This could be reduced if every state developed a schedule of payments to settle malpractice claims. Expert arbitrators would review claims. If there were charges of malpractice, the arbitrators, not lawyers, would order a financial settlement based on the schedule.

• Make all health care equally tax deductible.

Currently, part of health care is tax deductible by individuals and employees.

But some people have to buy their own health insurance policies or pay health care bills using after-tax dollars.

Let's make health care equally tax deductible and give everyone a tax deduction for what they spend on health insurance and health care.

• Let individuals make health care cost decisions.

If the cost of health care and health insurance were tax deductible and self-monitored, individuals suddenly would be intimately involved in their health care cost decisions. They would seek physicians, hospitals, and insurance policies with the best monetary value. Before using health care services, patients would ask about the costs and alternatives. Millions of individuals would police the health care market instead of government bureaucrats, insurers, and employers.

• Make it possible to buy customized, no-frills, affordable insurance.

Legislators in many states have pushed the price of individual and small-group insurance policies out of the reach of low and middle-income workers by requiring carriers to include benefits such as treatment for drug abuse and alcoholism, and the services of psychologists, chiropractors, acupuncturists, and naturopaths. The result is that healthy young persons or persons between jobs who need health care coverage only for catastrophic illness, find the cost of health care insurance outrageous, and are being asked to subsidize care neither wanted nor needed.

We need to free insurance companies so that they can offer no-frills, basic, affordable insurance to those who want only that kind of protection.

• Make it possible for insurance carriers to charge fair prices for health care.

Many states dictate that in pricing health care insurance carriers adopt "community pricing" or "one-price-for-all." That means that young, healthy people with good lifestyles are being forced to subsidize health care for those with unhealthy habits such as alcoholism, drug abuse, etc.

We should free the insurance companies from these restrictions and allow them to price insurance based on age and lifestyle categories, much like life and auto insurance policies are priced.

Recognizing that this would increase health care costs for some, we also should have a system of subsidies so that all can afford basic medical insurance.

In summary, we have an excellent health care system. It is not in crisis. The institution of medical reform, equal tax deductibility, individual responsibility for the payment of medical costs, no-frills insurance, and fair-priced insurance would reduce the costs of medical care without affecting quality and access. That also would allow us to focus on those who need financial assistance so that all can be included in the world's finest medical care network.

Richard R. Kelley MD

Richard Kelley MD is well known to Hawaii's medical community and the visitor industry. Rich attended Punahou School, Stanford and Harvard. He served as a pathologist at Queen's and later Kapiolani Hospitals. In the 1970s ,the call of the family hotel chain beckoned Rich to retire from medicine and take over Outrigger Hotels Hawaii.

Rich Kelley wears many, many hats, but still he is very concerned with medicine in Hawaii. In this guest editorial, Dr Kelley presents his views forthrightly and clearly—the views of a physician and a businessman—a great combination. Mahalo, Rich, for your many contributions to education, medicine, and tourism in Hawaii.—ED.

Letter to the Editor

The *Journal* welcomes letters in good taste on any topic. All letters must be signed with the writer's correct signature and include the address and telephone number for our verification. Letters should be on a single subject and no longer than 200 words. Letters of any length may be trimmed.

Send to: Letters to the Editor, Hawaii Medical Journal, 1360 S. Beretania Street, Second Floor, Honolulu, HI 96814.

I was pleased to read Irwin Schatz's article, "On the Quest for the Humane Physician" (*Hawaii Med J.* 1994;53:196-199) and would have liked to have heard the original unedited presentation. Now 26 years out of medical school and with little ensuing contact with academia, I am a bit dated, but it doesn't sound like much has changed since my departure.

I would like to suggest that the primary origin and solution to the problem lies not somewhere in society but in medical school itself. Dr Schatz suggested as much, but failed to allow the buck to stop there. Interestingly, the medical school effects he does mention are primarily those of policies, programs, and technology rather than persons.

Medical schools are responsible for selecting their own students, but, unless a lot has changed since the sixties, they are selected for qualities allowing them to be successful medical students rather than good physicians. Furthermore, medical school professors are academicians and their first priorities rarely are patient care. Often they consider academic medicine to be a higher calling than practice. I recall reading a report a few years ago that ranked the nation's top medical schools giving Harvard the prize. The primary criterion? Harvard had the most medical school professors among its graduates.

Medical schools also are responsible for selecting their own faculty, and it is unlikely that humaneness is one of the criteria. Medical students and house staff are incredibly impressionable and eager to model themselves after mentors whom they consider attractive. Many professors are excellent, humane physicians, but many are not and it takes fewer to make it bad than it does to make it good. If the primary behavioral values being demonstrated do not include humaneness as superordinate, behaving humanely will be an individual accident. It was refreshing to have Dr Schatz debunk the absurd contention that

one cannot be a compassionate and scientifically minded physician simultaneously. One of the country's leading biologically oriented psychiatric residency programs states that, "We want our graduates to think like neuroscientists and behave like Marcus Welby."

Changing all this would take some work, but wouldn't require changing society at large.

Jon Betwee MD

Medical School Hotline

Curtis Takemoto-Gentile MD
Chair, Department of Family Practice and Community Health

Family Practice in Hawaii

The residency program in family practice and community health began on July 1, 1994 at the John A. Burns School of Medicine.

The program director is Curtis Takemoto-Gentile MD and the primary training hospital for the residency is Wahiawa General Hospital.

In September 1993, the Family Practice Residency Program was approved and accredited by the Family Practice Residency Review Committee (RRC). By October of that year, medical schools and Family Practice Program directors throughout the United States were notified of the availability of positions for 12 residents: Six first-year and six second-year. On July 1, 1994, 12 residents began their training.

The training of family physicians is comprehensive in that it covers the general scope of health care from "womb to tomb." The first year of training includes two months with a general surgeon, a month each in obstetrics, gynecology, emergency medicine, medical ICU, pediatric ward medicine, intermediate newborn nursery care, and three months on in-patient care. The second year will include rotations in cardiology, obstetrics, dermatology, urology, orthopedics, newborn nursery, outpatient pediatrics, three months of inpatient care and two months of rural medicine in Hilo. The final year will have rotations in pediatric emergency medicine at Kapiolani Medical Center for Women and Children, sports medicine, newborn nursery and outpatient pediatrics, otorhinolaryngology (ENT), ophthalmology, geriatrics, two months of inpatient and two months of rural medicine.

Throughout the training, the curriculum focuses on behavioral aspects of health care related to the family systems, family dynamics, parenting skills and their stresses. The doctor-patient relationship and communication skills are integrated throughout the training with special attention paid to cross-cultural values found in the Hawaii community; ie, Hawaiian, Chinese, Japanese, Samoan, Filipino, Caucasian, and Korean.

Currently, the Residency Program has been successful in obtaining three federal grants to further enhance and develop the newly formed Department of Family Practice and Community Health. The grants are entitled, "The Establishment of a Family Medicine Department," "The Establishment of a Pre-doctoral Family Practice Curriculum" and "The Establishment of a Family Practice Residency Program."

The department is staffed by: Kay Bauman MD, Carole Tsou MD, Phil Bohnert MD, David Brown MD, Allan Chun DO, MPH, Gordan Greene PhD, Laurie Hopman MD, Neal Palafox MD, MPH, Linda Tom MD and Scott Choe.

All faculty are involved with teaching medical students and residents as well as providing community service through the Physician Center at Mililani and at Wahiawa General Hospital. In addition, faculty members have initiated research activities that include a current study in the Marshall Islands by Dr Neal Palafox on ciguatera poisoning and the effect of mannitol as a treatment.

Historical Notes

John A. Breinich
Hawaii Medical Library

The Board of Health has a long history in Hawaii. In 1836, the first public health measure was taken to prevent pestilent disease. The document read in part that they should try "...to ascertain whether there has been any case of smallpox or other pestilent disease aboard vessels approaching the harbor." If disease was present, the ship's master was directed to hoist a yellow flag at the main and immediately give the information to the authorities.

In 1839 King Kamehameha III appointed a "Board of Health" to inspect incoming ships, "...smallpox having been clearly ascertained to prevail on a few ships already." In 1840 R.C. Wyllie, Minister of Foreign Relations, and others were urging the adoption of comprehensive health measures and the formation of an all-island Board of Health. On December 13, 1850 King Kamehameha III responded to these urgings by establishing an island–wide Board of Health. The new Board of Health was directed "to provide for the preservation and cure of contagious, epidemic, and other diseases" and to enforce sanitary measures. This new Board of Health was established just two years after the formation of the General Board in London, England, and five years before the formation of the first State Board on the Mainland in Louisiana in 1855. Dr T.C.B. Rooke, who was then port physician, was named as the first president of the Board of Health.

By the early 1900s, the position of president of the Board of Health had been held by nonphysicians and at the July 11, 1908 meeting of the Hawaii Territorial Medical Society the following motion was passed: "That the Governor be communicated with that it is the sense of the Medical Society that a medical man be President of the Board of Health." Even today, the question of who shall head the Department of Health has a familiar ring to