IMPROVEMENT IN LIKELIHOOD TO DONATE BLOOD AFTER BEING OFFERED A TOPICAL ANESTHETIC
Kyle M. Watanabe MPH; Jeffrey Jay MPH, BSN; Christopher Alicto; and Loren G. Yamamoto MD, MPH, MBA

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Improvement in Likelihood to Donate Blood After Being Offered a Topical Anesthetic

Kyle M. Watanabe MPH; Jeffrey Jay MPH, BSN; Christopher Alicto; and Loren G. Yamamoto MD, MPH, MBA

Abstract

Background: While there are many reasons people choose not to donate blood, pain sustained during the venipuncture portion of the blood donation process is likely one deterrent to volunteer donation. The purpose of this study was to survey the improvement in likelihood of donation if participants were given the option of a topical anesthetic cream prior to venipuncture.

Study Design and Methods: Over a three month period 316 adults (convenience sample) completed a one page survey consisting of twelve questions pertaining to blood donation. Participants were asked about their likelihood of donating blood in the near future (No Possibility, Possible, Likely, Certain). They were then informed of the possibility of using a topical anesthetic cream prior to donation. Subsequently, their likelihood of donating blood was reassessed.

Results: Fifty (16%) subjects reported an increased likelihood of donating blood if offered a topical anesthetic (p<0.0001). Of these respondents reporting an increase in donation likelihood, eleven improved by 2 or more likelihood categories. Amongst the 169 participants who never donated blood, 34 (20%) reported an increased likelihood of donation after being told about the topical anesthetic cream, compared to 16 (10%) of the 147 subjects who had previously donated blood (p=0.02).

Conclusion: The findings of this study suggest that providing a topical anesthetic had a positive effect on the study participants’ likelihood of donating blood. This improvement was greater amongst those who have never donated blood.

Introduction

Of the more than 9 million blood donors in 2006, 2.7 million (28%) were first time donors and 6 million (72%) were repeat donors. This is consistent with prior studies demonstrating that “repeat donors contribute to the bulk of the nation’s blood supply”. Furthermore, although 37 percent of the US population is eligible to donate blood, less than 10 percent do so annually. Therefore, converting a first-time donor into a repeat donor can represent a significant contribution to the nation’s blood supply. The keys to increasing blood donations are:

1. Getting the donors in the door,
2. Keeping them happy while they are giving blood, and
3. Motivating them to return.

Although there are many reasons people choose not to donate blood, pain is likely a contributing factor. The purpose of this study was to determine whether reducing pain via a topical anesthetic cream prior to donation would improve the likelihood of volunteer donation.

Methods

A one page survey was developed to examine participants’ past blood donations and the likelihood of both current and future donations with or without a topical anesthetic. Likelihood to donate was scaled as: No Possibility, Possible, Likely, and Certain.

Over a three month period (January 2009-March 2009) a convenience sample was taken. Subjects came from 13 different areas on the island of O‘ahu. Locations included: Aiea, Aina Haina, Ala Moana, Ewa Beach, Hawaii Kai, Honolulu, Kaimuki, Kaneohe, Kapahulu, Manoa, and Waimalu. Potential subjects were approached at malls, beaches, parks, bus stations, and other public thoroughfares. No criteria were set for participant selection other than potential subjects should be adults at least 18 years or older and in visibly good health. Researchers informed participants of the voluntary nature of the study. If potential subjects expressed interest, an informed consent procedure was reviewed. Once consent was given, researchers gave subjects instructions on how to complete the survey.

Data was compiled, entered, and analyzed using EpiInfo version 3.5.1 for basic descriptive statistics. McNemar’s test was used to compare paired responses (i.e., with and without the topical anesthetic), and Chi-square testing was used to compare frequencies in unpaired samples.

Results

Over the three month collection period, a total of 316 participants completed the one page survey. Among respondents, 147 were previous blood donors, 169 had never given blood, 56 had given blood one or more times in the last 12 months, 103 indicated that they were healthcare workers or worked in a healthcare setting, 22 were transfusion recipients, and 133 reported they had parents, siblings, or grandparents who had received transfusions.

One hundred and eleven participants stated that over the next twelve months there was “no possibility” of donating blood, 124 said donation in the next year was “possible,” 31 indicated they were “likely” to donate blood, and 50 reported that they were “certain” to donate blood.

When a topical anesthetic was offered to reduce the pain experienced during blood donation, 88 subjects reported there was no possibility of giving blood in the next 12 months, 124 stated there was a “possibility of donation,” 46 said blood donation was “likely,” and 58 stated donation in the next 12 months was “certain.”

Of these 316 respondents, 266 participants responses showed no change/worse, 39 subjects responses improved by one likelihood category (i.e. No possibility to possible) and eleven improved by 2 or more likelihood categories (e.g., No Possibility to Likely).

Dichotomizing responses such that “no possibility” and “possible” are recoded to “lower likelihood of donation,” and “likely” and “certain” are recoded to “higher likelihood of donation,” 81 of 316 (26%) respondents reported a high likelihood of donating blood when no topical anesthetic was offered. However, when a topical anesthetic was offered this number changed to 104 of 316 (33%) p=0.00001 (Table 1).
Among the 169 subjects who have never donated blood, 34 (20%) improved their likelihood of future blood donation. Among the 147 subjects who had donated blood prior to this survey, 16 (11%) improved their likelihood of future blood donation \( p = 0.02 \) (Table 2), suggesting that topical anesthetics have a modestly greater benefit in those who have never donated blood. Additionally, healthcare workers who had never given blood appeared no more or less likely to change their responses after being offered a topical anesthetic than any of the other respondents.

Of the 56 participants who had donated blood one or more times in the past twelve months, 25 responded that they would donate a greater number of blood units in the next twelve months if a topical anesthetic were offered. However, 17 of these respondents indicated that this increase in future donations was unrelated to the benefit of the topical anesthetic, and only 4 of these 25 respondents indicated that the increase was either partially or totally due to the benefit of the anesthetic.

**Discussion**

Keeping volunteers happy during the blood donation process is one key to increasing blood donation.\(^3\) The benefits of offering a topical anesthetic prior to donation include reduced pain during venipuncture,\(^3,14,16\) the subsequent increase in comfort for volunteers,\(^12\) and a potentially higher probability of future donations. Draw backs include increased cost which should be addressed in future studies targeting the economic feasibility of topical anesthetic use prior to blood donation and longer wait times (1 hour for EMLA cream and LET Gel,\(^14\) 30 minutes for EMLA Max, and 10 minutes for lidocaine/tetracaine patch [Synera, Rapydan])\(^11\). Faster onset times may be possible using cold sprays in place of cream or ointment based topical anesthetics, though the safety and efficacy of this was not explored in our study.\(^9\)

Additional considerations include the sterility of topical anesthetics and the reduction of the beneficial effect upon the cleansing of the venipuncture site. However, as topical anesthetics are currently used and removed in a number of procedures prior to administration of local anesthetics (including laceration repair) it is unlikely the benefits of the cream will be immediately lost by the arm cleansing procedure prior to blood donation. Furthermore, there is a theoretical concern of contamination from a small amount of lidocaine entering the blood unit being donated. This could result in an adverse reaction if infused into a lidocaine allergic recipient. However, this risk is not likely to be greater than food allergy recipients who might receive a blood unit from a donor who recently ate the food allergen. Further limitations include that, while Schlumpf KS et al. found that intention is generally a good reflection of actual intent and return donation,\(^8\) this question was not examined for first time blood donors. Moreover, the adverse possibility of a lidocaine allergic amongst participants was never considered in this study and may exempt some individuals from participation in using topical anesthetic creams to reduce pain associated with venipuncture in blood donation.

Two-thousand and seven was the first year that the National Blood Collection and Utilization Survey Report (NBCUSR) collected data on the number of blood donors who were first time participants and how many were repeat participants.\(^5\) By increasing the number of first time donors, the burden of perpetuating the US blood supply by repeat donors is reduced. This study suggests that some people are more likely to donate blood if venipuncture pain is reduced using a topical anesthetic and that this increase was greatest amongst first time donors. Therefore, a program that offers a topical anesthetic prior to the venipuncture may increase both first time blood donor participation and convert never or first time donors into repeat donors.

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**Disclosure Statement**

The authors certify that they have no affiliation with or financial involvement in any organization or entity with a direct financial interest in the subject matter or materials discussed in this manuscript.

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**References**

Case Report and Management of Suspected Acute Appendicitis in Pregnancy

Daniel Murariu MD, MPH; Brent Tatsuno BS; Cori-Ann M. Hirai BS; and Ryan Takamori MD

Abstract
Suspected cases of acute appendicitis in pregnancy are considered surgical emergencies due to the potentially devastating outcomes for both mother and unborn child if the appendix perforates. Acute appendicitis is also the number one cause of non-traumatic acute abdomen in pregnancy, as well as the number one cause of fetal death. We present a case report with a typical presentation of suspected acute appendicitis in a pregnant woman. The work up and diagnostic tools available are discussed at length, as well as the finer points in treatment of this population.

Introduction
The non-traumatic, acute abdomen in pregnancy is a cause of grave concern to the physician in charge given that the lives of the patient and unborn child are at stake. The differential diagnosis can be divided into gastrointestinal (acute appendicitis, acute cholecystitis, acute pancreatitis, intestinal obstruction, ischemia, or perforation), gynecological (ovarian cyst rupture, adnexal torsion, degenerating myoma) or obstetrical (placental rupture, uterine rupture, hepatic rupture, ruptured ectopic pregnancy) etiologies. The most common cause is acute appendicitis, with an incidence of 1 out of 1500 pregnancies. While surgery may be avoided in some of the listed pathologies, suspected acute appendicitis is always a surgical emergency despite a false negative rate of up to 55% in pregnant women, compared to 10-30% in the non-pregnant population.

The following case report exemplifies a typical incidence of suspected acute appendicitis in a pregnant patient, while the discussion delves into the finer points of working up and managing such a case.

Case Report
A 25-year-old G2P1 woman at four weeks gestational age reported to the emergency department with a three day history of constant periumbilical pain, rated initially as 5 out of 10, localizing to the right lower quadrant and 10 out of 10 in intensity. The patient also complained of anorexia, a bout of emesis, and chills, but without subjective fever. The patient’s medical history was significant for discovery of an unplanned pregnancy 11 days prior to arrival with no pre-natal care. Physical examination revealed an obese female with tenderness over McBurney’s point, without psoas or obturator signs. Vital signs and laboratory values were within normal limits, including normal white cell count. The ultrasound study showed a small amount of free fluid in the right lower quadrant and tenderness over a non-compressible structure over the iliac vessels, suggestive but not conclusive of acute appendicitis (Figure 1).

Given the suspicion of acute appendicitis as the likely diagnosis, the patient consented to a diagnostic laparoscopy, which demonstrated no free fluid in the abdomen and a grossly normal appendix. Pathology reported the specimen as consistent with early acute appendicitis. Postoperatively the patient did well and was released on postoperative day two.

Discussion
Of those women who are afflicted with acute appendicitis during pregnancy the incidence by trimester is 32%, 42%, and 26%. The potentially devastating effects of not operating or even delaying surgery are tremendous for both mother and unborn child. Maternal mortality rate can reach 4% while fetal death can be seen in up to 43% of perforated appendicitis, accounting for the number one cause of fetal death during pregnancy.

The anatomic changes of pregnancy not only impact the way appendicitis presents, but its work up and management too. Current literature disagrees on whether the appendix moves superiorly throughout the course of pregnancy. Pates et al. confirmed Baer’s landmark 1932 study that there is upward displacement of the appendix above the iliac crest. However, Popkin et al. and Hodjati et al. both dispute these statements and claim that the appendix does not move throughout pregnancy.

While the perforation rate in non-pregnant patients is around 14.6%, in pregnant women it reaches as high as 43% in those whose surgery was delayed 24 hours. Although a delay in diagnosis may contribute to the high perforation rate, there may also be a physiologic cause in that the enlarged uterus renders the omentum and bowel unable to wrap around the appendix and wall off the infection.
The advent of computed tomography (CT) has led to a paradigm shift in diagnosing acute appendicitis from a clinical to a radiological diagnosis, except in pregnancy, where the risk of radiation may prevent the CT from being utilized and false negative rates as high as 55% may be deemed acceptable. Kal et al. report that exposure to radiation on the order of 100 rads (1 Gy) before week 16 of development can decrease IQ by up to 30 points, result in severe mental retardation, and increase cancer risk by up to 6% per 100 rads.\(^{16-17}\) Baseline risk of childhood cancer is about 1 in 2000 while exposure of 5 rads has been shown to increase that risk to 2 in 2000.\(^{18}\) However, radiation from a CT of the abdomen and pelvis normally ranges from 1 to 5 rads, depending on the institution and technician performing the study. Chen et al. found that the threshold above which the radiation exposure causes teratogenic effects is estimated at 5-15 rads (0.05-0.15 Gy).\(^{18}\) Although overall the low radiation content of a single CT has been shown to pose little risk to the fetus, employment of the scan should be weighed against the cumulative radiation exposure to the fetus that may contribute to spontaneous abortion, microcephaly, microphthalmia, growth restriction, cataracts, and behavioral defects especially if in the first trimester.\(^{16-17}\) Therefore, possible risks to the fetus need to be discussed with the patient prior to proceeding with CT.

When the risk of a CT scan may be greater than the benefit, other diagnostic modalities available include ultrasound and magnetic resonance imaging. Both have high false negative rates and a relatively low sensitivity (ultrasound having a sensitivity ranging between 67-100% as it is operator dependent).\(^{19}\) Nonetheless both are deemed safe as long as no intravenous Gadolinium is used with the MRI. In one study, Gjelsteen et al. have proposed a diagnostic algorithm for appendicitis in pregnant women in which CT imaging is reserved for patients in the second and third trimesters while ultrasound and MRI can be used throughout pregnancy.\(^{20}\) Ultrasound should be considered first line modality in possible acute appendicitis in the pregnant patient. If negative, diagnostic laparoscopy should be used if within the first trimester. Past the first trimester, conventional radiology with CT scan may be considered to confirm diagnosis.

Laboratory work may also reveal leukocytosis, which may not be diagnostic as it usually appears as a physiologic change during pregnancy.\(^{13}\) One study, Mourad et al., concluded that neither fever, nor leukocytosis, is a clear indicator of appendicitis during pregnancy, as these are common occurrences during gestation.\(^{14}\)

Treatment

The definitive treatment for suspected acute appendicitis in a pregnant patient is emergent appendectomy, even if intra-operatively the appendix is grossly normal. Immediate surgical intervention within the first 24 hours is warranted in any case of suspected or confirmed acute appendicitis in a pregnant woman to avoid perforation and resultant severe complications.\(^{7,8,21-22}\) Although laparoscopic surgery is deemed safe compared to an open approach and there are no studies showing increased risks, it is up to the surgeon’s preference for which technique to employ. Nonetheless, the trocar insertion points will shift upward towards subcostal regions depending on the week of pregnancy. The enlarging uterus may increase the risk of perforation and bleeding if trocars are placed in the usual sites around the umbilicus and overlying the bladder.

The SAGES (Society of American Gastrointestinal and Endoscopic Surgeons) recommendations for treatment in acute appendicitis include considering an obstetrical consult, deep venous thrombosis prophylaxis with intermittent pneumatic compression devices, early ambulation, and subcutaneous heparin in the high risk patient, pneumoperitoneum of 10-15 mmHg, and laparoscopic approach via Hassan technique or Verres needle.\(^{23}\) Turning the patient on their left side not only opens up the surgical path to the appendix but also relieves pressure on the vena cava and decreases impairment of blood return to the heart.

Given the availability of high definition laparoscopes in most institutions, it is also preferred to use 5 mm trocars which help minimize postoperative pain from disruption of the peritoneal fascia. Other considerations include good hydration pre- and post-operatively, pre-operative antibiotics such as a second generation cephalosporin or carbapenem, and continuous monitoring for fetal distress for gestational age greater than 20 weeks. Fetal distress is more commonly present in the third trimester and may require tocolytics, such as NSAIDS (before the third trimester), terbutaline, and magnesium sulfate. Lastly, a grossly normal appearing appendix during surgery should be removed as for the non-pregnant population to avoid confusion and eliminate appendicitis from the differential diagnosis for future right lower quadrant pain.

Conclusion

The evaluation of a pregnant woman presenting with acute abdominal pain warrants a careful work up due to the possible risks for the fetus and mother. Pain in either the right lower or upper quadrant accompanied by a leukocytosis should raise suspicion of acute appendicitis as a possibility. Depending on the trimester, an ultrasound, MRI or CT can be used to verify the diagnosis. Nonetheless, in a suspected case of acute appendicitis, emergent surgery should not be delayed given the high morbidity and mortality rates due to perforation. Removal of the appendix is warranted even if grossly normal during the operation.

Intra-operatively, the placement of the trocars depends on the size and location of the uterus and appendix if visualized on imaging studies. The patient should be positioned on the left recumbent position to allow increased venous return to the heart and the fetus monitored with a fetal monitor if older than 20 weeks. Post-operatively, the patient should be monitored for any bleeding and thromboembolism, infection, and signs of fetal distress.

No conflicts of interest.

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Access to Care: The Physician’s Perspective

Alan Tice MD; Janessa E. Ruckle; Omar S. Sultan; and Stephen Kemble MD

Abstract

Private practice physicians in Hawai‘i were surveyed to better understand their impressions of different insurance plans and their willingness to care for patients with those plans. Physician experiences and perspectives were investigated in regard to reimbursement, formulary limitations, pre-authorizations, specialty referrals, responsiveness to problems, and patient knowledge of their plans. The willingness of physicians to accept new patients from specific insurance company programs clearly correlated with the difficulties and limitations physicians perceive in working with the companies (p < 0.0012). Survey results indicate that providers in private practice were much more likely to accept University Health Alliance (UHA) and Hawai‘i Medical Services Association (HMSA) Commercial insurance than Aloha Care Advantage and Aloha Quest. This was likely related to the more favorable impressions of the services, payments, and lower administrative burden offered by those companies compared with others.

Introduction

The private practice of medicine is in jeopardy, especially for primary care specialties, as physicians are increasingly burdened by complex medical billing procedures as well as the time and costs associated with managed care. It has become routine for a primary care physician to spend at least two uncompensated hours per day dealing with managed care pre-authorizations, pharmacy benefit managers, formulary restrictions, confidentiality requirements, and care coordinations. Many plans will not pay for services without pre-authorization forms that can only be completed by the physician. Newer insurance plans in Hawai‘i are offering lower compensation for services, more billing problems, and increased managed care requirements. The average private practitioner spends an estimated $70,000 per year on office staff functions largely devoted to managing insurance related issues. In addition, Medicare’s “Sustainable Growth Rate” payment formula is slated to reduce physician fees by 30% over the next few years.

Administrative burdens including payment delays, inadequate reimbursements, and complex rules and regulations as to how claims should be filed are affecting the majority of primary care practitioners. Even physicians who join large groups in an attempt to avoid the billing and business aspects of medicine still must deal with all the pre-authorization requirements and formulary restrictions imposed by different insurance plans. Due to the ever-changing complexities of medical billing, there are no “economies of scale” for primary care practitioners, and even large practice groups can get into financial trouble due to inadequate collections resulting from inability to keep up with so many administrative insurance-related requirements.

Because of these limitations, many physicians in primary practice are restricting their practices to only a few insurance plans that offer better reimbursement, and some are opting out of participation with insurance plans entirely, expecting patients to pay cash. Issues such as these are driving many physicians to leave private practice, and are deterring young physicians from entering primary care as a vocation after residency. In a 2007 survey of fourth year students at eleven US medical schools, only seven percent planned careers in adult primary care. The American College of Physicians warned that “primary care, the backbone of the nation’s health care system, is at grave risk of collapse.”

These forces are leading to severe problems for many patients in getting access to health care, even if they have insurance. Finding a primary care physician has become increasingly difficult for patients with Medicaid, Medicare, and some private plans that offer low fees and high managed care hassles. A 2006 California survey found that one of the principal reasons for emergency room visits was due to lack of access to a primary care physician.

In order to assess the variety and magnitude of these problems, private practice doctors in Hawai‘i were surveyed to identify issues that they encounter with different insurance plans, and to determine their willingness to accept patients with various plans. Specifically, the insurance plans evaluated in this survey were Aloha Care Advantage, Aloha Quest, Hawai‘i Medical Assurance Association (HMMA), Hawai‘i Medical Service Association (HMSA) 65C+, HMSA Commercial, HMSA Quest, Medicaid-fee-for-service, Summerlin Commercial, Summerlin Quest, Tricare, and University Health Alliance (UHA). HMSA is the largest, preferred-provider health insurance network in Hawai‘i with 689,000 members, while HMMA is the second largest with 46,000 members after absorbing the Summerlin Hawai‘i insurance plans in 2010. Data for this survey were collected prior to the HMMA-Summerlin merge.

Methods

Patterned after the Harris County Medical Society Analysis of Payor Survey, a survey instrument was constructed with the input of practicing physicians in Hawai‘i. In early 2009, this survey was sent to 1,000 physicians who were in private practice according to the Hawai‘i Medical Association mailing list. A self-addressed, stamped envelope was included in the mailing. The questionnaire portion of the survey, shown in Figure 1, asked physicians to indicate whether their practice was accepting new patients from different local insurance companies and included specific questions about physician’s experiences with those insurance companies with regard to reimbursement, authorizations, referrals, and patient input. The form was structured using a graduated scale for each statement with the following scoring system: 1 = never, 2 = rarely, 3 = sometimes, 4 = often, and 5 = always.

The survey results were tabulated by pooling all 1 and 2 (never, rarely) scores, and all 4 and 5 (often, always) scores, while counting all 3 (sometimes) scores as neutral replies. After scoring the responses from physicians, insurance companies were ranked according to the number of times they were reported as the top two or bottom two. The survey also asked respondents to indicate the year they graduated from medical school and how long they expected to be in practice. An IRB exemption was granted through the University of Hawai‘i, as there were no patients involved in the study.
Results and Discussion

Out of 1,000 survey form mailings, a total of 95 were returned. Of those, 75 surveys were returned with partial or completed survey information, 12 had wrong or outdated addresses, and 8 respondents returned the survey blank, indicating that they were no longer in practice, retired, or otherwise ineligible to participate. Additional survey results are presented in the following sections.

Acceptance of New Patients
Survey results indicated a considerable variation in acceptance of insurance company programs (Figure 2). Physicians responded that they “often or always” accept UHA (73%) and HMSA Commercial (85%) compared with Aloha Care Advantage (25%) and Aloha Quest (30%).

Payments and Reimbursements
Physician responses to several aspects of payments and reimbursements by insurers are shown in Figure 3. Reimbursement below contracted rates was considered a common problem, and physicians reported that they “often or always” had issues with payments that were less than the contracted rate with Summerlin Commercial (30%) and Aloha Care Advantage (31%). Reimbursement issues were considered much less of a problem when working with
HMSA Commercial (7%) and HMSA 65+ (11%). A wide range of “sometimes” or neutral responses was noted, and while HMSA Commercial scored positively, it also had the highest percentage of “sometimes” ratings (29%). One survey respondent wrote, “I may not accept patients referred to me by HMAA...they require too many explanations in order to get paid, and the pay is very low.” Another said, “Unfortunately with reimbursement rates in general, it is hard to run a practice that focuses on preventative medicine that keeps patients healthy.”

Physician responses regarding their experiences with the poor timeliness of reimbursement varied, with Medicaid fee-for-service (41%) and Summerlin Commercial (45%) garnering the most “often and always” responses with respect to delays in payment. Conversely, HMSA 65+ (10%) and HMSA Commercial (11%) were considered the timeliest payors. One respondent indicated in the survey that they were “not planning to accept any more new Medicare patients due to numerous problems with reimbursement…it actually costs me to see Medicare patients when extra administrative costs are factored in.” Other studies have highlighted physician unwillingness to participate in the Medicaid program, which has been shown to be due in part to excessive paperwork, perceptions of limited reimbursement, and reimbursement delays.

Restricted Formulary Issues

The use of medication formularies is another way to control costs, but it requires valuable time and effort for the physician to continually learn and keep up with the listed medications. It also represents a barrier that must be crossed by the physician when a patient needs a medication that is not on the formulary, along with any additional pre-authorizations or written approvals necessary to prescribe it. Physicians reported that formularies for insurance companies Aloha Care Advantage (54%), HMSA Quest (54%), and Aloha Quest (55%) most “often or always” limited the medications necessary for treatment, while companies that ranked more favorably in this category included HMAA (30%), HMSA Commercial (30%), Tricare (30%), and UHA (32%), and HMSA 65 C+ (Figure 4).

Pre-authorizations and Specialist Referrals

Figure 5 represents responses from physicians in terms of how difficult it is to obtain pre-authorizations and specialist referrals from various insurance companies. The need to pre-authorize diagnostic studies, procedures, laboratory tests and other services is a significant problem which often takes considerable physician and office staff time without any financial compensation for the additional workload. Physicians responded that it was “often or always” difficult to obtain pre-authorization for services through Aloha Care Advantage (39%) and Aloha Quest (43%), while UHA (13%) and HMAA (17%) ranked most favorably.

The ability to obtain consultation and make referrals to specialist physicians, a vital resource for primary care physicians and their patients, varied considerably among payors, with physicians responding that it was “often or always” difficult to obtain specialist referrals from Aloha Quest (44%) and HMSA Quest (46%); however, HMSA Commercial (12%), HMAA (15%) and UHA (15%) scored more favorably.
General Communication

Responsiveness to physician questions and concerns by the payor is a valuable part of the physician-payor relationship and an important factor in efficient and appropriate patient care. As shown in Figure 6, physicians reported that HMSA Commercial (55%) and HMSA 65+ (56%) were “often or always” prompt in returning phone calls, compared to Summerlin Commercial (14%) and Aloha Care Advantage (23%) who had the least favorable scores in this category.

Excessive paperwork was determined to be an issue based on written responses that physicians provided on the survey. One physician said, “If National Health Insurance requires excessive paperwork, I will consider retirement.” Another indicated that they were planning “to concentrate on HMSA and Tricare and drop Medicaid. Too much headache — all the paperwork.”

Patient Experiences

Patients are often confused about their health plans, and are not aware of restrictions on which providers they can see, prior authorization requirements, formulary restrictions, and limitations on coverage. Physicians are often called upon to explain and justify the policies of the insurer, even though they may not fully understand the insurance company’s evolving policies or find them reasonable. This significantly detracts from the physician’s role in focusing on medical care. The practitioner perspective on the problems patients face with understanding their insurance plans, including co-pays and various other out-of-pocket expenses are reflected in Figure 7. Physicians reported that their patients “often or always” understood their insurance coverage and benefits 11% of the time with both Summerlin Quest and Medicaid fee-for-service, and 13% of the time with Aloha Care Advantage and Aloha Quest. Tricare, HMSA Quest, and HMAA all ranked 19% and HMSA 65C+ ranked 20% in this category. Interestingly, respondents thought that at least 50% of their patients “rarely or never” adequately understood their medical coverage for nearly all of the insurance companies represented.

Physicians responded that their patients reported difficulties paying for out-of-pocket expenses “often or always” with Aloha Care Advantage (23%) and Summerlin Commercial (25%) as opposed to UHA (10%) and Tricare (11%). However, the wide range of “sometimes” responses for both survey statements when scoring patient experiences indicates some neutrality on the part of the physician, perhaps because patients do not communicate these concerns directly to them in many cases, or because the survey statements are more subjective than others.

Overall Rankings

Overall, the top ranked insurance companies, based on the total number of top two positive ratings for all of the survey questions, were UHA and HMSA 65 C+ with five top two ratings and HMSA Commercial with six. The companies with the fewest positive ratings overall were Aloha Quest with five showings in the bottom two and Aloha Care Advantage with seven. Table 1 shows a summary of responses to the survey statements ranked according to the percentage of physicians surveyed willing to accept new patients with different plans.

The willingness of physicians to accept new patients from specific insurance company programs clearly correlates to the range of difficulties and limitations physicians perceive in working with
them (Figure 8). Spearman ranking correlation analysis shows a significant correlation between total rank scores and accepting new patients with different plans (p = 0.0012; Graphpad Software, San Diego, CA). As emphasized by the overall ranking scores, providers are much more likely to accept UHA and HMSA Commercial than Aloha Care Advantage and Aloha Quest, probably due to the more favorable impressions of the services, payments and reimbursements, and lighter administrative burden offered by those companies that ranked highest.

Conclusions

The overwhelming majority of physicians agree that all Americans should receive needed medical care regardless of ability to pay. However, there are major barriers that are limiting access to primary care, including administrative burdens by private and government funded health care plans. This study documents physician responses to variations in how insurance companies operate, and the vast differences among insurers in problems encountered by physicians. The evaluations of the insurance carriers are important, generally consistent, and may be useful in helping physicians, employers, and prospective patients in choosing an insurance company. Comparisons may also be useful to insurance companies in an effort to improve their programs for both physicians and patients based on the information gathered.

This study is limited by the number of responses. The reason for this is unclear but likely related to the ability to identify doctors who are in private practice and able to take the time to respond. The identification of practicing physicians with knowledge of the insurance companies they work with may not be sufficiently identified by the list we were able to get. It could not distinguish those in private practice from those practicing with large groups or organizations without personal knowledge of the insurance companies they work with. Additional responses about insurers may not be possible if a physician does not accept that carrier. The results of this study are further limited by the fact that health insurance plan policies and physicians’ feelings about them are “moving targets.” As with all surveys, question wording and numerical response grading options could have led to misinterpretation of question meaning or bias. Since this survey was performed, Medicaid fee-for-service has been converted to two for-profit managed care plans, with more restrictive formularies, more restricted networks of participating physicians, and more prior authorization requirements. HMSA has turned the pharmacy benefits for many of their plans over to mainland pharmacy benefit management companies that have even more restrictions on formularies and more prior authorization requirements. Additionally, HMAA bought the Summerlin Hawai’i insurance plans in April 2010, which is not reflected in this survey.

To rank insurance companies with the information from the survey is also very difficult given the many factors involved and the varying importance of them. Our findings can only be presented as a “gestalt” and do not lend themselves well to statistical analysis. Change and improvements in health care are desperately needed as many forces of change threaten the role of the private practice practitioner. Improving access to primary care will require major macro-level system reform and cooperation from insurance companies. In particular, increases in primary care reimbursement and general reduction of the administrative burden on primary care

Figure 7. Physician responses to how they view their patients (a) understanding of insurance coverage, and (b) difficulty paying for out-of-pocket expenses from various insurance plans

Figure 8. Correlation analysis comparing the total rank score from all survey questions with the rank score of physician willingness to accept patients with different insurance plans (p = 0.0012)
practitioners would be helpful in attracting more medical school graduates to the field. Future studies are needed to continuously evaluate private practice physician perspectives in Hawai‘i and provide feedback with information and education. Systems to track the responses of insurance companies regarding the problems and concerns physicians face in providing care are also needed for patients as health care programs evolve.

**Conflict of Interest Statement**

None of the authors identify a conflict of interest other than their income from private practice (Tice and Kemble) and the health insurance plan their employers carry.

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**References**

The Role of Morbidity and Mortality (M&M) Conferences in Medical Education

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M&M Conferences, Yesterday and Today
While adverse and unexpected clinical outcomes have probably been discussed since the dawn of medicine, the formal morbidity and mortality conference can trace its beginnings to the 1930s and the Philadelphia County Medical Society’s Anesthesia Mortality Committee.1 Later renamed the Anesthesia Study Committee, this multi-institutional group, composed of anesthesiologists, surgeons, and internists, met monthly to review fatalities related to anesthesia and “other interesting topics.” The cases were collected through the systematic review of hospital records when it became clear to the organizers that practitioners involved in adverse outcomes rarely volunteered their case for discussion. The focus of the meeting was on education, through open discussion of the patient’s course, and on improving the community standards of healthcare in the Philadelphia area through the dissemination of knowledge and experience. This original model of the M&M conference was a highly regarded, popular educational event.2

Today, depending on the specialty and the institution, morbidity and mortality conferences in Western medicine have variable formats and foci. In contrast to the Anesthesia Study Committee, national surveys have found that meetings billed as M&M conferences frequently concentrate only on interesting and unusual cases, completely avoiding the discussion of medical errors and adverse outcomes.2

Two of the prominent governing bodies of medical education in the United States; the Accreditation Council for Graduate Medical Education (ACGME) and the Accreditation Council for Continuing Medical Education (ACCME), address the importance of M&M conferences but fail to define them in any substantial way.3,4 On the other hand, the Liaison Committee for Medical Education (LCME) does not mention this educational venue, presumably because the MD curriculum has a different focus, given that medical students are not expected to be directly responsible for clinical decision-making.

The M&M Conference as an Instructional Venue
If it can be assumed that M&M conferences are meant to have an educational role, it seems important that the format of the event should follow as many of the proven adult learning principles as possible. Robert Gagne defines learning as a process that leads to a change in the learner’s disposition and capabilities that can be reflected in their behavior.5 Adults choose to participate in a learning opportunity with the intent of creating a change in their knowledge level, skills, attitude, or behavior. In 1984, Malcolm Knowles published his original principles of adult education6 and though his notion of andragogy7 has been examined and modified by several educational scholars over the past three decades, there is still widespread agreement on most of the basic tenets. In essence, adult learning is most productive when the teacher has: 1) gained the learner’s attention by making the topic relevant to their job or personal life, 2) stimulated their prior recall of the topic and given them the opportunity to integrate the new information with what they already know, 3) made the information practical, 4) made the instruction problem centered, rather than content centered, and 5) made the instructional environment respectful and safe. It is important to note that Davies, et al. found that exclusively didactic types of instruction, such as lectures, do not improve physician performance or patient care, while interactive and sequenced learning has been associated with a positive impact.5

The M&M Conference as a Venue for Improving Patient Safety
Since the Institution of Medicine’s publication, “To Err is Human” in 2000,8 considerable focus has been placed on a systems approach to improving patient safety. Experts recommend a culture of patient safety that permeates a healthcare organization and is embraced by all levels of the system.9 This “safety culture” must have the following elements: 1) acknowledgment of the high-risk, error-prone nature of an organization’s activities, 2) a blame-free environment where individuals are able to report errors or close calls without fear of reprimand or punishment, 3) an expectation of collaboration across ranks to seek solutions to vulnerabilities, 4) a willingness on the part of the organization to direct resources for addressing safety concerns. Coupled with the safety culture is the concept of a “just culture” which recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, “routine rule violations”). It is important to note that a just culture has zero tolerance for reckless behavior.10 In a just culture, professionals feel comfortable disclosing error, including their own, while maintaining accountability. Finger pointing, recrimination, and a hierarchal healthcare structure have all been shown to increase, rather than decrease the likelihood of medical error.11

A discussion of patient safety would not be complete without mentioning the “second victim” phenomenon. A second victim, as defined by the Joint Commission on Accreditation of Healthcare Organizations (JAHCO),12 is a health care provider involved in an unanticipated adverse patient event, medical error, and/or a patient-related injury, who becomes victimized in the sense that the provider is traumatized by the event. Frequently, second victims feel personally responsible for the unfortunate patient outcomes and feel as though they have failed their patients. This often leaves them second-guessing their clinical skills and knowledge base and can lead to significant psychological sequelae. Healthcare providers
in a system that fails to support second victims may be less likely to disclose adverse events. If M&M conferences are meant to raise the community standards of medical care, it stands to reason that the preparation and format should be designed to incorporate as many of these safety cultural principles as possible.

**M&M Conferences at JABSOM**

In September of 2010, an informal survey titled “Morbidity and Mortality Conferences at UH” was sent to the nine residency Program Directors of Hawaii Residency Program, Inc, with the following results obtained. The response rate was 100%. Sixty-seven percent of programs have a recurrent series of conferences that could fit the definition of a morbidity and mortality conference. The frequency of these meetings range from once per week to twice each year, with monthly being the most common interval. The respondents reported that these conferences are consistently led by the Program Director or a designated senior faculty member. Cases are presented by one of the resident physicians involved in the care of the patient. Residents are expected to attend and most departments encourage, but do not require faculty attendance. Community physicians, students, and nursing staff are typically invited. One program only allows physicians and mid-level providers (nurse practitioners, physician assistants, etc) to attend. A third of the programs offer continuing medical education credit to attendees.

Four of the nine programs claimed an effort at systematically identifying and presenting all cases of morbidity and mortality at their institution while the majority of programs left case selection up to the senior residents or faculty. As a general rule, several cases are presented and discussed in an open forum but some programs reported a more didactic treatment of a single case. All of the programs claim to present and discuss patients from a safety and just culture perspective without placing blame for the adverse outcome on individual physicians. Of note, only one program reported a concerted effort to address the “second victim” phenomenon by debriefing the physicians involved, while providing support and guidance during the stressful experience of having been involved in an adverse outcome.

**Discussion**

The ACGME Outcomes project requires programs to teach and evaluate residents in practice-based learning and improvement, systems-based practice, and professionalism. The ACCME requires that gaps in physician knowledge and behavior be identified and addressed. The M&M conference, when conducted with adherence to adult learning and patient safety principles, represents an excellent opportunity to address those goals. Standing between the status quo and the M&M conference designed around evidence-base tenets are the roadblocks of tradition, political pressure, concerns about professional and/or institutional liability, individual egos, and time constraints.

**Summary**

M&M conferences are an integral part of contemporary medical education and are often identified as a rich learning event in the instructional curriculum. While the conferences can have variable formats, they should adhere to some basic adult learning and patient safety principles if they are to be educational and change the standard of healthcare in a community. A just culture and a safe learning environment must be pervasive. Unexpected and adverse outcomes should be systematically identified, presented and discussed in a timely fashion. The case presentation should come from the providers most aware of both the details and the rationale for the medical decisions. Discussions should be free of finger pointing and accusations, be evidence-based, and have participation by individuals with expertise in the topic. The focus should not be on punishing errors, but rather on developing behaviors and systems that minimize the opportunity for misadventures and that recognizes mistakes will still occur and catches those errors before patients are harmed.

**References**


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**UPCOMING CME EVENT**

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HAWAI’I MEDICAL JOURNAL, VOL 70, FEBRUARY 2011 40
The Need
Chances are either you or someone you know has been touched by cancer. Cancer is the second leading cause of death in the islands, accounting for nearly one of every five deaths statewide. Each year more than 6,000 men and women in Hawai‘i are diagnosed with cancer, and another 2,000 die from the disease. The Hawai‘i Comprehensive Cancer Control Coalition is committed to reducing the burden of cancer in our state. Our vision is “No More Cancer.” Realizing that no one organization can accomplish this task alone, health care providers, elected officials, public health leaders, hospitals and clinics, community-based organizations, clinicians, and individuals (cancer survivors and family members) have united as members of the Hawai‘i Comprehensive Cancer Control Coalition.

What is Comprehensive Cancer Control?
Comprehensive cancer control (CCC) is a process through which communities and partner organizations pool resources to reduce the burden of cancer. The Centers for Disease Control and Prevention (CDC) initiated the National Comprehensive Cancer Control Program (NCCCP) in 1998 to help states, tribes, and territories form coalitions to fight cancer. These coalitions collect data to determine the greatest cancer-related needs in their area, and develop and carry out plans to meet those needs. The CCC plans include activities that —

- Encourage people to live a healthy lifestyle.
- Promote cancer screening tests.
- Increase access to good cancer care.
- Improve the quality of life for people who survive cancer.

Since 1998, the Centers for Disease Control and Prevention’s National Comprehensive Cancer Control Program (NCCCP) has made great strides to reduce the burden of cancer in the United States. NCCCP supports 50 states, the District of Columbia, 7 tribal groups, and 7 US Associated Pacific Islands/territories to establish coalitions, assess the burden of cancer, determine priorities, and develop and implement cancer plans. Currently there are 17 national partners including American Cancer Society; American Cancer Society Cancer Action Network; American College of Surgeons, Commission on Cancer; Association of State and Territorial Health Officials; C-Change; Centers for Disease Control and Prevention; Health Resources and Services Administration; Indian Health Service; Intercultural Cancer Council; Lance Armstrong Foundation; Leukemia and Lymphoma Society; National Association of Chronic Disease Directors; National Association of County and City Health Officials; National Cancer Institute; National Indian Health Board; North American Association of Central Cancer Registries; and Susan G. Komen for the Cure. (See Figure 1)

Progress in Hawai‘i
Cancer control stakeholders in our state have been actively engaged in comprehensive cancer control since 2003, when these stakeholders met to brainstorm and develop the first Hawai‘i State Comprehensive Cancer Control Plan (2004-2010). The Hawai‘i Comprehensive Cancer Control Coalition (HCCCC) is a legion of dedicated individuals, professionals, and cancer survivors who share expertise, resources, and ideas to tackle priorities that are too broad to confront alone. The result is a powerful network of groups across our state working to reduce cancer and improve survivors’ quality of life.

Two resources essential to drive the HCCCC toward our goal of “No More Cancer” are current data and a plan. In October 2010, the Hawai‘i Cancer Facts and Figures 2010 and the Hawai‘i State Cancer Plan 2010-2015 were unveiled in collaboration with key cancer control stakeholders including the University of Hawai‘i Cancer Center, the Hawai‘i State Department of Health, the American Cancer Society as part of a Coalition meeting held at the State Capitol auditorium.

The Hawai‘i Cancer Facts and Figures was last published in 2005. Recognizing the need to update the information, the HCCC Coalition’s Data/ Surveillance Action Team including key partners from the American Cancer Society, University of Hawai‘i Cancer Center, and Department of Health collaborated in revising the Facts and Figures under the leadership of the Hawai‘i Tumor Registry. It was a labor-intensive, time-consuming process to ensure the accuracy of the data. The result is a quality resource that describes the burden of cancer for our state and provides local cancer incidence, mortality, and survivorship data from the Cancer Center’s Hawai‘i Tumor Registry and the Hawai‘i Department of Health’s Behavioral Risk Factor Surveillance System. The information is available in printed format as an “at a glance” brochure and in a comprehensive format.

In early 2010, key leaders from across the state, with guidance from immediate past-Chair Senator Rosalyn Baker, convened to review the progress of the State Plan 2004-2009 and update it. The Hawai‘i State Cancer Plan 2010-2015 represents collective thoughts, goals, strategies, and also emphasizes the need to address health disparities in our community. It reflects the progress made in the first plan, and serves as a strategic roadmap for reducing the cancer burden on our state’s population. The result is a user friendly format with four goals:
Figure 1. The goal of CCC is decreased cancer morbidity and mortality, decreased health disparities, and an increased quality of life for everyone living in this country. CCC is accomplishing these successes through the development of a shared, comprehensive vision and an integration of programs, organizations, and sectors.

Goal 1: Prevention. Prevent future cancers by reducing exposure to known risk factors for Hawai‘i residents.

Goal 2: Early Detection. Increase early detection to decrease late stage cancer.

Goal 3: Equitable Access to Care. All Hawai‘i residents, especially cancer survivors and the medically underserved, must have facilitated access to the health care system.

Goal 4: Quality of Life. Improve the quality of life for cancer survivors and others battling the effects of cancer.

In addition to the four goals, health disparities including access to quality cancer care are addressed. Lastly, described are ways organizations and individuals can take action towards reducing the cancer burden in Hawai‘i. It is through these goals and objectives that the Coalition seeks to expand our community of cancer survivors and thrivers!

A Call to Action
To accomplish meaningful reductions in cancer morbidity and mortality and increase quality of life, many people must be involved, both personally and professionally. The passion for controlling and eliminating cancer must be driven by well-planned, well-funded goals, and must be carried out by identifying specific common priorities, designing effective solutions, and then by delivering results. We seek those who are committed to a future in which the HCCC Coalition addresses our state’s cancer burden though a CCC program that is well-equipped to deliver measurable outcomes. The Hawai‘i Comprehensive Cancer Control partners invite You to link your efforts to CCC to make the vision of “No More Cancer” for our state a reality.

For more information about the Hawai‘i Comprehensive Cancer Control Coalition or to become a member, call 808-692-7480. To obtain a copy of the Hawai‘i Cancer Facts and Figures 2010 or the Hawai‘i State Cancer Plan, call 1-800-227-2345 or to view the Hawai‘i Cancer Facts and Figures 2010 online at www.cancer.org, www.crch.org, or www.hawaii.gov/health/.

References
Johnson and Johnson is having serious problems with quality control. Having already recalled Tylenol, Benadryl, and Motrin, J&J now has issued a recall for 13 million packages of Rolaid's heartburn products. Consumers have found foreign materials, including metal and wood particles, in Rolaid's Extra Strength Sofchews, Rolaid's Multi-Symptom, and Anti-Gas Sofchews distributed in the United States. J&J said the contaminants may have been introduced during a manufacturing process done by an unnamed third party. The quality problems center around a manufacturing plant in Puerto Rico. J&J's McNeil Consumer Healthcare unit said the risk of adverse health consequences is remote, but production has ceased and will not restart until corrective actions have been taken. Previously, J&J has enjoyed a sterling reputation. Wells Fargo has downgraded its rating for shares, citing the possibility of regulatory action by the Food and Drug Administration (FDA). Meantime the FDA is advising Americans to avoid buying drugs from Canada. They might be unsafe.

DON'T FORCE IT. GET A BIGGER HAMMER.
Some part of the human frontal cortex dictates that when a particular plan doesn’t work, the solution is to enlarge the failing effort. Plavix has long been used as a blood thinner, but when it doesn’t produce the desired effect (about 40% of patients), physicians generally increase the dose. A Scripps research team tested 2,214 patients who were poor responders to Plavix and found that twice as much drug was still ineffective. A similar big effort with no bonus was the attempt by a Yale team to reduce readmission for congestive heart failure (CHF). They instituted daily monitoring of 1,653 patients with CHF for weight change and symptoms, but the effort failed to reduce hospital returns and did not extend longevity. Sometimes more is not better.

CHECK LISTS ARE FINE. BUT ONLY IF YOU USE THEM.
Medical or surgical procedures done on the wrong side, or more critically on the wrong patient are the kind of errors that should never happen. A series of reports from hospitals documenting these devastating mistakes prompted the Joint Commission in 2004 to mandate a three-step protocol: (1) Physicians and ancillary health care personnel must verify the procedure; (2) mark the correct site and (3) conduct a “time out” discussion as a final check before action. In Colorado data were collected by the Colorado Physicians Insurance Co. documenting 132 such events from 2002 to 2006. Everyone assumed that after the 2004 protocol was introduced it would result in a decrease in “never happen” occurrences. Au contraire! Not only did they not decrease, but the number actually increased. Further analysis showed that the problem was not the protocol, but failure to follow it. “Time out” was not done in 74% of cases, the staff frequently rushed the steps and the surgeon often missed the “time out.” The findings, published in the Archives of Surgery, brought a ruling from the Centers for Medicare and Medicaid Services (CMS) to withhold payment for procedures performed on the incorrect site or the wrong patient. Insurance carriers have followed suit, so lack of dollars will surely alter behavior.

ANNUAL MEDICAID COST FOR HIV – FOUR BILLION DOLLARS AND CLIMBING.
HIV/AIDS therapy has become more confused with current findings reported in the New England Journal of Medicine (NEJM) that an existing antiretroviral drug can ward off HIV infection. In 2009 a study of 2,500 gay and bisexual males on four continents who took the drug in pill form were 44% less likely to become infected than the control group. Those who took the drug every day as directed had a 73% lower risk of disease. Moreover, these new reports show that a vaginal gel can cut the HIV danger for women as well. President Obama said this “could mark the beginning of a new era in HIV prevention.” Researchers call it a major advance in the quest to prevent HIV, but there are questions. The drug, Truvada (made by Gilead Sciences, Inc.) markets for $1,000 for a 30 day supply. It costs as little as $12 a month in developing countries Medicaid is already spending multi-billions to treat HIV patients, most of whom got the disease by using dirty needles or failing to use condoms. Should Medicaid fund this additional expense to possibly prevent HIV in the at-risk population by providing medication which they might use? And would that encourage a lack of caution in sexual activities? Since AIDS treatment can be successfully treated in many patients, gay males have already decreased condom use.

SOMETIMES IT TAKES SEVERAL YEARS TO ACKNOWLEDGE THE OBVIOUS.
The light can even permeate the supposedly-green skull of Al Gore, one-time presidential candidate. In a recent speech, Mr. Gore stated, “It is not a good policy to have these massive subsidies for first generation ethanol.” He added that the benefits of ethanol are “trivial,” but it’s hard to stop once such a program is put in place. “I had a certain fondness for the farmers in the state of Iowa because I was about to run for President.” The subsidies began during the Carter administration when “gasohol” was initiated as a substitute for foreign oil. Despite reports that ethanol production was expensive and of little value, the push continued through the 1980 and 1990s and was supported by Clinton EPA chief Carol Browner. When the Senate split 50-50 to repeal the de facto mandate, the deciding vote was cast by Vice President Al Gore in support of ethanol! That vote served him well in the primaries against Democratic candidate Bill Bradley who openly opposed ethanol subsidies. So, the motorizing public is stuck with an inefficient mandated fuel that reduces mileage, that can damage internal combustion engines, and remains in place with powerful lobbies to keep it going.

DO YOU REALLY WANT YOUR BABY TO LOOK LIKE CONAN O’BRIEN?
More and more infertile and gay couples, as well as single women, are turning to sperm banks to help them create families. Historically, clients were given relatively simple information such as height, weight, hair color, ethnicity, and skin tone of the donor. Now the California Cryobank (for a fee) will supply packets including detailed profiles with baby pictures, description of facial features, personality tests, hair texture, religion, education level, personal goals, favorite pet, art, sports or musical talent, and even audio interviews with the donor. The packet has a “look-alike” section that lets women select from a long list of approximations like Adam Sandler, Bill Gates, Andy Gibb, Garth Brooks, and Conan O’Brien. Donors are paid $100 per vial of sperm and names and current photos are not released to protect anonymity. Yes, but is there a money-back guarantee?

CAN YOU COLOR CODE HARM’S WAY?
Everybody knows about “code red” because Jack Nicholson explained it to Tom Cruise in “A Few Good Men” (You can’t handle the truth!). The other colors have been rather vague – code green sounds okay, but what is code orange or code yellow, and does code brown mean really scared? Homeland Security is proposing to discontinue this rainbow system of terror-alerts which came in with the Bush administration following the Nine-Eleven attack on the Twin Towers and the Pentagon. By trashing the color designation for threat levels, the Obama administration is proposing a more descriptive method for terrorist danger, so far not defined. Another Bush legacy will bite the dust, but the tax cuts are still in.

THEY BEEP WHEN THEY BACK UP.
Two people were arrested for shoplifting in Edmond, Oklahoma. Inside rolls of body fat they had concealed a wallet, pair of gloves, pair of jeans, and a pair of boots! Would you rather be the arresting officer conducting the search, or the clerk accepting the returns?

JOE FRIDAY WOULD HAVE ROLLED DOWN THE WINDOW.
In Kansas City, Missouri, police responded to a report of gun shots coming from a white van parked near Interstate 435. When they arrived they heard what they thought was gun fire coming from the vehicle, so they opened fire from the squad car shattering their own windows. The van was not hostile, but was back-firing in serious combustion engine distress. No one was injured, but some police dignity was damaged.

ADDENDA
❖ Ford Motor Co. is using recycled denim as soundproofing in their 2011 Ford Focus. You can have any color you want as long as it’s green.
❖ At the office Christmas party you are supposed to sit naked on top of the photo-copier not the shredder.
❖ Guns don’t kill people. Husbands who come home early kill people.
❖ Please don’t bother me; I’m living happily ever after.

ALOHA AND KEEP THE FAITH — rts■
(= Editorial comment is strictly that of the writer.)