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Infiltrating Mammary Carcinoma with Osteoclast-like Giant Cells

Amy Stratton DO; Timothy P. Plackett DO; Christina M. Belnap MD; and Kevin M. Lin-Hurtubise MD

Abstract

Mammary carcinoma with osteoclast-like giant cells is an uncommon variant. The following case examines a 36-year-old woman incidentally found to have a left breast mass on routine physical exam. Initial ultrasound-guided core biopsies revealed infiltrating mammary carcinoma with focal mucinous features, for which a left breast lumpectomy and sentinel lymph node biopsy were performed. The sentinel lymph nodes were positive for metastatic mammary carcinoma with osteoclast-like giant cells on permanent section corresponding to the lumpectomy breast specimen, thus a left completion axillary node dissection was subsequently performed.

Introduction

There are a wide variety of breast lesions that on histologic examination may show multinucleated giant cells, one of which is an osteoclast-like giant cell. Mammary carcinomas with osteoclast-like giant cells are extremely rare and have been shown to constitute a small percentage of breast carcinomas. Mammary carcinoma with osteoclast-like giant cells was first described by Rosen in 1979. In a series of 200 consecutive mastectomies They reported finding nine cases (4.5%) of mastectomy specimens. Since this initial report, only a few case reports and small case series of mammary carcinoma with osteoclast-like giant cells have been reported. The following case report adds to the growing clinical experience with this atypical variant of mammary carcinoma.

Case Report

The patient is a 36-year-old woman who was incidentally found to have a palpable 2 cm mass in the left breast on routine physical examination. The patient denied any systemic symptoms, weight loss or bone pain and had never noticed or felt the breast mass herself. She has no family history of breast, uterine, or ovarian malignancy.

The patient underwent further evaluation with a diagnostic left breast mammography and ultrasound. These imaging studies documented a 1.9 cm by 1.2 cm hypoechoic mass. Ultrasound guided percutaneous core biopsies were performed, diagnosing invasive mammary carcinoma with focal mucinous features. Preoperative genetic testing was negative for the presence of a BRCA1 gene mutation.

Following the patient’s diagnostic biopsy, she underwent a lumpectomy with sentinel lymph node biopsy. Macroscopic examination of the lumpectomy specimen revealed a well-circumscribed mass that was 1.6 x 1.3 x 1.3 cm in size. Hematoxylin and eosin stained slides revealed an infiltrating mammary carcinoma with osteoclast-like giant cells (Fig. 1). Changes consistent with lymphovascular invasion were identified. Immunohistochemical staining revealed strong estrogen receptor and progesterone receptor reactivity. The carcinoma was also HER2 and E-Cadherin immunoreactive. Ki-67 was less than weakly positive with a DNA index/ploidy of 1% and S-phase of 2.6. Additionally, three of four sentinel lymph nodes were positive for the presence of metastatic disease on hematoxylin and eosin stained slides.

Given the presence of metastatic disease by sentinel lymph node biopsy, the patient returned to the operating room for a completion left axillary lymph node dissection. Four additional axillary lymph nodes were identified in the second surgical specimen. In total, two of eight lymph nodes were found to contain metastatic moderately differentiated mammary carcinoma with osteoclast-like giant cells. A third lymph node contained a micrometastasis, less than 2 mm. The final pathologic diagnosis was a Stage IIA (T1cN1M0) moderately differentiated infiltrating mammary carcinoma with osteoclast-like giant cells.

The patient has done well since her breast and axillary surgery, and adjuvant chemotherapy and radiation therapy were well tolerated. She is currently being treated with tamoxifen.

Discussion

Typically osteoclast-like giant cells have been associated with invasive ductal adenocarcinoma of the breast. However, they have also been associated with other histologic types of both malignant and benign breast lesions. These include cribriform, tubular, squamous, papillary, and mucinous breast carcinomas. Osteoclast-like giant cells have also been reported in infiltrating lobular carcinoma and ductal carcinoma in situ, but their presence is a more rare finding in these two types of carcinoma. In approximately one third of cancers with osteoclast-like giant cells there is axillary node metastasis, leading to a worse prognosis for patients with this form of carcinoma.

Initial diagnosis of mammary carcinoma is often based on fine needle aspiration or core needle biopsy. Cytologic finding of osteoclast-like giant cells include large cells with abundant cytoplasm and centrally located nuclei ranging in size and number. There are also prominent, associated nucleoli. Diagnosis of osteoclast-like giant cells can be extremely difficult on cytologic exam as these cells can be bland in appearance and have a similar appearance to foreign-body giant cells associated with fat necrosis. As a result, malignant cells may be missed, leading to a false negative diagnosis.

Microscopic examination of mammary carcinoma cells in the setting of osteoclast-like giant cells often demonstrates hyperchromatic nuclei that are atypical with occasional small nucleoli and fine chromatin structure. Mitotic figures are typically rare. There are many other lesions and diseases that may histologically show osteoclast-like giant cells. Examples of such conditions include tuberculosis, sarcoidosis, or granulomatous mastitis. However, in contrast, mammary carcinoma has no histologic characteristics consistent with granulomatous disease.

The mechanism for development of osteoclast-like giant cells is unknown. However, a current hypothesis states that the cancer cells secrete vasoendothelial growth factor, which promotes angiogenesis and macrophage migration to the neoplasm. Eventually, stromal cells of monocyte origin fuse with each other to become osteoclast-like giant cells.

In a single institution study utilizing immunohistochemistry to analyze for p53 gene mutations within the carcinoma, the intraductal components had a high expression of p53 with a single point mutation whereas the osteoclast-like giant cells had no expression of p53. This proposes another theory that the osteoclast-like cells are of a different origin than the carcinoma and are possibly a reactive infiltrate. To date, no formal studies have been performed to correlate prognosis with the presence of osteoclast-like giant cells. There have only been a few reports that have described a less favorable
outcome for patients with carcinoma with osteoclastic-like giant cells when compared to other types of mammary carcinoma.3,6 Further research is needed into this atypical variant of breast cancer to better understand its underlying mechanism of development and its effects on tumor biology.

The views expressed in this manuscript are those of the authors and do not reflect the official policy or position of the Department of the Army, Department of Defense, or the US Government.

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References
Diagnosis of E.Coli Tricuspid Valve Endocarditis: A Case Report

Takahiko Tsutsumi MD; Eiji Hiraoka MD, PhD; Kenji Kanazawa MD, PhD; Hozuka Akita MD, PhD; and Lawrence J. Eron MD, FACP

Abstract
Escherichia coli is a rare cause of bacterial endocarditis. We report a case of an elderly man with cirrhosis who developed bacterial endocarditis due to E. coli. We review the literature that summarizes a total of 41 cases, with a predominance of elderly women, diabetics, and patients with urinary tract infections and prosthetic heart valves. E. coli bacteremia may be mistakenly attributed to a more benign source such as urosepsis and overlooked as an indication of endocarditis. A delay in diagnosis may lead to higher mortality as the opportunity for early valve replacement in appropriate cases and more prolonged courses of antibiotics may not be considered.

Case Report
A 60-year-old Japanese man with a past history of end stage alcoholic liver disease was admitted to the hospital for evaluation of a fever of one month’s duration and general fatigue. Three months prior to admission, he incurred a blunt injury to his left arm in a car accident, and the pain from this injury continued for two months. One month prior to admission, he had sudden onset of fever to 39 degrees Celsius and pain in his right sternoclavicular joint. He was admitted to another hospital where empiric treatment with ceftriaxone was started. No murmurs were noted on physical exam. No blood or urine cultures were ordered at that time.

He remained febrile on ceftriaxone. On the 3rd hospital day two sets of blood cultures were obtained, both of which were positive for Escherichia coli, which was sensitive to all antibiotics. CT and MRI scans of the abdomen as well as ERCP did not reveal a source of the sepsis. The antibiotic was changed to meropenem, and on the 4th hospital day his fever resolved. The patient was discharged on the 10th hospital day. Seven days after discharge, the patient developed a fever to 39 degrees Celsius, and he was transferred to Kobe University hospital for further evaluation and treatment.

The patient had been diagnosed with alcoholic liver cirrhosis ten years previously. He had not had dental work in the past years. He was allergic to NSAIDs. He had no prior history of valvular heart disease or rheumatic fever. He smoked two packs of cigarettes per day for forty years, and he consumed five cups of sake daily. He had never used illicit drugs. Medications taken on a daily basis included lactulose, ranitidine, propranolol, furosemide, and spironolactone.

On the first hospital day at Kobe University Hospital, his temperature was 37.5 degrees Celsius, pulse 84 beats per minute, blood pressure 128/68 mm Hg, and respirations 18 per minute. The oxygen saturation was 95% on room air. He appeared exhausted but not in acute distress. Dention was poor, but with no obvious abscesses or gingivitis. The conjunctivae were pale. There was no cervical lymphadenopathy. Auscultation of the lungs was clear bilaterally. There was a new grade 2/6 systolic murmur, heard best at left lower sternal border. The point of maximal impulse was not displaced. The jugular venous pressure was 8 cm. The abdomen was mildly distended but there was no tenderness or hepatosplenomegaly. Shifting dullness was observed. There was no mucocutaneous stigmata of endocarditis. His left sacro-iliac and right sternoclavicular joints were tender.

His white blood cell count was 2900 per ml with a left shift, hemoglobin 14.3 gm/dl, hematocrit 41.1%, and platelet count 35000 per ml. His electrolytes, calcium, and phosphorus were normal. The AST was 573, ALT 268, gamma glutamyltransferase 2556, ALP 609, direct/total bilirubin 7.6/10.4, and LDH 451. Amylase level was normal. HIV antibody was negative. An electrocardiogram showed normal sinus rhythm without any abnormalities. The urinalysis and cultures of urine, ascites, and blood were negative.

On the first hospital day at Kobe University Hospital, a transthoracic echocardiogram revealed a mobile, hyperechoic mass which was suspicious for a vegetation on the tricuspid valve. Chest radiograph and CT scan of the chest revealed a right lower lobe nodular infiltrate consistent with a septic embolism. He was begun on ceftriaxone 4g every 24 hours.

On the eighth hospital day, a transesophageal echocardiogram disclosed a mobile, hyperechoic mass which measured 0.10 cm by 0.14 cm and was attached to the anterior tricuspid leaflet consistent with a vegetation (Figure 1). There was no evidence of a valve ring abscess, leaflet perforation or fistula formation. Mild left ventricular dilatation was also reported.

On the twentieth hospital day, an MRI revealed osteomyelitis of the left sacro-iliac joint and the right sternoclavicular joint. Ceftriaxone was continued eight weeks during which time the patient remained afebrile. He was discharged in satisfactory condition to be followed in the outpatient clinic. He remained well following discharge.

Discussion
The patient’s bacteremia, combined with a mobile vegetation on his tricuspid valve, suggests that this patient had endocarditis due to Escherichia coli. The modified Duke criteria classify this case as definite endocarditis, given one major (the mobile vegetation on the tricuspid valve) and three minor criteria (fever, positive blood cultures for an atypical organism, and septic infarcts on chest radiography). The presence of metastatic abscesses involving the right sternoclavicular and the left sacroiliac joints makes the diagnosis of endocarditis even more compelling. Although sterile urine cultures were obtained only after the institution of antibiotics, there was no indication on diagnostic imaging of a genito-urinary or an intra-abdominal source of the E.coli bacteremia.

E.coli is the most common cause of gram-negative bacteremia, but it is a very rare cause of endocarditis. Of 861 cases of E.coli bacteremia, only two had evidence of endocarditis. Two recent reviews describe 39 and 41 cases of E.coli endocarditis, respectively. Both studies identify certain risk factors for E.coli endocarditis, including advanced age, female gender, diabetes, the presence of a prosthetic heart valve, and a preceding urinary tract infection.

The number of elderly patients with E.coli endocarditis has been increasing. The proportion of patients over 70 years of age rose from 5.3% in 1982 to 22.9% in 2002. A preceding urinary tract infection occurred in 37% to 47% of cases. Bacteriuria increases with age and elderly females may be especially at risk of E.coli endocarditis. Thinning of the vaginal epithelium and the decrease...
in the number of lactobacilli that occurs with aging, encourage the overgrowth of coliforms and offer a potential entrance site to the blood stream through the thin vaginal epithelium. Diabetes was reported in 21%.

The site of infection was the mitral valve in 58% of cases, the aortic valve in 5-37%, the pulmonic valve in 11-17%, and the tricuspid valve in 17%. Although E. coli does not stick to native heart valves as easily as staphylococci and streptococci, it does cause prosthetic valve endocarditis as reported in 7 (19%) of 37 cases.

In this case, the etiology of the infection remains unresolved. The patient had no history of intravenous drug abuse, diabetes, nor did he have any indication of a urinary tract or intraabdominal infection. Cirrhosis of the liver may have led to bacteremic seeding of the tricuspid valve from an intestinal source.

Mortality rates of patients with E. coli endocarditis between 53% to 65% have been reported. However, in a more recent study, of seven patients with E. coli endocarditis, only one patient expired (17%). The higher mortality rates in previous studies may have been due to a delay in the diagnosis of endocarditis. The unfamiliarity of clinicians with the possibility that a bacteremia due to E. coli could have been due to endocarditis, may have led to inadequate medical and surgical treatment.

Recent recommendations for the management of gram-negative endocarditis suggest that early valve replacement be considered. Prior to 1960, valve replacement was not utilized in treating patients with E. coli endocarditis and 16 of 16 cases died. In a recent study, 4 of 6 patients underwent valve replacement, and all of them survived. In another study, of patients with gram-negative endocarditis, the mortality rate was identical (approximately 25%) for patients who did or did not receive surgical intervention. This study included patients with non-HACEK gram negative endocarditis, and the authors concluded that endocarditis caused by these organisms is not an absolute indication for surgical therapy. While cardiac decompensation is an indication for valve replacement, our patient did not exhibit this complication perhaps because of antibiotic treatment during the prior hospitalization.

Because of the small number of patients with E. coli endocarditis, evidence-based treatment recommendations are impossible to make. The combination treatment with a penicillin or a broad-spectrum cephalosporin with an aminoglycoside is recommended by expert opinion whether or not valve replacement is performed. However, according to an observational study, there was no statistically significant survival benefit among patients who received combination antibiotic therapy. A quinolone was used in some of the cases, but its efficacy could not be evaluated. The duration of the antibiotic treatment in the observational study was 42 days (interquartile range, 38 to 42 days).

Clinicians should consider the possibility that patients with E. coli bacteremia may be suffering from endocarditis rather than a more benign process such as urosepsis. It is recommended that early echocardiography be performed on selected patients with E. coli bacteremia to identify those with endocarditis. Secondly, early valve replacement should be considered for patients with E. coli endocarditis to reduce the mortality rate of E. coli endocarditis. Finally, bactericidal antibiotics should be used for appropriate durations in these patients.

The acronym HACEK refers to a grouping including Haemophilus aphrophilus, Actinobacillus actinomycetemcomitans, Cardiobacterium hominis, Eikenella corrodens, Kingella kingae. These organisms are the most common gram negative bacilli which cause infective endocarditis among patients who are not drug abusers.

** ESBL stands for extended spectrum beta lactamases which are enzymes that confer resistance to most beta-lactam antibiotics. Infections with ESBL-producing organisms have been difficult to treat because of this resistance and is associated with poor outcome.

Disclosure: This report was a joint effort of all the authors. There was no grant funding and we report no conflicts of interest.

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References
A Comparison of Surgery and Family Medicine Residents’ Perceptions of Cross-Cultural Care Training

Maria B.J. Chun PhD; David S. Jackson PhD; Susan Y. Lin MA; and Elyse R. Park PhD, MPH

Abstract
The need for physicians formally trained to deliver care to diverse patient populations has been widely advocated. Utilizing a validated tool, Weissman and Betancourt’s Cross-Cultural Care Survey, the aim of this current study was to compare surgery and family medicine residents’ perceptions of their preparedness and skillfulness to provide high quality cross-cultural care. Past research has documented differences between the two groups’ reported impressions of importance and level of instruction received in cross-cultural care. Twenty surgery and 15 family medicine residents participated in the study. Significant differences were found between surgery and family medicine residents on most ratings of the amount of training they received in cross-cultural skills. Specifically, family medicine residents reported having received more training on: 1) determining how patients want to be addressed, 2) taking a social history, 3) assessing their understanding of the cause of illness, 4) negotiating their treatment plan, 5) assessing whether they are mistrustful of the health care system and/or doctor, 6) identifying cultural customs, 7) identifying how patients make decisions within the family, and 8) delivering services through a medical interpreter. One unexpected finding was that surgery residents, who reported not receiving much formal cultural training, reported higher mean scores on perceived skillfulness (i.e. ability) than family medicine residents. The disconnect may be linked to the family medicine residents’ training in cultural humility — more knowledge and understanding of cross-cultural care can paradoxically lead to perceptions of being less prepared or skillful in this area.

Introduction
Ethnic disparities in health outcomes have been documented in epidemiological studies of a variety of ethnic groups and health conditions in the United States. The population of foreign-born individuals in the United States has increased tremendously in the past few decades, and the minority population is projected to increase throughout the next decades surpassing that of non-Hispanic Whites. This growing diversity justifies an increase in cross-cultural training to aid in lessening disparities in health outcomes and treatment.

The need for physicians formally trained to deliver care to diverse patient populations has been widely advocated. For example, the Accreditation Council for Graduate Medical Education (ACGME) has formalized requirements related to cultural competency, by including it under “Professionalism” and “Interpersonal and Communication Skills.” The publication of seminal works, such as the Institute of Medicine’s Unequal Treatment, laid the groundwork for cross-cultural healthcare training and focused on not just individual physician characteristics, but also larger social and institutional factors. Based on their work on residents’ perceived preparedness to provide cross-cultural care, Betancourt et al. noted four implications for medical education policy that echo the Institute of Medicine’s recommendations:

1. Integrating cross-cultural curricula in graduate medical education;
2. Building the cross-cultural curricula on what was learned in medical school so there is continuity;
3. Training of attending physicians and fellows in the curricula so they can serve as role models to the residents; and
4. Conducting mandatory and formalized evaluations of general and cross-cultural communication skills.

Betancourt et al. note the importance of cross-cultural training spanning all disciplines, making particular note of emergency medicine and surgery because of the critical issues of diagnostic accuracy and informed consent. Other researchers such as Paasche-Orlow would argue that training and providing culturally competent care practices is essentially a matter of ethics. However, research has revealed variations across specialties regarding the degree to which culture is viewed as an important factor in patient care. Park et al. conducted a qualitative study involving seven focus groups and ten individual interviews on residents’ perceptions of their experiences learning cross-cultural care, which included 68 internal medicine, surgery, pediatrics, obstetrics/gynecology, emergency medicine, psychiatry, and family medicine residents at various institutions in the United States. All residents viewed culture as an important factor in patient care; however, the degree of importance varied among the specialties. Family medicine and psychiatry residents held the strongest views on the importance of cross-cultural training, and also noted having received formal instruction to develop these skills. In contrast, surgery and emergency medicine residents were significantly more likely to report little or no training in areas such as how to address a patient from a different culture. Any skills related to cross-cultural care were largely acquired on an informal and “ad hoc basis.” Although surgery and emergency medicine residents felt that culturally-sensitive care was important, they viewed it as “unrealistic” due to time constraints.

A related quantitative study surveying 2,047 residents from the same specialties in their last year of training, asked residents to assess their perception of their “preparedness” (i.e., readiness) and their “skillfulness” (i.e., ability) to provide cross-cultural care to a diverse patient population. Weissman et al. found that most respondents viewed a patient’s culture as an important factor when providing care (moderately important = 26%; very important = 70%). Of note, surgery and emergency medicine residents were less likely to deem cultural issues as “very important” (43% and 47%, respectively), compared with the other specialties, of which 67% to 94% felt it was “very important.” Family medicine residents received more instruction in cross-cultural skills than did residents in any of the other six specialties, and had perceived themselves as more skillful.
For this study, two specialties — surgery and family medicine — were selected because of the variation in training with regard to cultural competency. For surgery residents, cultural competency is an emerging area of interest, which contrasts with family medicine residents who have cultural training as a formal part of their curriculum. Family medicine also makes a distinction in terminology with a preference for utilizing the term “cultural humility.” The argument is that no one can become “competent” with regard to understanding all cultures, so the approach to take is one of making the patient the expert while placing the physician in the position of learning.17

Building on past work documenting these differences,13,15,16 the aim of this current study was to compare surgery and family medicine residents’ perceptions of their preparedness and skillfulness to provide high quality cross-cultural care. Other than the studies cited, limited research exists in this area. In light of clear health disparities and residency training requirements, this study is part of a research program that attempts to build on these initial research efforts to examine the needs for resident education in cross-cultural care. The findings will translate into improved training programs that develop surgery residents’ preparedness and skillfulness in cross-cultural care. This is of particular interest to residency programs located in culturally diverse locations, such as Hawai‘i.

Methods

With permission from the lead investigators, a copy of the Residency in Cross-Cultural Care survey was obtained for use in this study. This survey was developed by Betancourt and Weissman in an attempt to measure residents’ perceptions of their preparedness to provide cross-cultural care and their perceived skillfulness with regard to providing such care.15 The survey defined culturally diverse patients as those patients who are a member of a culture different from the respondent’s own culture. Consisting of five sections, respondents were asked about perceptions regarding their: 1) cross-cultural training beyond medical school, 2) cross-cultural experiences, 3) availability of resources when dealing with a diverse population, 4) skills in their specialty, and 5) demographic information. Park and colleagues’ recent psychometric assessment of their measure of residents’ perceived readiness and abilities to provide cross-cultural care yielded three components: general cross-cultural preparedness, general cross-cultural skillfulness, and cross-cultural language preparedness and skillfulness.18 These three components resulted from a weighted principal components analysis and showed adequate internal reliability (with Cronbach’s alpha); thus, they were used for this study. Evidence for construct validity was also shown through the total scale’s inverse correlation with residents’ feelings of helplessness in providing cross-cultural care.

The protocol for this study was submitted to the Committee on Human Studies of the university and was granted an “exclusion” from the Institutional Review Board process. The protocol was also submitted to the Research and Institutional Review Committee of the major teaching hospital and received approval via an expedited process. The findings, conclusions, etc., of this study do not necessarily represent the views of the Queen’s Medical Center, Honolulu, Hawai‘i.

For the surgery residents, the survey was distributed in April 2008 by the principal investigator’s research assistant. All residents who were physically present after Grand Rounds were invited to participate. Participation was strictly voluntary with 20 of 23 surgery residents in attendance and completing the survey. The survey took approximately 20 minutes to complete. The principal investigator administered the survey in May 2008 to family medicine residents present at Grand Rounds. The Director of Research in the Department of Family Medicine and Community Health assisted with distributing surveys to those residents who were not present that day. Participation was also strictly voluntary and 15 of 18 family medicine residents completed the survey.

Simple descriptive analyses were conducted to compare surgery and family medicine residents on their background characteristics, perceptions of preparedness, and perceptions of skillfulness. Cross-cultural skill training variables were analyzed using Multiple Analysis of Variance (MANOVA) to assess the significance of differences between the two independent groups of surgery and family medicine residents on the multiple ratings of various skills training components. T-tests were also conducted to examine differences between these two groups on the General Cross-Cultural Preparedness Scale, the General Cross-Cultural Skillfulness Scale, and the Cross-Cultural Language Preparedness and Skillfulness Scale. An alpha level of 0.05 was used as criteria for statistical significance. All analyses were performed with the SPSS version 11 statistical package.

Results

Table 1 compares basic background information for surgery and family medicine residents who participated in this study. A larger proportion of surgery residents were male (85%) while a larger proportion of family medicine residents were female (67%). The distributions of race/ethnic background reported by residents and whether they were born in the United States were comparable between surgery and family medicine. While all (100%) family medicine residents attended medical school in the United States, 84% of surgery residents attended medical school in the United States.

Surgery and family medicine residents were compared on their mean ratings of the amount of training they received in various cross-cultural skills. The Hotelling’s Trace multivariate test of overall differences among groups was statistically significant: $F(10,24) = 2.32$, $p = 0.04$. Univariate between-subjects tests revealed statistically significant differences between surgery and family medicine residents on most ratings of the amount of training they received in cross-cultural skills. Specifically, family medicine residents reported having received more training on: 1) determining how patients want to be addressed ($F = 12.75$, $p = 0.001$), 2) taking a social history ($F = 7.58$, $p = 0.001$), 3) assessing their understanding of the cause of illness ($F = 14.54$, $p = 0.001$), 4) negotiating their treatment plan ($F = 7.41$, $p = 0.010$), 5) assessing whether they are mistrustful of the health care system and/or doctor ($F = 7.39$, $p = 0.010$), 6) identifying cultural customs ($F = 8.54$, $p = 0.006$), and 7) identifying how patients make decisions within the family ($F = 7.87$, $p = 0.008$), and 8) delivering services through a medical interpreter ($F = 12.89$, $p = 0.001$). Means, standard deviations, and effect sizes are reported in Table 2.

Residents were also compared on their perceptions of their level of general preparedness, general skillfulness, and language preparedness and skillfulness, in delivering cross-cultural care. No significant differences were found between surgery and family medicine resi-
dents on the General Cross-Cultural Preparedness Scale (t = -0.02, p = 0.99), General Cross-Cultural Skillfulness Scale (t = -1.34, p = 0.19), or the Cross-Cultural Language Preparedness and Skillfulness Scale (t = 0.52, p = 0.61). While significance testing was not conducted on individual scale items, the comparison of item mean scores is noteworthy. Family medicine residents reported higher mean scores on four of the six General Cross-Cultural Preparedness items (Table 3). Surgery residents only reported higher mean scores on their perception of preparedness on dealing with distrust of the U.S. health care system and in the use of alternative/complementary medicine. Alternatively, surgery residents reported higher perceived skill levels on all ten General Cross-Cultural Skillfulness items (Table 4).

Discussion
We sought to compare surgery and family medicine residents’ perceptions of their preparedness and skillfulness to provide high quality cross-cultural care. In light of clear health disparities and requirements of such medical education accrediting bodies as the ACGME, this study is part of a research program that attempts to build on initial research efforts to examine the need for resident education in

Table 1.— Characteristics of Residents

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<th>Variable</th>
<th>Surgery (n = 20)</th>
<th>Family Medicine (n = 15)</th>
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<td>Frequency (Percent)</td>
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</tr>
<tr>
<td>Yes</td>
<td>15 (75)</td>
<td>11 (73)</td>
</tr>
<tr>
<td>No</td>
<td>5 (25)</td>
<td>4 (27)</td>
</tr>
<tr>
<td>Location attended medical school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In United States</td>
<td>16 (84)</td>
<td>15 (100)</td>
</tr>
<tr>
<td>Outside United States</td>
<td>3 (16)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

Table 2.— Reported Training Received For Cross-Cultural Skills

<table>
<thead>
<tr>
<th>Cross-Cultural Skill</th>
<th>Surgery</th>
<th>Family Medicine</th>
<th>Effect Sizea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determining how a new patient wants to be addressed**</td>
<td>2.10</td>
<td>0.72</td>
<td>3.07</td>
</tr>
<tr>
<td>Taking a social history**</td>
<td>2.35</td>
<td>0.93</td>
<td>3.20</td>
</tr>
<tr>
<td>Assessing a patient’s understanding of the causes of illness***</td>
<td>2.20</td>
<td>0.83</td>
<td>3.27</td>
</tr>
<tr>
<td>Negotiating a treatment plan*</td>
<td>2.40</td>
<td>0.75</td>
<td>3.13</td>
</tr>
<tr>
<td>Identifying mistrust of the system or physician*</td>
<td>2.15</td>
<td>0.81</td>
<td>2.93</td>
</tr>
<tr>
<td>Identifying ability to read &amp; write English</td>
<td>2.30</td>
<td>0.80</td>
<td>2.87</td>
</tr>
<tr>
<td>Identifying religious beliefs that might affect care</td>
<td>2.35</td>
<td>0.81</td>
<td>2.93</td>
</tr>
<tr>
<td>Identifying cultural customs that might affect care**</td>
<td>2.40</td>
<td>0.82</td>
<td>3.20</td>
</tr>
<tr>
<td>Identifying how patient makes decisions with family**</td>
<td>2.30</td>
<td>0.87</td>
<td>3.07</td>
</tr>
<tr>
<td>Delivering services through a medical interpreter**</td>
<td>2.45</td>
<td>1.00</td>
<td>3.47</td>
</tr>
</tbody>
</table>

*Scale: 1=None, 2=Very Little, 3=Some, 4=A Lot. **Partial eta squared. *** p < .05, ** p < .01, *** p < .001

Table 3.— General Cross-Cultural Preparedness

<table>
<thead>
<tr>
<th>Item</th>
<th>Surgery</th>
<th>Std. Dev.</th>
<th>Family Medicine</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>From cultures different from own</td>
<td>3.75</td>
<td>1.07</td>
<td>3.80</td>
<td>1.01</td>
</tr>
<tr>
<td>With health beliefs at odds with Western medicine</td>
<td>3.35</td>
<td>1.09</td>
<td>3.40</td>
<td>0.99</td>
</tr>
<tr>
<td>With a distrust of the US health system</td>
<td>3.30</td>
<td>1.08</td>
<td>3.07</td>
<td>1.16</td>
</tr>
<tr>
<td>Whose religious beliefs affect treatment</td>
<td>3.30</td>
<td>1.13</td>
<td>3.40</td>
<td>0.99</td>
</tr>
<tr>
<td>Who use alternative/complementary medicine</td>
<td>3.55</td>
<td>1.00</td>
<td>3.40</td>
<td>0.83</td>
</tr>
<tr>
<td>Racial/ethnic minority</td>
<td>3.85</td>
<td>0.99</td>
<td>4.00</td>
<td>1.07</td>
</tr>
</tbody>
</table>

*Scale: 1=Very Unprepared, 2=Somewhat Unprepared, 3=Somewhat Prepared, 4=Well Prepared, 5=Very Well Prepared.

‘Ohana: family
cross-cultural care. Validating prior research, the results reflect that family medicine residents receive more formal cross-cultural care skills training than surgery residents. This is not surprising given that cultural competency is an emerging area of interest in surgery, whereas cultural training is integrated within family medicine graduate programs. On a related note, family medicine residents generally reported perceiving themselves as more prepared to deal with cross-cultural care issues than surgery residents.

One unexpected finding was that surgery residents, who reported not receiving much formal cultural training, rated their perceived skillfulness (i.e., ability) as higher than family medicine residents. This conflicts with prior research that found a positive correlation between perceived preparedness and perceived skillfulness. Although more research is needed to explain this discrepancy, the disconnect may be linked to the surgery residents reflecting that although they had not received formal training (preparedness) they feel they still have the skills (ability) to deliver cross-cultural care. The responses may also be a reflection of the ethnic diversity of the residents and their past exposure to cross-cultural situations. With regard to the family medicine residents, the cultural humility perspective that is promoted in their training may provide a rationale for why those who reported more training, also reported lower perceived skillfulness. Although more research is needed to explain this discrepancy, the disconnect may also be a reflection of the ethnic diversity of the residents and their past exposure to cross-cultural situations. With regard to the family medicine residents, the cultural humility perspective that is promoted in their training may provide a rationale for why those who reported more training, also reported lower perceived skillfulness. Park et al. have described it as the “preparedness paradox,” whereby residents expressed that the more exposure to patients from different backgrounds, the less prepared one feels.

Recommendations for Future Study
This study builds on the work of Weissman et al., particularly their development and refinement of a valid and reliable measure – the Cross-Cultural Care Survey – to assess resident preparedness to provide cross-cultural care. In order to assess and establish the efficacy of training in cross-cultural healthcare, such a tool can both serve as a baseline and a means to gauge improvement. Therefore, further research on this tool and its practical application is important. However, the current study has some limitations that can be addressed in future work. To build on this work and address this study’s limitations, subsequent investigations should:

1. Increase the sample size to improve the generalizability of the findings to other residency programs outside of Hawai’i and beyond. With a larger sample and multisite work, analyses can be conducted by program year to identify any potential differences;
2. Collect additional residents’ sociodemographic information for examination of mechanisms explaining perceived preparedness and skillfulness. For example, more information on the residents’ cultural training experiences in medical school could be obtained as well as how experiences outside of the formal residency curriculum impact their ability to provide cross-cultural care; and
3. Utilize an “objective” tool to corroborate the self-assessment. Self-assessment tools are often an accepted part of the evaluation of skills-based curricula, but research on resident self-assessment have been inconclusive. In addition to self-report and other written assessments, future evaluations of both surgery and family medicine residents’ preparedness and skillfulness to provide cross-cultural care should include observations in actual and/or simulated settings. This would allow for a more objective view of a resident’s skill level based on specified criteria.

---

**Table 4.— General Cross-Cultural Skillfulness**

<table>
<thead>
<tr>
<th>Item</th>
<th>Surgery</th>
<th>Family Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Dev.</td>
</tr>
<tr>
<td>Determining how a new patient wants to be addressed</td>
<td>3.75</td>
<td>0.91</td>
</tr>
<tr>
<td>Taking a social history</td>
<td>3.95</td>
<td>0.83</td>
</tr>
<tr>
<td>Assessing a patient’s understanding of the causes of illness</td>
<td>3.60</td>
<td>0.88</td>
</tr>
<tr>
<td>Identifying mistrust of the system or physician</td>
<td>3.25</td>
<td>0.91</td>
</tr>
<tr>
<td>Negotiating a treatment plan</td>
<td>3.45</td>
<td>0.95</td>
</tr>
<tr>
<td>Identifying ability to read &amp; write English</td>
<td>3.55</td>
<td>0.89</td>
</tr>
<tr>
<td>Identifying religious beliefs that might affect care</td>
<td>3.15</td>
<td>1.04</td>
</tr>
<tr>
<td>Identifying cultural customs that might affect care</td>
<td>3.15</td>
<td>0.99</td>
</tr>
<tr>
<td>Identifying how patient makes decisions with family</td>
<td>3.35</td>
<td>0.93</td>
</tr>
<tr>
<td>Delivering services through a medical interpreter</td>
<td>3.60</td>
<td>0.88</td>
</tr>
</tbody>
</table>

*aScale: 1=Very Unprepared, 2=Somewhat Unprepared, 3=Somewhat Prepared, 4=Well Prepared, 5=Very Well Prepared.*

**Table 5.— Cross-Cultural Language Preparedness and Skillfulness**

<table>
<thead>
<tr>
<th>Item</th>
<th>Surgery</th>
<th>Family Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Dev.</td>
</tr>
<tr>
<td>With limited English proficiency*</td>
<td>3.20</td>
<td>1.01</td>
</tr>
<tr>
<td>New immigrants*</td>
<td>3.05</td>
<td>1.15</td>
</tr>
<tr>
<td>Working effectively through a medical interpreter*</td>
<td>3.60</td>
<td>0.88</td>
</tr>
</tbody>
</table>

*aScale: 1=Not At All Skillful, 5=Very Skillful.*
Finally, any training opportunities should be conducted with a standardized protocol to allow for formal evaluation of whether the intervention was truly successful and to potentially allow for comparisons across different programs. By utilizing the Cross-Cultural Care Survey, this study has made a positive contribution to this effort.

Disclosure: None of the authors have any financial or personal relationships that bias this work and we have not received any funding for the work done.

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References

Onipaʻa: be steadfast
A Better Idea for United States Health Care – The Balanced Choice Proposal

Stephen B. Kemble MD

Editor's Note
The Hawai‘i Medical Journal, a Journal of Asia Pacific Medicine, has not generally entertained articles of a political nature for publication. However, on rare occasions, an article addressing a key niche in Hawai‘i’s healthcare system has been accepted. It is the opinion of the physicians on the Editorial Staff that this article represents a strongly biased opinion, addresses a somewhat controversial insurance scheme, and does not reflect the collective opinion of the Editors. However, we believe that increasing the information to our readers regarding this subject will enhance their ability to understand and judge the evolving healthcare system in Hawai‘i.

Abstract
This article introduces a promising new health care financing proposal for physician payment called Balanced Choice. It summarizes the implications of health care economics and current well-publicized health care reform proposals, each of which is problematic for physicians and their patients. The Balanced Choice proposal is for an integrated two-tier national system, which has an economically efficient universal plan similar to single-payer, but with an option for enhanced services using market forces at the doctor-patient level to manage care. The two tiers are linked together and balanced so that each complements and enhances the other. Balanced Choice solves the problems of other proposals in a way that would work well for doctors and for patients, and represents a fresh and uniquely American solution to the problem of health care financing.

The health care reform proposal recently passed by Congress maintains the inefficiencies and perverse incentives of an insurance model that rewards denial of care and imposes intolerable administrative burdens on the practice of medicine. A new universal proposal called Balanced Choice offers economic efficiency, administrative simplicity, and returns care management and control of fees to doctors and patients. To explain, we need to start with a review of basic health economics.

Basic Health Economics
US health care spending rose from 5.2% of GDP in 1960 to 17% in 2008, and is growing rapidly. Rising health care costs are driven by the costs of new medical technologies and by the aging of the baby boomers, compounded by a very fragmented, inefficient, and expensive “system” of health care financing. About 60% of health care in the United States is paid by taxes via government programs, including Medicare, Medicaid, government employees’ insurance, Tri-care, and integrated programs such as military health and the VA. About 20% of health care is paid with private insurance, and patients pay about 20% out of pocket.1 Government and employers are both increasingly reluctant to pay for rising health care costs, and an increasing share is being pushed onto patients. About 17% of the US population had no health insurance in 2008, and many more have policies that don’t adequately cover their health care needs. The uninsured and under-insured populations are growing rapidly. Over half of bankruptcies in the United States now are triggered in large part by illness and its financial consequences.2

American health care financing is very inefficient. The total administrative costs of health care in the United States in 1999 (adding administrative costs for government, private insurance, physicians, hospitals, and employers) were estimated to consume 31% of the health care dollar. This compared to 16% in Canada, including private insurance administration as well as their national plan. Administrative costs for the Canadian national health plan were only 1.5%, compared to 3.6% for US Medicare. We know that other countries with national plans spend one half to two thirds per capita on health care compared to the United States, provide universal coverage, and achieve better general indicators of public health.4

Health care costs are not evenly distributed across the population. About 20% of the population with chronic or serious diseases consumes 80% of the health care dollar. A high percentage of those using the most health care resources have low incomes or are elderly or disabled, and cannot possibly pay for their own health care. Uncompensated care leads to greater costs when patients avoid care until they are seriously ill, and often end up medically bankrupt in Medicaid and Medicare, paid with tax dollars. There are also serious public health risks with a large uninsured population. Therefore, any serious health care financing proposal must include a mechanism for redistributing much of the costs of care for the sick onto the healthy. Nonetheless, most Americans agree that individuals should shoulder some share of their health care costs, according to their ability to pay.

Drivers of United States Administrative “Overhead”
So what are we paying for with those 31% administrative costs? Practicing physicians must pay for basic claims submission, plus submission of claims to multiple insurers for patients with dual coverage, re-submission of denied claims or claims for patients who failed to notify the doctor’s office when their insurance changed, responding to prior authorization requests and requests to justify non-formulary drugs, and responding to calls and letters from care managers.

Government and private insurers pay to administer all these things on their side. Private insurers also pay for marketing, underwriting (screening out or increasing charges for “high risk” individuals and groups), negotiations with employers, maintaining insurance reserves, duplication of administrative staff for competing insurance plans (including highly paid executives), managed care, lobbying, and profit. This is why the administrative overhead for private insurance is usually about 3-4 times that of government programs. Employers also must pay to manage employees’ health benefits.

Malpractice insurance is mostly “administrative cost.” Only a small fraction of malpractice premiums pays for health care for injured patients. Malpractice costs are also inflated by the lack of universal health coverage. A large portion of malpractice, automobile insurance, and worker’s compensation costs are for estimated future medical expenses, often inflated to “worst case scenario” assump-
tions. Injured patients often feel compelled to sue if they are afraid their future medical costs will not otherwise be covered.

The Hassle Factor
The other big problem with the mix of American health care financing is the hassle factor. Doctors and their office staffs spend un-billable time dealing with eligibility checking, multiple insurance plans with different procedures and forms, crossover claims, denied and lost claims, prior authorization requirements, changing benefits and drug formularies, pharmacy benefit managers requesting a switch to a preferred drug, and writing letters and reports to justify payment. Physicians often provide uncompensated care for patients who were unaware of restrictions in their plan, lost coverage due to loss of a job, or whose coverage excludes pre-existing conditions. These things have a severe negative impact on the practice satisfaction of doctors, especially for primary care specialties.7

Third Party Control of Physician Fees
Doctors are angered by these costs and hassles. Insurance plans and government payers control their fees. Medicare’s “Sustainable Growth Rate” formula is threatening drastic cuts in physician fees. Doctors are barred from negotiating individually or collectively, and can’t raise fees to compensate. “Free market” forces in health care are not at the doctor-patient “point of service” level, but at the level of negotiations between employers and insurance plans. Doctors are finding their fees being frozen or cut, while the costs and un-billable time of providing care are increasing.

Responses of Physicians
Doctors are trying to cope with rising costs and lower fees by sched-uling shorter visits to increase the volume of patients seen, spending less time with each patient. Tighter scheduling makes all the “hassle factors” even more frustrating. Physicians are increasingly refusing difficult patients and difficult or low-paying insurance plans, and more patients can’t get access to care even if they have insurance. Also, doctors have less time or patience to listen to their patients about new or complex problems, leading to missed diagnoses. Computerized care management systems can help ensure appropriate monitoring for established chronic diseases, but can’t compensate for lack of time to listen and think about diagnostic issues when the nature of the problem is not obvious. Both doctors and patients feel frustrated by this, and are increasingly dissatisfied with their respective experiences of the provision of health care. Many established physicians have moved out of primary care practices, out of rural or poorer neighborhoods, and out of high malpractice risk fields. Many are retiring early or getting out of clinical practice.

Reform Proposals
One of the main reasons physicians have not come together on the issue of health care reform is that all of the well-publicized proposals have serious negative implications. There are tremendous pressures from both government and employers to reduce health care spending, and this means reduced payments to physicians and more barriers to care for patients. Most of the administrative costs and “hassle factors” listed above are direct results of the fragmentation and complexity of multiple payers, insurance-based financing with its high administrative overhead, and use of the tort system to deal with adverse medical outcomes. The unraveling of employer-based health insurance is also the major force pushing more Americans into uninsured and under-insured status.

Single-payer
With single-payer, almost all of the administrative costs and “hassle factors” listed above would disappear, and the administrative over-head would drop from around 30% of the health care dollar to around 10-15%, freeing up enough money to fund universal coverage. Savings would come from the 30% administrative costs, instead of from lowered provider fees or restrictions on coverage for patients. However, US physicians have justifiable fears of a government-run single-payer system because they have experienced incompetent administration, frustrating provider services, and inadequate and ir-rational fees in the Medicare program. There are always pressures to reduce taxes and funding for public systems, leading to compromises in physician reimbursement and patient access to care in countries with universal plans. To varying degrees, these countries have allowed private insurance options for those who can afford them.

Medical Savings Accounts
MSA’s are intended to make patients more cost conscious in purchasing health care. They consist of tax sheltered accounts and large annual health care deductibles, with insurance for “catastrophic” health costs only. This works well for the relatively healthy and wealthy who can afford to fully fund an MSA, who can use the tax break, and who have low annual medical expenses. However, the 20% of the population that consumes 80% of health care resources are unable to make effective use of MSA’s. They will stay in regular insurance plans or end up in government programs, driving up the cost of those programs. Also, a recent Rand study found that when people pay for medical expenses themselves instead of relying on insurance, they cut back on necessary care at least as much as un-necessary care.5,6

Individual Health Insurance Plans
Private health insurance has much higher administrative costs than government funded plans. Insurance companies attempt to contain costs by reducing reimbursement, using managed care, and constructing barriers to treatment or reimbursement, none of which make life easier for physicians. Individual insurance plans are also problematic as a means of assuring affordable health care for patients. Insurance companies compete on the basis of how they manage the “risk” of paying for health care. The core idea of insurance is risk pooling, or spreading the cost for the sick across a large, mostly healthy population. However, in health insurance, a high proportion of the population knows their risk because they have pre-existing conditions or health risk factors. Those with pre-existing conditions are highly motivated to purchase insurance, but without a mandate to force everyone to buy insurance, the healthy will often decide to save their money and take their chances. This leaves a sicker than average pool of subscribers, driving the cost of insurance up, and undermining the benefits of risk pooling. To counter adverse selection, insurance companies use underwriting strategies to deny coverage or care, especially for those with seri-ous or chronic illness, which runs counter to the whole purpose of health insurance. Underwriting and competition also carry substantial administrative costs.
Privatizing Medicare and Medicaid
Efforts to privatize Medicare and Medicaid by shifting funds to private Medicaid Managed Care plans, Medicare Advantage plans, and Medicare Part D plans are already turning out to be more expensive than the government programs they replace, not to mention the hassles faced by physicians and patients in dealing with a myriad of plans with complex policies and changing drug formularies.

Consumer Directed Health Care
Surveys show that a majority of Americans believe that individuals with greater means should shoulder part of the burden of financing health care, and that individual responsibility and cost-consciousness should be harnessed to help control and manage health care costs. Neither a universal single-payer program nor insurance-based financing does this effectively, because after paying their fixed co-payment, the patient does not care about the cost. Cost-consciousness is felt by the payer of the “last dollar” much more than “first dollar,” so it is insurance companies and government payers, not patients, who have a vested interest in controlling physician fees and managing health care. MSA’s also have the patient pay “first dollar,” and are subject to the problems mentioned above. By its nature, health care requires some mechanism by which the public at large subsidizes much of the costs of care for the chronically and seriously ill. However, none of the well-publicized proposals finds an effective balance between a cost-effective publicly funded base, and use of “last dollar” market forces at the doctor-patient level to manage health care costs.

A Better Alternative - Balanced Choice
Balanced Choice is a new two-tier proposal for universal health care that combines the administrative simplicity and efficiency of single-payer with the cost containment and flexibility of market-driven controls at the doctor-patient level. Here’s how it works:

Balance Choice proposes a single-payer style standard option with a small co-payment (“Standard-of-Care Option”, or SO) in which all funding sources are pooled and good health coverage is universal. Fees and covered procedures would be set by a “Balanced Choice Governing Board,” analogous to the Federal Reserve Board in the financial markets. The co-payment in the SO could be waived in circumstances of financial hardship. Like single-payer, billing and administration would be vastly simplified.

Each office-based doctor would also have the option of offering an “Independent Option” (IO), in which they would charge higher fees for expanded services (e.g. prime appointment times, longer visits, enhanced access to the physician). Balanced Choice would pay a base payment somewhat less than the SO fee for that service, the doctor would charge whatever they felt the expanded services were worth, and the patient would pay the difference (gap payment = last dollar).

Doctors would be encouraged to offer both options, and patients could choose which option they would use with each doctor. Doctors could also choose how much of their practices would be devoted to each option. Those patients with limited health care needs or limited means could choose the SO, and those who wanted and could afford expanded services would choose the IO. Since the IO patient would be paying “last dollar,” cost consciousness would become part of doctor-patient negotiations about choice of treatments, and market forces would manage care at the point of service, with no need for management by insurance or government. Doctors would also have incentives to innovate and focus on patient service to justify IO fees. Some of the resulting improvements, plus the benefits of generally improved physician satisfaction, would likely spill over to the SO patients as well.

In order to avoid inadequate SO fees, the two options would be linked with a balancing mechanism. The Balanced Choice Governing Board would be required to maintain a 70-30 funding split between the SO and IO. If SO fees became too low and too many doctors were refusing SO patients, the Board would have the power to adjust SO fees or vary the IO base payment as a percentage of SO fees, so as to maintain the mandatory 70-30 funding split between the options. The balancing mechanism allows market forces at the doctor-patient level to influence SO fees, limiting central control of fees for the whole system.

Balanced Choice could also be the agency to fund medical training and research, quality improvement programs, peer review, and other functions for the public benefit that need central administration. Hospitals could be paid with global budgets, saving vast amounts of money on billing and administration. Throw in tort reform and the Balanced Choice proposal would provide universal coverage, efficient use of the health care dollar for actual health care, and administrative simplicity and transparency, all of which are sorely lacking at present. Unlike single-payer, it limits government control by giving doctors the freedom to set their IO fees higher than the SO rates. It encourages those who can afford it to pay a higher share for health care and get something worthwhile for their money, and it effectively uses point of service market forces to keep fees reasonable and manageable. Instead of private insurance competing with a public system for health care resources, it brings the “Independent” tier into the public system without the excess administrative costs of private insurance. Although it has not yet been implemented anywhere, it shares all of the cost-control elements that have made single-payer health care financing so much more cost-effective in other countries, with the exception of government control of fees for the IO. However, Balanced Choice IO base payments are less than SO fees for the same services, so the public plan would actually pay less for those choosing the IO. Like single-payer, Balanced Choice would take the responsibility for providing health care off the backs of American businesses. It is a plan that could be implemented either nationally or on a state-by-state basis. Of course, it would also make the health insurance industry obsolete, and would likely be opposed by the insurance lobby.

The Future of United States Health Care
So where can we go with health care financing reform? Even with health care reform, the current trend is toward more centralized management by insurers and government, more complexity, and reduced fees for providers of medical care. We are already witnessing a rapid decline in physicians willing to practice primary care medicine. If these trends are not reversed, we will see escalating demoralization and de-professionalization of the physician work...
force, increasing barriers to care for the American public, and deterioration in health care quality. The economics of insurance mean that any solution involving competing insurance plans can only “succeed” by squeezing physician payment and patient access to care, which are the very heart of health care. MSA’s can work for the healthy and wealthy, but not for the seriously or chronically ill. Single-payer can provide universal coverage for less than we now spend on health care, but involves government control of fees. Single-payer plus private insurance pits the wealthy against the rest for access to health care resources. Balanced Choice, on the other hand, allows single-payer economic efficiency and free market choices between doctor and patient to complement and enhance each other. It returns much of the control of health care costs and management to doctors and patients, where they belong.

Acknowledgment

I am indebted to friends and colleagues who reviewed and commented on drafts of this article. These include my Sunday morning coffee group: Dr. Daniel Davis, Jr., Dr. Alan Tice, and David Kemble; and also Dr. Janet Onopa and Marcia Kemble. I am also indebted to the Balanced Choice A-Team, and particularly Ivan Miller PhD who developed the Balanced Choice proposal and who also reviewed and provided helpful comments on drafts of this manuscript.

Disclosure

This paper was written entirely by myself. I did not receive any financial compensation from anyone in relation to writing it. I have no conflicts of interest to report.

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Makaʻala ke kanaka kaheea manu:
a man who calls birds should always be alert.
Service with Compassion: H.O.M.E. Project’s Keiki Ola Pono Sports (KOPS) Program

Anne Yoshizawa MSII, Jaryd Yee MSII, Erin Liu MSII, Nicolas Villanueva MSII, and Zachary Thielen MSIII; John A. Burns School of Medicine, University of Hawai‘i

H.O.M.E. (Homeless Outreach and Medical Education) Project is a health clinic operated by medical students from the John A. Burns School of Medicine. It was established in 2005 to provide free healthcare to homeless shelters on O‘ahu. H.O.M.E. Project is also geared toward increasing medical students’ awareness and understanding of the homeless population and their healthcare needs. In 2009-10, a few first year medical students developed a sustainable exercise program for homeless children to enable them to increase their exercise levels while finding an interest and motivation to improve their physical and mental health. The Keiki Ola Pono “children’s health and wellness” Sports Program was adapted from an existing one that was started a few years ago.

In the past decade, rates of body mass index (BMI) and risk for being overweight have increased alarmingly among children and are continuing to elevate. Childhood obesity is a major public health focus because adult-associated co-morbidities such as diabetes mellitus type II, metabolic syndrome, cardiovascular disease, and nonalcoholic fatty liver disease are emerging at a younger age. A contributing factor to childhood obesity is the scarce opportunity for structured exercise outside of physical education offered in schools. Furthermore, in 2000, less than 10% of United States schools had daily physical education classes available, and recess periods were insufficient as stated in the physical activity guidelines recommended by the American Academy of Pediatrics. Studies show that implementation of intervention programs that provided game equipment and organized sports activities resulted in enhanced physical activity during leisure time and less of a decline in moderate to vigorous physical activity after two years.

Goals of the Project

Although the primary goal of the sports program was to reduce early onset of obesity through exercise, it was equally important to examine the benefits of exercise beyond physical changes. These benefits include improved quality of life and commitment to healthy lifestyle choices among all participants, even those that were not overweight. Studies have shown that physical activity is negatively correlated with depression, anxiety, and low self-esteem. Social learning variables are also important correlates to the frequency at which children exercise; 5th and 6th grade males and females demonstrated increased participation in physical activity due to enjoyment of physical activity and family support; and, girls were additionally influenced by the availability of exercise-related equipment at home. Previous research also shows that children who do not participate in traditional structured physical activities demonstrate lack of confidence and enjoyment in these activities.

The Keiki Ola Pono Sports Program is designed to incorporate team sports activities to encourage fun competition and increase the excitement to improve fitness.

Methodology

Participants in the program included male and female residents, 18-years-old or younger, at the Kaka‘ako Next Step Shelter (temporary homeless shelter located in Honolulu, O‘ahu) and the Onelua Shelter (provides housing units for the homeless and is located in Kapolei, O‘ahu). The schedule of the program consisted of two 60-minute exercise activities at the Kaka‘ako Next Step Shelter and one 120-minute exercise activity at the Kalaeloa Onelua Shelter every week (a total of four hours per week at each shelter). Unfortunately, the program at Onelua Shelter was discontinued after a few months due to low attendance, which may be attributed to scheduling and conflicting activities for children during this time.

The methodologies employed are based on the effective exercise programs found in literature. One program equated to 225 minutes every two weeks (112.5 minutes a week) and resulted in improved body composition and cardiovascular fitness in non-obese children. The study maximized the effectiveness of a program of shorter duration by reducing the number of children on a team to maximize the duration of continuous movement. Another program incorporated behavioral modifications such as self-monitoring, awareness of health benefits, decision-making, and fundamental motor skills into a program that increased exercise enjoyment and participation.

The activities of Keiki Ola Pono Sports Program included basketball, soccer, football, jump-ropes, volleyball, tennis, and relay races. Multiple activity stations were run simultaneously by University of Hawai‘i student volunteers to maximize the time of child play. Sports equipment was generously funded through a health grant written by a former JABSOM graduate and appropriated by Aloha Care (a non-profit organization that offers a health plan to Hawai‘i residents; a grant was awarded on the basis of promoting preventative health care and reducing the onset of childhood obesity).

Assessments

Children were evaluated for mental health and physical health status at the start of the program. Repeat assessments were attempted at the end of the program, but due to the transitional nature of the shelters, there were only a few participants who were reevaluated. Mental and physical health status was measured with the Pediatric Quality of Life (PQL) Survey. Survey statements, which were orally administered to each individual, included physical assessments (e.g., “It is hard for me to run”), emotional assessments (e.g., “I feel sad or blue”) and social assessments (e.g., “I have trouble getting along with other kids”). Participants responded with “not at all,”...
“sometimes,” or “a lot.” Additionally, questions were asked about the KOPS program and exercise motivation.

Thirteen children were evaluated with the PQL survey. Although it was not possible to obtain significant numbers for post-evaluation, the initial surveys still highlighted some key areas of interest. At least one child from the group responded “A lot” to each of these statements: feeling sad, angry, worried, having trouble sleeping, and a range of social and school-related problems (e.g., paying attention, peer relationships, and trouble with schoolwork).

Some concerning emotional and social responses included the following:

“I worry about what will happen to me”
(7- “not at all”, 5- “sometimes”, and 1- “a lot”)
“It is hard to keep up when I play with other kids”
(5- “not at all”, 5- “sometimes”, and 3- “a lot”)
“I have trouble getting along with other kids”
(6- “not at all”, 3- “sometimes”, and 4- “a lot”)

These negative responses suggest that children in homeless shelters may benefit from exercise programs that allow children to practice positive social interactions with their peers through team sports. Some activities that allowed the children to improve their social skills included tag-relay races, alternating turns for jump-roping, and a range of games involving teamwork.

The statements concerning physical abilities generally resulted in a wide spread of responses, suggesting that the participants in the program are at a range of needs and skills. It was difficult to quantify the physical improvements of the participants, but the consistent attendance of some participants yielded marked improvement over the course of the program. For example, one child learned how to jump-roping through an entire medley involving a complicated routine of simultaneous toe-touches, turning, and hops; this was a proud feat for the young girl who started the program quietly observing the others jump-roping.

The survey suggests strongly that the children reflected upon Keiki Ola Pono as positive to their health. Three responded “sometimes” and ten responded “a lot” to “I enjoy being in the KOPS Program.” There were zero “not at all” responses to statements pertaining to the program’s goal of promotion of health and happiness.

Role in Medical Education
The Keiki Ola Pono Sports Program has been a valuable learning experience for the medical students’ education. Initially, the intent was to focus on affecting physical change and combating obesity, but the program ended up recognizing other important areas of well-being. For example, it was discovered that homelessness predisposes children to greater risk of abuse. The supervising medical students were able to earn some of the children’s trust through regular interaction in the clinic. As a result, some children voiced problematic details about past domestic violence or abuse. The alarming survey responses suggested that programs focusing on homeless children’s wellbeing are urgently needed in order to manage the care and custody of children who do not feel safe in their current living situations. Furthermore, working with the homeless children has helped medical students to identify important social determinants in their physical and mental health. Living in a homeless shelter subjects children to poorer health conditions, including limited sanitation, educational resources, food choices, and living space. The medical students were able to witness the tremendous impact of these conditions on the children’s wellbeing, ability to stay active, and ability to concentrate on schoolwork. Serving as mentors in this program has helped the medical students prepare for their future as practicing physicians because they will have the background and understanding to properly care for homeless patients.

In addition, the program has helped the medical students to develop skills that are important for interacting with children and their parents. During the program, there were many opportunities to encourage, support, and converse with children of different ages. There were times when parents would ask the medical students for advice regarding proper diet and exercise habits for their children. These moments of interaction paved ways of learning effective communication that will be beneficial in becoming physicians.

Although the physical changes or risk of obesity for the child participants were not quantifiable, the Keiki Ola Pono Sports Program challenged students to strengthen their preventative medicine efforts. Initial unpredictable and poor attendance prompted the development of feasible and effective ways to maximize attendance. Water bottles were dispensed for the child participants that resulted in increased participants’ return every week to the program. The water bottles were one way to indicate to children that exercise can be rewarding and fun. The relatively inexpensive water bottles served other purposes as well: promoting hydration, environmental awareness, and taking responsibility for one’s possessions. This mindset for approaching problems through realistic, effective interventions served as valuable training for effecting public health and preventative medicine for future physicians.

H.O.M.E. Project has since supported the continuation of weekly exercise sessions at Kaka’ako and now all H.O.M.E. Project first-year students will have this educational opportunity to participate in the sports clinic. It is anticipated that the Keiki Ola Pono Sports Program will continue to grow and provide valuable teaching experience for participating medical students.

References

Kulia i ka nuʻu: strive for the summit
Hawai‘i Foods Website: A Locally Based Online Nutrition and Food-Composition Resource for Healthcare Professionals and the Public

Kristine Wallerius Cuthrell MPH, RD; Sylvia Yuen PhD; Suzanne Murphy PhD, RD; Rachel Novotny PhD, RD; and Donna Lyn Au MPH, RD; University of Hawai‘i College of Tropical Agriculture and Human Resources and the University of Hawai‘i Cancer Center

Introduction
The mission of the Hawai‘i Foods website (www.hawaiifoods.hawaii.edu) is to improve the health of Hawai‘i’s people by providing food and nutrient information to help them make healthier dietary choices. Over 500 foods are currently featured on the website, with the following information generally available for each: description, scientific and common names, photo, and amount of 25 macro and micronutrients. Because the foods eaten in Hawai‘i reflect the cultural range of its people, the website focuses on foods typically found in Western, Asian, Pacific Islander, and other “local” diets. It is an evolving resource, as nutrient data, recipes, publications, photos, and other information are continually being added to the databases.

Development
Hawai‘i Foods was developed with base funds from the Vitamin Settlement Fund to the University of Hawai‘i’s Center on the Family with the aim to serve Hawai‘i’s need for information on “local” foods.

The website was launched in October 2007 with the initial conceptual framework developed by faculty of the College of Tropical Agriculture and Human Resources (CTAHR) at UH. The present website is a collaboration of CTAHR with the UH Cancer Center, where nutrient and recipe databases are maintained by the Nutrition Support Shared Resources at the Center. The My Diet feature of the website is based on the Pacific Tracker (PacTrac), which was developed by a USDA/CSREES/Integrated National Research Initiative grant for the Healthy Living in the Pacific Islands: Healthy Pacific Child Program.1 Programming and computer support for the website are provided by CTAHR, and research and verification of the scientific names for foods is provided by Hamilton Library at UH-Manoa.

Website Content
The Hawai‘i Foods website continues to grow as new information is gathered, analyzed, and prepared for presentation. The information is organized in four major sections: Search, Browse, Learn, and Discover.

Search
Specific foods are searchable by food item or ingredient. Results can be viewed by name of food or as photos, both of which are linked to the nutrient data for selected serving sizes.

Browse
Foods in the database can also be located by (a) food group—user selects from a list including beverages, fast foods, fruits, seafood, and other categories, or (b) food name, user selects from an alphabetical listing of all the foods in the database, such as apple, arare, and andagi. Figure 1 is a typical example of how nutrient information is displayed on the site.

Learn
Users can learn about the quality of their diets in this section, which features My Diet, an online dietary assessment tool. After entering foods consumed in a single day, users learn the amount of calories, total fat, saturated fat, cholesterol, and sodium they consumed, as well as additional nutrient information. They also receive a “score” on the overall quality of their diet for that day, based on the types and amounts of food eaten as compared to those recommended by the Food Guide Pyramid of the United States Department of Agriculture (USDA).2 Since the development of the My Diet tool, USDA has revised the original Food Guide Pyramid, which is now called My Pyramid, but the food groups and number of recommended servings are very similar.3 USDA authorization and software codes for displaying the latest version of My Pyramid on the Hawai‘i Foods website have been secured, and programmers are currently working to install it. Dietary assessments on Hawai‘i Foods will then conform exactly to current USDA guidelines.

Discover
This section contains Local Recipes, Publications, and Related Links. There are 20 recipes on the Hawai‘i Foods website, each of which (a) contains one or more locally produced or consumed ingredients; (b) is relatively low in fat, sodium, and calories; and (c) has been analyzed by a registered dietitian for its nutrient content. Selected recipes from the A Dash of Aloha cookbook,4 published in 2007 by Kapi‘olani Community College, UH, are currently being formatted to add to the website.

Eighty-four publications relating to foods produced and/or consumed in Hawai‘i are featured on the site. A citation—author, title of publication, source, date of publication—is available for each, as well as a pdf file of the publication where permission was obtainable.

Users can also select from a list of 14 links to reputable websites for more science-based information on food composition and nutrient analysis.

Usage
From January 1, 2009 to December 31, 2009, there were 56,276 visitors to the Hawai‘i Foods website, with an average of 4,685 unique visitors per month. Visitors were from 94 different countries/territories, with 89% from the United States and 56% of this...
national total from Hawaiʻi. Other countries visiting the website most frequently included: Canada, Australia, Philippines, United Kingdom, and Japan.5

Comments received from users indicate that the Hawaiʻi Foods website is an extremely valuable resource for obtaining nutrient information that generally is not available elsewhere about local foods. The site has been used to guide food choices for those with chronic health conditions, a desire to reduce weight, and a general interest in the nutrient content of foods. The website is also used by dietitians and other health and lifestyle counselors as an educational tool for their clients and by teachers, researchers, and students for academic purposes.

Looking Ahead

The content on the Hawaiʻi Foods website will continue to expand with the addition of more recipes and a local snack food section, the updating of the My Diet assessment section with the PacTrac II tool, and the most recent USDA My Pyramid.

The Hawaiʻi Foods website continues to benefit from the expertise, resources, and statewide networks of many pro bono collaborators, enabling it to disseminate locally based offerings and reach new audiences. To further leverage base funds, new funding sources are sought to support the development of educational materials that meet the mission of Hawaiʻi Foods and can add value to the website. Hawaiʻi Foods has become the state’s premier resource on “local” foods, serving as a prevention and educational tool to meet the health and nutritional needs of people in Hawaiʻi and beyond its shores.

References

The Weathervane
Russell T. Stodd MD, Contributing Editor

❖ Sometimes Reading the Label IS NOT ENOUGH.
In April 2000 a professional musician went to the hospital emergency room for complaints of migraine headache and nausea. A technician administered Phenergan by IV push, a dangerous practice since it was known by the manufacturer (Wyeth) that the drug could damage arteries and should be given by IV drip. Ultimately the patient suffered arterial necrosis with gangrene and subsequent amputation of her arm. She was awarded $6.8 million by a Vermont jury. The plaintiff settled with the hospital and then brought complaint against Wyeth, stating that the Phenergan warning label was not adequate. Wyeth argued that the drug label was approved by the Food and Drug Administration (FDA) and that federal rules should pre-empt the Vermont decision. The issue rose to the U.S. Supreme Court where the court ruled 6-3 in favor of the plaintiff. The decision stated (in part) that the FDA rules were intended as a floor and not a ceiling for safety, and that pre-empting state law was a decision for Congress and not a regulatory body.

One obvious outcome will be longer and more detailed drug attachments. (Am I supposed to read all this stuff?)

❖ Have NO STRESS. JUST COMPRESS.
A study at Arizona Department of Health Services evaluated survival rates of 4,415 adults who collapsed following cardiac arrest in years 2005 through 2009. Survival rates were calculated on the basis of hospital discharge. Three parameters of immediate response were: standard CPR, chest compressions only or no attempt at resuscitation. Chest compressions only provided the best possibility for continued life with a rate of 13.3% at hospital discharge. Standard CPR yielded a rate of 7.8%, and no CPR was 5.2%. Best chance for the patient is the use of automated external defibrillator, but no data were recorded for use of the AED. It appears from this study that skipping mouth to mouth breathing in favor of rapid chest compressions is as effective as standard CPR and easier to provide for non-medical people at the site. Moreover, mouth to mouth is a big barrier for many people, according to the American Heart Association. (No tongue please)

❖ A LAWYER IS A PERSON WHO PROFITS BY YOUR EXPERIENCE.
According to the New York Bar Association an attorney can use social networking sites to find damaging information about opposing parties. The Association noted that the current explosion in social networks raises questions about privacy rights, but the committee on professional ethics stated that lawyers involved in litigation can access the public pages of another parties site so long as it is accessible to all members of the network. Hey, anybody foolish enough to reveal potentially damaging data in twitter or Facebook is shooting themselves in the foot or perhaps higher in the anatomy. While we may not like it, Wi-Fi users must recognize that everything that goes on the Internet is vulnerable to computer geeks. The internet is a fantastic tool, but not a friend you can trust.

❖ WILL THE PHARMACEUTICAL PEOPLE EVER FIND THE PATH TO VIRTUE?
Pharmaceutical companies routinely hire physicians to provide education and promotion of their products to their colleagues. Some of these companies are Johnson and Johnson, Merck and Co., Pfizer, Eli Lilly and Co., and GlaxoSmithKline; their combined expenditures exceeded $250 million. One would assume that they hire the most respected doctors in their fields for the critical task of teaching about the benefits of their drugs, right? Not! In fact they do not care. ProPublica a non-profit research organization uncovered hundreds of doctors getting paid even though they had been sanctioned by state boards, lacked credentials as specialists, inappropriately prescribed drugs, had multiple malpractice judgments, provided poor medical care and even had sex with patients, and some had lost their licenses. One pain physician hired by Eli Lilly and Co. had been cited by the state medical board for performing unnecessary nerve tests on 20 patients, subjected some to an excessive number of invasive procedures, including damaging injections. The state board voted to revoke his license in 2008. The company has paid him $85,000 since 2009. In summary, 384 physicians in the data base earned more than $100,000 for their consulting work, 43 were paid more than $200,000, and a pair of fat cats topped $300,000.

❖ EVERY CIGARETTE EVENTUALLY MEETS ITS MATCH.
Health experts claim that about 480,000 Americans die prematurely each year killed by tobacco. According to the CDC smoking costs companies about $3400 per smoking employee annually with health care bills, absenteeism, and reduced productivity. A recent study in the New England Journal of Medicine (NEJM) led by a team of researchers from the University of Pennsylvania, followed 878 General Electric employees scattered around the country for a year and a half from 2005 and 2006. Participating smokers averaged a pack a day and were divided in two roughly equal groups, with one group offered up to $750 in cash; $100 on completing a smoking cessation program, $250 if they stopped smoking for six months, and $400 if they stopped for one year. Saliva and urine samples were submitted for verification at quarterly intervals. About 15% of the group given financial incentives stopped smoking in the first year of the study, compared with 5% of the control. 10% of the rewarded group still abstained at 18 months, compared to 3.6% of the control group. In addition, by not consuming a pack/day the former smoker (at $5 per pack) gains more than $1800 each year.

❖ IF THE FACE IS RED RAISE THE HEAD. IF THE FACE IS PALE RAISE THE TAIL.
Ethicon, a Johnson and Johnson company, has come up with a cheap means of stopping blood flow on the battlefield or in any desperate situation when there is no time for sutures. The new blood-clotting material is a hydrogel, a Jello sort of mixture of water and a fibrous polymer, an acrylamide with positively charged nitrogen groups. The gel stimulates blood-clotting factor VII which results in a cascade of events leading to coagulation. In experiments on sheep tissue the gel stopped bleeding in the lung in two minutes; a liver hemorrhage stopped in four. It can be slapped on and the body cannot absorb it. Researchers at Ethicon believe the treatment will serve well applied topically. The gel would cost $10 per application, far cheaper than other gels in use today.

❖ GENETIC ROADMAP – WHERE THE RUBBER MEETS THE ROAD.
The NEJM published a report from Sloan Kettering Cancer Center in New York on a new treatment for melanoma. Tests in people whose melanoma had metastasized showed that the drug was able to shrink tumors in most patients. In a few cases tumors disappeared completely. The compound targets a mutated version of the BRAF gene that underlies melanoma in about half of patients. The study’s coauthor, Paul Chapman M.D., claimed it is the first time researchers have been able to treat the genetics of the tumor. In their study 48 patients were treated with a drug devised to stop the mutant BRAF protein from stimulating cell growth, and 37 showed tumor shrinkage of 30% or more. In three patients the tumors resolved completely.

❖ EVERY HOME NEEDS A BIT OF VISCERA OVER THE FIREPLACE.
In Laguna Beach, California, a woman had a hysterectomy and awoke from surgery with burns on her legs. After removal of the uterus her gynecologist had gratuitously “branded” the tissue with the name “Ingrid” in inch high letters using the electro-cautery. He explained that it was a “friendly gesture” in the event the patient planned to take the specimen home as a keepsake. He denied any knowledge of the burns on her legs. Perhaps he felt that she needed another souvenir.

❖ IF YOU THINK YOUR MOTHER STILL LOVES YOU, CHECK IT OUT.
In Dallas, Texas, a man approached a bank teller and demanded a large amount of money with a note that said “I have a bomb.” The teller said she needed ID before she could release a large amount of money and obtained a Texas ID card and a Wells Fargo debit card, both in the man’s name. Police arrived as he was leaving and he tried to take a woman with a child as hostage, but she knocked him to the floor. Some days you should just stifle the allure of bank robbery.

ADDENDA
❖ In Italy in thirty years under the Borgias they had warfare, terror, murder, and bloodshed, but they produced Michaelangelo, Leonardo Da Vinci and the Renaissance. In Switzerland they had 300 years of peace and democracy and what did that produce? The cuckoo clock. (Orson Welles)
❖ Dentists in Naples, Italy, first recorded the effect of fluoride in preventing tooth decay in 1802.
❖ Women with a history of migraines have a 26% lower risk for breast cancer (Berkeley Wellness Ltr.).
❖ Human beings are the only creatures that allow their children to come back home.
❖ Paper or plastic? I don’t care. I’m a transacksual.
❖ Washington, D.C. is to lying like Wisconsin is to cheese.

Aloha and Keep the Faith — rts

(Editorial comment is strictly that of the writer.)
## UPCOMING CME EVENTS

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<td>10/24-10/28</td>
<td>AN</td>
<td>California Society of Anesthesiologists</td>
<td>Grand Hyatt, Poipu Beach, Kaua‘i</td>
<td>2011 CSA Fall Hawaiian Seminar</td>
<td>Web: <a href="http://www.csahq.org">www.csahq.org</a></td>
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