td>PCC</td>
<td>American Lung Association of Hawai’i, Hawai’i Thoracic Society</td>
<td>Maui Prince Hotel, Maui</td>
<td>7th Annual Symposium: Current Concepts in Pulmonary and Critical Care</td>
<td>Tel: (480) 301-4580&lt;br&gt;Web: <a href="http://www.alta-hawaii.org">www.alta-hawaii.org</a></td>
</tr>
<tr>
<td>1/21-1/25</td>
<td>ON, FM</td>
<td>American Association for Cancer Research</td>
<td>Hilton Waikoloa Village, Waikoloa</td>
<td>In the Forefront of Basic and Translational Cancer Research AACR/JCA 7th Joint Conference</td>
<td>Tel: (215) 440-9300&lt;br&gt;Web: <a href="http://www.aacr.org">www.aacr.org</a></td>
</tr>
<tr>
<td>1/21-1/25</td>
<td>GS, SPI</td>
<td>Mayo Clinic College of Continuing Medical Education</td>
<td>Hapuna Beach Prince Hotel, Kohala Coast</td>
<td>International Spine Surgery Symposium 2007</td>
<td>Tel: (480) 301-4580&lt;br&gt;Web: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<td>1/22-1/25</td>
<td>CD</td>
<td>Mayo Clinic College of Continuing Medical Education</td>
<td>Hapuna Beach Prince Hotel, Kohala Coast</td>
<td>Arrhythmias &amp; the Heart in Hawai‘i</td>
<td>Tel: (480) 301-4580&lt;br&gt;Web: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
</tr>
<tr>
<td>1/29-2/3</td>
<td>R, N</td>
<td>NYU School of Medicine</td>
<td>Four Seasons Resort, Hualalai</td>
<td>Neuroradiology (and Head &amp; Neck) on the Big Island</td>
<td>Tel: (212) 263-5295&lt;br&gt;Web: <a href="http://www.radcme.med.nyu.edu">www.radcme.med.nyu.edu</a></td>
</tr>
<tr>
<td>2/14-2/18</td>
<td>OBG</td>
<td>Ian MacDonald Inter-University of Medical Ultrasound Hawai‘i &amp; Department of OB/GYN and Women’s Health, JABSOM</td>
<td>Hyatt Regency Waikiki Resort &amp; Spa, Honolulu</td>
<td>Evidence-based OB/GYN: Practical Application of New Advances</td>
<td>Tel: (808) 203-6528&lt;br&gt;Email: <a href="mailto:ckawahar@hawaii.edu">ckawahar@hawaii.edu</a>&lt;br&gt;Web: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<td>Hyatt Regency Waikiki Resort &amp; Spa, Honolulu</td>
<td>Contemporary Ob/Gyn Ultrasound: Recent Advances and Clinical Practice</td>
<td>Tel: (808) 203-6528&lt;br&gt;Email: <a href="mailto:ckawahar@hawaii.edu">ckawahar@hawaii.edu</a>&lt;br&gt;Web: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<tr>
<td>2/2-2/3</td>
<td>P</td>
<td>Mayo Clinic College of Continuing Medical Education</td>
<td>Sheraton Kauai Resort, Poipu Beach, Kauai</td>
<td>Psychiatric Pharmacogenomics</td>
<td>Tel: (480) 301-4580&lt;br&gt;Web: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<tr>
<td>2/3-2/4</td>
<td>OPH</td>
<td>Hawaii Ophthalmological Society</td>
<td>Halekulani Hotel, Honolulu</td>
<td>23rd Annual Hawai‘i Ophthalmological Spring Update</td>
<td>Tel: (808) 521-3535&lt;br&gt;Email: <a href="mailto:mwseninar@yahoo.com">mwseninar@yahoo.com</a>&lt;br&gt;Web: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<td>Mayo Clinic College of Continuing Medical Education</td>
<td>Wailea Beach Marriott Resort &amp; Spa, Wailea, Maui</td>
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<td>Tel: (480) 301-4580&lt;br&gt;Web: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<td>PD</td>
<td>University Childrens Medical Group</td>
<td>The Westin Maui</td>
<td>Pediatric Potpourri State of the Art 2006</td>
<td>Tel: (800) 354-3263&lt;br&gt;Web: <a href="http://www.ucmg.org/cme.html">www.ucmg.org/cme.html</a></td>
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<td>NPM</td>
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<td>The Westin Maui</td>
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<td>Tel: (800) 872-1119&lt;br&gt;Web: <a href="http://www.ucmg.org/cme.html">www.ucmg.org/cme.html</a></td>
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<td>Mayo Clinic College of Continuing Medical Education</td>
<td>Sheraton Keahou Resort, Kona</td>
<td>Selected Topics in Internal Medicine</td>
<td>Tel: (480) 301-4580&lt;br&gt;Web: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<td>Hilton Hawaiian Village, Honolulu 2/17-2/20 Hyatt Regency Hotel, Kaaapulehu Beach, Maui 2/21-2/24</td>
<td>Otolaryngology Updates</td>
<td>Tel: (816) 923-0820&lt;br&gt;Web: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<td>2/18</td>
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<td>Mayo Clinic College of Continuing Medical Education</td>
<td>Hapuna Beach Prince Hotel, Kohala Coast</td>
<td>Advanced Radiology Life Support Course</td>
<td>Tel: (480) 301-4580&lt;br&gt;Web: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<td>R</td>
<td>University of California, San Francisco</td>
<td>Fairmont Orchid Hawai‘i, Kaua‘i</td>
<td>Body Imaging in Paradise</td>
<td>Tel: (415) 476-5808&lt;br&gt;Web: <a href="http://www.cme.ucsf.edu">www.cme.ucsf.edu</a></td>
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<td>Grand Hyatt, Kaua‘i</td>
<td>Infectious Disease in Clinical Practice</td>
<td>Tel: (415) 476-5808&lt;br&gt;Web: <a href="http://www.cme.ucsf.edu">www.cme.ucsf.edu</a></td>
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Interested in having your upcoming CME Conference listed? Please contact Nathalie George at (808) 536-7702 x103 for information.
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.

For more information call (808) 536-7702.

INTERNIST
PART-TIME PHYSICIAN NEEDED:
The Honolulu Military Entrance Processing Station is recruiting a Physician for an on-call position. Duties will involve conducting medical qualification examinations on applicants for the Armed Forces. Looking for M.D. or D.O., any specialty. Individuals applying will be subject to a credentials review and must possess a valid, current, unrestricted license. If you are looking for a unique opportunity to be part of our team, send your C.V. to: John Kusterman, M.D., at honcmo@mepcom.army.mil or call at (808) 471-8725, ext 220.

PHYSICIAN NEEDED

CLINIC FOR SALE
WELL ESTABLISHED, RAPIDLY GROWING:
MODERN FAMILY PRACTICE/URGENT CARE CLINIC in high end hotel complex. Residential and tourist clientele with good cash flow and excellent long term lease. Inquiries: (808) 947-4997; www.WaikikiFP.com

OFFICE SPACE FOR RENT
SEEKING MEDICAL PROFESSIONAL: TO RENT OFFICE SPACE in Downtown Kukui Plaza. 3 exam rooms, 2 consultation rooms, kitchen, and waiting area. Fully furnished and equipped with ultrasound, colposcope, and wireless internet. Share with OB/Gyn who is there only 2 days a week. Approximately 1400 sq ft, $3000/month. Contact: (808) 722-7825.

PHYSICIAN NEEDED

OFFICE FOR SALE
RADIOLOGY OFFICE FOR SALE: CALL DR. ANWAR, 455-1077 / 671-1000.

The HMJ is published monthly by the Hawai‘i Medical Association. Incorporated in 1856 under the Monarchy.
BEAUTY COMES FROM WITHIN – JARS, TUBES, SYRINGES.

Historically, Allergan Inc., of Irvine, California, has been known for its ophthalmic products. Not any longer! Ocular medications now seem to be relegated to a sideline. Along came Botox for paralyzing facial muscles and smoothing wrinkles, and now with the introduction of Juvederm, an injectable cosmetic product recently approved by the Food and Drug Administration, Allergan is deeply into facial aesthetics. Juvederm, a hyaluronic acid dermal filler, is used to treat the deep skin folds that run lateral to the nose and down to the corners of the mouth. The effect is to plump up the creases by adding subcutaneous volume, but like Botox, Juvederm will wear off in approximately six months. For baby boomers, there is no need to fear geezerhood. Facial remodeling can keep the AARP population looking youthful indefinitely, but like with dental appointments, patients will have to see their cosmetic surgeon twice a year otherwise one morning they may look in the mirror and see the portrait of Dorian Gray. Allergan’s TV consumer advertising budget jumped from zero three years ago to $120 million per year.

ON BRITISH AIRWAYS IT’S LIFE-RISK VS. COST BENEFIT ANALYSIS.

Just seconds after take off from Los Angeles, California, last July the number two jet engine of a British Airways Boeing 747 with 351 souls aboard burst into flame and had to be shut down. The air traffic controllers immediately prepared to bring the huge jet back to the airport, but instead the flight crew contacted headquarters in Britain for advice. To the shock of the tower controllers, the captain was advised that the aircraft was certified to fly on three engines and to continue on its regular flight plan! The airplane continued across the United States, the Atlantic Ocean and eventually landed in Manchester, England, short of its destination because of worries about fuel consumption. Wow, is that legal? Not according to Federal Aviation Administration rules, but apparently okay by British air regulations. British Airways denied that the cost involved was a consideration, but admitted that $30,000 of fuel would have had to be dumped, and about $250,000 in passenger penalties and reroutes could have ensued. And if another engine had burst into flame over the Atlantic what would that cost? This is a disgraceful example of money trumping the safety of human cargo.

THE CLOSEST THING TO IMMORTALITY ON EARTH IS A GOVERNMENT BUREAU.

Nice work if you can get it, and you can get if you happen to be in the right place with the right spouse. Mrs. Barack Obama, wife of the charismatic Illinois senator, suddenly found herself promoted to Vice President in the University of Chicago Hospitals system, and her salary jumped from $121,910 to $316,962 in her role as liaison with the south side community. President Michael Riordan who scheduled the promotion stated that he had planned for the role to expand to VP level to demonstrate greater outreach in south Chicago. Michelle Obama earned a bachelors degree from Princeton and law degree from Harvard and is surely worth the money. However, one wonders about the other sixteen weepers who are all paid between $291,000 to $364,000 in the not-for-profit system.

PACK MY BAGS, SWEETIE. I’M GOING TO BERMUDA AND GET A NEW LIVER.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) began accepting applications from overseas hospitals early in the 1990s. Now more than 100 hospitals in twenty countries on five continents have received JCAHO approval including fourteen new hospitals this year. Cities as diverse as Hyderabad, India; Milan, Italy; and Izmir, Turkey, provide services where satisfied patients claim the quality of care is superior to what they received here. Medical tourism is now a commonplace event as patients (and third party payers) seek huge discounts for various operations. Procedures such as vascular bypass and shunt will cost you USA $62,000, overseas $8,750; CABG USA $63,000, overseas $15,000; kidney transplant USA $73,000, overseas $28,000. As the saying goes, “follow the money.” Obviously, there are risks in traveling abroad for major surgery, such as not understanding medical standards, surgical training, credentialing, and post-operative care. Moreover, what happens with complicated follow-up; does the patient return to India or Singapore or Brazil? And if a procedure is botched what is the recourse and venue for the unfortunate injured patient?

I CHANNEL SURFED FROM C-SPAN TO HOME SHOPPING NETWORK AND ACCIDENTALLY BOUGHT A CONGRESSMAN.

It requires some sort of blinders to be a politician. House Speaker Dennis Hastert was told by aides and members of his own party more than two years ago that Florida Representative Mark Foley was engaging in e-mail conversations of a sexual nature with underage Capitol pages. With Foley it was like when Hastert read ex-Senator Packwood’s diary – he couldn’t wait to get to the bottom of the page. Apparently, when Hastert was informed, he is quoted as saying “It’s been taken care of.” Now he claims he only knew of the problem on Friday, September 30, 2006. Come on, Mr. Speaker. Surely Ted Kennedy and Bill Clinton would advise you to get on with honest damage control immediately. Denial or delay hoping the sin will disappear is ineffective, stupid, and exposes one as a liar. Motive in this case could be that Hastert was fearful of losing a vital seat in the House of Representatives.

HONESTY IS THE BEST POLICY, UNLESS YOU ARE A VERY GOOD LIAR.

South Carolina revised its medical practice act last June, and the new law requires that an out-of-state physician must obtain a license before being able to offer testimony as an expert witness. Also, it is policy of the American Medical Association that providing expert testimony is considered the practice of medicine. The intention is to get medical-legal prostitutes off the street. It is no surprise that no such law has ever been suggested in Hawai‘i. Now three attorneys have filed a lawsuit against the South Carolina Board of Medical Examiners claiming that the license requirement violates state and federal constitutional guarantees of equal protection, due process, and free speech. And professional integrity, how about protecting that, counselor?

ONE TEQUILA, TWO TEQUILA, THREE TEQUILA, FLOOR.

A story in the South Florida Sun Sentinel stated that a 47-year-old off duty police officer was arrested for driving 90 MPH on the Florida turnpike when she swerved and almost collided with a police cruiser. She had a large open bottle of Southern Comfort on the seat and was naked from the waist down. When asked where her pants were, she replied, “I don’t know.” She refused to take a breath test, but failed the roadside sobriety test after donning a pair of sweat pants. Her job with the police department: DUI training for police recruits!

WHERE ARE YOU CALLING FROM? CAN YOU HEAR ME NOW?

The Washington Post reported that four men held in a maximum security prison in El Salvador had inserted cell phones, including chargers and chips, into their rectums in order to communicate while in prison. Suspicious police officers ordered X-rays which revealed the presence of foreign objects “in the body cavity.”

ADDENDA

36% of Americans between the ages of 18 to 29 have at least one tattoo.

It is not too late. You can still join the 728 people who are members of the I Hate Cilantro club.

We are born wet, naked, and hungry. After that things get worse.

ALOHA AND KEEP THE FAITH — rts
Did you know all of these are reportable diseases?

Health care providers in Hawaii are **required to report** clinically diagnosed complications of common infectious diseases such as:

**Hemolytic Uremic Syndrome (HUS) & Necrotizing Fasciitis (NF)**

To **report** an infectious disease or outbreak, call 24/7

**Department of Health**
**Disease Outbreak Control Division**

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oahu</td>
<td>(808) 586-4586</td>
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<tr>
<td>Maui</td>
<td>(808) 984-8213</td>
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<td>Kauai</td>
<td>(808) 241-3563</td>
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For the most current information, visit the Department of Health website: [www.hawaii.gov/health/about/rules/rules/11-156.pdf](http://www.hawaii.gov/health/about/rules/rules/11-156.pdf)
Medical Insurance Exchange of California (MIEC)

www.mieec.com