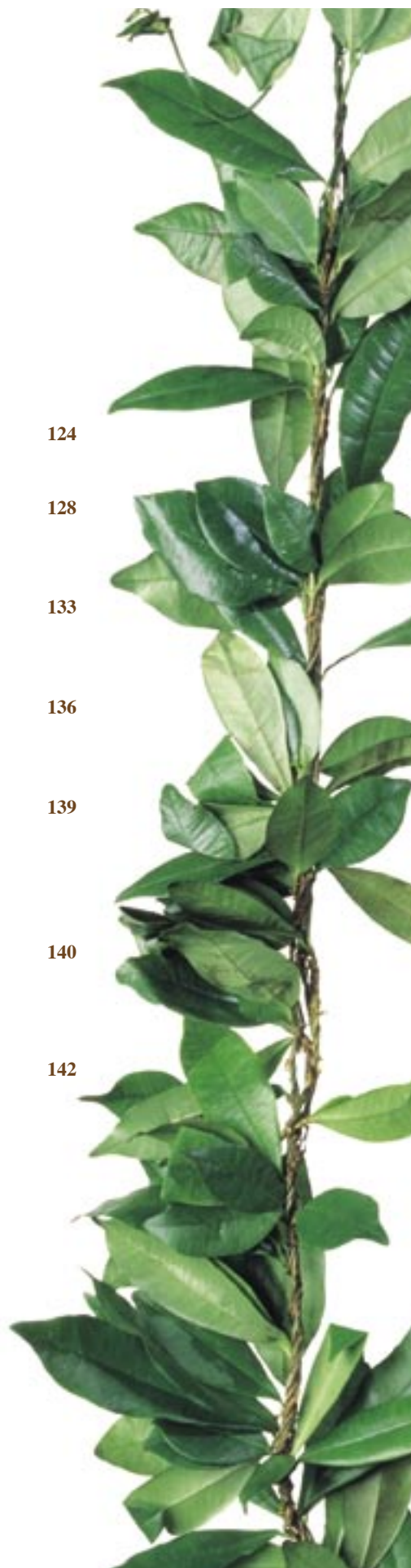


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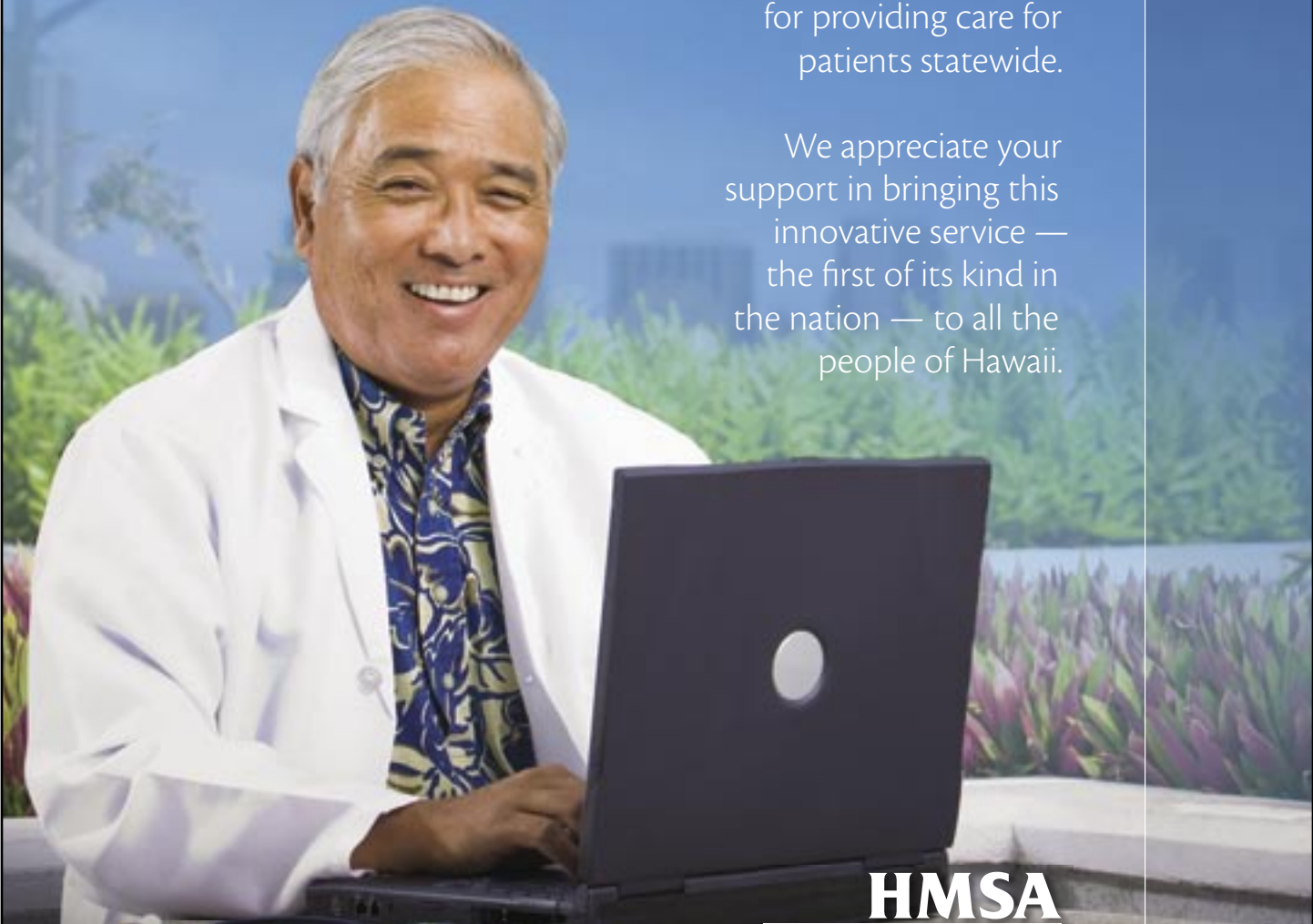
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A Practical Approach to the Healthcare Crisis: Solutions for Hawai'i and the Nation (Part 2 of 2)

Jerris R. Hedges MD, MS, MMM and Daniel A. Handel MD, MPH

Abstract

We have previously reviewed the challenges facing Hawai'i and the nation in terms of healthcare. Successfully addressing these challenges will require major changes in the delivery of healthcare and societal/legal perspectives. In this issue, we outline the key factors needed collectively and simultaneously to address these challenges. These factors are: (1) a capitated care model focused on health and chronic disease management; (2) universal access to a basic healthcare delivery system, and acceptance of the service limitations associated with such a model of care delivery; (3) a universal electronic shared health information system as a mechanism by which care in such a system can be coordinated; (4) an approach to developing state sanctioned, legal approaches to avoiding or minimizing futile care; (5) enhancement of systems of care (e.g., statewide trauma systems); (6) alignment of practitioner and hospital reimbursement with societal health goals, with legal protections; (7) a system of no-fault patient compensation when injuries occur in the course of medical care; and (8) support of expanded training programs for physicians, nurses and other practitioners.

Introduction

In the first part of this series, we reviewed the challenges facing Hawai'i and the nation in terms of health care. In this issue, we will look at possible solutions to these challenges. We discuss a number of key healthcare system factors that will likely be needed, not only in isolation, but more importantly in concurrent combination, to improve the health of United States and Hawai'i citizens. These key system factors are:

- 1) A capitated care model focused on health and chronic disease management.
- 2) Universal access to a basic healthcare delivery system, and acceptance of the service limitations associated with such a model of care delivery.
- 3) A universal electronic shared health information system as a mechanism by which care in such a system can be coordinated.
- 4) An approach to developing state sanctioned, legal approaches to avoiding or minimizing futile care.
- 5) Enhancement of systems of care (e.g., statewide trauma systems).
- 6) Alignment of practitioner and hospital reimbursement with societal health goals, with legal protections.
- 7) A system of no-fault patient compensation when injuries occur in the course of medical care.
- 8) Support of expanded training programs for physicians, nurses and other practitioners.

Capitated Care Model

A capitated care model need not be a single payer system. There can be competition with multiple payer systems. The key feature needed for such a capitated program is that it be focused on health and chronic disease management: that is, those activities that provide the best population return in years of productive life should be

rewarded. Health outcomes and process variables associated with meeting health objectives should be used to reinforce better practice patterns. Producing models that allow one to "risk adjust" for adverse patient selection will be difficult. Hence, at the outset, such a capitated program should provide both a base level of support for each patient with multiple chronic diseases and some supplemental support for acute interventions, albeit the latter would need to be reduced somewhat from current levels.

Unstated heretofore is personal responsibility in health and chronic disease management. There will be limits to what a program—whether state-focused or federal—can attain in terms of individual patient commitment to a healthy lifestyle and chronic disease management. Further, patients whose health declines as a result of poor personal health decisions will still expect the same level of healthcare. These are difficult issues around which universal policies are most likely to fail. Any capitated care model will need to account for potential noncompliance and disease progression. To ensure optimal practitioner commitment to enhancing patient outcomes for those patients at greatest risk, practitioner efforts made in good faith should not be held against the practitioner when determining reimbursement, should the patient choose an unhealthy lifestyle, despite appropriate physician guidance.

Compared to other states, Hawai'i has a highly capitated care system. 80% of those enrolled in Medicaid are under a capitated program compared to 64% nationally. Overall, 46% of people enrolled in a healthcare plan in Hawai'i are part of an HMO.¹ Unfortunately, as discussed below, although universal healthcare access requires universal health insurance coverage, universal insurance coverage without adequate providers participating does not equate to universal healthcare access.

Universal Access

A basic healthcare delivery system must be made available to all citizens. To exclude any group of citizens from such a system will adversely impact the ability of the United States to achieve desired health indices. Exclusion of such individuals also leads to inadequate prevention and management of chronic diseases. However, such an approach will not be economically feasible unless there are limits to the services provided. Thus, a basic level of healthcare must be societally defined and supported. This was the basis of the creation of the Oregon Health Plan, in that by limiting the services provided to those services that were most cost-effective for their impact on quality of life, the number of people covered was expanded.² Society must also protect the providers who limit their practice to this basic level of service. Options for self-paid or supplemental-insurance-based additional care should be available, but this optional additional care must be a small aspect of the total healthcare delivery system or the funding and societal support for the basic healthcare system will be compromised.

Universal access not only requires universal coverage, but a sufficient amount of providers to meet the demand. This fact became apparent in Massachusetts when law makers passed universal cov-

erage efforts in 2006. However, no policies were implemented at the time to address the shortage of primary care providers. In 2007, 49% of internists in the state were not accepting new patients, and given the increased demand for services with a covered population and fixed supply, the average time for patients to see a provider rose from 33 days in 2006 to 52 days in 2007.³

Universal Electronic Shared Health Information System

Chronic disease longitudinal care is dependent upon access to medical records by not only the care coordinator, but all providing care in consultation or emergency situations. Shared electronic health information should be funded by federal tax dollars and not the hospitals or practitioners. Such an approach allows the federal government to coordinate the features of such record systems and how they will interface. In order to improve the interoperability of electronic health records (EHRs), the Certification Commission for Healthcare Information Technology (CCHIT) was created to provide certification for those EHR vendors who complied with a common language in the structure of their systems. To date, they have certified both ambulatory and inpatient EHRs.⁴ Given greater uniformity in EHR systems and less impeded transfer of information between practitioners and hospitals, nursing and medical schools and post-graduate medical education programs can better coordinate the training that future practitioners will receive in the use of these tools. Further, health services researchers and administrators will be better able to investigate factors associated with better health outcomes and thus develop measures for guiding practice – often in real time while documenting the patient encounter.

A first step in creating an interoperable informatics system is through a Regional Health Information Organization (RHIO). Leaders in this field include the Indiana Health Information Exchange, created by the Regenstrief Institute.⁵ In Hawai'i, five RHIOs currently exist, all within Oahu, but have yet to begin information sharing across hospital systems.⁶ Among certain EHR vendors used in Hawai'i, interoperability between hospitals is a part of their core functionality and inter-hospital system information exchange can be implemented with limited supplemental funding. Criteria are needed for information exchange that is patient-focused and that facilitates statewide health planning and operations without exacerbating inter-hospital system competition.

State Sanctioned Approaches Regarding Futile Care

The role of medicine should be to maintain (and optimize) health and minimize the impact of injury or illness upon a productive life. When medical interventions will not appreciably further those goals and are associated with considerable risk – whether for an adverse event or resource depletion – these medical interventions should be considered futile. In such situations, practitioners should focus on comfort care.

This is an area associated with much controversy as many confuse the concept with the withdrawal of care rather than a change in the focus of care to a “rest-of-life” comfort mode. Others may perceive this as a “giving up” by the patient or family if asked to support such a change in care plan. Although advanced directives and physician

orders for life-sustaining therapy (POLST) have helped proactively define the direction that care might take, these tools are not always available and when available may be interpreted differently by different members of the care team and of the family. The development of a POLST system is variable from state to state. In Hawai'i, bills were recently introduced in the state legislature to develop a POLST program.⁷

Having an approach that is legally sanctioned and respects the wishes of the patient and family within the limits of reason is desired. Indeed, this specific intervention (i.e., how much of what type of care to undertake for the patient with declining health) will be the most important societal response to the financial imperative posed by a growing number of elders with chronic disease states – despite (or perhaps because of) an anticipated future focus on chronic disease management.

Systems of Care

Many take for granted their existing systems of care. Many states or regions have public health clinics, emergency medical service (EMS) systems, trauma systems, and poison control centers. These systems of care provide benefit on a larger scale than an isolated practitioner or hospital might be able to provide. With the exception of some recent allocations for federal emergency preparedness, support for these systems has not kept pace with the use of these systems. Further, additional systems associated with regional centers of care excellence may be needed to elevate the level of care that can be provided when resources for specific illnesses are pooled. Support for existing systems will need to be enhanced if a capitated care model does result in a reduction of practitioner and hospital payment for acute illness or injury.

While the state of Hawai'i has a statewide EMS division and Hawai'i Poison Hotline through its Department of Health, it lacks a trauma hospital designation process, transfer guidelines, and a statewide trauma registry.⁸ A statewide trauma registry need not be elaborate, but is important to monitor the quality of trauma care, transfer practices and the optimal utilization of statewide resources.

Alignment of Reimbursement with Societal Health Goals

The alignment of practitioner and hospital reimbursement with societal health goals is complex and will likely require a gradual phase in over a five-year period. Such a process will be very dependent upon obtaining accurate data from the EHRs. There is also the challenge (similar to what might occur when addressing futile care) related to societal acceptance of the limitation of capitated care. Clearly, the capitated process must not financially reward practitioners for not giving care as was done when managed care was introduced. Rather, the practitioner must be rewarded for maintaining health and minimizing exacerbations of disease – regardless of the amount of care needed – with the exceptions being patient noncompliance and futile care as outlined above. Factoring patient noncompliance into a reimbursement plan will be challenging in that there must be bonafide evidence – perhaps as documented via a behavioral counselor consultation that the patient is recalcitrant to lifestyle changes or compliance with her/his therapeutic regimen.

No-fault Patient Compensation with Care Delivery-associated Injuries

Medical legal insurance premiums continue to increase disproportionately to physician practice revenue and cases are often raised on the basis of physician-patient communication concerns rather than merit. At times, the adverse events that occur in the course of medical care may be closely related to the patient's underlying health state – i.e., some adverse event may have been inevitable given similar medical care on a sufficient number of similarly-affected patients. Further, awards seldom account for the patient's level of responsibility, the loss of practitioner time with other patients, or the impact of such a case on the practitioner's subsequent practice (whether settled in the practitioner's favor or not).

Although physicians should be monitored for professionalism, the basis of malpractice claims should be reliant upon the application of proven therapeutic approaches and outcomes in regards to their peers. The court system is too capricious to do this in a manner that will truly protect the public and help the practitioner improve her/his practice. Rather, new approaches including the use of community health care ombudsmen to address professionalism and EHR review to address approaches and outcomes for key patient populations with peer comparisons will be more valuable.

This does not negate the need for some mechanism to compensate the individual who undergoes a catastrophic unexpected adverse event during a course of care. Here, a no-fault compensation fund established by the state with contributions by insurance companies, hospitals, and practitioners should be established. An independent legal panel could review the concerns and stated needs of the injured individual and may make a "wealth transfer" to that individual and representing attorney without prosecuting the practitioner.

Thus evaluations of the practitioner can be made by medical peers based upon objective data from multiple similar cases and not focus on one case for which the patient or family elected to raise a concern. This no-fault approach will be controversial as many trial attorneys do not trust physicians to monitor their peers. Trial attorneys may also complain that the settlements may be smaller. Although smaller settlements might impact the financial health of the trial attorneys, more rapid processing of claims in a non-confrontational manner may encourage rapid healing of the injured patient/family and provide needed support to many more families who might take advantage of such an approach. Many argue as well that such a rapid processing of no fault claims through medical courts will also decrease the costs of malpractice coverage and its impact on costs in the healthcare system.⁹ Overall medical liability tort reform is needed in Hawai'i as well as recommended by a 2006 task force addressing the crisis in physician on-call availability within the state.¹⁰ One of the primary benefits of liability tort reform is the proven ability to draw physicians to a state with tort reform. Improved access to care was demonstrated in California and Texas following liability tort reform.¹¹

Support of Expanded Practitioner Training Programs

Training programs for physicians, nurses and other practitioners are expensive and when done in the private sector, trainees often leave the training programs with considerable educational debt. National investment in the expansion and strengthening of current educational programs, particularly in the support of rural practitioner training, is critical. Presuming a state and federal initiative aligned with the principles outlined above, medical schools could be incentivized to demonstrate how their curriculum enforces these principles and how the goals of greater rural practitioners and a culturally sensitive workforce are being met.

The number of positions in current physician residency training programs has not kept pace with the growth in US population.¹² Nor has there been a sufficient growth in the additional numbers of medical student and resident level trainees needed for an increasingly complex and growing elder and chronic disease population. A student loan repayment program modeled after the National Health Services Corps Loan Repayment Program¹³ is under consideration by the Hawai'i state legislature. This state loan repayment program would recruit primary healthcare professionals and specialists to rural or under-served parts of the state.¹⁴

Given that trainees are most likely to eventually practice in the state where they grew up, attended medical school, or did their residency training,¹² it is vital that the University of Hawai'i John A. Burns School of Medicine continue to create opportunity at both the medical student and resident levels for those with strong ties to the Hawaiian and Pacific Islands. Indeed, expansion of the state's family medicine and other training programs to the neighbor islands is more likely to result in subsequent rural practice by these physicians than loan forgiveness programs alone.¹⁵ An innovative multiprofessional rural training environment could be established with local, state and federal support on the neighbor islands to meet the community needs via evolving contemporary models of health care delivery.¹²

Telehealth also has the potential to provide accessibility for patients to specialists who cannot otherwise afford to practice in low-density population centers. The Telehealth Task Force was convened in 2008 at the request of the Hawai'i State Legislature by the University of Hawai'i John A. Burns School of Medicine's Telehealth Research Institute. Some progress has been made, but further efforts are needed to make this a fully integrated tool within the Hawai'i healthcare enterprise. One primary issue with telehealth is creation of a reimbursement system for telehealth patient encounters. The Hawai'i Medical Service Association has done so for some encounters, but telehealth continues to represent a low proportion of charges submitted.¹⁶

Summary

The basis of the current healthcare crisis can largely be reduced to four key factors: 1) Expenditure of large portions of the US gross domestic product with a disproportionate achievement of health targets; 2) An aging population with increasingly complex and demanding healthcare needs; 3) Disparities in healthcare access, delivery and outcomes; and 4) An aging, understaffed, and progressively disenfranchised healthcare workforce. Within each of these factors are multiple interlocking parts; resolution of the crisis will require that all factors be simultaneously addressed.

A number of actions requiring societal commitment can address this evolving crisis. Attempting to solve this dilemma by addressing only a part of the crisis or through only a few of the needed actions will not succeed. This article provides an outline of the key healthcare system design and related societal/legal factors that will be needed. The time for coordinated simultaneous action on multiple fronts is now.

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HIV/AIDS in Hawai'i: State of the State

Kathleen M. Sullivan PhD

Abstract

This paper describes the HIV/AIDS epidemic in Hawai'i over the last decade and identifies characteristics of those infected, including race/ethnicity, age, and risk behaviors related to HIV acquisition. State-based HIV/AIDS surveillance and counseling and testing data were reviewed, along with a comprehensive review of HIV/AIDS-related literature and reports emerging from agencies in Hawai'i. Recent legislative measures concerning HIV testing, counseling and HIV reporting were reviewed and summarized. Hawai'i continues to have low HIV/AIDS prevalence compared to other US states. There have been continuing changes in the face of HIV/AIDS in Hawai'i over the last decade, including increased number of AIDS cases among Hispanics and African Americans and a decreased percentage of cases among Caucasians and also among men who have sex with men. Legislative and policy changes have been implemented with the intent of enhancing the efficiency and quantity of HIV testing, and of strengthening the HIV prevention and care services offered in the State.

Introduction

The HIV epidemic is now in its third decade with new infections in the United States occurring at a much higher rate than previously thought. With refined methodologies used for estimating rates of new infections, the 2006 yearly estimated incidence of HIV in the United States rose from 40,000 to 56,300.¹ About 25% of Americans living with HIV are unaware of being infected because they were either never tested or did not return to obtain serostatus results after testing. With new HIV cases continuing to occur, it is important to monitor local HIV/AIDS rates and HIV care and prevention efforts offered to the people of Hawai'i, where the face of HIV is diverse and unique compared to most states in the US mainland.

A low AIDS prevalence rate has historically existed in Hawai'i, with less than 10 cases reported per 100,000 persons in recent years.² Yet, there is a continued need to closely monitor HIV/AIDS rates in Hawai'i, as this state serves as a migratory hub for the Pacific, and as a gateway to the United States for international travelers. A 21-year ban on travel to the United States by people living with HIV/AIDS has recently been relaxed through streamlining of the process for granting temporary, non-immigrant visas to HIV-positive applicants.³ Based on the diversity of persons newly infected with HIV, including ethnic minorities and heterosexual persons,¹ the effectiveness of long-standing behavioral risk-based testing to identify infected persons (including primarily gay men and injection drug users) needs to be re-examined. By keeping abreast of trends, policies, and surveillance methods to track HIV incidence, Hawai'i can remain a model state with low HIV seroprevalence. The aims of this review are to: describe the characteristics of persons living with HIV/AIDS in Hawai'i; to provide an update on current issues in testing and counseling and medical care services available in the State; and, to provide references to important publications pertaining to these issues. This will inform health and social service personnel and foster continuing efforts to address HIV prevention and care in Hawai'i.

Methods

Epidemiological data on HIV and AIDS were collected from reports of the Hawai'i Department of Health (DOH) HIV/AIDS Surveillance Program,^{2,4,29} STD/AIDS Prevention Branch,⁵ and the HIV/AIDS Community Planning Group.⁶ Reports about state-funded programs and projects were reviewed.⁷⁻⁹ In addition, published literature on HIV/AIDS rates, and prevention and care services nationally and locally was reviewed Current DOH revised administrative rules on laboratory testing and Hawai'i statutes on informed consent for HIV testing and counseling were reviewed¹⁰ as well as a current report from a workgroup addressing CDC-recommended changes in routing HIV testing in medical settings.¹¹

Results

Most published HI DOH epidemiological and surveillance profiles include data for clients diagnosed with AIDS. DOH counseling and testing data include numbers of HIV tests performed and numbers of seropositive results confirmed.^{5,12} By 2008, Hawai'i has reported more than 3,000 cases of AIDS and according to a recent assessment on the care needs of persons living with HIV state-wide,⁹ there are presently 2,767 persons living with HIV/AIDS who know their status. A low AIDS prevalence rate has historically existed in Hawai'i, with fewer than 8.5 cases per 100,000 persons reported annually in 2005 and 2006 (Figure 1).² The national average for population-based AIDS prevalence rates for 2005 and 2006 were 13.5 and 12.7 respectively, while some areas reported a much higher prevalence, including Washington, DC at 146.7 and New York at 32.1 cases per 100,000 persons.¹³ In Hawai'i, for the period 2000-2003, a declining trend in numbers of AIDS cases was reported.¹⁴ Since then the number of new AIDS cases has remained relatively stable with 82 cases (6.4/100,000) reported in 2007.²

Year	Cases	Rates
1998	138	11.4
1999	115	9.7
2000	123	10.4
2001	110	8.8
2002	109	8.8
2003	100	8.0
2004	121	9.6
2005	107	8.4
2006	88	6.8
2007	82	6.4
	1093	
Cumulative	3043	

Race/Ethnicity: Recent epidemiological data indicate that the face of AIDS in Hawai'i continues to contrast from the US mainland. Estimates of HIV/AIDS infections in the United States during 2003-2006 highlight a larger proportion (68%) of newly infected individuals being of racial or ethnic minorities including African Americans (50%), Hispanics (16%), and Asian/Pacific Islanders (2%).¹ In Hawai'i, persons of ethnic minorities do represent the majority of new infections but the ethnicities of those minorities are in sharp contrast to Mainland United States cases (Table 2a-2b). Hawai'i Counseling and Testing data since 2003 indicate that HIV-positive test results occurred most frequently among Caucasians (44.1%), and Asian Pacific Islanders (36.4%), followed by Hispanics (11.9%) and African Americans (3.5%).¹² When comparing cumulative AIDS cases during two five-year time periods from 1998- 2002,⁴ and from 2002-2007² (Table 3), the proportion of cases of AIDS in Caucasians has declined (60% vs. 50%) while the proportion of cases has increased among Hispanics (6% vs. 10%) and African Americans (5% vs. 5.4%). During the two five-year time periods, the proportion of AIDS cases among Asian Pacific Islanders as a whole, has stayed relatively the same (28.5% vs. 28.6%). Compared to the general Hawai'i population, ethnicities overrepresented with AIDS diagnoses include Caucasian, African American and Hispanic.^{2,4} While per capita, Asian/Pacific Islanders in Hawai'i with AIDS are underrepresented, further desegregation by ethnicity shows that Hawai'ians were disproportionately affected by AIDS during the 1998-2002 period (12%, *n* = 117). There was a decline in the number of cases of AIDS reported among Hawaiians (8.0%, *n* = 40,) during 2003-2007.

Gender: AIDS cases have occurred predominantly among men, who represent 89% of the people living with AIDS in the state.¹⁵ AIDS cases among women in Hawai'i are relatively low compared to national statistics.^{1,2} A total of 129 female AIDS cases were reported in one decade (2003-2007) in Hawai'i with a near equal number of cases during each five-year increment. This accounted for 11% of the documented AIDS cases during that time period. While women have accounted for a gradually rising *percent* of cases, the absolute *number* of new female AIDS cases has not changed dramatically over two consecutive five-year periods. Women represented 17% (*n* = 15) of the newly reported cases of AIDS in Hawai'i in 2008.

Risk Factors for HIV Infection: The HIV transmission risk factor reported for the majority (56%) of new HIV infections in the United States was men having sex with men (MSM), followed by heterosexual contact (30%) and injection drug use (11%). In Hawai'i a similar consistently large percentage of AIDS cases have been reported among MSM (73%).¹⁵ The proportion of AIDS cases in Hawai'i attributed to MSM has decreased over time however, with a greater proportion of cases being of undetermined transmission risk (Figure 1).^{2,4} The cumulative total of AIDS cases in Hawai'i attributed to injection drug use (8%, *n* = 237) and heterosexual contact (6%, *n* = 175) have remained relatively low and stable over time.

Age: Most individuals in Hawai'i were diagnosed with AIDS when they were in their thirties and forties.¹⁵ Fewer young people are being diagnosed with AIDS in the United States since the advent of HAART, as the time between HIV infection and progression to

Table 2a.— Estimated incidence per year, of New HIV Infections, 50 US States and District of Columbia, 2003-2006, by Race/Ethnicity N = 55,400

Categories	Percent
White	32%
Asian/Pacific Islanders	2%
Black	50%
Hispanic	16%
Other	0

Table 2b.— HIV Positive Tests, Hawai'i Counseling and Testing Data 2003-2006 by Race/Ethnicity

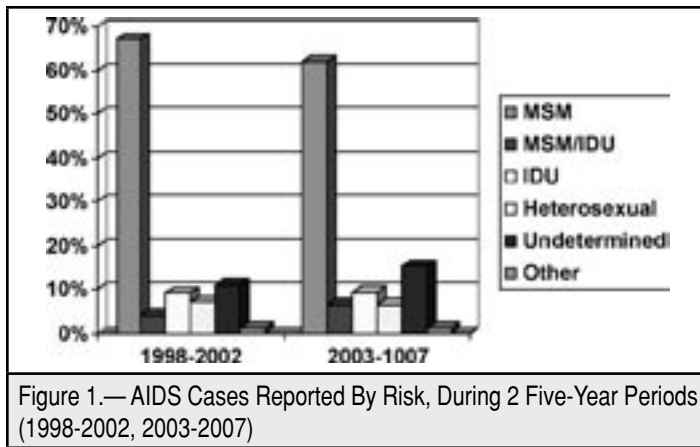
Categories	Percent
White	44.1%
Asian/Pacific Islanders	36.4%
Black	3.5%
Hispanic	11.9%
Other	4%

Table 3.— AIDS Cases and Population*

	Year	Percent
Caucasian (N = 630)	1998-2002	60%
	2003-2007	50%
	Population	32.4%
Hispanic (N = 91)	1998-2002	6%
	2003-2007	10.2%
	Population	7.2%
African American (N = 134)	1998-2002	5%
	2003-2007	5.4%
	Population	2.3%
API (N = 325)	1998-2002	28.6%
	2003-2007	28.5%
	Population	65.9%
Hawaiian (N = 117)	1998-2002	12%
	2003-2007	8.03%
	Population	8.6%

*Redistributed 2000 Population

AIDS has increased. Over a recent three-year period (2003-2006), HIV Counseling and Testing (CT) data from Hawai'i indicate that nearly three quarters (73%) of all clients who tested positive at these centers were between the ages of 20-44. More recent CT data (2006-2007) is further disaggregated by age, and indicate that over 30% of the HIV positive test results (31%, *n* = 26/83) occurred among individuals in their twenties, and another near 30% (28.9%, *n* = 24/83)



of positive tests occurred among individuals in their thirties. While the CT data provide information on high-risk populations who agree to be tested at a DOH publicly funded site, it is not representative of all who are HIV-positive in Hawai'i.⁵

HIV Care

The majority of AIDS cases have been reported by the central county of Honolulu (68%), with the remaining bulk of additional cases reported by the remote island counties of Hawai'i (15%) and Maui (13%).⁹ There are no HIV-specific health care clinics on the outer islands of Kaua'i or Moloka'i, while Maui has one, and O'ahu has four relatively small HIV-specific clinics located in the urban district of Honolulu. Historically in Hawai'i the majority of HIV seropositive clients have been cared for by relatively few doctors specializing in HIV/AIDS, and most of those physicians maintain a practice on Oahu. A recent report⁹ indicates that there are seven physicians on O'ahu certified by the American Association of HIV Medicine, and eight additional doctors that specialize in infectious diseases who each care for five or more seropositive clients. Many of those doctors are reaching the age group at which other physicians choose to retire. This accentuates the ongoing challenge of providing HIV-specialty services to clients living with this chronic illness. HIV-specific satellite health clinics have only recently become available to clients on the islands of Hawai'i and Maui, offered by the Hawai'i AIDS Clinical Research Program (HACRP).⁹

For more than 1,000 of the seropositive persons living in Hawai'i, it is not known whether they are receiving health care for their illness.⁹ The HACRP report indicates that some barriers to accessing care among A/PI include "shame, fear and stigma" (pg. 31). It was reported that A/PIs were less likely than other ethnic groups to receive a minimum frequency of care, with those of Hawaiian ancestry more likely to omit medication administration. The challenges facing the health care industry and the clients living with HIV in Hawai'i are magnified by the low disease prevalence in the state. Hawai'i does not attract many physicians or health care providers that specialize in HIV care, and providing professional services for the limited number of clients on the remote islands is challenging.

HIV Screening and Testing

Routine Testing: In 2006, the CDC published revised recommendations for HIV testing that include routine testing for adults and adolescents ages 13-64, and pregnant women who utilize health-care settings for prenatal care and/or delivery.¹⁶ Clients who visit emergency departments, or urgent care, substance abuse, correctional, and primary care facilities are recommended to be screened for HIV routinely. The revised recommendations include: 1) opt-out HIV screening where general consent for medical care is considered sufficient to encompass consent for HIV testing, and 2) client notification that testing will be performed (unless he/she declines). Separate written consent and prevention counseling are not recommended as part of the routine HIV screening in health-care settings. CDC's recommendation for routine testing is aimed to help decrease barriers to HIV testing such as a clinician's perceived discomfort with discussing client risk behaviors or the imposed time constraints with mandatory prevention counseling.¹⁶ Each state decides if, how, and when to address the CDC's recommendation for routine HIV screening,

Recently in Hawai'i, a workgroup of key stakeholders in the HIV arena wrote a full report addressing the CDC's recommendations for routine testing, and developed proposed revisions to the Hawai'i statutes regarding HIV testing in Hawai'i.¹¹ The current Hawai'i statutes require written informed consent and pre- and post-test counseling with each HIV test administered.¹⁷ The proposed revisions include that healthcare providers and employees of healthcare facilities (excluding those who rely upon treatment by spiritual means alone) can administer HIV testing procedures without written informed consent or pretest prevention counseling. However, clients must be offered the opportunity to decline the test. In the event that a test result is reactive, indeterminate, or confirmed HIV positive, the provider is required to relay those results to the client and offer post test counseling.

The workgroup, hosted by the Life Foundation, the Hawai'i Medical Association and the Hawai'i Department of Health, recommended that requirements for written consent and pretest counseling be eliminated for health care providers only, to decrease the potential barriers to testing in health care settings. However, pretest counseling and consent would continue to be required for non-health care providers who administer HIV testing including blood banks and plasma centers for examples. The state-supported Hawai'i HIV/AIDS Community Planning Group put forth a statement about the CDC's recommendations¹⁸ that includes the following stipulations: 1) that anonymous testing continue to be readily available; 2) that all relevant providers and the community-at-large be educated about the new testing procedure for which the DOH will take the lead; 3) that this education process begin prior to any implementation of the new testing procedures; 4) that post-test counseling be offered for those who test positive or indeterminate to assure that referrals to appropriate services are made; and 6) that the cost of the test will be covered by health insurance. The proposed statute revision drafted by the workgroup recommends that HIV screening be offered to all clients in health care settings in order to reduce the possible stigma of only testing consumers considered at high-risk for HIV/AIDS. This recommendation was supported by the workgroup as long as the consumer does not need to pay for the HIV screening.

Rapid Testing: In 2002, the Federal Drug Administration (FDA) approved the use of a finger prick rapid HIV antibody screening test for which results are available within 20 minutes, and which are reported to be more than 99% accurate.^{19,20} While same-day test results are reported to clients, reactive tests require traditional HIV testing to confirm a diagnosis. When rapid-test results are reactive, clients should be counseled about the likelihood of being infected and about taking precautions to prevent transmission until their status is confirmed.¹⁹ Incentives for rapid testing include: 1) obtaining results quickly and at times without a blood draw; 2) determining the need for post-exposure or perinatal prophylaxis; 3) reaching at-risk populations that may not frequent urban health care settings and who otherwise might not be tested; and 4) capturing the 25% to 30% of HIV-positive persons who do not typically return for their standard HIV test results.²⁷ Several factors influence the decision to implement rapid testing procedures. One is the urgency for the need of test results such as with pregnant women who have not previously been tested, have engaged in high-risk HIV transmission behaviors since last tested, and/or are about to deliver. Persons who are tested are typically informed of their HIV status and receive information about HIV transmission risks and prevention.

In 2004, a rapid HIV test using oral fluids was FDA approved.¹⁹ A sample can be stored at room temperature and requires no specialized equipment. The use of rapid testing in health care facilities and community-based organizations in Hawai'i was facilitated by the implementation of policy changes regarding clinical laboratories and laboratory personnel (Clinical Laboratory Improvement Amendments, or CLIA). Currently, rapid tests that use oral fluids (OraQuick) or whole blood are categorized as waived tests under CLIA, allowing for test administration in any facility that has CLIA certification.²¹ This allows the tests to be administered in many health care settings by many different health providers. HIV testing that requires a serum and/or plasma sample are considered higher complexity tests and require more highly trained laboratory personnel for administration. Non-clinical testing sites that plan to offer waived rapid HIV tests must either apply for their own CLIA Certificate of Waiver or establish an agreement to work under the CLIA Certificate of an existing laboratory. The fee for a Certificate of Waiver is currently \$150 and the waiver is valid for two years.

In Hawai'i, the use of rapid testing was facilitated by efforts from the Hawai'i DOH STD/AIDS Branch and through changes to administrative rules.¹⁰ In July 2007, the Hawai'i Administrative Rules for Laboratory Testing and Laboratory Personnel were revised to allow for CLIA-waived rapid testing. Personnel from the CDC provided appropriate training for DOH personnel about rapid testing. The State now has trainers with the capacity to train other people in rapid testing administration.²³ To date, agencies in Hawai'i that have been publicly acknowledged for instituting rapid testing include the Life Foundation, a nonprofit organization that provides HIV counseling, testing, care and prevention services for persons affected by HIV and the Diamond Health Clinic. Rapid testing services are also available via mobile outreach offered by Life Foundation. Over 1,900 rapid tests have been administered via mobile outreach with 22 reactive tests reported.²⁴ Fewer tests have been administered at the Hawai'i DOH clinics as implementation is being piloted.²³ Rapid testing has not been instituted at public obstetric wards in Hawai'i.

There are some points of concern with rapid testing. While the FDA cited a near 99% accuracy rate with rapid testing, results are not 100% accurate. The CDC is currently investigating a higher than expected number of false positive results in some locations of New York City that occurred when using the oral rapid test.²⁵ This has led to the suspension of oral rapid HIV testing in STD clinics there. The cost of using rapid testing for routine HIV screening in the low HIV prevalence area of Hawai'i is of concern. Currently rapid testing is offered to high-risk populations in Hawai'i, rather than to the public in general.

HIV/AIDS Reporting: In March, 2008, in response to a Hawai'i Administrative Rules change,²² the DOH implemented HIV names-based reporting on all islands. All primary care providers and laboratories in Hawai'i need to report confirmed HIV cases by client name (not AIDS cases only) along with additional pertinent information.²⁶ All cases of HIV or AIDS ever diagnosed in Hawai'i need to be reported, whether the person is alive or deceased. Providers no longer report HIV cases using unnamed coding. The names of HIV-positive clients are not sent to the CDC or elsewhere, and individual information is maintained at the HI DOH only. All US states are now using the names-based reporting system, which is required in order to receive federal HIV/AIDS care funding under the Ryan White CARE Act. There are service sites in Hawai'i that still offer anonymous and confidential testing, including several state-run clinics and some community-based organizations.²⁹ HIV-positive test results that are administered anonymously or confidentially are not reported by name. However, when the individual who tested positive enters medical care, the health care provider is required to provide the client's name to the Hawai'i DOH.

From March through December 2008, the cumulative total of HIV (non-AIDS) cases newly reported to the Hawai'i DOH was 701. Of those, 630 were diagnosed in Hawai'i. Although reported for the first time in 2008, many of these cases were diagnosed in previous years. More complete data on HIV (non-AIDS) case reporting is anticipated to facilitate future HIV prevention and care planning activities in the state.

Discussion

In Hawai'i several important changes have occurred in the HIV/AIDS arena that have the potential to boost the strength of the State's response to the epidemic. The enactment of new administrative rules has the potential to provide more accurate tracking of the incidence and prevalence of HIV in Hawai'i, and to contribute to the national epidemiological profile of HIV in the United States. This is especially important as the face of HIV is unique in Hawai'i. Increased immigration, migration, and extended international travel, coupled with the recent relaxation of the travel ban on persons living with HIV, raises the potential for greater transmission rates in Hawai'i.

The anticipated adoption of administrative rule changes that facilitate routine HIV testing in health care settings including hospitals, emergency, urgent care and outpatient clinics, creates a need to assess health care workers' current knowledge about the CDC recommendations for routine testing. Care providers will need to be introduced to and informed about the newer policies, technologies and procedures for testing, especially in settings where testing could be frequent, such as emergency and birthing units, and in community-based settings.

Policies and procedures for routine and rapid HIV testing need to address the unique circumstances of differing health care arenas and should be formalized and individualized to ensure correct and ethically sound testing implementation. The revised CDC guidelines and Hawai'i statutes can assist providers working in clinical facilities with development of protocols for routine testing. Education and training offered through the DOH is recommended for consistency and accuracy of test administration and for HIV names-based reporting and documentation. A team of professionals with expertise in strategic planning, protocol development, and training could assist with the dissemination of information, and offer demonstration projects focused on implementation. A consistent and accurate process is needed for addressing reactive, indeterminate, positive and false positive test results, especially in situations where a pregnant woman will need to alter plans for breastfeeding her newborn because of the test result. In addition the question of who will bear the cost of routine HIV testing in Hawai'i, where HIV prevalence is currently low, needs to be answered. It is anticipated that insurance companies will be interested in the cost effectiveness of implementing routine and rapid testing. If individuals in Hawai'i can easily and efficiently determine their serostatus and know if they are infected, treatment options and prevention services can be accessed.

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Obstetric Anal Sphincter Injury Repair Workshop for Residents

Ian A. Oyama MD; Michael C. Aaronoff MD; and Janet M. Burlingame MD

Abstract

Objective: *Obstetric anal sphincter injury (ASI) is associated with significant morbidity. We conducted an ASI workshop for 20 obstetrics and gynecology residents and assessed its impact. Our goal was to determine and enhance residents' knowledge using a multimedia presentation, hands-on simulator, and tests. We comment on trends regarding residents' knowledge bases and their retention of the material.*

Study Design: *The workshop consisted of a pretest, lecture with slideshow, DVD, and 20 simulator stations. The porcine tongue simulator represented the human perineum, bungee cord the anal sphincter, and a laceration created in each tongue an obstetrical ASI. Faculty members supervised the residents' suture repairs. We analyzed responses from identical immediate posttests and delayed posttests.*

Results: *Out of a possible 18 points, the average scores were: pretest 9.1 (SD 2.32), posttest 17 (SD 1.34; $P < .001$), and delayed posttest 15.1 (SD 1.52; $P < .001$). On a 10 cm visual analog scale (VAS) evaluating the helpfulness of this exercise, the average respondent marked 9.0 (SD 0.95). On a VAS evaluating the comfort level in repairing ASI, the average pre-simulator score was 3.9 (SD 3.13) and the average post-simulator score 5.2 (SD 2.96; $P < .001$).*

Conclusion: *Relevant structured workshops with simulators for ASI repair could help improve residents' background knowledge and skills in repairing such injuries.*

Introduction

Obstetric anal sphincter injury (ASI) occurs in 0.6¹ to 20%² of vaginal deliveries and can cause significant morbidity including pain, dyspareunia, anal incontinence, or defecatory dysfunction. Rectovaginal fistula may further complicate such an injury, and in cases of post-repair infection or abscess, wound healing is delayed. After correctly identifying a third or fourth degree perineal laceration, its expert repair is critical in reducing or eliminating complications. In recent years, some obstetrics and gynecology residents have had only limited experience in repairing these complex lacerations,³ and frequently residency programs provide no formal, standardized training in ASI repairs.⁴ The American College of Obstetricians and Gynecologists is attempting to reverse this recent trend and, to that end, recently released the monograph "Episiotomy: Procedure and Repair Techniques"⁵ and a DVD entitled "The Beef Tongue Model: A Tool In The Teaching Of Obstetric Laceration Repair."⁶

We conducted an ASI structured workshop for University of Hawai'i obstetrics and gynecology residents that included a multimedia presentation and an animal tongue simulator created by modifying the model described by Sauerwein.⁷ Our low-fidelity simulator utilized porcine tongue to represent the human perineum and bungee cord to represent the external anal sphincter. By definition, low-fidelity models are less realistic than high-fidelity models. Low-fidelity models have been shown to be effective teaching tools⁸ and their advantages include lower cost and easier preparation compared with high-fidelity models. In our analysis of the residents' test results, we comment on trends regarding their knowledge of the subject matter and their retention of the material.

Our objective was to determine and enhance residents' knowledge of ASI repair. The workshop's lead-off lecture and DVD viewing⁹

were intended to highlight key anatomical and surgical pointers for both the end-to-end and overlapping repair methods. Modifying the animal tongue simulator described by Sauerwein reduced the cost of the simulator. In our modification, porcine rather than bovine tongue was used, and bungee cord rather than plastic tubing was implanted within the tongue. Faculty supervised the residents in their suture repairs to increase learner buy-in. The aim of the test (thrice administered) was to gauge residents' baseline knowledge of ASI and its repair, to assess score improvement after the simulator, and whether and to what degree score improvement would be maintained after five weeks.

Methods

The simulator was exempt from Institutional Review Board approval as we report on the results of our educational intervention without information identifiable to the individuals. This educational exercise consisted of several parts including a pretest, a lecture, viewing the DVD, "Repair Of A Fourth Degree Obstetrical Laceration,"⁹ from The American College of Obstetrics and Gynecology's DVD library, a practical exercise with the porcine tongue, a posttest, and finally a five-week posttest. Each test consisted of the same 18 questions that tested the residents' knowledge of anatomy, surgical technique, complications associated with ASI, and management of these complications. Two examples of the test questions include: "1) Name the muscles that comprise the perineal body," and "2) Anal sphincter injuries can be repaired using what two techniques?" At the conclusion of the pretest, a 30-minute lecture was given to the residents discussing material covered in the pretest. Next, the aforementioned DVD demonstrated the proper technique to repair an ASI.⁹

The next step in this exercise was a hands-on practicum where each resident was able to repair an ASI simulated with a porcine tongue. The simulator was modified from Sauerwein's protocol, and each simulator was prepared as follows. A 60d nail was used to create a tunnel through the long axis of each tongue (Figure 1). A length of bungee cord wrapped in duct tape was then passed through the tunnel (the duct tape is necessary to prevent suture pull through) (Figures 2, 3, and 4). The tongue simulates the perineal body with the anterior surface simulating the vaginal skin, and the posterior surface simulating the rectal mucosa. The bungee cord simulates the external anal sphincter. The tongue and bungee cord were then cut with a scalpel to simulate an ASI (Figures 3 and 4). Each resident had his or her own simulator and next repaired it with an overlapping or end-to-end technique. We familiarized the residents with the results of the latest Cochrane review comparing these two techniques of ASI repair.¹⁰ The authors supervised the residents to monitor their suturing technique and to inspect each simulator for an appropriate repair.

Finally, the exercise was concluded with a posttest that was composed of the exact same questions posed on the pretest. The pretest contained a 10 cm visual analog scale (VAS) and the residents were asked to use the scale to rate their comfort level in repairing an ASI with 0 being completely uncomfortable and 10 being completely comfortable. This scale was then presented to the residents upon



Figure 1

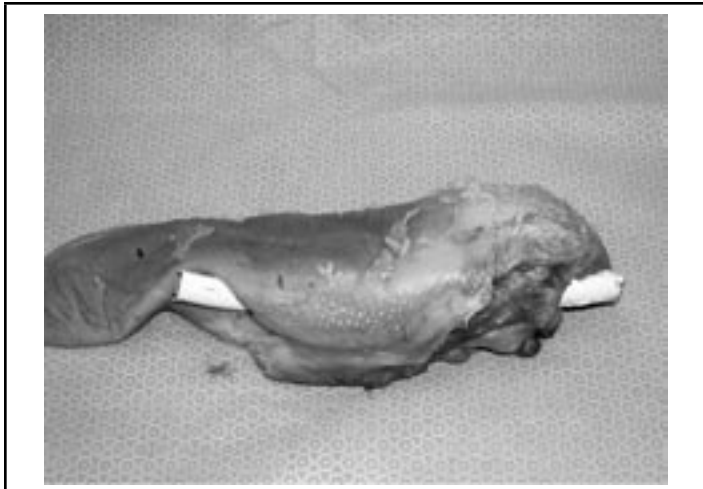


Figure 2

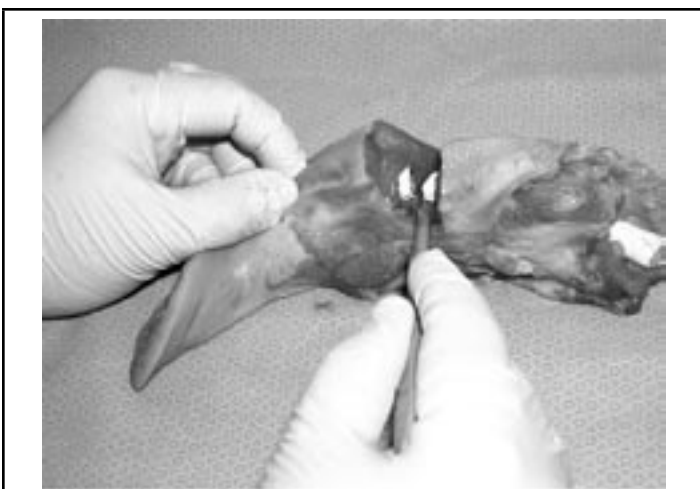


Figure 3

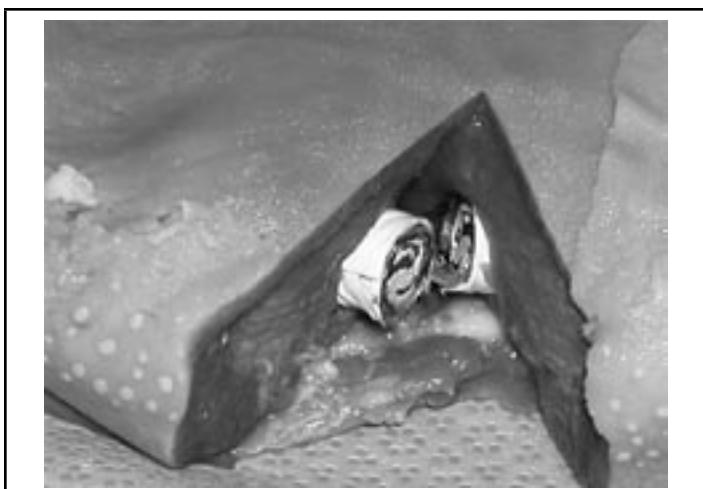


Figure 4

completing the entire exercise along with another 10 cm VAS to evaluate their thoughts on the usefulness of the exercise with 0 being completely not useful, and 10 being absolutely useful. Another copy of the test was administered five-weeks after the exercise to determine how much information the residents retained. Paired Student's t-test was used for analysis. Statistical significance was defined as $P < .05$. We used the scores on the three tests to comment on trends in the residents' knowledge bases.

Results

Twenty residents participated in the exercise, and 10 of these residents completed the five week posttest. Out of a possible 18 points, the average scores were: pretest 9.1 (SD 2.32), posttest 17 (SD 1.34; $P < .001$), and delayed posttest 15.1 (SD 1.52; $P < .001$). There did not seem to be a significant difference between postgraduate year levels. Prior to starting the exercise, the residents rated their comfort level regarding repair of an ASI as 3.9 on the 10 cm VAS (SD 3.13). After completing the exercise, the residents' comfort level increased to 5.2 (SD 2.96; $P < .001$). The residents rated their overall feeling of the exercise's helpfulness at a 9 (SD 0.95).

Discussion

Fenner¹¹ recently outlined the educational challenges faced by today's obstetrics and gynecology residents and faculty and called for new approaches to meet these challenges. There is a recognized need to improve and standardize residency educational efforts for repair of complex perineal lacerations which include ASI. Residents now graduate with less experience in ASI repair. This procedure lends itself well to surgical skills workshops. Recent important steps forward in education on episiotomy include The American College of Obstetrics and Gynecology's release of the monograph "Episiotomy: Procedure and Repair Techniques," which was distributed to all residents, and the work with surgical simulators of Nielson et al¹² and of Banks et al.¹³

Goff et al¹⁴ previously had demonstrated the feasibility of using the objective structured assessment of technical skills (OSATS) to evaluate the surgical skills of obstetrics and gynecology residents. This early work focused on gynecologic procedures and drew from the methodology outlined by Reznick et al¹⁵ from their work with general surgery residents. Nielsen et al¹² administered an episiotomy OSATS and demonstrated its reliability and validity. Banks et al¹³

randomized residents to surgical skills laboratory or traditional episiotomy repair education and showed that the skills laboratory improved resident performance of repair of episiotomy and second degree perineal lacerations in the actual delivery room. By examining the residents' delivery room performance, the authors bring Phase 3 of the Accreditation Council for Graduate Medical Education's Outcome Project into focus, where performance data is used as the basis for improvement.

Unlike Nielsen et al or Banks et al, Siddighi et al¹⁶ included ASI repair in their residency structured workshop. The authors used the OSATS and a written examination and found good correlation between the two. They selected the Sultan Anal Sphincter Trainer (Limbs and Things Inc., Bristol, UK) as their inanimate model. Other less expensive models for use in residency training include "the sponge perineum"¹⁷ and the beef tongue model.^{6,7} Our modification of the beef tongue model, using porcine tongue within which bungee cord represents the external anal sphincter, further reduces the cost of the simulator (approximately \$3.50 per tongue).

The authors spent one hour preparing the tongue simulators (Figures 1, 2, 3, and 4). During the 2.5-hour structured workshop each resident repaired his or her own model. This increased the efficiency of the workshop. Limitations of our workshop include the small numbers, and the low-fidelity of the porcine tongue model, which may decrease learner interest, increase the difficulty of suture placement, and oversimplify the anatomy (e.g. lack of the internal anal sphincter layer). This structured workshop could be adopted for use in other residency programs as its low cost and efficiency facilitate its easy implementation.

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Carcinoid Tumor Presenting as a Primary Mesenteric Mass: A Case Report and Review of the Literature

Justin Yamanuha MD; Ray Ballinger MD, PhD; David Coon PhD MD; and James Navin, MD

Abstract

We report a case of a primary carcinoid tumor arising in the mesentery of the small bowel of a 52-year-old man. The mesenteric mass in this patient was first identified as an incidental finding on CT imaging for bilateral nephrolithiasis. As a result of the abnormal findings, follow-up evaluation identified a partially calcified lobulated mesenteric lymph node. Diagnostic laparoscopy with lymph node sampling showed no evidence of hepatic or other metastatic disease. Pathologic analysis and immunohistochemistry of the mesenteric tissue revealed a malignant neuroendocrine tumor. Since all radiographic studies and subsequent workup revealed no evidence of other primary masses, this was determined to be a primary carcinoid tumor arising in the mesentery of the small bowel. Primary mesenteric carcinoid tumors are very rare because of their location of origin.

Introduction

Carcinoid tumors are rare, slow-growing tumors that display neuroendocrine properties. Greater than 90% of carcinoid tumors arise in the gastrointestinal system, and these are the most commonly occurring gut endocrine tumors.¹ In contrast, primary carcinoid tumors of the mesentery are rare.² Solid tumors arising in the mesentery are usually metastatic. True primary solid tumors of the mesentery include carcinoid tumors, fibromatoses, neurofibromas, teratomas, germ cell tumors, and primary neoplasms composed of either smooth muscle, blood vessels, or fat.³ This case demonstrates a primary mesenteric carcinoid tumor.

Case History

A 52-year-old man was evaluated for bilateral renal and ureteral stones. He denied any gastrointestinal symptoms other than occasional cramping pain. The patient noted a five-pound weight loss over the previous month but denied any anorexia. He reported an aunt who had a carcinoid tumor of the lung removed roughly five years earlier.

Physical examination revealed a well-developed, well-nourished man, in no acute distress. Examination of the abdomen revealed minimal tenderness along the spine but no guarding. No masses or hepatosplenomegaly were present. The remainder of the history and physical examination was normal.

The patient underwent a CT scan of the abdomen, which showed a partially calcified lobulated mass in the mesentery along with multiple smaller nodes in the adjacent mesentery (Figure 1). The initial diagnostic impression included granulomatous disease or mesenteric adenitis, desmoid tumor, or metastatic disease. The presence of calcification made lymphoma a less likely possibility. A subsequent enhanced CT scan abdomen (Figure 1) confirmed these findings and showed no other abnormalities. A full body enhanced CT scan showed no other abnormalities.

The patient underwent an uncomplicated CT-guided biopsy with a 22-gauge needle. The pathology showed a malignant neoplasm with features suggestive of a neuroendocrine tumor. Laboratory blood studies for neuroendocrine markers were normal, as shown in Table I. A subsequent colonoscopy to the cecum was positive for

only a diminutive polyp in the rectum, which was found to be benign lymphoid hyperplasia. The scope was advanced into the terminal ileum for 10-20 centimeters but showed no further pathologic lesions. A nuclear medicine octreotide scan showed activity in the base of the mesentery but no activity elsewhere.

The patient was taken to surgery, which showed a 4-cm area of matted tumor in the base of the small bowel mesentery. The ileomesentery containing the lesion and a portion of the corresponding ileum was resected. At the time of surgery, the entire small bowel was meticulously transilluminated and stripped and no evidence of tumor was found. The liver was free of palpable masses, and there was no evidence of tumor anywhere else in the abdomen.

Pathologic Findings

Pathologic examination showed a malignant carcinoid with moderate nuclear pleomorphism and 17 mitoses per 10 high power fields (Figures 2 and 3). The Ki-67 measured proliferation index was approximately 7%. A total of 10 lymph nodes were identified with one showing metastatic disease. Immunohistochemistry showed the tumor to be positive for multiple neuroendocrine markers including chromogranin, synaptophysin, and neuron specific enolase (Figures 4, 5, and 6). The tumor was negative for leukocyte common antigen (LCA), excluding a diagnosis of a lymphoproliferative disorder.

Discussion

The mesenteric mass in this patient was first identified as an incidental finding on a CT KUB for bilateral nephrolithiasis. Diagnostic laparoscopy with lymph node sampling showed no evidence of hepatic metastases or other metastatic disease. Pathologic analysis and special stains of the mesenteric tissue found a malignant neuroendocrine tumor consistent with carcinoid.

The presence of neuroendocrine cells in the mesentery has been supported by other publications.² The neural crest cells, a multipotential cell population, can form small amounts of tissue outside of the conventional distribution of the paraganglia. Locations of such collections include the interatrial septum of the heart, the liver hilus, and mesenteric vessels. The diversity of tissue sites can be explained by the dispersed migratory properties of the neural crest.⁴ Mesenteric paraganglionomas, while rare, have been described in the literature as tumors occurring in such unusual locations. In our research, a review of the literature found a similar case of an ectopic ACTH-secreting neuroendocrine carcinoma of the mesentery which lends further evidence to the existence of neuroendocrine cells in the mesentery.⁵

Follow-Up

Two years after surgical resection, the patient was noted to have several small liver metastases on CT scan. He is asymptomatic, with no tumor in the bowel or mesentery. At the time of this writing, the patient had been on Sandostatin therapy for six months with no progression of metastatic disease.



Figure 1.— Contrast-enhanced CT scan of the abdomen and pelvis showing a 2 cm partially calcified soft tissue mass in the mesentery with two adjacent lymph nodes. Soft tissue stranding into the adjacent mesenteric fat is seen along the anterior margin of the mass.

Table 1.— Laboratory Data

Lab Test	Value	Normal Range
Urinary 5-HIAA	4.4 mg/24 hrs	< 6.0/24 hours
Chromogranin A	8.3 ng/mL	< 36.4 ng/mL
Neuron Specific Enolase	5.4 ug/dL	3.7 ug/dL - 8.9 ug/dL
Substance P	< 160 pg/mL	< 160 pg/mL

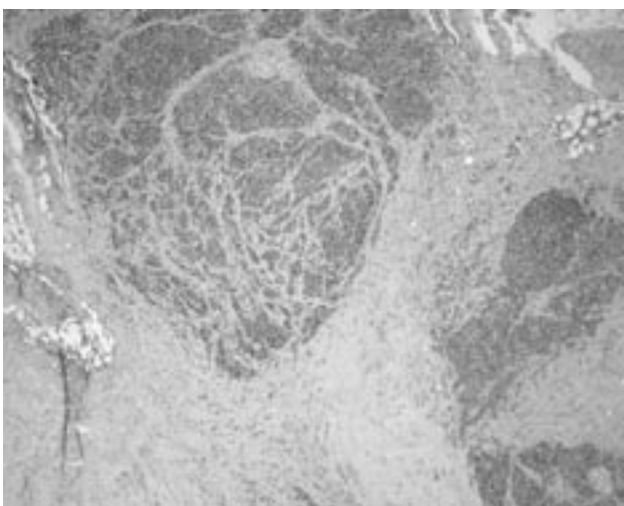


Figure 2.— Biopsy of carcinoid tumor at 40x magnification. The tumor is composed of nests of pleomorphic relatively small cells with eosinophilic cytoplasm and prominent irregular hyperchromatic nuclei which in some areas had a stippled chromatin pattern.

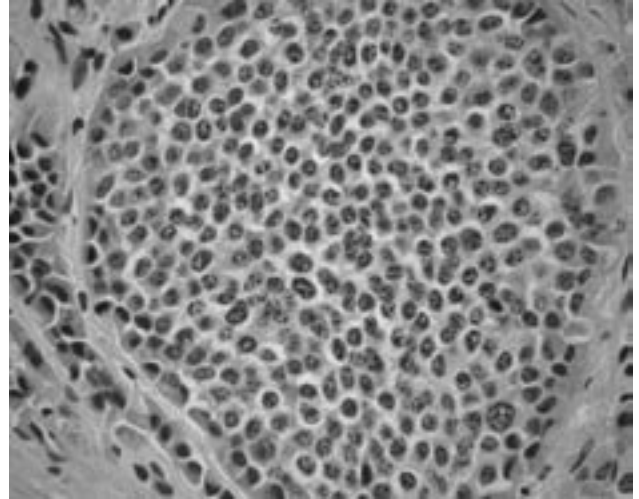


Figure 3.— Carcinoid tumor specimen (400X magnification).

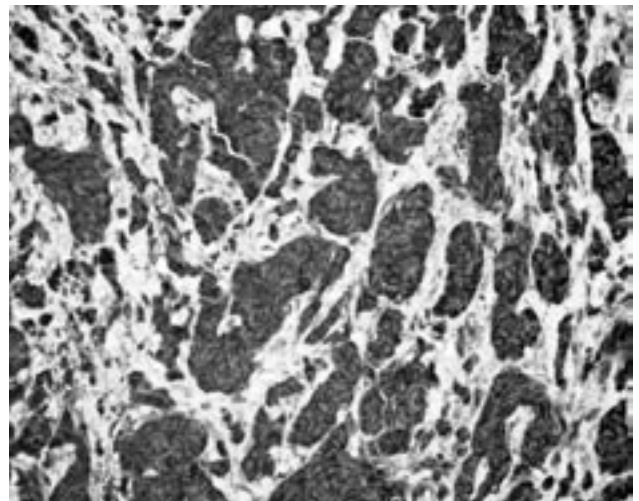


Figure 4.— Positive staining for chromogranin (20x magnification).

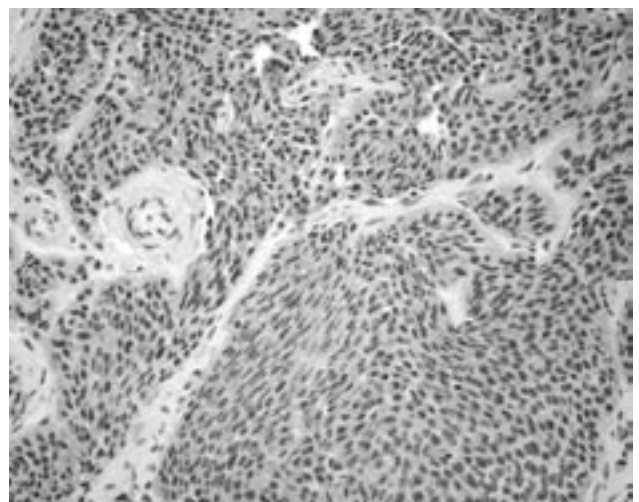


Figure 5.— Positive staining for neuron specific enolase (20x magnification).

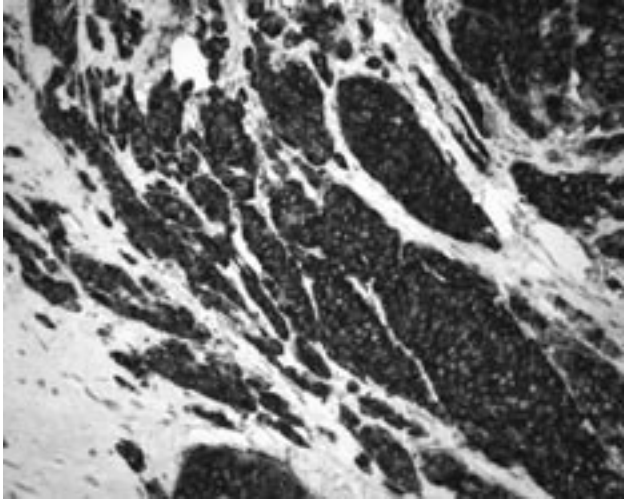


Figure 6.— Positive staining for synaptophysin (20x magnification).

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Surviving Cancer and Thriving: Impacting Health Behaviors for People Who Have Survived Cancer

Erin O'Carroll Bantum PhD; Cheryl Albright PhD, MPH; Gabriela Layi MA; and Jeffrey Berenberg MD

Surviving Cancer

The National Cancer Institute reports that there are about 11 million people in the United States who have survived cancer.¹ While this demonstrates the progress that has been made medically, significant physical and psychological sequelae of cancer has been well documented.^{2,3} While going through diagnosis and treatment for cancer can result in a great deal of distress, it also provides a “teachable moment”⁴ for the many people who are interested in positively impacting their health. This “teachable moment” refers to a renewed interest in such things as lifestyle change.

Changing Health Behaviors

Home-based physical activity programs have been beneficial with cancer survivors.^{5,6} In addition, home-based interventions promoting a combination of exercise and stress management has been related to benefit for cancer survivors.^{7,8} Health-related information is also frequently accessed via the Internet by people who have survived cancer.⁹ Further, a fair bit of literature demonstrates that people who have survived cancer frequently use online interventions as a way of gaining and giving support to others who have also survived cancer.¹⁰ The combination of health behavior change education and social support could provide a worthwhile platform for making lifestyle changes.

Online Intervention for Cancer Survivors

As part of a study funded through the Department of Defense a partnership between Tripler Army Medical Center and the Cancer Research Center of Hawai'i provided the impetus for creating an online intervention for people who have survived cancer. The first step in this process was the facilitation of seven focus groups with health care providers ($n=24$) and cancer survivors ($n=21$). The purpose of these groups was to identify the level of need and interest in an online health behavior change project as well as to identify topics that would be of most interest. Three focus groups were run with healthcare providers (nurses, oncologists, and social workers) and four focus groups were run with people who had survived cancer.

While only 17% of health-care providers currently referred cancer survivors to websites for health behavior change concerns, nearly all participants reported the need for and interest in online health behavior change projects for people who have survived cancer. Cancer survivors reported using the internet frequently for cancer-related information, although they did not report engagement in health behavior change interventions online. Some of the areas of most interest were diet, exercise, fatigue, and stress management. Participants in the focus groups also are interested in learning about long term and late effects of treatment. One of the most consistent findings among participants in the focus groups was the desire to interact with other people who had survived cancer.

Collaboration with Existing Team

For over 30 years researchers at Stanford University have been conducting both face-to-face and online peer led workshops in the area of chronic disease self-management.¹¹ The workshops are based on self-efficacy theory and use action planning and feedback as tools to help improve behavior. This group of researchers, led by Kate Lorig, has found significant improvements in health behaviors and health status^{12,13} for people who have engaged in peer led self-management. In addition, health care utilization has also been positively impacted after engaging in the self-management intervention.^{13,14} One of the unique aspects of these groups is that the participant is not instructed to pick a goal that fits into a particular lifestyle change area (e.g., diet). Participants pick the goal in any lifestyle change area that is of most interest and can change that goal throughout their participation in the intervention. Pairing this type of existing project with our proposed project was a nice fit to examine how the self-management program could benefit people here in Hawai'i.

Surviving Cancer and Thriving

At the present time the development of the joint project *Surviving Cancer and Thriving* is underway. As previously stated, this is a collaboration between the University of Hawai'i at Manoa Cancer Research Center and Stanford Medical School Patient Education Research Center, with funding from the Department of Defense. The Self-Management program at Stanford has not previously been modified for people who have survived cancer, so a major recent task has involved making changes to the current structure to lead to an appropriate and useful intervention for people who have survived cancer. The intention is to create a program in which people who have survived cancer can learn to make positive health behavior changes by learning from other people who have survived cancer and made similar changes. Trials of this online intervention are projected to begin in the last summer of early fall of 2009.

The project is an exciting collaboration for the CRCH and any inquiries are welcome. Please feel free to email us at: thriving@crch.hawaii.edu.

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Upcoming issue: The 40th Anniversary of Transplant in Hawai'i



A Letter to the Freshman Class from the Graduating Seniors John A. Burns School of Medicine

**Damon H. Sakai MD, Associate Professor, Department of Medicine,
Office of Medical Education, John A. Burns School of Medicine, University of Hawai'i**

A new trend in medical education is to foster reflection among students to maintain their connection to the humanistic elements of their medical school experience.^{1,2} At Senior Seminars, a three-week course capping the four-year curriculum at JABSOM, students complete reflective in-class writing exercises on a variety of issues that are thematically linked to the topics presented that day. In one exercise, they are asked to share some advice with incoming first-year students in the form of a letter. Excerpts from these letters are captured here. Most of the sentiments expressed by the seniors of the Class of 2006 and 2007 could be grouped under eight themes.

Words of Warning

Some seniors shared a warning with incoming students about the training that awaits them. They wanted students to know that medical school is a rigorous experience that will challenge them, both mentally and emotionally.

You will never work so hard, feel so inadequate, and feel so helpless.

You thought this was a good idea, but it wasn't. If you have half a brain, you would get up and walk out right now, never to return...

The Best Four Years of Your Life

But these warnings were always followed by encouraging words that emphasized how wonderful medical school will prove to be. They felt the educational experience should be savored.

These past four years were great! While there were many hard times, the good times greatly outnumbered them.

Above all this is the best 4 years of your life, have fun and enjoy.

Know and Value your Classmates

At JABSOM, medical students have an opportunity to participate in many events such as the annual JABSOM Luau, the JABSOM Student Olympics, and class-wide community service projects. Seniors felt strongly that incoming students should participate in these class activities and get to know their colleagues, many of whom will become life-long friends. A class of students, bonded together, creates an effective learning environment. Graduating seniors also pointed out the importance of supporting classmates academically and avoiding advancement and the expense of others.

Get to know your classmates – they will be your best friends for life.

Make an effort to attend as many class events as possible. The stronger you are as a class, the better you will perform as individuals in medical school.

Be supportive of fellow classmates and don't undercut or "gun" people down to get ahead.

Study Hard

Not surprisingly, seniors encouraged their future colleagues to learn as much as possible while in medical school. Studying was no longer just about preparing for exams. It's now about saving lives.

Study...study...don't ever question if you're studying too much.

You better study your butts off! Don't let yourself fall behind because that hole you dig yourself could get exponentially deeper every unit.

Everything you learn could potentially save a life.

When times get tough, think back when you were begging God to please get you in! Remember how you vowed to put up with staying up all night studying and pushing yourself harder than you ever thought possible if only they'd let you in?! Well, now is the time...

Pick Yourself Up When You Fall

Knowing the challenges of medical school, many seniors felt it important to encourage perseverance. Rarely will a student navigate four years without having to overcome an unexpected challenge in their academic or personal life.

When you must – pick yourself up, dust yourself off and start all over again.

On many occasions you will feel overwhelmed, hopeless, dumb, embarrassed, depressed, and feeling like you want to quit. But keep on keeping on. You WILL get through it!

Stick to it, pick yourself up after you fall, and you will be so glad, so happy when you are finally done four years from now, like I feel right now.

Maintain Balance

Maintaining personal balance and important relationships outside of medicine was an especially important theme for seniors. Students felt that earning a medical degree through the sacrifice of important friendships and the love and affection of family members would be an empty achievement.

Don't forget to stop every so often and thank those loved ones who have supported you along the way. You will become selfish in medical school. So remember all who have had to sacrifice for your dream.

Buy an X-box if you can...

A special message for those of you with families – you have the special challenge of managing your time between medical school and home life. Yes, doing well in med school is important, but would it be at all worth it without your spouse or your kids? Remember them first.

Have Faith in Your School

Seniors emphasized trust in the medical education provided at JABSOM.

The most important advice I can give you is to put your faith in the faculty and advisors at JABSOM, the PBL process, your classmates...

Believe in PBL.

I'd Do it Again

When all is said and done, seniors wanted the incoming students to know that the journey will be worth the effort.

These last four years here have been the best of my life by far. At times you will feel stressed and will struggle to find the light at the end of the tunnel...but in the end it is so worth it!

You are lucky! If I could go back, I would do it all over again! Best of luck!

These themes can be combined into short note from the JABSOM Classes of 2006 and 2007 to all entering students at JABSOM.

Dear MSI,

You will work very hard in medical school. But it will be the best four years of your life. Study hard, but remember to get to know your classmates and support them. Many will become life-long friends. Maintain the relationships that brought you to this point, and should you fall, pick yourself up and keep going. You will get through it. Believe in JABSOM. Enjoy these four years. I did and I would do it all over again.

Best of luck,

JABSOM Classes of 2006 and 2007

References

1. Feigelson S, Muller D. "Writing About Medicine": An exercise in Reflections at Mount Sinai (with Five Samples of Student Writing). Mt Sinai J Med. 2005;72(5):322-326.
2. Sakai DH. Senior Student's Reflections on their Medical Education at JABSOM Hawaii Medical Journal 2007;66:216-217.

HMJ

Upcoming issue: American College of Physicians Hawai'i Chapter Meeting Abstracts

UPCOMING CME EVENTS

Interested in having your upcoming CME Conference listed? Please contact Nathalie George at (808) 536-7702 x103 for information.

Date	Specialty	Sponsor	Location	Meeting Topic	Contact
August 2009					
8/11-8/14	EM	University of California, Davis, Health System	Grand Wailea Hotel Resort & Spa, Maui	Emergency Medicine Update: Hot Topics 2009	Tel: (866) 263-4338 Web: cme.ucdavis.edu
8/21-8/23	EM	East Hawai'i Independent Physicians Association	Mauna Lani Bay Hotel & Bungalows, Kona, Hawai'i	Life Can Be a Pain: Pushing the Envelope in Pain Management	Tel: (808) 227-7786 Email: rmuria@healthunified.com Web: www.easthawaiiipa.com
October 2009					
10/5-10/10	GYN	Mayo Clinic	Hyatt Regency Maui, Ka'anapali Beach, Maui	22nd Annual Advanced Techniques in Endoscopic & Robotic Gynecologic Surgery and Optional Hands-on Laparoscopic and Robotic Suturing Techniques Workshop	Tel: (480) 301-4580 Email: mcs.cme@mayo.edu Web: www.mayo.edu/cme
10/15-10/17	CD, IM	University of California, Davis, Health System	Hyatt Regency Maui, Ka'anapali Beach, Maui	29th Annual Current Concepts in Primary Care Cardiology	Tel: (866) 263-4338 Web: cme.ucdavis.edu
10/18-10/23	Multi	Scripps Health	Kaua'i Marriott Resort, Kaua'i	9th Annual Destination Health: Renewing Mind, Body, and Soul	Tel: (858) 652-5400 Email: med.edu@scrippshealth.org
10/20-10/24	Multi	American Society of Human Genetics	TBA	2009 Annual Meeting	Web: www.faseb.org/genetics/ashg
10/27-11/1	CHP	American Academy of Child and Adolescent Psychiatry	Hilton Hawaiian Village, Honolulu	56th Annual Meeting	Tel: (202) 966-2891
10/25-10/28	OBG	Central Association of Obstetricians & Gynecologists	Maui, Hawai'i	2009 Annual Meeting	Tel: (701) 838-8323
0/26-10/30	AN	California Society of Anesthesiologists	Grand Hyatt, Poipu Beach, Kaua'i	2009 CSA Fall Hawaiian Seminar	Web: www.csahq.org
10/31-11/6	PD	University Children's Medical Group	Grand Hyatt Kaua'i	Aloha Update: Pediatrics 2009	Tel: (800) 354-3263 Email: info@ucmg.org Web: www.ucmg.org
November 2009					
11/1-11/6	DR	University of California San Francisco School of Medicine	Hyatt Regency Maui, Ka'anapali Beach, Maui	Diagnostic Radiology Seminar	Tel: (415) 476-4251 Web: www.cme.ucsf.edu/cme
11/15	Multi	The Queen's Medical Center & the Hawai'i Chapter, American Academy of Pediatrics	Kahala Resort & Spa, O'ahu	Physician Health Thyself	Tel: (808) 377-5738
11/21	Multi	Hepatitis Support Network of Hawai'i	Queen's Conference Center	Viral Hepatitis in Hawai'i 2009	Tel: (808) 373-3488 Web: www.hepatitis.idlinks.com
December 2009					
12/2-12/4	PD	Department of Pediatrics, Stanford University School of Medicine	Mauna Lani Bay Hotel & Bungalows, Kona, Hawai'i	Popular Pediatric Clinical Topics 2009	Tel: (650) 497-8554 Web: www.cme.lpch.org

January 2010					
1/18-1/22	AN	California Society of Anesthesiologists	Hyatt Regency Maui, Ka'anapali Beach, Maui	2010 CSA Winter Hawaiian Seminar	Web: www.csahq.org
February 2010					
2/10-2/13	Multi	The Society of Laparoendoscopic Surgeons	Hilton Hawaiian Village, Honolulu	Asian American MultiSpecialty Summit IV: Laparoscopy & Minimally Invasive Surgery	Tel: (305) 665-9959 Email: Conferences@SLS.org
2/11-2/12	Multi	Department of Surgery, John A. Burns School of Medicine	Hyatt Regency Waikiki, Honolulu	Cross-Cultural Health Care Conference: Collaborative and Multidisciplinary Interventions	Tel: (808) 586-2920
2/13-2/16	OTO	University of California San Francisco School of Medicine	Hilton Hawaiian Village, Honolulu	Pacific Rim Otolaryngology Head and Neck Surgery Update Conference	Tel: (415) 476-4251 Web: www.cme.ucsf.edu/cme
2/14-2/19	IM, ID	University of California San Francisco School of Medicine	The Fairmont Orchid, Kohala Coast, Hawai'i	Infectious Diseases in Clinical Practice: Update on Inpatient and Outpatient Infectious Diseases	Tel: (415) 476-4251 Web: www.cme.ucsf.edu/cme
March 2010					
3/26-3/30	AN	International Anesthesia Research Society	Hawai'i Convention Center, Honolulu	84th Congress	Tel: (216) 642-1124 Web: www.iars.org
April 2010					
2/14-2/19	IM	University of California San Francisco School of Medicine	Wailea Beach Marriott, Maui	Primary Care Medicine: Update 2010	Tel: (415) 476-4251 Web: www.cme.ucsf.edu/cme
November 2010					
11/1-11/5	AN	California Society of Anesthesiologists	Mauna Lani Resort & Spa, Kailua-Kona, Hawai'i	2010 CSA Fall Hawaiian Seminar	Web: www.csahq.org



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THE WEATHERVANE

RUSSELL T. STODD MD, CONTRIBUTING EDITOR

❖ ASK NOT FOR WHOM THE BELL TOLLS –

Many of the older members of the Hawai'i Medical Association as well as many, many good people both in and out of the house of medicine were deeply saddened by the death of Jon Won, the face and voice of the the HMA for 20 or more years. Jon's kind and generous heart gave out. Jon Won could work to get things done with local businessmen, politicians, insurance companies, AMA contacts and others when thorny medical issues needed resolution. Jon Won and Becky Kendro worked together as a powerful leadership team to build and maintain a strong and effective Hawai'i Medical Association force representing Hawai'i doctors, and constantly advocating for the health of all Hawai'i's citizens. Jon Won's smiling face, his always warm spirit and welcoming voice will remain with so many of us. His legacy lives on as what a premier medical executive should be.

❖ BEING GOOD DOES NOT NECESSARILY PAY OFF.

According to a study reported in the February 2009 New England Journal of Medicine (NEJM), Medicare spending increased steadily over the last 15 years, but the dollars spent per enrollee varied considerably from state to state. The average recipient cost Medicare the most in New York at \$9,564 while Hawai'i is at the bottom at \$5,311 per patient. Analysis of data revealed that physicians in higher-spending regions were much more likely to recommend discretionary services, such as referral to a sub-specialist. Moreover, they were three times more likely to send an end-stage heart failure patient to the intensive care unit, and 30% less likely to discuss palliative care with patient and family. By these data, if President Obama's health plan mimicked Hawai'i's physicians' behavior, Medicare might be solvent.

❖ CAFFEINE: THE GIFT OF LIFE!

Because of the ultra-violet damage to skin cells, which can mutate and become cancerous, medical scientists have long known that exposure to sunlight is a major factor in causing skin cancers. In a recent Journal of Investigative Dermatology, researchers from Harvard Medical School and Pfizer found that caffeine helps eliminate cells damaged by UV light causing those cells to commit suicide. The point is that adding caffeine to a topical sun-screen or an after-sun preparation should be evaluated to minimize or reverse the effects of the UV damage. Unfortunately for us coffee addicts, imbibing multiple cups each day is not the best route of administration. Better for a sun bum to take a café au lait bath before lounging on the beach or at pool side.

❖ OFTEN A NOBLE FACE HIDES FILTHY WAYS.

Hundreds of parents of autistic children are turning to the "Lupron protocol" being pushed all across the United States. A physician and genetic counselor, Mark Geier, M.D. and his son who has a bachelor's degree in biology, perform at conferences and seminars presenting Dr. Geier's own research (not peer reviewed), and which is not supported by mainstream medicine. His theory is that autism is caused by an abnormal link between mercury and testosterone, and that chemical castration is the solution. The protocol calls for multiple blood tests (50 in all totaling \$12,000) to prove that testosterone is excessive, and which will be followed by frequent injections of Lupron. The American Academy of Pediatrics and top pediatric endocrinologists have stated that the Lupron protocol is baseless and frankly "junk science." The Institute of Medicine report concluded that a connection between mercury in vaccines and autism did not exist. The committee said the Geiers' work was un-interpretable and marred by serious methodological problems. Abbot Laboratories, which markets Lupron for prostate cancer therapy, said there was no scientific evidence to justify autism research. Federal judges have said Geier is not qualified to make such claims or to treat autistic children, and one judge stated "there is no evidence that Dr. Geier has either the training or the background to diagnose autism or to treat autism in any child." However, desperation brings on behavior that rational people would otherwise logically reject, and since hope springs eternal the door is open for charlatans and pretenders when a problem seems beyond control.

❖ I BELIEVE THERE'S SOMEONE OUT THERE WATCHING OVER US. UNFORTUNATELY, IT TURNS OUT TO BE THE GOVERNMENT.

According to author George Orwell in his landmark novel, 1984, the sexual act, successfully performed, was rebellion against the state. Too exaggerated, right? Wrong! This was premature exasperation on Orwell's part because in Wearside, England, a 48-year-old housewife was in custody for having "excessively noisy sex." It has been 25 years beyond 1984 to fulfill Orwell's prescience. The police took the housewife into custody after neighbors complained of hearing her shouting and groaning and her bed banging against the wall of her home. The woman defended her right to be

a howler saying, "I can't stop making noise during sex. It's unnatural to not make any noises and I don't think that I am particularly loud." In 1998 the priggish Labor government passed the Anti-Social Behavior Order to stop anyone else from doing something that they find "irritating, alarming or threatening." The applicant does not have to go through the criminal justice system in order to get a civil ruling preventing someone he/she doesn't like from doing something that one finds irritating, alarming or threatening. Perhaps it should not be surprising in Britain, which already has five million closed-circuit television cameras to watch everybody, as well as monitoring cameras that remind people to stop littering and loitering. Big Brother really is watching you.

❖ IF YOU CAN'T BEAT THEM, ARRANGE TO HAVE THEM BEATEN.

In May 2008, the Journal of the American Medical Association (JAMA) published a report that the off-label use of the anti-depressant drug Lexapro, was useful in post-stroke patients. The leading author pushed a flurry of reports in the media, but failed to acknowledge that Lexapro was statistically no more effective than non-pharmacologic psycho-therapy. Dr. Jonathon Leo, a neuroanatomy professor, pointed out the peer-review failure to the JAMA editor and also mentioned that the lead author of the report has financial ties to Forest Labs, which makes Lexapro. After waiting five months for a response from JAMA, Dr. Leo and assistant Dean Jeffrey LaCrosse, published a letter in the on-line British Medical Journal reporting the conflict of interest and further implications. According to reports, without providing any explanation, the JAMA editor-in-chief, Catherine DeAngelis MD, called the Dean of Dr. Leo's university and demanded a retraction, moreover JAMA's Executive Deputy Editor, Phil Fontanarosa MD, threatened retribution against Dr. Leo. Dr. DeAngelis called Dr. Leo "a nobody – a nothing." Holy ballpoint! Are these the people protecting the scientific integrity of JAMA? And what about the AMA code of ethics to provide an open forum and respect for the rights of patients and colleagues? This is not a casual mistake, but a grievous fault of the AMA editorial oversight committee. Wake up, AMA president and trustees!! Our JAMA is headed for the toilet.

❖ THE EAGLE MAY SOAR, BUT THE WEASEL NEVER GETS SUCKED INTO A JET ENGINE.

The dramatic highly successful water landing in the Hudson River of the U.S. Airways jet with 155 souls aboard served as a signal event emphasizing the surging increase in aircraft bird strikes. The causes are believed to be due to increasing numbers in bird populations and the growing number of flights at U.S. airports. In 1990 1,759 bird strikes were reported and in 2007 that number was 7,666, a four-fold increase. The FAA doesn't know the real extent of wild life strikes because facilities are not required to issue reports. Estimates are that only about 20% of bird strikes get reported. The National Transportation Safety Board has pushed the FAA to make such reporting mandatory. Every major airport has a program to discourage wild life and make the airport as unattractive as possible. How about using some amplified idiotic so-called music (rap) spilling out of over-size pickups? It would surely drive me away.

❖ A CRIMINAL TRIAL CAN BE HABIT FORMING.

At 12:15 a.m. a French-speaking nun driving a van to her convent in Chicago collided with a Honda Civic carrying four teenagers, one of whom died as a result of the crash. The teen driver said she had a green light, and three people said the nun caused the crash. The nun was allowed to wear her habit to court, and did not testify, though she claimed her signal was green. Prosecutors were not allowed to mention the death because the judge stated it might prejudice the jury. The jury took all of 30 minutes to acquit.

❖ GOOD SEX IS LIKE BASKETBALL. ONE ON ONE WITH A MINIMUM OF DRIBBLING.

In Miami, Fla., 40 year-old Father Alberto Cutie ran the Archdiocese international radio network where he was known as "Father Oprah" for providing his advice on relationships. Alas, he was removed from his job when he admitted he had a two-year relationship with a woman, and had struggled with celibacy for a long time and lost the battle. Hey, give him a break. He left the kids alone.

ADDENDA

❖ A Chicago couple who weighed a total of 707 pounds, gave each other gastric bypass surgery for Christmas. No report yet on results.

❖ Time it takes to sail 220 yards at 1 nautical mile per hour is called one knot-furlong.

❖ Never judge a book by its movie.

ALOHA AND KEEP THE FAITH — rts■

(Editorial comment is strictly that of the writer.)

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