FACULTY AND RESIDENT PERCEPTIONS REGARDING OVERNIGHT STUDENT CALL DURING THE THIRD YEAR OB/GYN CLERKSHIP 189
Mark Hiraoka MD; Stephen Sung BS; James Davis PhD; and David Kim MD

EMERGENCE OF COMMUNITY-ACQUIRED EXTENDED-SPECTRUM BETA-LACTAMASE ESCHERICHIA COLI (ESBLEC) IN HONOLULU: A CASE SERIES OF THREE INDIVIDUALS WITH COMMUNITY-ACQUIRED ESBLEC BACTERIURIA 193
Reid R. Hoshide MPH, MSIII; Heath Chung MD, and Jinichi Tokeshi MD

PERCEPTIONS RELATED TO DIET AND EXERCISE AMONG ASIANS AND PACIFIC ISLANDERS WITH DIABETES 196
Nafanua Braginsky PhD, APRN Rx, NP-C; Jillian Inouye PhD, APRN; Chen Yen Wang PhD, APRN; and Richard Arakaki MD

MEDICAL SCHOOL HOTLINE 200
The Physician's Promise; To Cure Disease, Pain, and Suffering? Keynote Presentation at the JABSOM White Coat Ceremony for the Class of 2015
Alson S. Inaba MD

WEATHERVANE 206
Russell T. Stodd MD
“At MIEC, our policyholders are our primary marketing resources and our staff is our number one retention tool.”

Underwriter
Maya Campaña

Service and Value

MIEC takes pride in both. For 30 years, MIEC has been steadfast in our protection of Hawaii physicians. With conscientious Underwriting, excellent Claims management and hands-on Loss Prevention services, we’ve partnered with policyholders to keep premiums low.

Added value:
- Zero-profit carrier with low overhead
- Dividends with an average savings on 2011 premiums of 35.4%*

For more information or to apply:
- www.miec.com
- Call 800.227.4527
- Email questions to underwriting@miec.com

* (On premiums at $1/3 million limits. Future dividends cannot be guaranteed.)
Learn How to Practice Online with HMSA’s Online Care!

Attend an in-depth training session to help you jump start your Online Care practice. Training sessions at the HMSA Center will provide an overview of Online Care and hands-on experience.

Seating is limited, so reserve your seat today!

For training dates and to RSVP, go to https://physiciansonline.hmsa.com/sign-up/.

Please call HMSA’s Online Care Help Desk at 948-6013 on Oahu or 1 (866) 939-6013 (toll-free) on the Neighbor Islands if you have any questions.

Note: You must be a participating provider with HMSA’s Preferred Provider Plan (M.D.s and D.O.s, APRNs, certified nurse midwives, optometrists, podiatrists, psychologists, child psychologists, and psychiatric APRNs).
HAWAI‘I MEDICAL JOURNAL

A Journal of Asia Pacific Medicine

The Journal’s aim is to provide new scientific information in a scholarly manner, with a focus on the unique, multicultural, and environmental aspects of the Hawaiian Islands and Pacific Rim region.

Published by University Clinical, Education & Research Associates (UCERA)

HAWAI‘I Medical Journal
677 Ala Moana Blvd., Suite 1016B
Honolulu, Hawai‘i 96813
Fax: (808) 587-8565
http://www.hawaiimedicaljournal.org
Email: info@hawaiimedicaljournal.org

The Hawai‘i Medical Journal was founded in 1941 by the Hawai‘i Medical Association (HMA). HMA was incorporated in 1856 under the Hawaiian monarchy. In 2009 the journal was transferred by HMA to UCERA.

Editors
S. Kalani Brady MD
Michael J. Meagher MD

Editor Emeritus: Norman Goldstein MD

Associate Editors:
Alan D. Tice MD
Kawika Liu MD

Copy Editor: Alfred D. Morris MD

Contributing Editors:
Satoru Izutsu PhD
Malcolm Schinistine MD, PhD
Russell T. Stodd MD
Carl-Wilhelm Vogel MD, PhD

Editorial Board
Benjamin W. Berg MD,
Patricia Lanoie Blanchette MD, MPH,
John Breinich MLS, Satoru Izutsu PhD,
Kawika Liu MD, Douglas Massey MD,
Michael J. Meagher MD, Alfred D. Morris MD,
Myron E. Shirasu MD, Russell T. Stodd MD,
Frank L. Tabrah MD, Carl-Wilhelm Vogel MD, PhD

Journal Staff
Production Manager: Drake Chinen
Subscription Manager: Meagan Calogeras

Advertising Representative
Roth Communications
2040 Alewa Drive
Honolulu, Hawai‘i 96817
Phone (808) 595-4124
Fax (808) 595-5087

Full text articles available on PubMed Central

The Hawai‘i Medical Journal (ISSN 0017-8594) is a monthly peer-reviewed journal published by University Clinical, Education & Research Associates (UCERA). The Journal cannot be held responsible for opinions expressed in papers, discussion, communications, or advertisements. The right is reserved to reject material submitted for editorial or advertising columns. Print subscriptions are available for an annual fee of $150; single copy $15 plus cost of postage; contact the Hawai‘i Medical Journal for foreign subscriptions. ©Copyright 2011 by University Clinical, Education & Research Associates (UCERA).
Hawaii’s Physicians CHOOSE HAPI as their Medical Malpractice Carrier

In recent years, hundreds of Hawaii’s physicians have switched their coverage to HAPI, saving thousands of dollars on their medical malpractice coverage costs.

Started 32 years ago, HAPI is Hawaii’s first, physician-owned medical malpractice coverage provider.

As a leading medical malpractice coverage provider, HAPI protects and defends Hawaii’s most influential and respected physicians.

With a strictly local presence and NO profit motive, savings are distributed to our members.

HAPI’s rates have remained stable, with several rate decreases or no change in rates in recent years.

In these tough economic times and challenging industry trends, you don’t have to worry about your medical malpractice coverage costs. Let HAPI’s financially sound, affordable plan protect you. Join your fellow colleagues...contact HAPI and start saving today.

2009 HAPI’s Total Quarterly Costs (Including Fully Mature Retroactive Coverage)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>$4,168</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>$1,373</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$1,662</td>
</tr>
</tbody>
</table>

The above illustration is an example of HAPI’s 2009 fully mature costs. These costs apply to physicians who need three years or more of retroactive coverage upon joining HAPI. If you do not need retroactive coverage or if you join HAPI out of a residency or fellowship, you will pay significantly less than shown above. The above specialties were selected for illustrative purposes only. Call HAPI for your specialty’s costs.

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

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

“I was pleasantly surprised with the additional savings I received when signing up with HAPI. They have been extremely accommodating in providing liability coverage for my practice, and I would recommend other Osteopathic Physicians to consider HAPI as their carrier as well.”
Leland Dao, D.O., Family Practitioner

If you are a D.O. or M.D. in private practice, call Jovanka Ijacic, HAPI’s Membership Specialist to discuss the cost savings HAPI could offer you.
Faculty and Resident Perceptions Regarding Overnight Student Call During the Third Year OB/GYN Clerkship

Mark Hiraoka MD; Stephen Sung BS; James Davis PhD; and David Kim MD

Abstract

Objectives: The objective of this study is to identify university faculty, community physician, and resident perceptions of how a schedule that employs overnight call in addition to a traditional weekday schedule affects medical student education, well-being, and patient care during the third year obstetrics and gynecology clerkship.

Methods: In July 2007, a descriptive study was performed by distributing surveys to community teaching physicians, current residents, and faculty in the University of Hawai’i Department of Obstetrics and Gynecology. A total of 114 surveys were distributed to all current residents, clinical faculty and full-time faculty in the University of Hawai’i Department of Obstetrics and Gynecology. The survey included questions regarding the effect of the student call/work hour restrictions.

Results: A response rate of 45.6% was obtained (52/114). Results demonstrate that 84.6% (44/52) of residents, faculty, and community attendings agree that third year medical students should take call during their obstetrics and gynecology clerkship. Data was analyzed utilizing Spearman correlation and Cochran-Mantel-Haenszel statistics. No statistical difference was detected in terms of age or physician type (resident vs faculty vs community attending).

Conclusion: Most physician-educators believe that medical students benefit from taking overnight call during their obstetrics and gynecology clerkship. Careful consideration should be given prior to elimination of overnight call in the obstetrics and gynecology clerkship.

Introduction

In 2002, the Accreditation Council on Graduate Medical Education (ACGME) established guidelines that restrict the resident work week to 80 hours per week averaged over a 4-week period. Effective July 2003, this was mandated for all resident training programs. This represented a significant change relative to the standard at the time. Surgical based residencies such as obstetrics and gynecology have seen the most dramatic changes in work hours. As many other programs around the country, the University of Hawai’i has employed a night float system to limit the resident work shift to 12-14 hours per day. This represented a significant change relative to the standard at the University of Hawai’i Department of Obstetrics and Gynecology. Like many student clerkships have eliminated 24-hour call/work shifts, the University of Hawai’i John A. Burns School of Medicine continues to require medical students to take overnight call as part of their third year obstetrics and gynecology clerkship. Thus, we were interested in identifying university faculty, clinical teaching staff, and resident perceptions of how a schedule that employs 24-hour call affects medical student education, well-being, and patient care during their third year obstetrics and gynecology clerkship. Although this has been studied in other specialties, there has been little to no research looking at benefits or detriments of long call hours of students while on the obstetrics and gynecology clerkship.

Methods

This study was deemed exempt by the University of Hawai’i Institutional Review Board. The survey instrument was pre-tested to assure clarity. Surveys were distributed to all current residents (n=25) and faculty (n=26) in the University of Hawai’i Department of Obstetrics and Gynecology. They were also distributed to the private practitioners (n=63) who held clinical teaching privileges. All physicians were active in both medical student and resident teaching. They were familiar with the current student curriculum and course objectives.

All participants were provided with an explanation of the study and were informed that information garnered would be used for curriculum development and research purposes. A total of 114 surveys were distributed. The data was collected in an anonymous fashion. Responses were rated on a Likert scale of 1 to 5 with “strongly agree” assigned a value of 5 and “strongly disagree” a value of 1. Surveys included demographic information and opinions on the effect of the student call/work hour restrictions.

All descriptive statistics were performed using the SAS statistical software Version 9.1 (SAS Institute Inc., Cary, NC). Spearman correlation coefficient statistics were utilized to test for any possible gender differences in responses to certain items. Cochran-Mantel-Haenszel statistics were utilized to determine if any differences in physician type were present. Chi-square statistics were used to compare the group responding “strongly agree” or “agree” with the group responding “neither agree nor disagree,” “disagree,” or “strongly disagree.” The level of significance was alpha <0.05.

Results

A total of 52 of 114 surveys were completed with an overall response rate of 45.6%. Of the 52 surveys returned, 14 were from University faculty, 19 from community attendings, and 18 from resident physicians. One respondent did not indicate his/her provider type. Refer to Table 1 for the full demographic data of the respondents. Overall, respondents (84.6%, P<0.001) agree or strongly agree that third year medical students should take call during their obstetrics and gynecology clerkship. Respondents agreed that there were increased learning opportunities during overnight call (88.46%, P<0.001) and did not believe that overnight call posed patient (94.23%, P<0.001) or student (94.23%, P<0.001) safety concerns. Overall survey results...
are displayed in Table 2. The results of each provider type were found to be significant and there was no difference detected between provider types (resident vs faculty vs community attending). These results per provider type are presented in Table 3.

<table>
<thead>
<tr>
<th>Table 1. Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Median Age</td>
</tr>
<tr>
<td>Race/ethnicity</td>
</tr>
<tr>
<td>Caucasian</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Pacific Islander</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Subspecialty</td>
</tr>
<tr>
<td>Generalist</td>
</tr>
<tr>
<td>MFM</td>
</tr>
</tbody>
</table>
*MFM = Maternal Fetal Medicine

<table>
<thead>
<tr>
<th>Table 2. Overall Survey Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
</tr>
<tr>
<td>Medical students benefit and should take overnight call</td>
</tr>
<tr>
<td>Overnight call allows students to experience how schedule is in residency</td>
</tr>
<tr>
<td>Overnight call prepares students for life as an attending</td>
</tr>
<tr>
<td>Overnight call allows students to learn how to function when tired</td>
</tr>
<tr>
<td>Overnight call provides a better environment to evaluate clinical performance</td>
</tr>
<tr>
<td>Overnight call provides more clinical/procedural experience</td>
</tr>
<tr>
<td>Overnight call provides more opportunity for active student participation in cases</td>
</tr>
<tr>
<td>Overnight call allows for more learning opportunities</td>
</tr>
<tr>
<td>Overnight call results in fatigue that detracts from learning while on call</td>
</tr>
<tr>
<td>Overnight call provides less clinical/procedural experience due to the post call period</td>
</tr>
<tr>
<td>Overnight call compromises patient care</td>
</tr>
<tr>
<td>Overnight call is dangerous to students</td>
</tr>
<tr>
<td>Overnight call discourages students from choosing obstetrics as a specialty</td>
</tr>
</tbody>
</table>

Discussion
Past studies involving residents have demonstrated fatigue and sleep deprivation to be significantly related to worsening mood, increased levels of anger, and poor cognitive function. Students on hospital ward rotations or those requiring overnight call were more likely to have burnout than those not requiring overnight call. The new work hour restrictions are a response to some of these issues. Third year medical student clerkships in many specialties have eliminated overnight and/or 24-hour call in response to some of these issues. However, are these issues pertinent to six to eight week long medical student clerkships?

Prior studies have demonstrated that students prefer not taking 24-hour call. Student perception of the overall quality of the clerkship increases significantly with fewer hours worked while on the clerkship. In addition, medical students often overestimate the number of hours worked during more labor intensive clerkships such as obstetrics and gynecology. These findings suggest that student opinions should not be given too much weight when making decisions regarding call hours. This being said, it cannot be ignored that third year clerkship satisfaction is an important factor in specialty choice and that call hour restrictions may result in increased interest in our specialty.

Although interest is important, having some exposure to life as an attending can be helpful for students to make career choices. Residents may rarely take overnight call anymore; however attendings often continue to do so. This survey demonstrates a large majority of university faculty and community attendings believe that overnight call prepares students better for life as an attending. Studies that have looked at factors influencing a medical student to choose obstetrics and gynecology show that lifestyle, career opportunities, prestige, liability, and the predominance of females in the profession are important to students. Thus, while student overnight call may negatively affect a medical student’s lifestyle, an attending’s lifestyle may play a bigger factor when making career choices and overnight call may provide a more realistic experience upon which students may base their career choices.

ACGME resident work hour restrictions have often resulted in decreased resident presence and increased faculty clinical workload. It is unclear whether this impacts medical student education negatively or positively. Some have reported an improvement in medical student education and others a negative impact. Student evaluations have mentioned that, since the advent of the resident night float schedule, students who are on call are often working longer shifts than residents. This can result in a misperception that students are working harder than the residents, leading to negative interactions and conflicts between students and residents. Ultimately, this may result in poor clerkship satisfaction.

Care must be taken that training and experience are not sacrificed. There are valid concerns regarding taking less call hours. The students may receive less teaching or may obtain suboptimal amounts of clinical experience, effectively shortening the clinical rotation. A negative outcome was demonstrated at one institution when the duration of the obstetrics and gynecology clerkship was cut from 8 weeks down to 6 weeks. This resulted in lower student performance on the National Board of Medical Examiners (NBME) subject examination in obstetrics and gynecology at the end of the clerkship. Although this suggests that overnight call may be ben-
Table 3. Survey Results per Provider Type

<table>
<thead>
<tr>
<th>Question</th>
<th>University Faculty (n=14)</th>
<th>Community Attending (n=19)</th>
<th>Resident Physician (n=18)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical students benefit and should take overnight call</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree/Strongly Agree (%)</td>
<td>85.71</td>
<td>78.95</td>
<td>88.89</td>
<td>0.527</td>
</tr>
<tr>
<td>Neither/Disagree/Strongly Disagree (%)</td>
<td>14.29</td>
<td>21.05</td>
<td>11.11</td>
<td></td>
</tr>
<tr>
<td>Overnight call allows students to experience how schedule is in residency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree/Strongly Agree (%)</td>
<td>85.72</td>
<td>84.21</td>
<td>88.88</td>
<td>0.771</td>
</tr>
<tr>
<td>Neither/Disagree/Strongly Disagree (%)</td>
<td>14.28</td>
<td>15.79</td>
<td>11.22</td>
<td></td>
</tr>
<tr>
<td>Overnight call prepares students for life as an attending</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree/Strongly Agree (%)</td>
<td>78.57</td>
<td>68.42</td>
<td>55.55</td>
<td>0.291</td>
</tr>
<tr>
<td>Neither/Disagree/Strongly Disagree (%)</td>
<td>21.43</td>
<td>31.58</td>
<td>44.45</td>
<td></td>
</tr>
<tr>
<td>Overnight call allows students to learn how to function when tired</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree/Strongly Agree (%)</td>
<td>50.00</td>
<td>57.90</td>
<td>77.78</td>
<td>0.778</td>
</tr>
<tr>
<td>Neither/Disagree/Strongly Disagree (%)</td>
<td>50.00</td>
<td>42.10</td>
<td>22.22</td>
<td></td>
</tr>
<tr>
<td>Overnight call provides a better environment to evaluate clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>performance</td>
<td>Agree/Strongly Agree (%)</td>
<td>35.72</td>
<td>36.83</td>
<td>55.55</td>
</tr>
<tr>
<td>Neither/Disagree/Strongly Disagree (%)</td>
<td>64.28</td>
<td>63.17</td>
<td>44.45</td>
<td></td>
</tr>
<tr>
<td>Overnight call provides more clinical/procedural experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree/Strongly Agree (%)</td>
<td>85.71</td>
<td>94.74</td>
<td>88.89</td>
<td>0.402</td>
</tr>
<tr>
<td>Neither/Disagree/Strongly Disagree (%)</td>
<td>14.29</td>
<td>5.26</td>
<td>11.11</td>
<td></td>
</tr>
<tr>
<td>Overnight call provides more opportunity for active student participation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in cases</td>
<td>Agree/Strongly Agree (%)</td>
<td>100.00</td>
<td>78.92</td>
<td>83.33</td>
</tr>
<tr>
<td>Neither/Disagree/Strongly Disagree (%)</td>
<td>0</td>
<td>21.05</td>
<td>16.67</td>
<td></td>
</tr>
<tr>
<td>Overnight call allows for more learning opportunities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree/Strongly Agree (%)</td>
<td>100.00</td>
<td>78.92</td>
<td>88.89</td>
<td>0.232</td>
</tr>
<tr>
<td>Neither/Disagree/Strongly Disagree (%)</td>
<td>0</td>
<td>21.05</td>
<td>11.11</td>
<td></td>
</tr>
<tr>
<td>Overnight call results in fatigue that detracts from learning while on</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>call</td>
<td>Agree/Strongly Agree (%)</td>
<td>21.43</td>
<td>10.53</td>
<td>5.56</td>
</tr>
<tr>
<td>Neither/Disagree/Strongly Disagree (%)</td>
<td>78.57</td>
<td>89.47</td>
<td>94.44</td>
<td></td>
</tr>
<tr>
<td>Overnight call provides less clinical/procedural experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>due to the post call period</td>
<td>Agree/Strongly Agree (%)</td>
<td>28.57</td>
<td>31.58</td>
<td>22.22</td>
</tr>
<tr>
<td>Neither/Disagree/Strongly Disagree (%)</td>
<td>71.43</td>
<td>68.42</td>
<td>77.78</td>
<td></td>
</tr>
<tr>
<td>Overnight call compromises patient care</td>
<td>7.14</td>
<td>26.32</td>
<td>16.67</td>
<td>0.158</td>
</tr>
<tr>
<td>Overnight call is dangerous to students</td>
<td>7.14</td>
<td>89.47</td>
<td>100.00</td>
<td>0.312</td>
</tr>
<tr>
<td>Overnight call discourages students from choosing ob/gyn as a specialty</td>
<td>7.14</td>
<td>10.53</td>
<td>0</td>
<td>0.281</td>
</tr>
</tbody>
</table>

In providing more clinical opportunities, other studies have suggested that this is actually not the case. At the University of Utah, students on their general surgery clerkship appeared to spend significantly more time involved in educational activities during the regular weekday shifts, than during any of their call shifts. Thus, leading them to conclude that overnight call had limited educational benefit to medical students. Some people may argue that working too many hours may negatively affect test scores. A study performed at Creighton University compared NBME test scores of students during their surgery clerkship who had a “slow” rotation vs. a “busy” rotation. Those on the slow rotation worked an average of 8-10 hours/day while those in the busy rotation worked an average of 12-14 hours/day. NBME test scores showed no significant difference between the two groups. This suggests that there is a fine balance in determining the optimum length of the clerkship as well as the numbers of hours worked and how those hours are spread throughout the day.

As the residency education landscape undergoes dramatic changes, the medical student educational process has come under scrutiny. Clerkships in many specialties have eliminated overnight call. Although the elimination of overnight call may positively influence student perceptions of the overall quality of the clerkship, clinical experience must not be sacrificed. The results from this survey demonstrate that educators feel very strongly that overnight call provides valuable student training and helps to provide a more realistic exposure to the lifestyle of an attending physician. Overnight call, while beneficial to the student educational experience, does not compromise student or patient safety. Future studies should seek to gather more information regarding overnight call and student performance so that curricular decisions can be made based on outcomes data. Careful thought must be given prior to making dramatic curriculum changes such as the elimination of overnight call during the third year clerkships.

None of the authors report any conflicts of interest or significant financial disclosures relevant to this paper.

Authors’ Affiliation:
- University of Hawai‘i John A. Burns School of Medicine; Department of Obstetrics, Gynecology and Women’s Health; Honolulu, HI
Correspondence to: Mark Hiraoka MD; 1319 Punahou St. Suite #824, Honolulu, HI 96826; Ph: (808) 753-2617 Fax: (808) 955-2174; Email: hiraokam@hawaii.edu

References

Over 50 Years of Dedication to Hawai‘i’s Physicians

The Board of Directors at Physicians Exchange of Honolulu invite you to experience the only service designed by and for Physicians in Hawai‘i.

President: Robert Marvit, M.D.
Vice President: Garret Yoshimi
Secretary: Paul DeMare, M.D.
Treasurer: Richard Philpott, Esq.
Directors: Derek Ching, M.D.
Myron Shirasu, M.D.
Vince Yamashiroya, M.D.
Ann Barbara Yee, M.D.
David Young, M.D.
Manager: Rose Hamura

- Professional 24 Hour Live Answering Service
- Relaying of Text Messages to Pagers and Cell Phones
- Calls Confirmed, Documented and Stored for 7 Years
- HIPAA Compliant
- Affordable Rates
- Paperless Messaging
- Receptionist Services
- Subsidiary of Honolulu County Medical Society
- Discount for Hawai‘i Medical Association members

Discover the difference of a professional answering service. Call today for more information.

Physicians Exchange of Honolulu, Inc.
1360 S. Beretania Street, #301
Honolulu, HI 96814
524-2575
Emergence of Community-Acquired Extended-Spectrum Beta-Lactamase *Escherichia coli* (ESBLEC) in Honolulu: A Case Series of Three Individuals with Community-Acquired ESBLEC Bacteriuria

Reid R. Hoshide MPH, MSIII; Heath Chung MD, and Jinichi Tokeshi MD

Abstract
Community-acquired extended-spectrum beta-lactamase *E coli* (ESBLEC) have not been previously described in Honolulu. Its emergence as a community-acquired pathogen is concerning. This case series describes three patients who were diagnosed with community-acquired ESBLEC bacteriuria in 2010.

Introduction
First detected in Germany in 1983, extended-spectrum beta-lactamase producing *Enterobacteriaceae* were considered to be a microbiological anomaly. As years progressed, this anomaly became more and more present throughout Europe and into the rest of the world, which was found especially in *K pneumoniae* and *E coli*. Prior to the turn of the century, extended-spectrum beta-lactamase *E coli* (ESBLEC) had always been known to be nosocomial in origin secondary to overuse and misuse of cephalosporins. The emergence of community-acquired ESBLEC in the 21st century is concerning. The unique microbiological properties of community-acquired ESBLEC limit the antibiotic options available for proper management. In this case series, we describe and discuss three cases of community-acquired ESBLEC infections occurring in Honolulu in 2010.

Patient 1
Patient 1 is an 82-year-old, widowed, Japanese, retired woman who presented to her primary care physician’s office with a chief complaint of foul-smelling urine for seven days, not associated with hesitancy, dysuria, fever, or chills. She had no pertinent past medical history. She does not reside in a nursing home, nor has she been exposed to a health care facility within the last 6 months. Physical exam was benign. Urinalysis and reflex culture revealed *Citrobacter koserii* urinary tract infection (UTI) with appropriate sensitivity to ciprofloxacin. She was instructed to complete her three-day course of ciprofloxacin, and to follow up if urinary symptoms persist. Seven days later, she reported back to her physician with continued symptoms. Repeat urinalysis revealed the following: Appearance, Clear; Color, Yellow; white blood cells, 15-20/hpf; Specific Gravity, 1.105; pH, 6.5; Leukocytes, 3+. Her urine was again sent off for culture and sensitivity. The patient was switched from ciprofloxacin to amoxicillin-clavulanate and was instructed to follow up in three days if urinary symptoms persist. Two days later, cultures returned positive for ESBL *E coli*. Sensitivities are listed in Figure 1. A telephone conversation with the patient revealed that her symptoms resolved after two days on amoxicillin-clavulanate, despite displaying resistance. No new therapy was started. She has not presented with new UTI symptoms to this date.

Patient 2
Patient 2 is a 60-year-old, divorced, Japanese, retired woman with a past medical history significant for rheumatoid arthritis treated with methotrexate. She presented to her primary care physician with symptoms of fever, nausea, malaise, and chills following the consumption of raw oysters. After her physician prescribed a 10-day course of azithromycin, her symptoms resolved. Forty-five days later, she visited Las Vegas where she had developed similar flu-like symptoms. She visited an emergency room in Las Vegas where she was assessed and given azithromycin and ibuprofen. No diagnosis was made at discharge. Seven days after returning home to Hawai‘i, she presented to her primary care provider with fever, chills, malaise, and nausea. A complete blood count (CBC) and basic metabolic panel (BMP) were significant for white blood cell (WBC) of 13,600 per µL (13% bands), a blood urea nitrogen (BUN) of 41 mg/dL, and a creatinine of 1.5 mg/dL. She was treated with empiric azithromycin without improvement, and was admitted to the hospital 2 days later due to failed outpatient management. On admission, she revealed that she had increased urinary frequency for a “really long time,” of which she attributed it to her long-term use of diuretics for bilateral leg edema. She did not have hesitancy or pain. Several lab tests including CBC, blood culture, BMP, urinalysis, and urine culture were ordered on admission. Her WBC count was 18,000 per µL. Urinalysis showed: Appearance, Cloudy; Color, Yellow; Specific Gravity, 1.020; pH, 5.5; Nitrites, 1.05.
Positive; Leukocyte Esterase, Negative; WBC 0-5/hpf; Bacteria, Moderate. BMP was unremarkable. Urine and blood cultures were pending. She was initially treated with piperacillin-tazobactam for her suspected urosepsis, but was changed to ciprofloxacin due to an anaphylactic reaction. She was then switched from ciprofloxacin to meropenem once cultures returned positive for ESBL \textit{E coli} with sensitivities listed in Figure 2. Blood cultures also revealed ESBL \textit{E coli} with the same sensitivities. Two hours after meropenem infusion, the patient developed wheezing, tachycardia, and hypertension. Meropenem was discontinued. Treatment strategies including amikacin and tigecycline were discussed with the patient, but were refused by the patient due to the possible adverse reactions associated with amikacin. A re-challenge with meropenem was deemed as the best course of antibiotic action. The patient was pre-medicated with famotidine, diphenhydramine, and methylprednisolone, and then re-challenged with meropenem. No adverse events occurred. Meropenem was continued for two weeks without any adverse events. The patient made a full recovery and was discharged eight days after admission.

**Patient 3**

Patient 3 is a 76-year-old, married, Japanese, retired man with a past medical history significant for benign prostatic hyperplasia (BPH) and asthma treated with oral prednisone. He does not reside in a nursing home, nor has he been exposed to a health care facility within 6 months. He presented to his primary care physician for a regular 3-month check up for ongoing asthma. Routine urinalysis was performed. The patient reported being in good health and had no complaints of asthma exacerbations or urinary symptoms. Physical exam was benign. Routine urinalysis showed: Appearance, Clear; Color, Light Orange; WBC, 30-40/hpf; Specific Gravity, 1.025; Blood, 1+; pH, 5.0; Leukocytes, 3+. In the face of the abnormal UA, the specimen was sent off for culture and sensitivity. The patient was not given antibiotics due to the lack of presenting symptoms. Two days later, culture and sensitivities revealed ESBL \textit{E coli} with the sensitivities listed in Figure 3. An infectious diseases specialist was consulted and a 10-day course of nitrofurantoin was initiated in light of his underlying BPH. The patient never developed any complaints of UTI symptoms.

### Discussion

This case series is the first published report of community-acquired ESBLEC in Honolulu. The three above cases describe ESBLEC infections lacking nosocomial origins.

Previous studies have described different gene-types of ESBLs in \textit{E coli}: TEM, SHV, and CTX-M. \cite{1-5} In terms of community acquired ESBL \textit{E coli}, CTX-M beta-lactamases appear to be the main subtype. \cite{1,5,6} CTX-M subtype ESBLEC is capable of being acquired in different ways. One way would be fecal-oral spread either through human-human, animal-human, or fomite contact. \cite{7} Second, de novo acquisition of the CTX-M gene into \textit{E coli} can occur through plasmid conjugation from \textit{Kluyvera} species, a non-pathogenic Enterobacteriaceae present in our normal gut flora. \cite{8-11} These plasmids may also harbor genes for resistance to aminoglycosides, chloramphenicol, sulfonamides, trimethoprim, and tetracyclines. \cite{12-14}

Risk factors for developing community-acquired ESBLEC urinary tract infections include diabetes mellitus, recent use of fluoroquinolones or cephalosporins, recurrent urinary tract infections, and age greater than 60 years old. \cite{14-16}

According to the Clinical Laboratory Standards Institute (CLSI), identification of ESBLEC requires one of two criteria: double disk diffusion or minimum inhibitory concentration (MIC) analysis. \cite{16} Double-disk diffusion has been the laboratory standard, and was the method used to confirm ESBLEC in our samples. Our cases of community-acquired ESBLEC were confirmed using double-disk
diffusion containing clavulanic acid with cefotaxime and ceftazidime. Enhancement of the zone ≥5 mm of the cefotaxime or ceftazidime disk on the side facing the clavulanic acid indicated the presence of an ESBL. ESBLEC can also be detected by examining MICs of a broth dilution containing one of the five extended-spectrum beta-lactam antibiotics (cefepoxide, ceftazidime, aztreonam, cefotaxime, or ceftriaxone) alone and in addition to 4 µg/mL clavulanic acid. A decrease in the MIC ≥3 twofold dilutions in the presence of clavulanic acid indicates the presence of ESBL.16-17

Despite the results of the susceptibility report, if an organism has been identified as ESBLEC, all cephalosporins and aztreonam should be deemed as inappropriate antibiotic therapy.18 An inoculum effect may be an explanation behind varying susceptibilities.19,19 An increased inoculum may be associated with a marked increase in MIC. Regardless of the sensitivities, with enough inoculum, the ESBLEC is assumed to overcome all extended spectrum beta-lactams. Additionally, if the CTX-M gene is present, there is a concern that the ESBLEC organism acquired a plasmid which may also give resistance to aminoglycosides, chloramphenicol, sulfonamides, trimethoprim, and tetracyclines.12-14

Carbapenems have been described as mainstays of treatment for ESBLEC infections.20-22 Meropenem may be the best choice in the event of ESBLEC meningitis due to having fewer chances of neurolologic side effects compared to imipenem.23 The use of a cephalosporin with a beta-lactamase inhibitor has been controversial and prone to treatment failure, and thus should not be used as first-line treatment.21,24

In the outpatient setting, oral antibiotics such as fosfomycin or nitrofurantoin have been proven to be effective antibiotics against ESBLEC UTIs (>94% in-vitro susceptibility).24 Fosfomycin-resistant strains of ESBLEC are starting to emerge with increased use.25

The clinical significance of ESBLEC is two-fold. First, the mortality rate of susceptibility/treatment mismatched patients has ranged from 42-100%.27-29 Second is the previously-mentioned inoculum effect of ESBLEC. Susceptibility reports may be deceiving by showing susceptibility to various antibiotics. As mentioned before, all cephalosporins, aztreonam, aminoglycosides, chloramphenicol, sulfonamides, trimethoprim, and tetracyclines should be avoided due to in-vivo and in-vitro differences in susceptibility via an inoculum effect.

In retrospect, gene studies and pulsed-field gel electrophoresis would have been worthwhile techniques to employ on the urine samples of our three patients. Such tests would allow us to determine if the ESBLEC cases were from the same origin through genetic similarities. To our knowledge, these three cases have at least 1 degree of separation; none of which would be from a hospital setting. If gene studies revealed CTX-M genes, it would provide stronger evidence that our patients had community-acquired ESBLEC.

Conclusions

The emergence of community acquired ESBLEC is concerning and is a serious threat to our community. Antibiotic susceptibility of these new superbugs is limited so the evolution of antibiotic resistance may be outpacing the development of new, active antibiotics. These new superbugs are challenging our approach to effective antimicrobial therapy.

None of the authors identify a conflict of interest.

Authors’ Affiliation: - University of Hawai’i John A. Burns School of Medicine, Honolulu, HI

Correspondence to: Jinichi Tokeshi MD;405 N. Kuakini St #707, Honolulu, HI 96817, Ph: (808) 536-3267 Fax: (808) 536-3947; Email: jinichi.tokeshi@gmail.com

References
Perceptions Related to Diet and Exercise Among Asians and Pacific Islanders with Diabetes

Nafanua Braginsky PhD, APRN Rx, NP-C; Jillian Inouye PhD, APRN; Chen Yen Wang PhD, APRN; and Richard Arakaki MD

Abstract
The purpose of this study was to explore the perceptions of Asians and Pacific Islanders (API) with Type 2 diabetes related to diet and exercise. A descriptive content analysis was conducted on verbalized responses from 15 participants in focus groups who were asked “What role does your culture play in what, when, and how much you eat?” and “If and/or how much you exercise and what type of exercise you do?” The participants recorded responses were transcribed verbatim and analyzed for themes utilizing the social ecological framework.

The families, environment, and the local culture in Hawai’i greatly affect the dietary and physical activities of the participants. Psychosocial themes related to diet included depression, denial, and lack of self-control. Physical activities were impacted by motivation and awareness of complications of diabetes. Family upbringing, social events, food portions and variety, and reciprocity contributed to eating behaviors of the participants. Family values in sports and role expectations of gender influenced physical activities.

This study identified social ecological influences on health behavior among Asians and Pacific Islanders. The findings suggest various efforts for physicians and other health care providers to assist API in taking care of their diabetes.

Introduction
The state of Hawai’i has the largest representation of Asians and Pacific Islanders (APIs) in the United States, making up approximately 49% of nearly 1.2 million residents. This multi-ethnicity offers a unique blend of racial and cultural influences in everyday life. Unfortunately, APIs are disproportionately affected by chronic health conditions, especially diabetes mellitus. The prevalence of diabetes in Hawai’i is estimated between 72,000 to 100,000 people or six to eight percent of the population with approximately 25% undiagnosed.1 Controlling blood glucose levels through modification of diet and lifestyle is the mainstay of diabetes therapy.2 Improvement of hyperglycemia reduces long-term complications,3 and diabetes management requires a committed partnership between health care providers and patients, and the patient’s family.

A few studies have examined perceptions of API with diabetes related to diet and exercise. Filipino Americans in Hawai’i perceive rice as a significant source of energy and therefore served at every meal.4 Korean American immigrants with diabetes perceive family support in food preparation valuable for improving blood glucose control.5 Chinese Americans maintain the use of herbs and traditional diet because diabetes does not cause pain or affect their daily activities.6 Pacific Islanders perceive diabetes as a complex health problem involving physical and emotional stress with much needed behavioral change.7,8 This study explored social ecological influences on perceptions of API related to diet and exercise in taking care of their diabetes.

Methods
Content analysis is a research technique for the subjective interpretation of textual data through the systematic classification process of coding and identifying significant themes or patterns.9 The organization of data was based on the social ecological model (Figure 1)10 which depicts the processes of interactions between the individual and his immediate environment; interpersonal relationships; interactions with organizations, community and society.10 These relationships vary in context of time periods in which these processes take place.

Data were collected from focus group sessions of participants in the Cognitive Behavioral Training (CBT) group during the module on social support, cultural values, and beliefs on diet and exercise. The organization of themes and sub-themes from focus groups was completed separately by authors (NB and JI), and a registered nurse with no knowledge of this study. Any disagreement on the coding was resolved to 100% agreement after discussing quotes from participants. Reliability was achieved through several independent coding plus re-examination and agreement among the researchers. The questions asked were “What role does your culture play in what, when and how much you eat?” and “If and/or how much you exercise and

Figure 1. Social Ecological Model
what type of exercise you do?" The responses by participants were tape recorded; transcribed verbatim by an administrative assistant; and were organized using NVivo 8™ computer software.

Focus groups were part of a controlled clinical trial “The Study of Cognitive Behavioral Interventions in Diabetes Self-Management” that compared the effect of Cognitive Behavioral Training (CBT) versus Diabetes Education and Support (DES) on diabetes self-management. Asian (n=150) and Pacific Islander (n=57) patients with type 2 diabetes between 18 to 76 years of age were recruited. Participants attended 6 successive weekly sessions that average 1-2 hours per session with group size ranging between 4-8 individuals per group. Participants in the CBT group were provided self-management tools which included biofeedback, breathing exercises, and stress relievers, and the DES group were given additional diabetes education and allowed to discuss issues and needs. “The Study of Cognitive Behavioral Interventions in Diabetes Self-Management” was approved by the University of Hawai‘i’s Committee on Human Studies (CHS 12473). All participants signed informed consent, which included audio-taping of focus group sessions. Coded numbers were assigned to each participant to assure confidentiality.

Results
Responses from eight men and seven women ages 50 -76 years in more than three focus groups were analyzed. By convention, the minimum number of focus groups in a study is three to four with an adequate number of four to twelve participants in each group. This number of focus groups and participants provide representative data for patterns and themes to emerge across the groups. To set the stage of discussion on how diabetes mellitus is perceived in Hawai‘i, one participant shared her observation that diabetes was not a big deal in Hawai‘i and that it was accepted. She felt that there was no urgency in taking care of diabetes unless there was an emergency. When the participants were asked the question, “What role does your culture play in what, when, and how much you eat?” One participant answered, “It’s a big role; you know the Hawaiians, they eat till they’re tired; they eat till they are full.” One gentleman’s comment summed up the significance of the Hawaiian plate lunch on the variety and amount of food the local people eat:

I think the Hawaiian culture’s a good example of it. I mean when I came here and had my first plate lunch, I almost had a heart attack because I got something like roast beef with gravy, rice and macaroni salad. I could not believe there were two starches sitting on a plate. The first time I had stew and they put it on rice. I couldn’t believe it; there’s potatoes in the stew; when I had chili, it was on rice.

Psychosocial Themes Related to Diet and Exercise
The psychosocial findings related to diet included depression, denial, and lack of self control. A participant described her mood in the following manner, “For me, I was always healthy. But then the shock of finding out my diabetes, that really turned me around. I went through a period of having depression, and didn’t wanna exercise, didn’t wanna sleep…. “ Another participant experienced difficulty accepting that he had diabetes. He stated, “When I started with diabetes, to be honest with you, I never took it seriously, ’cause I kept telling myself, it’s not me. I’m not diabetic. I would tell my girls, okay okay I would stop my sugars. I never took it seriously…. “ The participants acknowledged the difficulty in controlling their diets when they went to dining facilities or cooking at home. One of them shared how she could not control herself when it came to food: “I’m very weak and I’m not willing to give up everything. I just won’t give up everything even to be healthy. It just seems like it’s such a major problem for me…. I’m very bad at my dieting…. “

Depression, denial of illness, and lack of self control have been associated with decreased quality of life and poor self care, lack of acceptance of required lifestyle changes, and inability to control impulses in making poor dietary choices. Individuals with diabetes with worsening depressive symptoms showed poor adherence to dietary and exercise regimens. Denial of disease is also associated with poor metabolic control.

Lack of motivation and physical complications of diabetes were reasons for not participating in exercise. One gentleman shared being “plain lazy” and not wanting to do any exercise; on the other hand, another gentleman expressed how exercising in a group would motivate him to do physical activities. He commented,

I see the value of exercise. I watch myself be very good about following a food plan or a diet and not losing weight, and had I exercised, I know that would have been a pound and a half; but the motivation is not there. And then I’m not fond of doing things by myself, I would want it to be a group thing….

One woman participant shared how neurovascular disease as a complication of diabetes limited her physical activities. She stated, “My foot is getting numb so I can’t walk like before.”

Motivation deals with factors that stimulate desire and energy to fulfill a goal. People who participated in sports or weight loss regimens were more motivated by the enjoyment of the activity or their appearance. It is established that peripheral neuropathies impact mobility and physical activities of daily life of individuals with diabetes. Maintaining and nurturing relationships with culture-specific exercise are important to increase participation in exercise programs among diverse minority older adults including APIs.

Cultural Themes Related to Diet and Exercise
Culture is about how people and groups define themselves, including societal aspects in language, customs, values, and norms. Three diet-related cultural themes emerged: (1) food variety and portions, (2) family upbringing and social events, and (3) reciprocity.

Food variety refers to the different types of food at any given event. Participants recognized that multi-ethnic groups contributed to the varieties of food at a social event. The participants listed foods from different cultures including Filipinos, Chinese, Japanese, and Hawaiian. One gentleman shared his experience:

But you look at the local diet, no wonder Hawai‘i is so high in diabetes. Look at all the carbs, you go to a Hawaiian dinner, so here’s the sweet potato, there’s the long rice, here’s the rice; we throw in some sushi that isn’t even Hawaiian and poi, you got the fat meat, and you know, there’s always the cakes ….What a horrible meal!

Large portions of food from the carbohydrate food group was recognized by participants as a factor affecting their blood sugar levels. They commented on eating too much rice, noodles, and bread because they were the only food available. Some of them grew up on plantations in Hawai‘i and all they had to eat was rice. The older participants who grew up in times of economic hardship were taught
to eat all the food and not to waste it, a behavior passed down to subsequent generations. A participant remembered her grandmother telling her that “if not enough food, you put shame upon your family.” Preservation of family honor and not bringing shame to family is of utmost importance in many cultures. One gentleman stated,

“If I have a potluck, and I invite nine friends from the mainland to the potluck, we might have enough food. If I invite nine local people to the potluck, we’re gonna have enough food and food to take home. So I think that’s another thing in Hawai’i. You make large amounts. You brought out a snack, three of them — you have a choice. If you’re on the mainland, they will bring out one thing — here it is; would you like this? You know, I think the cultural eating habits are totally different.

Family upbringing and social events influenced the participants’ diet. One participant shared how her family influenced how much she ate as a child; “So there’s so much food and kids are taught to eat as much as you can….so that’s why we’re all heavy, you know.” Family social events involved bringing food to share. One gentleman reminisced about the different ethnic foods shared during Christmas and New Years celebrations. He shared about family members bringing Korean foods, Japanese foods, and other varieties of ethnic dishes.

Reciprocity is about giving and taking something. A gentleman shared his experience in the Mainland. “When I was living on the Mainland, whenever I go for dinner, I always bring something. And I know that wasn’t always the case with others, — something as simple as a bottle of wine. But in the Mainland, yeah, they don’t have this — you bring something.”

Variety and large portions influenced the eating patterns of the participants. Consumption of a variety of food from the same high energy density food like carbohydrates and snacks are associated with increased body weight. The same high energy density foods were served in the local plate lunch. For example, “roast beef with gravy, rice and macaroni salad….” The gravy over the beef and the mayonnaise mixed with the macaroni plus rice add calories. Limiting the amount from fat-dense foods in the diet helps sustain weight loss.

The challenge is to educate APIs to make modifications in their choices of food to maintain balanced meals.

A unique finding of this study was the practice of “always bringing something” as a gift in social events. A study of 104 Japanese families in Hawai’i found gift giving an important mechanism in perpetuating family relations. To maintain cultural practices the API can exchange food items that are healthy in family social events.

When the participants were asked about the role of their culture in exercise, they mostly reminisced about their childhood days. They spoke about exercise from playing in their yards all day with friends in the neighborhood. They rode their bikes and climbed fruit trees and “not having TV, iPods, or cellular phones.” One female participant shared her fishing expedition:

“The only exercise I remember us doing is getting up at 5 o’clock in the morning, drive down to Waianae, hauling all the fishing gear, and diving off the cliff. Hiking half a mile in, that’s the only exercise, true exercise I remember. And with luging all that fish and cooler and fishing pole and all that gear up the hill again…”

The themes emerged related to exercise included organized sports and gender. One participant shared not remembering people walking or jogging for exercise. Family values and parental involvement influenced which organized sports and physical activities the participants were involved in while growing up. One woman participant commented that since her father valued sports, her brothers played sports except for her. A man participant commented that many parents would not allow their daughters to be in organized sports like martial arts unless they were “really, really exceptional.” Another woman participant stated; “When you grow up in Japanese households…we were not allowed to do sports, you know, hockey, or soccer stuff. Instead we went to ikebana classes, to tea classes; we went to do Japanese embroidery.”

Family values and parental involvement determined the family members’ organized sports and physical activities. Studies have found that adolescents who received parental encouragement engaged in physical activities compared to their counterparts. When physical activities become habitual in childhood, their influence continues into adult life.

It is important for health care providers to understand how APIs behave in the present if their lives are seen in the context of the past.

**Discussion**

This study presents results that are consistent with published literature in which food variety, food portions, and limited physical activity affect diabetes management. From the social ecological perspective, environmental factors such as family, friends, and community influence diet and exercise of APIs. Thus, interventions as suggested by others should include the individual, the ethnic family, and support systems in the planning, implementing, and evaluating of health care outcomes.

The psychosocial issues emerging from this study should be handled in culturally sensitive approaches. Depression adversely impacts self-management of diabetes, and screening for depression in people with diabetes is important. This study suggests that for the API patient, the use of an older counselor of similar ethnicity that speaks the same dialect would be culturally appropriate to enhance better responses. Health care providers should be culturally sensitive when engaging individuals from API populations in all stages of self management.

The limitations of this small study of fifteen participants are that the findings cannot be generalized to all API populations. The data only allowed for descriptive analysis, therefore limiting interpretation and developing possible interventions. Content analysis is an inconspicuous technique and vulnerable to bias related to interpretation of text. Also, only a few participants identified their specific ethnic backgrounds, resulting in using API as an aggregate. The data analyzed were obtained from one module session of the Cognitive Behavioral Training; and information provided could reflect what participants learned from prior sessions. Findings from this study suggest a combination of qualitative and quantitative methodologies; and sampling could include several community sites across the islands.

This study explored the perceptions of Asians and Pacific Islanders with diabetes related to diet and exercise. The psychosocial themes of depression, motivation, lack of self control, and awareness of complications are common in those with diabetes. The cultural
themes of family values, social events, and past family experiences contribute to shaping the dietary habits and physical activities of participants. The concept of reciprocity is particular to the local Hawaiian culture. Maintaining family relationships and family honor are important considerations when educating API in choosing foods that are healthy at family social events. Family values clearly influence childhood participation in organized sports and overall physical activities which shape the role of exercise in the management of diabetes.

The results of this study support the value of employing a social ecological perspective when attempting to understand health behavior.12 The required effort should reflect increased awareness and positive changes within the broader cultural context of families, work places, neighborhoods, and communities. By increasing the availability of environmental and social support resources in additional to personal and interpersonal resources, one can expect to see greater improvement to diabetes self care practices.

Disclosure and Conflict of Interest Statement

“The Study of Cognitive Behavioral Interventions in Diabetes Self-Management” was funded by the National Institute of Nursing Research grant #5R01-NR007883 to the University of Hawai‘i School of Nursing and Dental Hygiene; principal investigator J. Inouye. Additional support provided by the National Institute of Child Health and Human Development grant #5G11HD054969 and the National Institute of Nursing Research grant #P20NR010671. The authors report no conflict of interest.

Acknowledgement

We acknowledge Ms. Elizabeth Flormata (Administrative Assistant) for transcribing data; Ms. Jean Lizardi (RN) for coding themes; and Mr. Dominic Estrella (Research Program Manager) for technical and editorial support.

Authors’ Affiliation:
- University of Hawai‘i at Manoa, School of Nursing and Dental Hygiene, Honolulu, HI (N.B., J.I., C.Y.W.)
- University of Hawai‘i John A. Burns School of Medicine, Honolulu, HI (R.A.)

Correspondence to:
Nafanua Braginsky PhD, APRN Rx, NP-C; University of Hawai‘i at Manoa, School of Nursing and Dental Hygiene; 2528 McCarthy Mall, Webster Hall 220A, Honolulu, HI, 96822; Ph: (808) 956-2619; Fax: (808) 956-3257; Email: nafanua@hawaii.edu

References

Thank you for that very kind introduction. Good evening faculty, staff, and honored guests. Aloha and welcome to the mothers, fathers, family, and friends of the incoming John A. Burns School of Medicine (JABSOM) Class of 2015. And to the Class of 2015…Alright you made it! Congratulations and welcome to medical school!

Students you are probably wondering why am I wearing a graduation cap at tonight’s white coat ceremony? That’s an excellent question! During your four years of medical school, there are two very special events that you will remember throughout your medical careers. One event of course will happen four years from now when you graduate from JABSOM as a doctor of medicine. This is the actual graduation cap that I had the privilege of wearing 17 years ago when I delivered the keynote speech to the JABSOM graduating class of 1994. In just four short years from now you too will be wearing a similar graduation cap with the traditional green tassel which signifies that you are a doctor of medicine.

The other very significant and memorable event during medical school is happening tonight. And that is the traditional white coat ceremony which first began in 1993 at the Columbia University College of Physicians and Surgeons. So tonight, we the faculty and staff of JABSOM, welcome you, the Class of 2015, into this honored profession and into this awesome medical school!

Students, up to this point, all of you have worked very hard and put in long hours of studying to get to where you are tonight. Not only are you the largest incoming class in JABSOM history, but all of you who are about to receive your white coats tonight were in the top 4% of the 1,600+ applicants who were hoping to be in the Class of 2015. Through your perseverance and dedication you have demonstrated your commitment in becoming a doctor of medicine. However up to this point, you have all worked very hard as individuals. Now, as you study to become a physician, you need to learn how to work well as a supportive and contributing member of a healthcare team. In order to provide excellent and comprehensive healthcare to your patients you will have to depend upon many other professionals on the healthcare team. If you think that during your four years of medical school training that you will become smart enough and skilled enough to provide excellent care for your patients all by yourself, you will fail your patients.

Let me use an example from my Emergency Department (ED). When a critically ill child is rushed in to the ED by the paramedics I sometimes literally only have a matter of seconds or minutes to figure out what’s wrong with the child and to decide what life-saving interventions need to be done by the team. Despite my 19 years of experience in pediatric emergency medicine I cannot do this all by myself. I must rely upon a team of experts to perform what they each do best. The nurses, technicians, therapists, and clinical assistants all perform critical roles during a resuscitation. So the key concept for successful teamwork is to get a “team of individual experts” to function as an “expert team!” (Dr Inaba held his hands up with interlaced fingers to signify “teamwork.”) So please remember this idea of teamwork and don’t wait until your residency to learn how to function as a supportive and contributing member of a team. Embrace the concept of teamwork from the very first day of medical school and you will have a much more enjoyable and much more rewarding experience as a medical student.
And speaking of medical school. (Six members of the class of 2015 got up from their seats and made their way to center stage for a demonstration. They each took out various props from Kyle’s backpack to signify various elements of their medical education.) From day one of medical school you will be challenged to learn a lot of facts, and to learn how to use those facts to help you figure out what is wrong with the patient and what you need to do to fix the patient’s problems. (Dr Inaba held up a magic black bag symbolizing the traditional doctor’s black bag and showed the audience that there was nothing inside.)

(1) You will be challenged to learn a lot of basic science materials such as anatomy and physiology in order to build a broad knowledge base. (Jennifer Nishioka held up a picture of an anatomy chart and placed it into the magic black bag)

(2) You will have to learn how to interpret various diagnostic studies to help you sort through your differential diagnosis. (Raymond Machi held up a picture on an x-ray and placed it into the black bag.)

(3) You will have to learn how to select various medications to treat your patient’s conditions and you will also be expected to know all of the indications, contraindications, and side effects of each of those medications. (Jennifer Sasaki held up a pill bottle and syringe and placed both items into the black bag.)

(4) You will have to master several technical and surgical procedures to help you treat your patients. (Sean Matsuwaka wearing surgical gloves held up a pair of hemostats and placed both items into the black bag.)

(5) And finally you will also have to master several life saving skills if your patient requires resuscitation. (Nicole Shirakawa held up defibrillation pads and placed them into the black bag.)

So with all of the knowledge and technical skills that you will be asked to master in four short years, my question to you, the Class of 2015, is this: “What should be your primary goal as a physician and what should be your promise to each and every one of your patients?”

And the students have come up with the answer of “C-U-R-E.” An excellent and logical answer, but perhaps there is a better answer. Although during the next four years of medical school you will have to study very hard to learn how to figure out what to do to cure your patient’s disease, pain, and suffering, please remember that curing disease, pain, and suffering should not be your primary goal and promise to your patients. Why? Because we cannot always cure a patient’s disease. And we cannot always completely eliminate their pain and suffering. But that’s okay, because our patients expect much more from us.

So what should be your primary goal and promise to each and every one of your patients? The correct answer is right in front of us. If you took one letter in the word C-U-R-E and changed it to another letter, then that should be your primary goal and promise to each and everyone of your patients. Medical student Nishioka please reach into the black bag of medicine and pull out the correct answer. (Jennifer Nishioka reached into the black bag held by Kyle and pulled out the letter “I.” Dr Inaba then pushed his hand through the bottom of the bag and turned it inside out to demonstrate that all of the items that the students had previously placed into the bag had now mysteriously vanished.)

The letter “I”? That’s an interesting choice but not quite the letter that I was hoping that you would produce. (Jennifer Nishioka then consulted with the other students then attached the “I” onto the middle of the letter “U” in a horizontal orientation.)

Well students that still looks like the word “C-U-R-E” with a funny looking letter “U”. (Kyle then pulled out a magic wand from his backpack and showed it to Dr. Inaba and the audience.)

“Oh, medical student Watanabe, do I detect a touch of Harry Potter? Excellent!” (Kyle and Dr Inaba walked to center stage where the four students were holding up the poster boards. As Kyle waved the magic wand at the altered letter “U,” white streamers mysteri-
ously appeared as a fountain from Dr Inaba's hand. The altered letter “U” then rotated vertically 180 degrees to now reveal that the “U” had changed to an “A”.

Correct! Yes, your primary goal and promise to each and every one of your patients should be to CARE for them. So what do you need to learn in order to become a caring physician? Once again the answer is right in front of us. If you look at the word care, C-A-R-E stands for: COMPASSION, ACTION, RESPECT, EMPATHY.

COMPASSION: Treat all of your patients and their families with compassion and kindness.

ACTION: It is not good enough to just feel compassion and kindness in your heart and it is not good enough just to have caring thoughts in your head. You need to let your actions reflect that of a compassionate and caring physician.

RESPECT: Respect you patient’s opinions about their illness and their treatment plans. And respect their families and respect their culture.

EMPATHY: Empathy is not the same thing as “sympathy.” Sympathy is merely feeling sorry for someone. Empathy on the other hand is being able to step into a person’s shoes to truly understand what they are feeling and going through, and by doing so you will be better able to help and support that person.

Thank you students. Audience, how about a nice round of applause for my student volunteers: Kyle Watanabe, Raymond Machi, Sean Matsuwaka, Jennifer Nishioka, Nicole Shirawaka, and Jennifer Sasaki.

Speaking of “caring,” I would like to share a personal story with all of you. Thirty-two years ago before I left for college my pediatrician, Dr Herbert Nakata, cared enough to give me a piece of advice that he wanted me to remember throughout my medical career. So, during my freshman year at Creighton University, I went to the bookstore and purchased a poster board and some rub on letters and made a poster of what Dr Nakata wanted me to remember. This is the actual poster that I made 32 years ago and tonight I would like to share with you the advice that Dr Nakata wanted me to remember: (Dr Inaba held up the poster that he made 32 years ago and read the words on the poster to the class of 2015 and the audience.)

“In medicine always remember…FIRST treat the PERSON…and THEN...treat the disease.”

“First treat the person”…that is exactly what a caring physician should do by always demonstrating: COMPASSION, ACTION, RESPECT, EMPATHY.

So in closing I would like to humbly thank all of you for allowing me to share in this wonderful celebration tonight as your sons and daughters begin their exciting journey in becoming doctors of medicine.

And to the Class of 2015. (The entire Class of 2015 then stood up.) From day one of medical school and throughout your entire careers, please remember to embrace the concept of “TEAMWORK” (The entire class then held their hands up and interlaced their fingers to symbolize “teamwork”) and always remember to CARE for your patient as a PERSON and to CARE for them with (The class then each made a shape of a heart with their hands to symbolize “CARING and COMPASSION”):

COMPASSION
ACTION
RESPECT
EMPATHY

And now for the highlight of tonight’s ceremony, the presentation of the white coats! Mahalo nui loa and please enjoy the rest of the night.

Note: This keynote presentation incorporated various demonstrations by the students and a few magic effects by Dr Inaba. The italicized portions of this manuscript describes what the audience saw during these demonstrations.
Manuscripts
Submit manuscripts to Hawai‘i Medical Journal, c/o Drake Chinen, 95-1027 Ainamakua Dr. #114, Mililani, Hawai‘i 96789. Contact: drakechinen@gmail.com.

Manuscripts are reviewed by the editor, the peer review panel, and other experts in the particular specialties. Please be aware that your article will be edited to comply with the AMA style, corrected for grammar, and recommendations could be made by the peer reviewers. Submit only articles that have not been submitted elsewhere.

• Please submit one copy on 8-1/2” x 11” paper. Also, submit a digital Word document and a PDF file to: drakechinen@gmail.com.
• Use Microsoft Word.
• Use Times font in 10 point size.
• Do not underline and do not use full caps.
• Use double spaces between lines. Do not use 1-1/2 spacing.
• Use a single space between sentences. Do not use two spaces.
• Number pages consecutively beginning with the title page.
• Tables, figures, graphs, and illustrations can be up to 7-1/2 inches in width. They must be black and white (grayscale). They cannot be in color. They must be prepared in Microsoft Word or Excel. Numerical data should accompany graphs. Do not embed tables, figures, and graphs within the text their placement must be at the end of the manuscript.
• Photos must be black and white (grayscale). Photos must be submitted as JPEG.

****Keep manuscript to 3,000 words maximum.

Cover
A cover should contain the name of the author with whom HMJ will correspond. Include an address, phone number, and email address. Also, list authors’ names: first name, middle initial and last name of each author with highest academic degrees; and name of department and institution to which the work should be attributed.

****Keep the title short and specific.

Abstract
The second page of the manuscript should include an abstract that highlights for the reader the essence of the authors’ work. It should focus on facts rather than descriptions and should emphasize the importance of the findings and briefly list the approach used for gathering data and the conclusions drawn.

****Keep abstract to 250 words maximum.

The abstract summarizes the main points of an article: (1) the purpose of the study, (2) the basic procedures followed, (3) the main findings, and (4) the principal conclusions. Expressions such as “X is described,” “Y is discussed,” “Z is also reviewed” should be avoided in favor of a concise statement. A few specific guidelines to consider in preparing an abstract follow:

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

Style
Use JAMA style consult the AMA Manual of Style.

Common AMA style errors:

• Use the objective case, such as “the team determined” or “the study involved,” not I or we, and avoid medical jargon.
• Use generic drug names unless citing a brand name relevant to your findings. Do not use abbreviations in the title and limit their use in the text.
• Use human terms, ie, men and women instead of males and females.
• Use a comma before the conjunction (and, or, nor, but) that precedes the last item in a series.
• Do not use periods with eg, ie, etc, vis, or similar abbreviations. Follow these with a comma and enclose the entire expression in commas or parentheses — (eg, eggs, apples, and nuts)
• Use close parentheses in numbered items (1), (2), (3), etc.
• Citing references in your paper

Identify references with superscript Arabic numerals corresponding to the item in your reference list:

Research Institute of Infectious Disease and was subsequently confirmed to contain viable Bacillus anthracis (anthrax) spores that were dispersible in air. Scanning electron microscopy of the spores used in the Senate...

If you are using the same citation in more than one location within the paper; you can refer to the same citation number.

...Russia,6 occupational studies of workers in goat hair processing mills,7 and modeling analyses by the US Army.

Place citations outside of punctuation marks.

• Creating your bibliography

List the citations in their order of appearance within your paper.

References

• Statistical Probability
  P
  Standard Error  SE
  Standard Deviation  SD
  Relative Risk  RR

Title of books  Italics
Title of Journals  Italics

Text
We recommend that articles be divided into sections with headings:

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

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

**Ethical Approval of Studies and Informed Consent.** For human or animal experimental investigations, formal review and approval, or review and waiver, by an appropriate institutional review board or ethics committee is required and should be described in the Methods section. For those investigators who do not have formal ethics review committees, the principles outlined in the Declaration of Helsinki should be followed. For investigations of human subjects, state in the Methods section the manner in which informed consent was obtained from the study participants (ie, oral or written).

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

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

Acknowledgments
Acknowledge only persons who have made substantial contributions to the study. Authors are responsible for obtaining written permission from everyone acknowledged by name; readers might believe those acknowledged are endorsing the study and conclusions.

Disclosure Statement
In order to facilitate the citation and indexing of articles for MEDLINE and for full-text access on PubMed Central, the National Library of Medicine requires that disclosure information be provided by each author. This disclosure information must be specific and address any financial relationship with the sponsoring organization, any interests represented, and/or products discussed or implied. These statements should appear within the paginated text of the article. This is to promote transparency and allow PubMed users to judge the value of findings in published articles.

While you may file ICMJE (International Committee of Medical Journal Editors) Uniform Disclosure Form for Potential Conflicts of Interest (http://www.icmje.org/coi_disclosure.pdf), a simple statement disclosing all relationships that could be viewed as presenting a potential conflict of interest would be sufficient. This includes a financial disclosure statement pertaining to: grants, honoraria, royalties, payments for manuscript preparation or other activities, patents, stock options, travel expenses, gifts, and so on.

A disclosure can be a team statement such as: “None of the authors identify any conflict of interest.” Or “Dr. XXX reports serving on the scientific advisory boards of XYZ Company. Dr. YYY reports serving on…Associated honoraria for Drs XXX and YYY are paid to…No other authors reported any financial disclosures.” Or “This work was supported by grant ABC from …Treatment and placebo capsules were donated by XYZ Company…” Please refer to JAMA or NEJM for model statements.

Conflict of Interest
Authors must disclose all relationships that could be viewed as presenting a potential conflict of interest.

Copyright Transfer/Publishing Agreement
Please fill out form on page 3 of the “Instructions to Authors” downloadable from the Website (http://www.hawaiimedicaljournal.org). This form must accompany your submission or it will not be accepted.

Reprints
Authors will be able to download a PDF file of the Journal. A high-resolution PDF file will be available upon request.
CHEST 2011
The Perfect Blend of Clinical Education and Tropical Paradise

Recognized around the world as the authority in clinical chest medicine, CHEST 2011 will feature a learning program in pulmonary, critical care, and sleep medicine. Essential updates on patient care and practice management strategies will keep you at the forefront of chest medicine. The unique setting at CHEST 2011 will be complemented by a unique education program, which will include:

- Postgraduate Multipass Courses
  Additional Saturday Courses
  Saturday, October 22

- General Sessions
  Sunday, October 23 – Wednesday, October 26

- After-CHEST Postgraduate Courses
  Friday, October 28 – Saturday, October 29

- Visit the Centers of Excellence and the Clinical Resource Center

Register Now
www.accpmeeting.org
Prior to the raid at Abbottabad which killed bin Laden, President Obama wanted to confirm that the terrorist leader was in the compound before risking American lives. The Central Intelligence Agency (CIA) recruited a Pakistani physician to run a vaccination program for Hepatitis B. In reality the goal was to obtain DNA from bin Laden’s children. The Associated Press verified details about the program from U.S. officials, but neither the CIA nor the White House would comment. Both the World Health Organization (WHO) and the Pakistani International Red Cross expressed concern over the bogus vaccination effort. Mixing political ends with medical goals compromises the perception of impartiality of all medical personnel and is contrary to medical ethics. It appears that the White House believes the end justifies the means, and in this case, it is hard to disagree.

The road to success is always under construction.

GlaxoSmithKline is testing a vaccine labeled RTS.S which targets the protozoan Plasmodium falciparum, the ugly organism that causes the most virulent form of malaria. Malaria kills more than one million each year, most of them children. A study in the New England Journal of Medicine reported two research programs from Kenya and Tanzania that show the vaccine halves a child’s risk of getting malaria. A phase III pivotal trial is underway in seven African countries with expectations of enrolling 12,000 to 16,000 children. Researchers realistically do not expect it to be 100 percent effective because there are several types of malaria parasite, all spread to humans by Anopheles mosquitos. Additionally, a person can be simultaneously infected with several different strains with multiple encoding antigens. Tough sledding for a research team, but a magnificent way to share the wealth from a Bill and Melinda Gates Foundation grant.

Statistics on obesity are in round figures.

If we did not have enough information describing the disease problems generating with obesity, new eye surgeons can add macular degeneration. An Australian study of 21,287 citizens who were followed from their age 40s to mid-80s found that each 0.1 increase in waist/hip ratio generated a 13% increased chance of developing early-stage age-related macular degeneration (AMD). The increased ratio was more pronounced for the more severe late-stage AMD which added a 75% chance of visual loss. The increased risk was strictly in men. Surprisingly, the increase in abdominal fat in women decreased (!) the AMD risk by 7% to 11%. Researchers noted that abdominal fat releases estrogen and other chemicals that may contribute to inflammation associated with AMD. The inverse association in women could reflect a genetic protective effect of long-term estrogen exposure.

The doctor made him do it.

In 2002 a Georgia man was accused of stabbing his mother to death. He was found to be incompetent to stand trial and was committed to a mental institution. The man’s father wants to file a malpractice complaint against the psychiatrist for the accused’s care. The claimant should not have discontinued the son’s anti-psychotic medication. The Georgia Supreme Court heard arguments and is considering whether the family of the accused man can sue the psychiatrist for malpractice. Attorneys for the doctor argue that the man cannot “shift the blame” for the murder to the physician and then file a malpractice complaint. Moreover, does the court really want to get into evaluating a doctor’s decision about therapy?

If you billed it, they (dollars) will come.

Published in the Journal of the American Medical Association, a study was done noting that 600,000 angioplasty (stent implant) procedures are performed annually in the USA at a cost of $20,000 each. Seventy percent of the patients were symptomatic, but the remainder suffered only mild symptoms or none at all. The report concluded that about one in eight patients (12%) were done inappropriately. The big warning that stents were being over 2007 when the New England Journal of Medicine (NEJM) published the “Courage” study. Buffalo cardiologist William Boden tracked 2,287 heart patients for five years, and showed that stents weren’t any better than a cocktail of medicines for patients with stable chest pain. In December 2010, the Senate Finance Committee released a report on a Maryland cardiologist, Dr Mark Midel, who allegedly performed unnecessary angioplasties on hundreds of patients. Abbott Laboratories, one of the primary makers of stents, had feted the doctor with a $1,407 roast pig party when he implanted 30 stents in a single day. St. Joseph Medical Center suspended his privileges and the Maryland State Board of Physicians charged Dr Midel with unprofessional conduct. Following the doctor’s departure from St. Joseph’s, the number of patients receiving stents dropped by more than half from 2008 to 2009. After the hospital barred him from operating on patients, Abbott Laboratories hired Dr. Midel as a sales consultant.

How do you like your eggs in the morning, fertilized?

A 2010 book, “A Baby At Last!” has been written by fertility experts at New York Presbyterian/Weill Cornell Medical Center. Infertility is defined as the inability to conceive after one year of unprotected sex, and affects one in six couples of child-bearing age in the U.S. Data reveals that in 40% of cases the problem is with the man, 40% with the woman, and in 20% something is amiss in both. Evaluating the male side, 70% of the problems are treatable. Smoking cigarettes, heavy alcohol consumption, using marijuana, cocaine, and other opioids can all lower the level of testosterone needed to make sperm. Exposure to radiation can also make a man permanently sterile. Men seeking to conceive need to be cool, literally. Heating the testicles even a few degrees can hamper or stop sperm production. Hot baths, hot tubs, tight pants should be avoided and resting a laptop on the lap for one hour can raise temperatures in the scrotum by five degrees. Obesity lowers libido, reduces sperm counts and disrupts hormone balance. A healthy weight and diet can increase a man’s chance of conceiving, but strenuous exercise like running more than 100 miles a week, or bicycle riding beyond 30 miles at a time, can lower sperm counts and testosterone. Play it cool, Big Daddy!

Penis envy carried a bit too far.

In Garden Grove, California, a 48 year-old woman drugged her husband’s dinner to make him drowsy. She tied him to his bed and cut off his penis with a 10 inch kitchen knife, then tossed the detached organ into the garbage disposal and turned on the power. She called 911 and reported a medical emergency. She met police at the door and directed them to the bedroom where they found the man tied down and bleeding profusely. She told police, “He deserved it.” He was taken to the hospital emergency department where the bleeding was controlled, and he is listed in good condition. The woman was detained for psychological evaluation.

Cultivate vices when you are young. And when you’re old they won’t forsake you.

In 1978 the Federal Communications Commission (FCC) established rules against broadcast indecency. A radio station could be fined for broadcasting the “dirty words” of the late comedian George Carlin, or a television show would be penalized for revealing no-nudity. The ban extends to the hours from 6:00 A.M. to 10:00 P.M., supposedly the time when children are more likely to be in the audience. Currently a case brought by broadcasters is seeking to overturn the FCC’s curb. Previously, the Supreme Court has not directly addressed the First Amendment issues related to the FCC’s rules, but now the Court has indicated it would hear broadcasters’ argument challenging the constitutionality. Geez, we already have a wasteland of drivel. If the FCC ban disappears, viewers and listeners might also get 24/7 drivel liberally spiced with vulgarity. God bless our naked, over-weight, tobacco-sucking, foul-mouthed America!

It was a lottery and he had the short straw.

Five young men gathered around the Mt. Tabor reservoir in Portland, Oregon, at 1:30 AM, June 14th, and one dude urinated into the pool. A security officer alerted the police and the culprit was promptly apprehended. Water Bureau administrator, David Shaff, called the reservoir contaminated. He stopped the inflow of water and drained the reservoir of 7.2 million gallons of water at a cost of approximately $55,000. When asked by a reporter if he would drain the pool if an animal urinated or died in the water, he said no but human pee is different. Right! It’s probably cleaner.

Addenda.

In 1959 sci-fi author Arthur C. Clarke wagered that man would land on the moon by June 1969.

Not for 101 years has any country other than the US produced two straight winners of a major golf championship until Northern Ireland’s Rory McIlroy and Darren Clarke won back-to-back titles this year.

My wife wanted plastic surgery, so I cut up her credit card.

Aloha and keep the faith.
Go Paperless and Get Paid

Register NOW for CMS Electronic Health Record Incentives

The Centers for Medicare & Medicaid Services (CMS) is giving incentive payments to eligible professionals, hospitals, and critical access hospitals that demonstrate meaningful use of certified electronic health record (EHR) technology.

**Incentive payments will include:**
- Up to $44,000 for eligible professionals in the Medicare EHR Incentive Program
- Up to $63,750 for eligible professionals in the Medicaid EHR Incentive Program
- A base payment of $2 million for eligible hospitals and critical access hospitals, depending on certain factors

Get started early! To maximize your Medicare EHR incentive payment you need to begin participating in 2011 or 2012; Medicaid EHR incentive payments are also highest in the first year of participation.

Registration for the EHR Incentive Programs is open now, so register TODAY to receive your maximum incentive.

For more information and to register, visit: [www.cms.gov/EHRIncentivePrograms/](http://www.cms.gov/EHRIncentivePrograms/)

For additional resources and support in adopting certified EHR technology, visit the Office of the National Coordinator for Health Information Technology (ONC):