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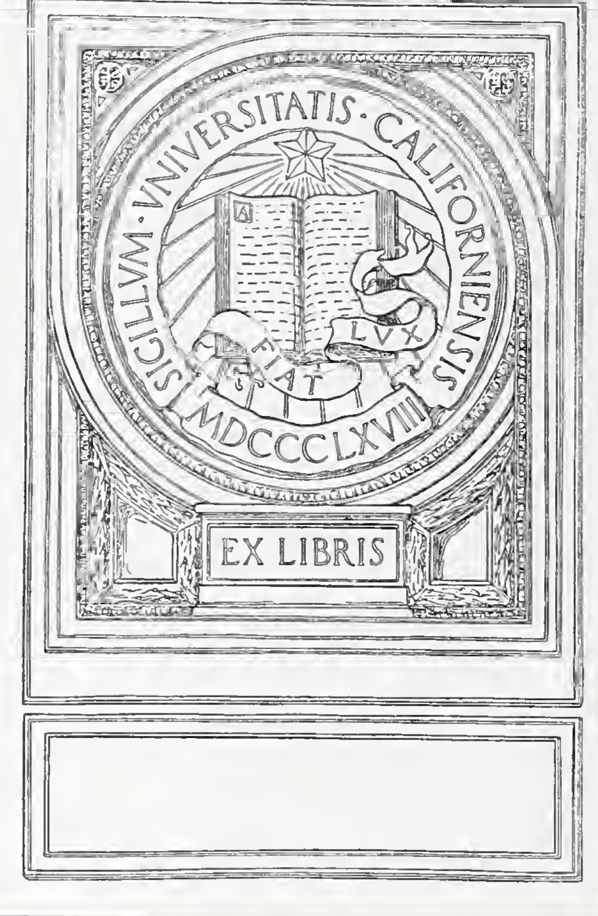

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## *In this issue*

Benzocaine Poisoning

Eczema in Chinese Boys

Centipede Venom Myelitis

AMA Delegates' Reports

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VOLUME 22 • NUMBER 1

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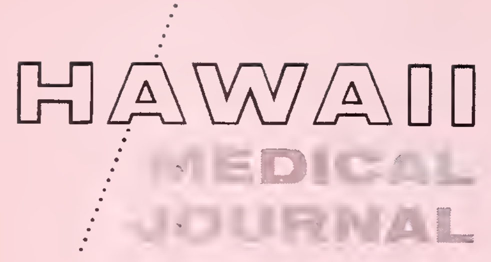

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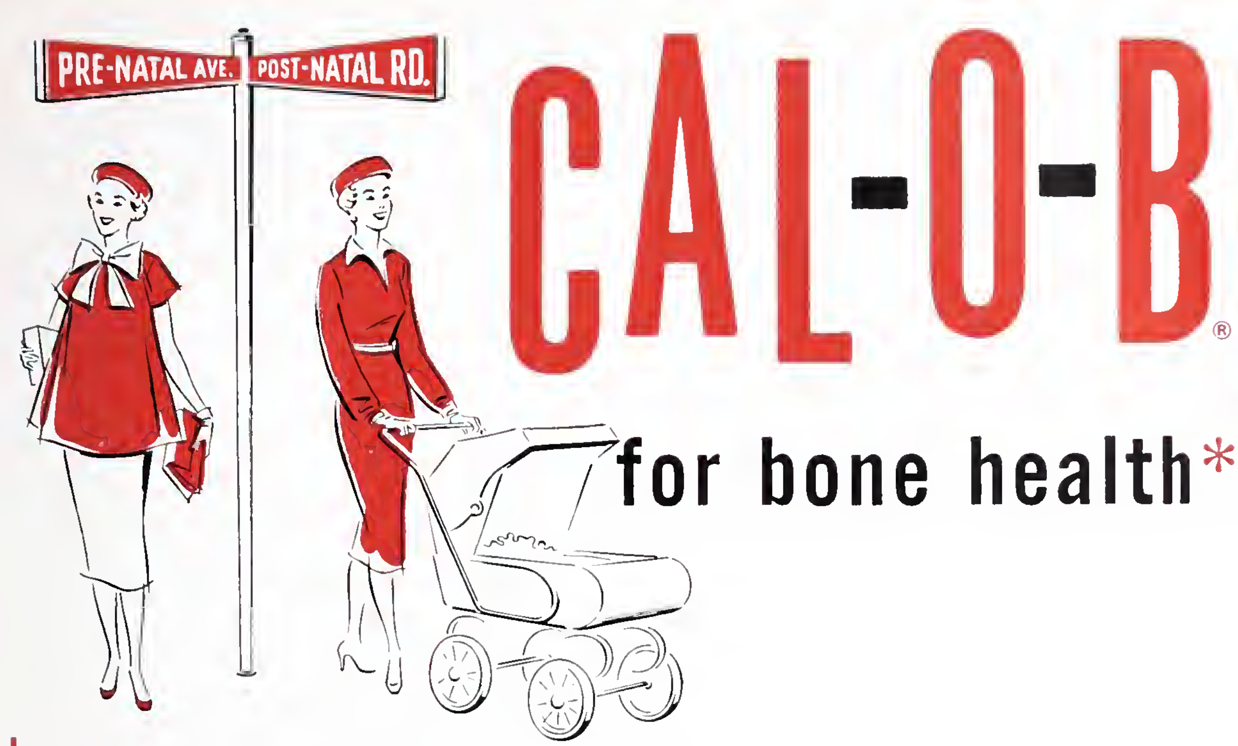


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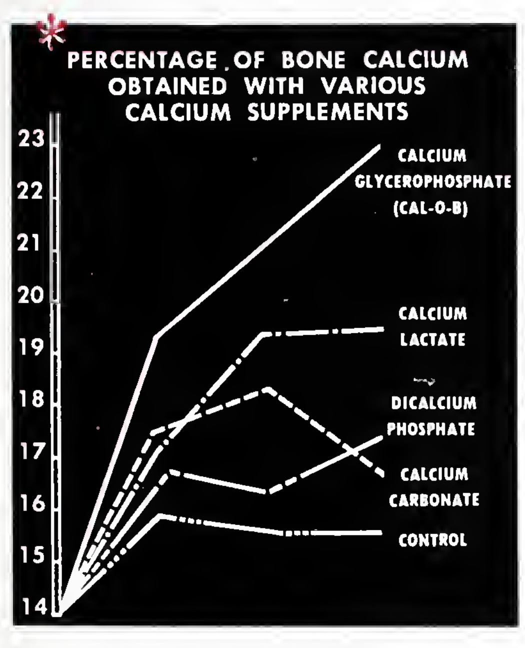


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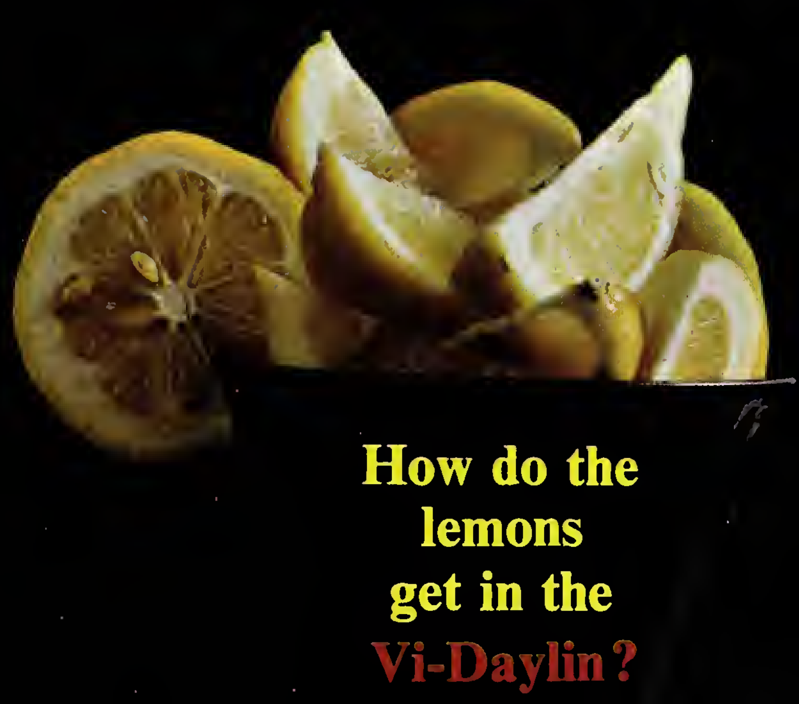

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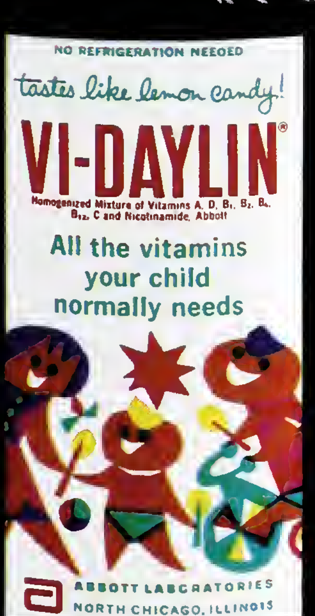


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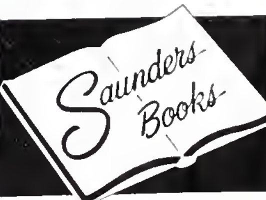


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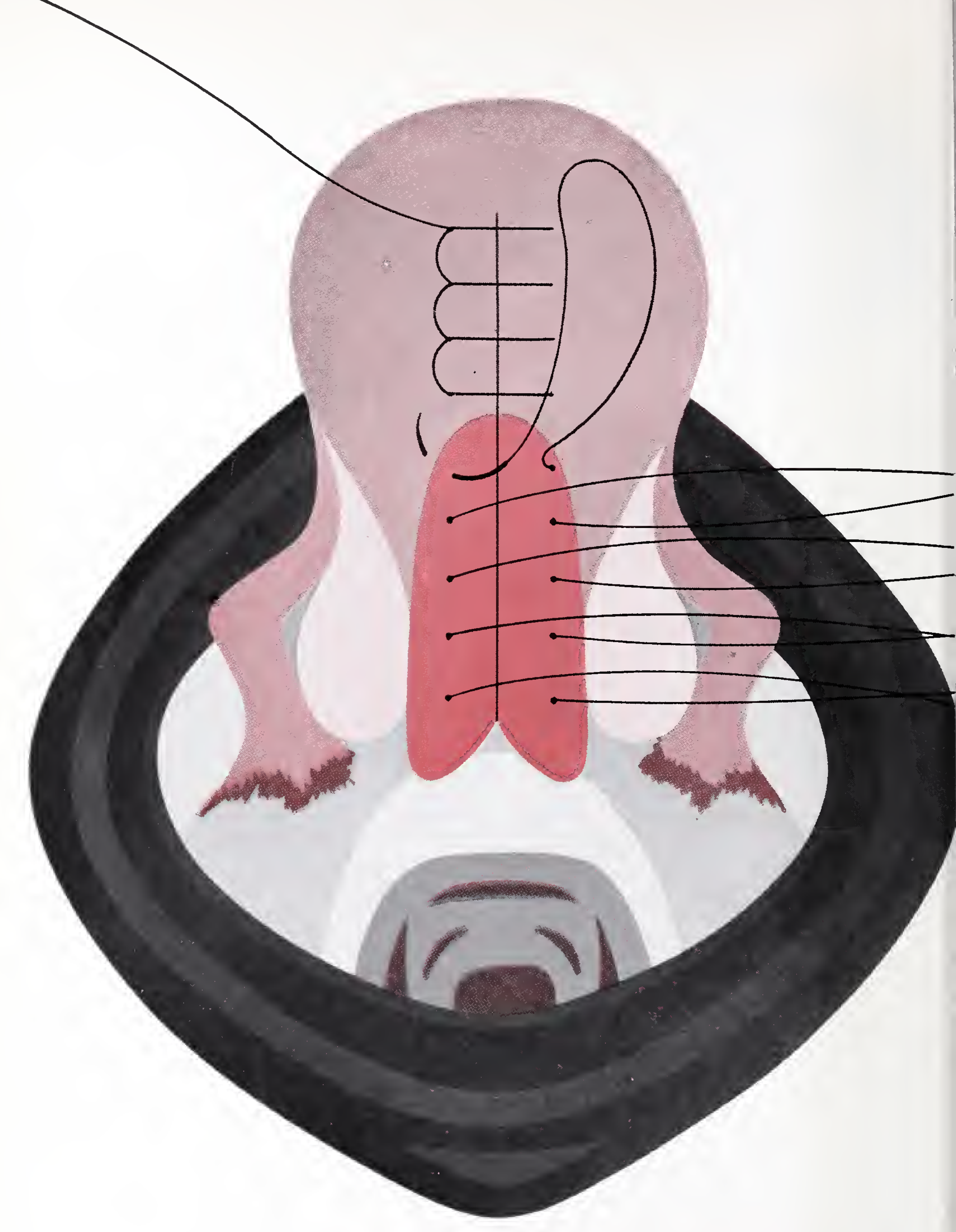


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| Pyloric Channel Ulcer | 6 | 3 | 1 | 0 | 2 | 2 | 1 | 1 | 0 | 0 |
| Pyloric Ulcer | 4 | 2 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 |
| Gastric Ulcer, bleeding | 3 | 1 | 2 | 0 | 0 | | | | | |
| Gastric Ulcer | 48 | 31 | 11 | 1 | 5 | 12 | 5 | 7 | 0 | 0 |
| Gastric Ulcer, penetrated | 1 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 |
| Gastric Ulcers, multiple | 1 | 1 | 0 | 0 | 0 | | | | | |
| Duodenal Ulcer | 494 | 220 | 195 | 48 | 31 | 99 | 41 | 38 | 13 | 7 |
| Duodenal Ulcer, bleeding | 38 | 19 | 15 | 3 | 1 | 2 | 1 | 0 | 1 | 0 |
| Duodenal Ulcer, obstruction | 13 | 4 | 3 | 1 | 5 | | | | | |
| Duodenal Ulcer, perforated | 5 | 2 | 1 | 0 | 2 | 6 | 0 | 3 | 1 | 2 |
| Gastric and Duodenal Ulcer | 4 | 2 | 2 | 0 | 0 | | | | | |
| Peptic Ulcer, unspecified | 25 | 19 | 4 | 0 | 2 | 18 | 8 | 7 | 2 | 1 |
| TOTALS | 653 | 307 | 239 | 57 | 50 | 142 | 58 | 57 | 17 | 10 |
| | | 83.6% | | | | | 81.0% | | | |

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# Reports & Snorts

**We mentioned the googol ($10^{100}$) in the last issue, and the googolplex ($10^{10^{100}}$). Of more practical importance in medicine are the prefixes like deci- ($10^{-1}$ or 1/10), centi- ($10^{-2}$) and milli- ($10^{-3}$ or 1/1000); or in the other direction, kilo- ($10^{3}$). As nuclear medicine gets doctors more deeply involved in physics, however, we may need to know mega- ($10^{6}$, or a million) and micro- ($10^{-6}$, or a millionth). Now international approval has been given to nano- ($10^{-9}$, or a thousand millionth) and pico- ($10^{-12}$, or a million millionth); femto- means $10^{-15}$ and atto- $10^{-18}$. In the upward direction, we now have giga- ($10^{9}$, or an American billion) and tera- ($10^{12}$, a million million). A millionth of a millionth of a gram isn't a micromicrogram, it's a picogram, and a 1,000 megaton bomb is a gigaton bomb. An Angstrom is a nanometer. (*Scientific American*, August 1962.)**

• • •

A case of eczema vaccinatum was dramatically cured, and a case of progressive vaccinia was not helped at all, according to the May 12 *British Medical Journal*, by N-methylisatin—thiosemicarbazone (250 mg orally q 6 hours in a nine-month infant).

• • •

*The California College of Medicine, an osteopathic school formally accredited as a medical school last February, graduated its first class of M.D.'s last June, and in July nearly 2,000 of its graduates (including the last class) were awarded the M.D. degree.*

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**Thirteen topflight medical scientists, including such names as Paul Cannon, Thomas Francis, Jr., Philip Hench, and Chester Keefer, have been appointed to a new Commission on Drug Safety by the Chairman, Lowell Coggeshall. The Commission was established by the Pharmaceutical Manufacturers Association.**

• • •

*Dr. Edward R. Annis, President-elect of the A.M.A., was once nominated for the presidency of his county medical society. Opposition from the local medical school defeated him. Now he's in a position to give the top-level A.M.A. administration a close, unbrainwashed look. It may be very good for us!*

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• • •

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• • •

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*A blue baby's blueness may be iatrogenic and easily reversed by proper treatment*

# Methemoglobinemia Due to Benzocaine

## Case Report and Review

JOHN C. MILNOR, M.D., and
WILLIAM F. MOORE, JR., M.D., *Honolulu*

• *Moderately severe acute secondary methemoglobinemia occurred in a two-week-old infant about three hours after the insertion of a suppository containing about 65 mg of benzocaine and lubricated with ointment containing 2% benzocaine. Symptoms—cyanosis with tachycardia, but without dyspnea—were typical. The cyanosis was abolished promptly and almost completely by two intravenous injections of 1% methylene blue solution. The oxidation of ferrous iron to ferric in the hemoglobin molecule by benzocaine, and its reduction to ferrous again by methylene blue, are discussed in detail.*

METHEMOGLOBINEMIA is uncommon in early infancy and has only rarely been reported to have been caused by benzocaine. The purpose of this paper is to call attention to this toxic reaction to benzocaine used in ointments or rectal suppositories.

### CASE REPORT

A boy born at term after a normal gestation and delivery, weighing 9½ pounds, was started on a Sobee formula because of a strong family history of allergy, and because two siblings had been reared successfully on a soybean formula.[1] At three days of age, Sobee was changed to Mull-Soy because of frequent watery stools. His stools became soft and less frequent. However, he cried during and for a prolonged period after each stool, in obvious pain.

At the age of two weeks, during his first routine postnatal checkup, severe erosions of the anal canal and perianal skin were noted. Because petroleum jelly and a zinc oxide ointment had failed to heal these, a suppository containing benzocaine* was prescribed for relief of pain. During the office visit, one-half of a suppository, coated with a small amount of a benzocaine-containing ointment† supplied with it, was inserted to demonstrate its use to the mother.

Three and one-half hours following insertion of the suppository, the infant was noted by his parents to be blue and was returned to the office. Physical examination disclosed deep cyanosis, tachycardia, and tachypnea, but no dyspnea. He was admitted to Kauikeolani Children's Hospital, where blood drawn on admission (five hours after insertion of suppository) showed 65 per cent methemoglobin on spectrophotometric analysis. At the time blood was withdrawn for analysis, 3 ml of 1% methylene blue and 500 mg of ascorbic acid were injected intravenously. Forty-five minutes later, his cyanosis had disappeared except for traces in hands, feet, and lips; analysis of his blood at this time showed only 2.5% methemoglobin.

Twenty-four hours after admission, minimal cyanosis was still visible in his extremities, and he was given a second intravenous injection of 1 ml of 1% methylene blue. Within one hour, this cyanosis disappeared. Oxygen, administered since admission, was discontinued. He was discharged on the following day, again faintly cyanotic cir-

From the Department of Pediatrics, Straub Clinic.

| | | |
|---|---|---|
| * | Benzocaine | 130 mg |
| | Witch Hazel | 65 mg |
| | Bismuth Subcarbonate | 65 mg |
| | Cocoa Butter | |
| † | Benzocaine | 2% |
| | Aluminum Acetate | 2% |
| | Phenol | 1% |
| | Witch Hazel | 2% |

cumorally and in hands and feet, but otherwise normal on examination. Subsequent checkup at six weeks of age disclosed a normal, active infant with no apparent sequelae of the methemoglobinemia.

### DIAGNOSIS

When cyanosis is present at birth or later in life without evidence of cardiovascular or respiratory disease, methemoglobinemia, sulfhemoglobinemia, or both, should be considered.

Greyish-blue cyanosis is the first noted and most striking sign in methemoglobinemia. As in this infant, it is associated with little or no dyspnea such as one might expect to see in congenital cardiovascular or pulmonary disease in which the level of unsaturated hemoglobin is high enough to produce the same degree of cyanosis. Increased respiratory and cardiac rates are present as a result of the lowered oxygen content of the arterial blood.

Symptoms are those produced by the anoxia or the side effects of the etiologic agent. Severe symptoms do not develop until the methemoglobin level is over 50%, although lower levels may produce fatigue and headache; at concentrations of 60%, stupor and respiratory depression usually occur. While 85 to 90% methemoglobin is fatal in dogs, the lethal level in man is not known.

### CHEMISTRY

Benzocaine (ethyl aminobenzoate) and related esters of aminobenzoic acid used as local anesthetics are characterized by poor solubility in water. It has been stated that as a result of this insolubility, these compounds can be applied directly to wounds and ulcerated surfaces because they are not absorbed with sufficient rapidity to be toxic.[2] However, methemoglobinemia has been reported following use of ointments[3, 4] and recently, a suppository[5] containing benzocaine. In our patient, the only change in his environment immediately prior to the onset of methemoglobinemia had been the administration of the suppository and ointment, both containing benzocaine and a combination of other ingredients. As methemoglobinemia has not been reported due to the other ingredients, it would appear likely that the methemoglobinemia resulted from absorption of benzocaine.

### TREATMENT

Methylene blue (methylthionine chloride*), a synthetic dye, is a specific therapeutic agent in acute methemoglobinemia. While it may be given orally, its action by this route is so slow that it is best given intravenously, in doses of 1 mg per pound for infants, or 0.5 mg per pound for adults. The entire dose is given over a three- to five-minute period, since more rapid injection may oxidize hemoglobin to methemoglobin.[6] Response is expected in 10 to 20 minutes. The initial dose may be repeated in one hour if cyanosis returns. Continued administration, however, may result in marked anemia due to accelerated destruction of erythrocytes. If methylene blue is not available, large doses of ascorbic acid (300 to 500 mg) given slowly intravenously may be substituted; its action is much slower (several hours).

Since the anoxia produced by severe methemoglobinemia, like that of severe anemia, results from insufficient hemoglobin available for oxygen transport, administration of oxygen by mask or tent may relieve the symptoms of anoxia by increasing the oxygen saturation of the patient's plasma and remaining hemoglobin. In spite of this increase in oxygen, cyanosis may deepen if the child cries or struggles. Oxygen should be continued at least two hours after methylene blue therapy has been instituted.

Patients should be at absolute bedrest if the methemoglobin level is over 40 per cent.

Intravenous fluids (30 to 40 ml per pound per 24 hours for infants) and blood are indicated if patient is in shock.

If possible, the etiologic agent should be eliminated. If it has been swallowed, lavage or emesis, or both, should be induced. Gastric lavage, if done within four hours after ingestion of the toxic oxidant, is usually successful in its removal and should be accomplished with water or universal antidote* in suspension. It may be advisable following lavage to introduce a saline cathartic into the stomach to hasten evacuation of unrecovered poison. Toxic substances may be removed from the rectum by enemas of water or saline; from the skin by soap and water.

### DIFFERENT CAUSES

There are two main types of methemoglobinemia: primary or congenital, and secondary or acute. The primary type, of which three subtypes have been recognized, is an inborn error of metabolism, the defect being within the erythrocyte.[8] In Type I, the flavoprotein, diaphorase I, which acts as a carrier in the conversion of methemoglobin to hemoglobin, is deficient. Methemoglobin levels of 20 to 40 per cent may be present (normal

* Discovered by Caro in 1876, methylene blue was the first dye to be used as an antiseptic. Its bactericidal properties are very mild, however, and it is no longer used for this purpose. It is used most often for its chemical reactivity and tissue staining properties. It is not to be confused with methyl blue (sodium triphenyl-pararosaniline trisulfonate), also an antiseptic and dye known as Brilliant Cotton Blue or Helvetia Blue.[7]

Methylene blue is available from William H. Rorer, Inc., Philadelphia, in 10 ml sterile ampules as a one per cent aqueous solution (10 mg per ml).

* Universal antidote consists of two parts activated charcoal, one part magnesium oxide, one part tannic acid. (Household equivalent is two parts burned toast, one part milk of magnesia and one part strong tea.)

newborn levels are 0.01 to 1.8 per cent). Type II results from an abnormal hemoglobin, designated "Hemoglobin M," with the defect in the globulin component: 15 to 20 per cent of the red cell pigment is methemoglobin. In Type III, the defect is not known; only one case has been reported.[9] The methemoglobinemia of Type I and Type III can be controlled by daily oral doses of 100 to 300 mg of ascorbic acid;[10] in addition, methylene blue, 25 mg orally, may be indicated periodically when the level is high enough to produce cyanosis. This therapy is of no value in Type II.

Secondary methemoglobinemia is caused by compounds that are direct oxidants: nitrites, nitrates, chlorates, quinones, aniline and its derivatives, certain sulfonamide preparations, acetanilid, and phenacetin. Aniline dye in ink and wax crayons is particularly dangerous. Death has occurred from aniline absorbed from freshly inked diapers used on newborns in nurseries[11] and severe, almost fatal, methemoglobinemia in children from eating orange or red crayons.* The mechanism involved in the production of secondary methemoglobinemia is the oxidation of the ferrous ($Fe^{++}$) iron of hemoglobin to the ferric ($Fe^{+++}$) iron of methemoglobin. In this state, it cannot be oxygenated. This reaction is reversible and problems occur only when the methemoglobin is produced more rapidly than the normal cell-reconversion mechanism can reduce it.

Methylene blue in low concentrations accelerates this cell-reconversion mechanism. This is accomplished in the following manner:

> The blue methylene blue is converted to a colorless leuko-form by the coenzyme diphosphopyridine nucleotide (DPN). Leukomethylene blue then reduces the ferric iron to ferrous iron. This reaction continues in the presence of reduced DPN.[13]

In high concentrations, it oxidizes ferrous iron of reduced hemoglobin to the ferric, creating methemoglobin.†[6]

* The pigment used in certain brands of red and red-orange crayons is para-red, a dye considered insoluble and harmless. However, the intermediate of this dye, p-nitroaniline, has been found in some red wax crayons[12] and produces methemoglobinemia.

† Finch,[14] contradictory to most authors, states that "over a dosage range of a fraction of a milligram to 10 mg per kilogram of patient's body weight, methylene blue acts to revert methemoglobin to hemoglobin and clinically significant amounts of methemoglobin are not produced. . . . Larger doses up to 7 gm administered slowly have been given without symptoms but have produced anemia in man."[15]

Sulfhemoglobin may be produced by most of the substances which produce methemoglobinemia, and the two may coexist. They are easily distinguished from one another by spectrophotometric analysis.* The mechanism of formation of sulfhemoglobin is not fully known and concentrations are rarely high enough to endanger life even though they may be high enough to produce cyanosis. Unlike methemoglobin, sulfhemoglobin is a stable compound and disappears from the blood only when the affected red cells are destroyed with age (three to four months). Thus if the cause is eliminated, the condition will clear spontaneously.

SUMMARY

Severe acute methemoglobinemia was produced in a two-week-old infant by a suppository containing 65 mg of benzocaine and coated with 2% benzocaine ointment. Treatment was effected with intravenous injections of methylene blue. The pathologic physiology and chemistry of methemoglobinemia are reviewed. ■

REFERENCES

1. Glaser, J., and Johnstone, D. E.: Prophylaxis of allergic disease in the newborn, J.A.M.A. 153:620 (Oct. 17) 1953.
2. Goodman, L., and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, MacMillan Co., 1955, pp. 1116-1117.
3. Wolff, J. A.: Clinical conference: methemoglobinemia due to benzocaine, Pediatrics 20:915 (Nov.) 1957.
4. Goluboff, N., and MacFadyen, D. J.: Methemoglobinemia in an infant associated with application of a tar-benzocaine ointment, J. Ped. 47:222 (Aug.) 1955.
5. Peterson, H. deC.: Acquired methemoglobinemia in an infant due to benzocaine suppository, New Eng. J. Med. 263:454 (Sept. 1) 1960.
6. Conn, H. F.: Current Therapy, 1960, Philadelphia, W. B. Saunders Co., 1960, p. 687.
7. Osol, A., and Farrar, G. E.: United States Dispensatory, 25th Ed., Philadelphia, J. P. Lippincott Co., 1955, pp. 855-856.
8. Hsia, D. Y. Y.: Inborn Errors of Metabolism, Chicago, Year Book Pub. Co., 1959, p. 174.
9. Eder, H. A., Finch, C., and McKee, R. W.: Congenital methemoglobinemia: a clinical and biochemical study of a case, J. Clin. Invest. 28:265 (Mar.) 1949.
10. Barcroft, H., Gibson, Q. H., Harrison, D. C., and McMurray, J.: Familial idiopathic methaemoglobinemia and its treatment with ascorbic acid, Clin. Sci. 5:145 (Dec. 12) 1945.
11. Mark, M. S.: Congenital methemoglobinemia in the newborn period, A.M.A. J. Dis. Child. 92:15 (July) 1956.
12. Rieders, F., and Brieger, H.: Mechanism of poisoning from wax crayons, J.A.M.A. 151:1490 (Apr. 25) 1953.
13. Dreisbach, R. H.: Hand Book of Poisons, Los Altos, Calif., Lange Medical Publications, 1955, p. 43.
14. Finch, C. A.: Medical Progress: methemoglobinemia and surfhemoglobinemia, New Eng. J. Med. 239:470 (Sept. 23) 1948.
15. Quoted by Finch.[14]

* Methemoglobin shows a spectrophotometric absorption band of 630 $m\mu$ which disappears quickly after the addition of two or three drops of potassium cyanide; that of sulfhemoglobin is 618 $m\mu$ and is unaffected by the addition of potassium cyanide.

*The good and the bad on the past and current medical scene as viewed from the perspective of six decades*

# Fifty-nine Years in Medicine

## Philosophical Observations on the Old and the New

CLARENCE E. FRONK, M.D., *Honolulu*

• *Fifty-nine years of medical education, military service, practice of general surgery (first alone and later in his own group), and retirement have provided this past President of the Hawaii Medical Association with a wide perspective from which he views medical education and the practice of medicine. He finds much to praise, and much to criticize.*

IN PHILOSOPHIZING upon the changes in medicine in my life span, time will allow the mention of but a few. These changes are so vast and recent that one could not practice the science of medicine today with the knowledge possessed only a few brief years ago. This I fully realize for although I have been retired from active practice five years, I am required (being the medical director of two large life insurance companies) to read more of medicine than ever before. The changes in the science of medicine have been tremendous and good. The art of the practice of medicine has also greatly changed, and in many ways not for the better.

### MEDICAL EDUCATION

I graduated in 1906, the high-water mark for the number of medical schools in the United States, 155, with more than 6,000 graduates. Not one school had entrance requirements above a high school diploma. It was in 1906, the year that the A.M.A. began its campaign to lessen the number of medical schools and to standardize those remaining. They set their goal for, and attained it in, 1922. The schools were reduced to 76, with no reduction in the number of graduates.

Many of the old schools were mere diploma mills. Very few graduates served internships as few were available. Those who became good physicians, and many did, learned the hard way but not necessarily at the expense of the patient, for they applied as well then as now the knowledge that was available. Medicine was a life of service, for the physician was dedicated to his patients. This dedication has not passed away, but I believe it has lessened, and to the detriment of medicine. Many things have contributed to this end—fixed fees, closed hospitals, panel systems, governmental interference, prepaid medical plans, overspecialization, reduction in the free choice of physician. Many of these changes in themselves are good and were inevitable, but the results disturb the physician-patient relationship profoundly.

### UNITY

The art of medicine is vitally necessary. Since the dawn of history, the medicine man has played a tremendous role in the development of civilization. By whatever name he was known, shaman, chief, sorcerer, kahuna, he was a leader. He played a positive role. He had to produce or die, so he produced. It is more vital today than at any time in history that we, as physicians, should assume the leadership to which our training and knowledge entitles us. It is an old and trite saying, but one that is vitally true: "only in unity is there strength." United and assuming a positive role, not only in medical matters but in all phases of community, state, and national life, we can rightfully regain and control our own destiny. We must acknowledge the fact that while the individual physician is still greatly beloved and respected, as a group we have lost much of the esteem of the public. The causes are obvious: disunity, factional quarrels, personal and group jealousies, placing too much emphasis upon the material phases of medicine—briefly it can be summed up under the heading of poor public relations. We have been our own worst enemies.

### OVERSPECIALIZATION

The age of specialization is upon us to a degree that is a cause for real alarm. Future physicians are choosing their specialties while they are still in high school. During their intern service, many deliberately neglect all services except their own future specialty, not being aware that it is neces-

sary to know the body as a whole. I fully believe that the time is rapidly approaching when a specified time in general practice will be required as a preliminary to specialization. In the animal world, when we reach a point in breeding known as specialization, there may be a rapid return to the primitive. In the ox family, horns crumple, the hair becomes heavy and coarse, and the disposition worsens.

IVORY TOWERS

Another extremely disturbing factor is the length of time required to become a practicing physician. Following high school, it should be shortened by at least two years. It can and will be, and with no decrease in the knowledge gained. Another most vital change must be made, and soon. The teaching and direction of medicine must be returned to practicing physicians and not left more and more in the hands of those who have never engaged in private practice. These "ivory towers" are necessary and desirable, but they must not completely control and direct.

GENERALISTS

The status of the general practitioner must not further deteriorate. He must be restored to his former high position. Let us not forget the role he plays. At least eighty per cent of the patients who enter his office would recover if they received no treatment at all. At least fifty per cent of all patients are mentally ill or disturbed to such a degree that it is the cause of many of their physical ailments. This is where the art of medicine is practiced at its highest level. Understanding and discernment on his part will lessen the need for the referral to specialists.

PUBLIC HEALTH

Let us not forget the great gains that have been made in the fields of public health: control of communicable and infectious diseases, reduction in infant mortality, vaccinations and inoculations, dietetic knowledge, personal and mass hygiene. These have lengthened the average life span of man, for they allow more people to reach adult life. All of our advances in medicine have added but a few brief months to those who have reached middle age. We may, however, be on the verge of the breakthrough in the controlling of the two great killers of mankind—cancer and cardiovascular diseases. When that is accomplished, then the span of adult life will be truly lengthened. But we physicians lose our perspective. We strain at a gnat and swallow the camel. Our greatest killers of life, our physical sufferings, and economic loss are not from disease but are of accidental origin. We should be the leaders in this vital issue. In our young population accidents cause more deaths than all other causes combined. These efforts must be made in the political field where we have been too reluctant to tread.

PSYCHIATRY

In philosophizing on the old and the new, there are some phases in our specialties that disturb me greatly. Especially one that as a medical student I never heard mentioned: psychiatry. Yet the old family physician practiced it to the nth degree. Only recently one of our leading psychiatrists said to me: "Dr. Fronk, if you know ten per cent of the psychiatry that I do, you can do much more for your patients than I. You are their friend, they know you." It is a vital and much needed specialty, but it must be brought to the patient in a more realistic way. How that can be accomplished, I do not know.

SURGERY

There is one field, however, where I do feel qualified to speak—surgery. The greatest advances have been in the areas of anesthesia, preoperative preparation, and postoperative care. When I entered medical school, local anesthesia was unknown, except the topical application of cocaine. Chloroform was on its way out and ether, by the drop method, was coming into its own. If we today were forced to choose one method, it would be ether by the open-drop method. In 1912, I developed the first apparatus for the giving of ether by vaporization. It was personally used in over 100 general surgical cases. Permission was obtained from the Surgeon General's office to publicize the method and to introduce it into some of our Army hospitals. I was then transferred to Mexican Border Service and neglected to follow through.

Some little time later, other hands developed the same method, which has progressed to its present state. Preoperative preparation, anesthesia, and postoperative care have developed to a point undreamed of during much of my surgical experience. The golden age of surgery truly arrived when vascular surgery was developed by early pioneers and gradually brought to its present status.

One phase of surgery, however, has retrogressed to an alarming degree, i.e., the time element and surgical technique. We surgeons, before the refinements of anesthesia, blood transfusions, etc., had to work rapidly or our patients died. I must emphasize again and again that rapidity does not mean the lessening of skill; in fact, it enhances it. The rapid surgeon must know his anatomy more thoroughly. The art of surgery is no different than the art of fine carpentry, metal working, the bricklaying, or fine needle work. There are certain basic things to do, so why not go ahead and do them? It was a pleasure to watch some of the old masters of surgery operate. They were swift and sure of themselves. Again I reiterate, they had to be swift

and sure or their patients died. Many of the operations that now take from three to seven hours to perform could be as safely accomplished, and not less expertly, in half that time by surgeons trained in the old school.

In the field of results obtained, the old methods are not completely outmoded. In 1929, at the first meeting of the Pan-Pacific Surgical Conference, I reported 40 cases of fractures of the os calcis of industrial origin. Only two cases were awarded any disability. All returned to work and all were treated by closed methods: general anesthesia, manipulation, a sand bag, wooden mallet, and plaster.

### BEDSIDE MEDICINE

One serious trend has been developing during the very recent years and shows no signs of lessening: the placing of too much reliance on laboratory reports and ignoring physical examinations and questionings, assuming that some adverse laboratory report is the cause of the patient's ailment when it may be only coincidental. Early in my medical career, I was taught to follow a certain routine on the first examination of all seriously ill patients. With the patient completely disrobed and in the supine position, the physician should sit by the bedside and watch the various physical actions—the character and rate of the respirations, the abdominal movements, the pulse rate. Require the patient to locate the areas of pain with the finger. A few minutes of careful observation will often reveal the cause of the disability and allow the physician to proceed intelligently. Correlating all of the findings is the true art of medicine.

### MEDICAL MISSIONARIES

Great advances have been made in bringing medical help to the underprivileged people of the world. During the past two decades, I have roamed the earth's big-game hunting fields and have become familiar with the work of medical missionaries. No one could admire them and their accomplishments more than I. This type of medicine was greatly advanced by the exploits of the late Dr. Tom Dooley, and Medico, which he was instrumental in creating. Advancing this type of program offers a challenge to medicine such as it has never had before. Here again, the old and the new must work in harmony—the science of the new, and the art of the old. Specifically, if each were given an equal amount of money to spend in primitive surroundings for hospital buildings, supplies, medicines, equipment, and personnel, the surgeon trained in the older methods would be able to render far more service than the younger man, and service of equal quality.

### PERSONALITY

To be a truly successful physician, one must have three attributes, each one being of equal importance—professional ability, personality, and business sense. The type of personality may vary, but it must have one quality: it must be a positive personality. The patient must leave his physician's office thinking: "My doctor knows what he is talking about." By business sense I mean one must have a decent office and general surroundings in which to practice both the art and science of medicine. The financial end should be on a positive and business-like basis. We need also to remember that life is not a matter of luck. It is a matter of cause and effect.

### RETIREMENT

A message such as I have tried to bring to you would not be complete without a few brief thoughts upon the closing phases of our life's work—retirement. This applies equally to men and women engaged in any business or profession. Retirement is also one of the newer phases of life. As the years pass by, one is often asked: "When are you going to retire?" "Retire to what?" we reply. "To idleness, for that means quick death and decay, so as long as I wish to remain physically sound and mentally alert, I will not retire." The rules and customs of the business and professional world require, and in this I concur, that at various ages one steps aside for a younger person. This does not mean, however, that we must retire to idleness. Fifteen per cent of all creative work is done by men and women past 80 years of age. Nearly all phases of life are divided into three parts—anticipation, realization, and retrospect—each equal with the other. In our profession, anticipation carries us through the period when we are preparing for our life's work to the day when we "hang out our shingle." Realization is the period when we begin and follow through with our career. Retrospect comes after retirement; we must prepare for it as earnestly as we did during the realization period, and the results will be just as rewarding.

### DEATH

A final thought on death, to which we all must submit, for it is inescapable. Death is being robbed of its dignity, and to what end? Certainly not to the prolongation of life beyond possibly a few brief days or hours. When surgery can offer no hope of cure, it should not be used except in cases where it may make the end more bearable. With the liberal use of pain-relieving drugs, let the patient pass on in peace and dignity.

"Let me go out like the candle light, snuffed
out at the break of dawn.
Give me high noon and then the night when
I pass on." ■

4706 Kahala Ave.

*Blunt abdominal injury can produce unexpectedly severe and extensive damage to internal viscera*

# Early Management of Nonpenetrating Abdominal Trauma

WALTER Y. M. CHANG, M.D., and EDWARD WILLIAMS, M.D., *Honolulu*

• *The consequences of seemingly minor nonpenetrating abdominal trauma may be serious, but can easily be overlooked unless frequently repeated examinations are performed. Surgical exploration may have to be done on the basis of relatively slight indications, unconfirmed by x-ray findings or laboratory tests in some instances.*

AN INJURED person whose abdomen has been contused must be examined repeatedly at short intervals in order to determine whether exploratory laparotomy should be done at once, or later, or not at all. X-rays and laboratory studies may be helpful but are less important than the history and physical findings. Levine intubation, bladder catheterization, and intravenous infusion should be performed almost routinely in such cases. If exploration is done it must include exposure of the pancreas and hidden portions of the duodenum.

With the advent of the automobile, nonpenetrating abdominal injuries have certainly become more frequent. Because of the urgency of the problems arising, the necessity for quick but accurate decisions, and the rapidity of action required, the wisdom and knowledge of the surgeon may be severely taxed. Review of the management of blunt abdominal trauma emphasizes the difficulties inherent in diagnosis and therapy.

Four cases are presented to demonstrate certain aspects of the early management of abdominal trauma and to stress surgical principles. Two of these cases, a severance of the common duct and hepatic artery, and a delayed rupture of the spleen, are included because of their rarity and special interest.

## ILLUSTRATIVE CASES

CASE 1. A 44-year-old Japanese carpenter was involved in an automobile accident on December 28, 1961. The patient, who had drunk a lot of alcohol just before driving, complained of severe and persistent epigastric pain only after he had been in the hospital emergency room 30 minutes.

The patient was unresponsive and writhing with severe abdominal pain. Occasionally, he would draw his legs up in an attempt to relieve his pain. Vital signs were normal and pulse was 84.

His right zygomatic area and right ankle were swollen, discolored, and tender. There were several small lacerations on his face. The abdomen initially was only mildly tender in the upper quadrants. Slight muscle guarding was present, but rebound tenderness was absent. No masses were felt and bowel sounds were normal. Kehr's and Ballance's signs were absent.

Leukocytosis of 19,100 was present, with a differential of 87 polymorphonuclear cells and 9 lymphocytes. Hemoglobin, hematocrit and urinalysis were normal. A diagnosis of traumatic pancreatitis was considered. The serum amylase was 97 units and the lipase, reported 48 hours later, was elevated to 4.3 units.

An intravenous solution of normal saline was started with a large gauge needle, and 4 units of blood crossmatched. A Levine tube and a Foley catheter were inserted. Roentgenograms of the abdomen showed nothing diagnostic except for gas in a loop of jejunum. A four-quadrant abdominal tap was done, but nothing was aspirated.

Repeated and frequent examinations, however, revealed increasing pain, tenderness, and muscle guarding in the upper quadrants. Because of the progressive severity of abdominal pain and tenderness, and because of decreasing bowel sounds, a diagnosis of peritoneal irritation secondary to a ruptured viscus was made. An exploratory laparotomy was carried out a few hours after admission.

Almost complete severance of the common duct near its entry into the duodenum, severance of the hepatic artery with hemorrhage into the hepatoduodenal ligament, and acute traumatic hemorrhagic pancreatitis were found. The common duct admitted only a #3 Bakes dilator into its lumen. Repair of the common duct, with a #8F catheter splinting the duct, was carried out with #5-0 atraumatic chromic catgut. Two Penrose drains were placed in the peritoneal cavity, one near Morrison's pouch and the second near the foramen of Winslow. Postoperatively, the patient was treated with high doses of antibiotics and did quite well.

*Comments:* Several important principles in this case should be emphasized. First, repeated and frequent examinations may be necessary for an accurate diagnosis, as patients are sometimes intoxicated and uncooperative. It may be difficult to distinguish between antisocial behavior and restlessness secondary to shock. It is risky to operate on an individual seriously injured but without intra-abdominal damage. Therefore, repeated observations may be necessary before a decision to explore can be made. Frequently, the exact etiologic or anatomical diagnosis cannot be made, but evidence of peritoneal irritation, probably secondary to rupture of viscera, is all that is needed. Repeated and frequent examinations can show the trend in the patient's condition.

Second, a large bore needle or catheter for intravenous fluids should be placed immediately, and blood crossmatched. Usually four units are adequate. Gastric aspiration should be done to ascertain whether there is bleeding in the stomach. A Foley catheter should be inserted and analysis of the urine made. If hematuria is present, intravenous pyelogram should be done.

Third, a thorough exploration of the intraperitoneal contents should be made. If a Kocher maneuver had not been done and the common duct investigated in this case, the ruptured area of the duct would have been missed. Initially, though, it was the slight amount of free bile staining the common duct that made the surgeon suspicious of common duct rupture.

Fourth, such a patient should be protected by antibiotics. Severely stressed patients suffer increased frequency of serious infections. In this patient, protection with penicillin against liver infection was necessary since his hepatic artery was severed so far distally.

Case 2. A 27-year-old white man was first seen on December 21, 1961, in shock. He had been hit by a car while driving a motor scooter. According to police reports, he and the scooter bounced against the curb and pavement in seven separate places before coming to rest against a telephone pole. It was learned that he had been drinking.

The patient was completely unresponsive, thrashing about and moaning. No specific complaints could be elicited until his abdomen was examined, and then he would say only that it hurt.

Blood pressure was 50/0. Pulse was faintly palpable at 72. Respirations were 32. A 1½-inch stellate laceration of his occipital scalp was bleeding freely. Multiple contusions of his face and body were seen. A unit of dextran was quickly started and six pints of blood crossmatched. With 200 cc of the plasma expander, the systolic blood pressure rose to 80 mm Hg.

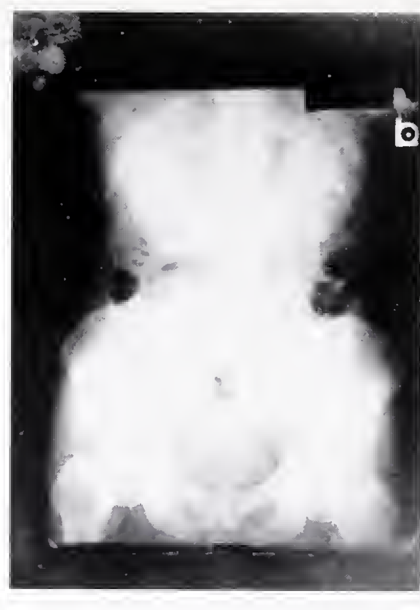

Fig. 1—*Showing sentinel loop of jejunum in the left mid-abdomen of patient 1.*

There was tenderness in the right upper quadrant, with muscle guarding and decreased bowel sounds. There were no masses. Rebound tenderness was present. Kehr's and Ballance's signs were negative. Abdominal taps in four quadrants yielded no fluid. A Levine tube and Foley catheter were inserted. Blood was started as soon as it was available. The systolic blood pressure then rose to 110 mm Hg and remained there.

Blood count was normal. Urinalysis showed many red blood cells. Therefore, 150 cc of saline solution was injected into the bladder and 140 cc of blood-tinged fluid returned. Intravenous pyelogram showed normal function in both kidneys.

Because of the combination of peritoneal irritation and shock, a diagnosis of intraperitoneal bleeding secondary to a ruptured viscus was made. Therefore, an exploratory laparotomy was carried out, and 1500 cc of blood was aspirated from the peritoneal cavity. Systematic exploration disclosed a ruptured spleen and two perforations in the mid-jejunum. Splenectomy and repair of the holes in the bowel were done. Three pints of blood was given.

Postoperatively, the patient did well and went home on the eighth postoperative day.

*Comments:* This case illustrates the necessity of replacing lost fluid immediately. With hemorrhage, hypovolemia is correctable only by blood, although the blood volume can be helped for a short time by plasma expanders.

Second, the fallacy in depending on laboratory data is evident here. Although 1500 cc of blood had been lost, the hematocrit and hemoglobin were normal. In mixed trauma with bleeding, the phenomenon of transcapillary refilling takes time. Only after many hours will a drop in the hematocrit be demonstrated.

Third, the value of systematic exploration was well demonstrated here. Without "running the

FIG. 2—*Showing sentinel loop of small bowel in the left upper quadrant in patient 2.*

bowel," the two perforations in the mid-jejunum would have been missed. These particular punched-out holes in the bowel resembled the perforations that occur occasionally in nonpenetrating injuries to the urinary bladder. The fluid within the lumen actually behaved as a missile and perforated the confining walls!

CASE 3. A 15-year-old white boy was admitted with a severe right femoral fracture. His car had been completely demolished in a traffic accident. Apparently, the patient dozed at the wheel, and the car left the road, flipped over, and crashed against a telephone pole. The patient, when questioned, complained only of his right supracondylar fracture and of mild abdominal pains. He claimed that the latter discomfort had actually been present for two days before the accident.

Examination revealed a restless boy with multiple lacerations of the face and fracture of the lower right femur. The abdomen was flat, soft, and only minimally tender in the left lower quadrant. Bowel sounds were active. No masses were felt. Kehr's and Ballance's signs were negative, and vital signs were stable. Pulse was 80.

In spite of a normal hemoglobin and hematocrit, the patient looked pale. Urinalysis showed many red blood cells. However, intravenous pyelogram was normal. Diagnostic abdominal paracentesis was also negative.

Intravenous fluid was started and blood crossmatched. Because of the loss of blood into his right thigh and because of the patient's restlessness and pallor, two units of blood were given. The restlessness and pallor quickly disappeared. A Steinman pin was inserted into his upper tibia and he was then placed in balanced traction.

The patient did well for the next 48 hours. Vital signs remained stable. He appeared alert, cooperative, and pink. His appetite was good and flatus was passed. On the second hospital day, he had a normal stool. Repeated examinations of the abdomen were normal. The tenderness had disappeared, the abdomen was soft, muscle guarding was absent, and bowel sounds were active.

However, on the morning of the third hospital day, the patient had a sudden onset of left lower abdominal pain. Blood pressure was 120/80 and pulse was 84. Tenderness and guarding were found in the left side of his abdomen, especially in the left lower quadrant. Bowel sounds were decreased. The patient was pallid, and a hemoglobin was reported as 10.4 gm.

Because of the evidences of peritoneal irritation and blood loss, a diagnosis of intraperitoneal bleeding secondary to a delayed rupture of the spleen was made. On exploratory laparotomy, 1000 cc of blood were found in the peritoneal cavity, coming from a lacerated spleen. The rest of the abdominal contents was normal. Splenectomy was done. Postoperatively, the patient did well and was soon discharged.

*Comments:* The value of repeated and frequent examinations is also illustrated here and requires no further comment. The initial blood count was normal and again showed that, except for use as a baseline, reliance cannot be placed on it. In all three preceding cases, the pulse rate was slow in spite of quite severe injury, but the caliber was weak and faint. Restlessness and pallor demonstrated in this particular instance, better than laboratory data or pulse rate, the nature of the patient's lesion. Furthermore, the ease of compressibility of the pulse suggested hypovolemia even more than did the pulse rate.

CASE 4. A 19-year-old Korean boy was first seen after a two-car collision. He had been drinking beer just before driving. The patient complained of severe generalized abdominal pain, although he was, for the most part, quite unresponsive and restless.

He was vomiting undigested food. Blood pressure was 130/80 and pulse was 140. There were contusions on his forehead, right jaw, and chest. The abdomen was flat and marked by a right paramedian scar. Muscle guarding, especially in the upper quadrants, was present. There was considerable tenderness in the epigastrium. Bowel sounds were decreased.

Laboratory work was normal. Taps in four quadrants were negative. Blood was crossmatched after an IV was started. A Foley catheter and Levine tube were inserted.

Repeated examinations soon revealed inconsistency of abdominal tenderness and muscle guarding. Bowel sounds became more active after several hours. Gradually, muscle guarding, abdominal

pain, and tenderness decreased. Within 12 hours, the abdomen became soft and nontender. Bowel sounds became active and the patient passed flatus. He became responsive soon thereafter and stopped complaining of any further abdominal pains.

After several other studies, he was discharged on the fifth hospital day in good condition.

*Comments:* The important principle illustrated here is the necessity of repeated, frequent abdominal examinations. If a decision had been made on the basis of the first examination, a laparotomy would probably have been done, and would probably have been detrimental to the patient.

### DISCUSSION

The early management of blunt abdominal trauma is probably one of the more difficult situations in surgery. According to Pender,[22] Welch and Giddings,[27] and others,[2, 4, 18, 23, 29] the acumen of the clinician is challenged, for the dual problems of early diagnosis and management are difficult. The value of repeated examinations at frequent intervals is emphasized by Estes,[5] Halter,[8] and Morton.[19]

The most frequently injured viscus is the spleen.[28] Benson and Prust[1] have mentioned that this is true in children also. Rupture of the biliary ducts secondary to nonpenetrating trauma is very unusual, only about 100 cases having been reported.[6, 10, 14, 16, 25, 26] Complete or nearly complete severance of the common duct is even rarer.[3, 20, 24] Apparently, the combination of hepatic artery and common duct severance secondary to blunt trauma has not been reported previously. Perforation of the intestine is also unusual, but occurs most frequently in the upper jejunum.[4] Like rupture of the common duct, injuries to the bowel can be difficult to diagnose.[11]

The value of abdominal paracentesis as a diagnostic aid has been questioned by Harkins[9] and Maughan.[17] But Wright,[28] Byrne,[2] and Shaer[23] have found the diagnostic tap to be helpful.

Examination of the abdomen will reveal guarding, tenderness, spasm, and decreased bowel sounds.[27] However, as Mansfield[15] and Larghero[12] pointed out, pallor proved to be one of the more helpful signs in the third patient.

Splenectomy and repair of perforated small bowel are unquestioned methods. For traumatic injuries to the biliary tract, primary repair is perferable,[3, 16, 21, 24] although a bypass may be necessary since some cases have been operated upon many days after the original injury.[1, 13, 16]

Mortality for splenic rupture has been high in the past.[18] In Byrne's[2] series, the mortality was 16.8%. Estes[5] found a mortality of 19.4%. In injuries to the biliary tract and liver, mortality is even higher.[7] For these reasons, the early treatment of blunt abdominal trauma assumes a position of paramount importance.

### SUMMARY

The surgical principles involved in the early management of blunt abdominal trauma have been presented. Repeated examinations at frequent intervals are necessary for accurate diagnosis. Certain procedures, e.g. Levine intubation, urinary bladder catheterization, insertion of a large needle or catheter for intravenous infusions, are indispensable for a work-up. Thorough exploration within the abdomen, including investigation of the hidden portions of the duodenum and pancreas, is necessary.

The decision for or against operative intervention is based on the history and physical examination. Helpful though they are, x-rays and laboratory studies can only be adjunctive. ■

### REFERENCES

1. Benson, C. D., and Prust, F. W.: Traumatic injuries of the liver, gall bladder and biliary tract in the infant and child, Surg. Clinics N.A. 33 (No. 4):1187 (Aug.) 1953.
2. Byrne, R. V.: Splenectomy for traumatic rupture with intra-abdominal hemorrhage, Arch. Surg. 61:273 (Aug.) 1950.
3. Donald, J. W., and Donald, J. G.: Complete severance of the common bile duct due to nonpenetrating trauma, Ann. Surg. 148:855. (Nov.) 1958.
4. Duncan, J. T., Jr.: Rupture of the small intestine through the intact abdominal wall without associated intraperitoneal injury, Amer. Surgeon 22:1215 (Dec.) 1956.
5. Estes, W. L., Bowman, T. L., and Meilicke, T. T.: Nonpenetrating abdominal trauma, Am. J. Surg. 83:434 (Mar.) 1952.
6. Forman, J. J., and Hinshaw, J. R.: Rupture of the hepatic ducts due to blunt trauma Surg. 39:322 (Feb.) 1956.
7. Glenn, Frank: Injuries to liver and biliary tract, Am. J. Surg. 91:534 (Apr.) 1956.
8. Halter, B. L.: Nonpenetrating wounds of the abdomen in children, Am. J. Surg. 93:667 (Apr.) 1957.
9. Harkins, H. N.: Delayed splenic rupture, Am. J. Surg. 57:159 (July) 1942.
10. Hicken, N. F., and Stevenson, V. L.: Traumatic rupture of the choledochus, associated with an acute hemorrhagic pancreatitis and a bile peritonitis, Ann. Surg. 128:1178 (Apr.) 1948.
11. Jacobson, G., and Carter, R. A.: Small intestinal rupture due to nonpenetrating abdominal injury, Am. J. Roentgenol. 66:52 (July) 1951.
12. Larghero, Y. P., and Giuria, F.: Traumatic rupture of the spleen, S. G. O. 92:385 (Apr.) 1951.
13. Lewis, K. M.: Traumatic rupture of the bile ducts, Ann. Surg. 108:237 (Aug.) 1938.
14. Lysaght, A. C.: A case of traumatic severance of the common bile duct, Brit. J. Surg. 26:646 (Mar.) 1939.
15. Mansfield, Robert D.: Traumatic rupture of the normal spleen Amer. J. Surg. 89:759 (Apr.) 1955.
16. Mason, L. B., Sidbury, J. B., and Guiang, S.: Rupture of the extra hepatic bile ducts from nonpenetrating trauma, Ann. Surg. 140:234 (Aug.) 1954.
17. Maughon, J. S., Geib, P. O., and Lenhardt, H. F.: Splenic trauma: an increasing problem, Surg. 49:477 (Apr.) 1961.
18. McIndoe, A. H.: Delayed hemorrhage following traumatic rupture of the spleen, Brit. J. Surg. 20:249 (Aug.) 1932.
19. Morton, J. H., Henshaw, J. R., and Morton, J. J.: Blunt trauma to the abdomen, Ann. Surg. 145:699 (May) 1957.
20. Neely, W. A., and Hardy, J. D.: Traumatic severance of the common bile duct, Ann. Surg. 154:874 (Nov.) 1961.
21. O'Malley, R. D., Aufses, A. H., Jr., and Whipple, A. O.: Benign extrahepatic biliary tract obstruction, Ann. Surg. 134:797 (Nov.) 1951.
22. Pender, B. W. T.: Traumatic rupture of the normal spleen in children, Lancet 2:544 (Sept. 12) 1953.
23. Schaer, S. M., Dziob, J. M., and Brown, R. K.: Bile duct rupture from external blunt trauma, Am. J. Surg. 89:745 (Apr.) 1955.
24. Tolins, S. H.: Complete severance of the common bile duct due to blunt trauma: a case report, Ann. Surg. 149:61 (Jan.) 1959.
25. Walker, J. H. M.: Traumatic rupture of the bile ducts, Lancet 2:969 (Nov. 7) 1953.
26. Watts, G. T.: Closed injury of the common duct and duodenum, Post-grad. Med. J. 31:37 (Jan.) 1955.
27. Welch, C .E., and Giddings, W. P.: Abdominal trauma, Amer. J. Surg. 79:252 (Feb.) 1950.
28. Wright, L. T., and Prigot, A.: Traumatic subcutaneous rupture of the normal spleen, Arch. Surg. 39:551 (Oct.) 1939.
29. Zabinski, E. J., and Harkins, H. N.: Delayed splenic rupture; clinical syndrome following trauma, Arch. Surg. 46:186 (Feb.) 1943.

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*Boys in well-to-do Chinese families appear to be especially liable to have atopic dermatitis*

# Atopic Dermatitis Among Chinese Infants in Honolulu and San Francisco*

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• *Atopic dermatitis occurs much more frequently in Chinese than in Caucasian children in both Honolulu and San Francisco; it is nearly twice as frequent in Chinese boys as in Chinese girls, and nearly twice as frequent in Chinese children of "white collar" parents as in those of laboring class parents. An extrinsic physical agent—probably a food—preferentially offered to Chinese boys in affluent families is the most likely explanation of these statistically significant discrepancies.*

ATOPIC DERMATITIS is the major allergic problem of the first year of life,[1, 2] and is important not only as a disease, but also for its prognostic value in identifying the infant likely to develop respiratory allergies later in life.[3, 4, 5, 6, 7]

There are no published data about racial differences in atopic dermatitis in infancy, but there is a clinical impression among many pediatricians in the San Francisco area that the incidence of atopic dermatitis is disproportionately high among Chinese-American infants. The purpose of this paper is to test the validity of this impression and to discuss etiologic hypotheses.

Preliminary inquiry revealed that there was an atopic dermatitis incidence of 3.8% among 500 Chinese infants followed during their first year of life at the University of Taiwan Medical School outpatient department.[8] This contrasts sharply with an incidence of about 30% found among 442 San Francisco Chinese infants followed in Health Department Child Health Conferences.[9] Studies among groups of infants who were probably largely Caucasian showed an incidence of atopic dermatitis of 3.1%[10] and about 7%,[9] and an incidence of "infantile eczema" (differential diagnosis not further defined) varying from 9.3%[11] to 29%.[12]

## METHODS

The study group was composed of three different samples:

1) One hundred and seven Chinese infants born at Chinese Hospital in San Francisco during 1958 and followed in Health Department clinics,
2) One hundred and seventeen Chinese and 127 Caucasian infants born at Kaiser Hospital in San Francisco during 1957 and 1958 and followed either there or at Health Department clinics, and
3) Seventy-nine Chinese, 65 Caucasian, 27 Japanese, and 45 infants of mixed ancestry followed in Honolulu at the Kaiser Hospital, the Straub Clinic, or the Medical Group.

These were cohort studies, with samples defined at birth from delivery room records. All Chinese infants born in the time period were admitted to the study group, but for other racial groups a random sample of infants was chosen from the total non-Chinese births in the same obstetrical unit. Follow-up was accomplished through reviewing the records of the well-baby clinics in which the infants were most likely to have been seen. There was a 10-15% loss rate from these samples during the period of observation.

A case of atopic dermatitis was defined as being any infant whose record stated that he had "atopic dermatitis," "atopic rash," or "eczema (or an eczematoid rash) on the face." The terms "eczematoid rash" on any other part of the body except the face, "seborrhea," or "contact dermatitis" were excluded. Undoubtedly a few cases of atopic dermatitis may have been wrongly excluded and a few cases of seborrheic dermatitis or contact dermatitis wrongly included under this definition.

Only infants seen by a physician at least three times during the first year of life were included in the study, since they were seen often enough to be considered as being at risk of having the diagnosis made.

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Because of the sampling method, no precise estimates can be made of the incidence of atopic dermatitis in the general population of infants in these two cities, but valid deductions can be drawn from comparisons made within each sample. Comparisons between the three studies introduce uncontrolled cultural, economic, and observer variables, but it is interesting to make such comparisons and to draw such inferences as may seem permissible.

RESULTS

The data are presented in the form of percentages to facilitate comparisons of rates and to minimize the number of tables necessary. In the tables presented below the percentages shown in parentheses are unreliable, due to the small numbers upon which they were based. Any difference in rates discussed in the text was found to be significant at the 1% level by chi-square test.

In each study, the Chinese infants had a significantly higher incidence of atopic dermatitis, ranging from 22.4-27%, than other racial groups, with an incidence of 3-11%. These data support a conclusion that atopic dermatitis is diagnosed more frequently in Chinese infants than in non-Chinese infants in both San Francisco and Honolulu (Table 1).

TABLE 1.—*Atopic Dermatitis Incidence Among Infants in Three Studies, by Race*

(Percentage with Diagnosis During First Year of Life)

| RACE | S.F. (CHINESE HOSPITAL) | S.F. (KAISER) | HONOLULU |
|---|---|---|---|
| Chinese | 22.4% | 27% | 23% |
| Caucasian | | 11% | 3% |
| Japanese | | | (11%) |
| Mixed | | | 7% |

The data in Table 2 show that there is a consistent tendency for incidence of atopic dermatitis among these Chinese infants to increase directly with the socio-economic status of the father, as measured by his occupation listed on the birth certificate.[13] This same gradient was seen among the Caucasian infants in San Francisco, but could not be tested for the Caucasians in Honolulu due to small numbers. A further look at Table 2 shows

TABLE 2.—*Atopic Dermatitis Incidence Among Chinese Infants in Three Studies by Occupational Status of Their Fathers*

(Percentage with Diagnosis During First Year of Life)

| OCCUPATIONAL GROUP | S.F. (CHINESE HOSPITAL) | S.F. (KAISER) | HONOLULU |
|---|---|---|---|
| White Collar | 32% | 31% | 30% |
| Blue Collar | 23% | 28% | ( 9%) |
| Service or Laborer. | 16% | 14% | ( 0%) |

TABLE 3.—*Atopic Dermatitis Incidence Among Chinese Infants in Three Studies by Birthplace of Their Parents*

(Percentage with Diagnosis During First Year of Life)

| BIRTHPLACE OF PARENTS | S.F. (CHINESE HOSPITAL) | S.F. (KAISER) | HONOLULU |
|---|---|---|---|
| Both Parents Born in China | 22.5% | 14% | |
| One Parent Born in China | | 23% | 41% |
| Both Parents Born in the U.S. | | 34% | 18% |

that within each occupational group the incidence of atopic dermatitis is virtually identical, despite the fact that the three studies involved different infants seen by different doctors in different settings. These observations support a conclusion that the factors responsible for atopic dermatitis among these Chinese infants are more pronounced in families higher on the economic scale.

The data in Table 3 support a conclusion that in San Francisco there is apparently a positive relationship between atopic dermatitis incidence and the Americanization of the parents; incidence is higher in families with nonimmigrant parents. In Honolulu, where there is no real Chinatown and where the assimilation of the Chinese into the general culture is likely to be much more rapid than in San Francisco, the offspring of American-born parents had a lower incidence of atopic dermatitis than did the offspring of immigrant parents. These observations suggest that the factors responsible for the high incidence of atopic dermatitis in these Chinese infants are to be found most prominently in families in a transitional state of acculturation, such as in American-born San Francisco Chinatown families or in Honolulu immigrant families, while it is less prominent in the relatively unassimilated immigrant Chinatown families or in the well-assimilated, American-born Chinese families of Honolulu.

TABLE 4.—*Atopic Dermatitis Incidence Among Infants in Three Studies, by Sex*

(Percentage with Diagnosis During First Year of Life)

| RACE | S.F. (CHINESE HOSPITAL) | S.F. (KAISER) | HONOLULU |
|---|---|---|---|
| Chinese | | | |
| Male | 27.4% | 36% | 29% |
| Female | 15.5% | 19% | 18% |
| Caucasian | | | |
| Male | | 10% | |
| Female | | 12% | |

Table 4 shows a consistent excess of atopic dermatitis among the male infants. This sex differential did not appear in the Caucasians in San Francisco, and could not be tested in Caucasians in Honolulu due to small numbers.

Table 5 shows that there was a tendency among Chinese cases in San Francisco to have a more protracted course than Caucasian cases of atopic dermatitis. This difference could not be tested in Honolulu due to small numbers.

There was a consistent tendency for the initial diagnosis of atopic dermatitis to be made early in the first six months of life among the Chinese infants, and a few months later among the Caucasian infants.

Table 5.—*Duration of Cases of Atopic Dermatitis in Infants in Three Studies, by Race*

(Percentage of Cases Probably Continuing into Second Year of Life)

| Race | S.F. (Chinese Hospital) | S.F. (Kaiser) | Honolulu |
|---|---|---|---|
| Chinese | 21% | 22% | (0%) |
| Caucasian | | 7% | (0%) |

Judging from the reports of the mothers quoted in the clinic records (Table 6), there was a consistent trend among Chinese to have a higher proportion of infants started on evaporated milk formulas and a lower proportion on breast feeding than among the Caucasians, and in both races there was more breast feeding in Honolulu than in San Francisco. A careful look at the feeding categories in each study by race and by atopic dermatitis incidence showed no reliable difference in incidence between those infants started on evaporated milk and those started at the breast. Therefore some explanation other than breast feeding patterns must be sought for the consistently higher incidence of atopic dermatitis, both in San Francisco and in Honolulu, shown in Chinese infants:

1) compared to other racial groups,
2) who were males rather than females, and
3) whose parents were relatively well-to-do people in a transitional stage in the process of acculturation.

## DISCUSSION

The 3-11% incidence of atopic dermatitis found in non-Chinese infants in these studies is a fair approximation to the 3-7% previously quoted for largely Caucasian groups.[9, 10]

Table 6.—*Initial Feeding Methods of Infants in Three Studies, by Race*

| Race | S.F. (Chinese Hospital) | S.F. (Kaiser) | Honolulu |
|---|---|---|---|
| Chinese | | | |
| Evaporated milk | 96% | 90% | 63% |
| Breast | 1% | 5% | 24% |
| Other | 3% | 5% | 13% |
| Caucasian | | | |
| Evaporated milk | | 68% | 46% |
| Breast | | 25% | 40% |
| Other | | 7% | 16% |

If the trends in atopic dermatitis incidence found in these studies are to be explained on a purely genetic basis, there must be postulated a sex-linked factor which shows up in Chinese males but not in Caucasian males. This hypothesis would not explain the excess incidence in Chinese females over Caucasians of both sexes, nor would it explain the excess of atopic dermatitis in Chinese infants of American-born parents in San Francisco and just the reverse phenomenon in Honolulu. These data do not fit any simple genetic hypothesis.

If a hypothesis concerning intrauterine sensitization of the fetus from transplacental passage of protein molecules is considered, one would have to assume that the Chinese mothers' diets in pregnancy (or materials inhaled during pregnancy, or both) were different for male fetuses as compared to female fetuses. Otherwise, it would be necessary to postulate different placental permeability for each sex, some differential influence of sex hormones from the fetus, or a preferential loss of female fetuses due to sensitization. Any of these things is possible, but it is improbable that they would occur in the Chinese and not in the Caucasians.

The data presented above are most compatible with factors in the postnatal life of the infants, particularly during the first six months. To explain these data one must postulate an etiologic agent or agents preferentially presented to infants who are Chinese, male, and born into relatively well-to-do families in a transitional stage of acculturation.

A purely psychiatric hypothesis, based on the particular anxiety of the Chinese parent undergoing the stresses of acculturation, would be unlikely, since this anxiety would hardly be more pronounced in the wealthy than the poor, and would hardly be more pronounced for male infants than for female. A psychiatric hypothesis based on lack of love for the infant must be rejected, because it is unlikely that Chinese infants are less loved than Caucasian infants, and it is a certainty that the Chinese male infant is cherished more than the female by cultural tradition.

The responsible agent is therefore most likely in the physical environment of the young infant, and would most probably be in the common classes of objects around any young infant—clothing, bedclothing, room furnishings, toys, medications, and food. In the Chinese culture, affection is characteristically expressed through giving food, with the presentation of special dishes or the presentation of special morsels from the dishes (personal observation). It therefore seems likely that the offending agent is a food item or items offered to the young Chinese infant as an expression of affection, and that this food is preferentially given

to boys, is a relatively expensive item found more in the homes of the well-to-do, that it is more readily available in the United States than in Taiwan, and is first adopted and then gradually discarded for infant feeding as the parents become more thoroughly assimilated into the general American culture.

Specific identification of the postulated food items responsible for the high incidence of atopic dermatitis among Chinese infants in San Francisco and Honolulu would most readily be made by a longitudinal study of groups of Chinese infants from birth until age six months. Very careful observation of feeding practices would be most essential in this study, which would attempt to associate certain food items with an increase in atopic dermatitis incidence.

Given a high incidence of atopic dermatitis in Chinese infants in San Francisco and Honolulu, it would be worthwhile to design a study among older Chinese children in either of these cities to discover if there is a concomitant high incidence of respiratory allergy. If so, it would support the concept that sensitization of the infant (with manifestations mostly in skin) sets the stage for later respiratory allergies. This may have some theoretical importance in the light of Burnet's[14] clonal selection theory of acquired immunity, particularly if this setting could provide an opportunity to discover if juvenile respiratory allergy can actually be prevented by preventing infantile sensitization.


## SUMMARY

Racial differences in atopic dermatitis incidence in infants were studied by following three cohorts of infants during their first year of life through existing clinical records in San Francisco and Honolulu. The results were as follows:

1) In each study the Chinese infants had an incidence of atopic dermatitis of 22-27%, while other racial groups had an incidence of 3-11%.

2) Among the Chinese infants, there was a consistent tendency for atopic dermatitis incidence to be higher among males and among those whose parents were relatively well-to-do people in a transitional stage of assimilation into the general American culture, rather than those who were already well assimilated or those who were immigrant and presumably poorly assimilated people.

Purely genetic, intrauterine, or psychiatric factors were not supported as explanations for these findings, and it was suggested that the responsible factor is an extrinsic physical agent preferentially offered to Chinese infants, particularly to those described above, and that it is probably a food.

Further studies are suggested for the specific identification of the offending agent (or agents) and for discovering whether there is a high incidence of respiratory allergy among older Chinese children in San Francisco or Honolulu associated with this high incidence of atopic dermatitis in infants. ■


## BIBLIOGRAPHY


1. Ratner, B.: Allergy in childhood: Its onset and natural progress. J.A.M.A., 111:2345-2351 (Dec. 24) 1938.
2. Hill, L. W.: Medical progress. New England Med. J., 242:286-290 (Feb. 23) 1950.
3. Edgren, G.: Prognosis and heredity: clinical-statistical study of allergic manifestations. Acta Paediat. (Suppl. 2), 30:1-204, 1943.
4. Ratner, B., Collins-Williams, C., and Untracht, S.: Allergic dermo-respiratory syndrome in children. Am. J. Dis. Children, 82:666-676 (Dec.) 1951.
5. Purdy, M. J.: Long term prognosis in infantile eczema. Brit. Med. J., 1:1366-1369 (June 20) 1953.
6. Finn, O. A.: Long-term prognosis in infantile eczema. Brit. Med. J., 1:772 (Mar. 26) 1955.
7. Burrows, D., and Penman, R. W. B.: Prognosis of the eczema-asthma syndrome. Brit. Med. J., 2:825-828 (Sept. 17) 1960.
8. Chen, C. L. (Personal communication). 1960.
9. Howard, H. E.: Allergic diseases in young children of three ethnic groups in San Francisco. (Unpublished term paper.) Berkeley: U. of California School of Public Health, 1959.
10. Walker, R. B., and Warin, R. P.: Eczema incidence in early childhood. Brit. J. Dermat., 68:182-183 (May) 1956.
11. Robinson, E. C.: Study of 240 breast-fed and artificially fed infants in the St. Louis area: incidence of rashes and gastrointestinal disturbances in breast-fed infants and in infants fed on fresh milk formulas and on acidified (lactic acid) and non-acidified evaporated milk formulas. Am. J. Dis. Children, 59: 1002-1005 (May) 1940.
12. Schwartz, A. B.: Incidence and management of eczema in the first year of life. Wisconsin Med. J., 49:1011-1013 (Nov.) 1950.
13. Edwards, A.: Classified index of occupations. (Bureau of the Census.) Washington: Government Printing Office, 1940.
14. Burnet, M.: Clonal selection theory of acquired immunity. The Abram Flexner Lectures, 1958. Nashville: Vanderbilt University Press, 1959.



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*A centipede bite that was followed by central nervous system involvement*

# Aseptic Meningitis and Probable Ascending Transverse Myelitis Following a Centipede Bite

## Case Report

WAYNE S. LIMBER, M.D., and
ROBERT WEINER, M.D., *Honolulu**

• *A persistently painful swollen centipede bite treated with ACTH, tetanus toxoid, procaine penicillin, Benadryl, and Declomycin, was found four weeks later to be associated with aseptic meningitis and neurologic signs suggestive of myelitis. Recovery was spontaneous.*

SEVERE acute reactions to insect bites are common in the medical literature. Death due to anaphylaxis, and acute neurological involvement with headaches, vomiting, and peripheral neuritis, have been reported.[1] Subacute and chronic neurological involvement is rare in the medical literature. The present case illustrates a delayed aseptic meningitis with probable subacute ascending transverse myelitis, associated with a centipede bite of the foot.

### CASE REPORT

A 33-year-old Portuguese mechanic was first seen on October 23, 1961, because of a painful, swollen left foot, immediately following a centipede bite occurring when he put his foot into a boot. He emptied the boot and the centipede fell out.

At the time of examination, the foot was edematous, tender, and slightly discolored. He was treated with ACTH, 40 units IM, and codeine, and advised to apply cold bicarbonate compresses to the foot.

He was seen twice weekly during the following three weeks because of persistent pain in the foot and ankle and swelling of the lower leg with pitting edema. Later he developed low back pain, superficial burning discomfort over the trunk from the lower abdomen to the chest, headaches, and disturbed bowel function with loose stools followed by obstipation. During this period he received tetanus toxoid, procaine penicillin, Benadryl, ACTH, and Declomycin. There were no signs of thrombophlebitis of the legs.

On November 5, 1961, he was noted to have a generalized papular pruritic rash over the entire body and Declomycin was discontinued. The course of the disease was characterized by remissions and exacerbations. On November 14 he seemed to be markedly improved, his deep tendon reflexes were normal, and he had a flexor plantar response. On November 16 he appeared moderately depressed. A urinalysis at that time was negative, except for 3 to 5 hyaline casts. Hemoglobin was 14 grams, hematocrit was 44 volumes per cent, WBC 6,400, polymorphonuclears 39%, lymphocytes 54%, monocytes 5%, eosinophils 1%, basophils 1%. Serologic test for syphilis was nonreactive.

* From Kaiser Medical Center.

On November 21 he was complaining of tenderness of the anterior chest and regurgitation of water through the nose, difficulty swallowing both liquids and solids, and had the sensation that foods stuck in the upper esophagus. He had lost 20 pounds in three weeks and had a poor appetite. His temperature was normal at each outpatient visit.

He had had scarlet fever in childhood and he occasionally over-indulged in alcohol. He had no allergic history, asthma, hay fever, hives, food allergies, or previous reaction to insect bites. He had not received polio vaccine. He had a history of mumps, measles, and chickenpox as a child, with no sequelae.

His examination on admission to the hospital November 21 showed an afebrile slightly lethargic man in no acute distress. Blood pressure was 134/80, and the pulse was 80 and regular. Positive findings were limited to definite nuchal rigidity. The remainder of his neurological examination was essentially negative, with normal cranial nerve function, normal station and gait, and unimpaired muscle function tendon reflexes. Sensations of pain, temperature, touch, and position were normal.

Laboratory studies showed a normal urinalysis, WBCs—5,500, polymorphonuclears 31%, lymphocytes 57%, monocytes 5%, eosinophils 7%. Sedimentation rate was 8 mm per hour (Wintrobe), BSP showed 4% retention in 45 minutes, and a heterophile of 1 to 14 (normal for this laboratory) was obtained. The serology was nonreactive. Lumbar puncture was performed and 6 cc of slightly cloudy fluid was removed, with an initial pressure of 200 and a final pressure of 150 mm of water. The spinal fluid contained 300 WBC per cmm, 98% of which were lymphocytes; total protein was 73 mgm % and the glucose was 57 mgm %. A colloidal gold curve was 1112210000. The Kahn was nonreactive and Pandy was negative. Gram stain of a spinal fluid smear showed no organisms; cultures for bacteria, tuberculosis, and fungi were negative.

On November 24, 1961, spinal tap was repeated. Initial pressure 235, final pressure 200 mm of water. Five cc of clear colorless fluid was removed. There were 64 WBC per cmm, all of which were mononuclear. Total protein was 42, sugar 84, chlorides 123 mEq per liter. Viral studies of the throat swab, stool, and spinal fluid for Coxsackie, ECHO, polio, measles, mumps, chickenpox, and lymphocytic choriomeningitis were negative. These were performed at the State Health Department laboratory in Honolulu. Chest x-ray was normal and x-ray of the esophagus showed no abnormalities of motor function of that organ. A leptospirosis agglutination test was negative.

The patient's hospital course was characterized by rapid improvement. His headaches, stiff neck, difficulty in swallowing, and paresthesias disappeared in three days. He was afebrile. He was discharged on November 27, and was seen on December 1, 1961, and January 4, 1962; he was free of symptoms on both these visits.

## DISCUSSION

Centipedes are representatives of the class of arthropods called Chilopoda, of which there are a number of species throughout the world. Baerg reported the effects of some supposedly poisonous arthropods in 1924.[2] He allowed Scolopendra heros, Scutogera forceps, and Scolopendra polymorpha—three species common to the southwest U. S.—to bite him on the finger and also to bite a white rat. The bites did not produce any systemic effects in Dr. Baerg. There was local irritation, swelling, and edema which lasted for 48 hours. The rats were somewhat more severely affected, with febrile response lasting 24 hours, plus a similar local reaction.

Scolopendra polymorpha is greatly feared in the southwest U. S. and there are local reports of death due to its bites.[1] This species grows to 7 inches in length and it preys on small animals, including mice and rats, which it paralyzes and sometimes kills with its venom. However, Scolopendra polymorpha has never been described in Hawaii. Our species of centipede are Scolopendra subspinipes, and Otostigma scaber. The latter is less common and has only been known here since 1946.

Cornwall[3] reported low incidence of toxicity of Scolopendridae in India in 1916. Most authors feel that the insect's sting is not dangerous to life.[4]

In our case, confusion with other causes of aseptic meningitis was excluded by viral studies. The question of desensitization of this patient to centipede venom was considered. However, it was felt that this procedure would be extremely hazardous. As far as we know this is the only case of delayed sensitivity and progressive ascending neurological involvement in the recent literature.

## SUMMARY

A case of aseptic meningitis associated with a centipede bite is presented. Symptomatology strongly suggested ascending myelitis. Other causes of aseptic meningitis, such as viral infection, were excluded by appropriate studies. ■

### REFERENCES

1. Riley, W., and Johannsen, O. A.: Medical Entomology, McGraw Hill, 1938.
2. Baerg, W. J.: Ann. Entomology Soc. Amer. 17:343-352, 1924.
3. Cornwall, J. W.: Indian Journal Medical Research 3:541-557, 1916.
4. Matheson, R.: Medical Entomology, Comstock Publishing Co., Inc., Ithaca, N. Y., 1950.

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# *The President's Page*

As physicians practicing the healing art, we have a long way to go to develop ourselves into an effective functioning organization which will permit us to make our influence felt in our communities. In the past, because of our training and the nature of our profession, our activities have been developed on an individual basis. These activities constitute influential contributions to the communities in both political and educational organizations. Because of the individualistic approach to our political problems we are looked upon as being rather ineffective and innocent victims lost in the wilderness of bewilderment.

Consequently, when we go to the Legislature to request passage of legislative bills which we feel will improve the health standards in the community, or to oppose legislative action which we are certain will be detrimental to the health standards of our community, we are often looked upon as being an organization that has to be "put up" with, but not as one which is to be reckoned with. The weakness of our organization is also reflected within ourselves, which confuses and misleads those whom we are trying to help.

What is the answer to this apparent difficulty which we have before us? It is my feeling that one answer to these problems is along the lines of a stronger organization. This organizational effectiveness and strength must be developed or should be developed from the county societies on through to the high echelons of the American Medical Association. It is true that each one must submerge his personal desires to some degree, and this constitutes certain loss of those liberties which we have always felt have been our strength as physicians. However, though this loss may weaken us individually temporarily, it will strengthen us as a group, and in the long run make us more effective in developing our health standards and our community activities.

Political activities of physicians are the object of increased interest these days because of the approaching elections and also because of the knowledge of individuals and organizations such as unions and businessmen's associations that doctors as a group are intent on being more effective politically. This political activity is shown in the organizations of the various state political activity committees and the American Medical Association Political Action Committee (AMPAC). These political action committees have been extremely effective in various states where the leadership has been intelligent and the membership has been united. Financial contributions to both the state political action committee and AMPAC are necessary to make these organizations effective.

Interest of the American Medical Association in international organizations and health was much in evidence at the recent AMA meeting, where one whole day was given over to the study of this aspect of health problems. With the rapidly growing speed of transportation and communication, which are making ever closer the relationships of countries of the world, there is a greater need for improving and integrating health and health organizational activities all over the world. This will become of much greater importance as time progresses.

One phase of activity long neglected by the AMA and the physicians in the United States is that of the political side. If we as physicians forget that politics often forms the basis for decisions which are reached in providing health activities, we will risk being submerged by the various socialistic types of medicine being practiced in those countries which we may become integrated with.

We as physicians must look to the future both in our own state and abroad and must submerge our personal and, sometimes, selfish approaches to problems. We must develop our organizations as strongly as possible so that the people will receive the medical care which they deserve and which they can receive only by the principles which we have stood by in years gone by, that is, free choice of physician and fee for service.

Th. Giles MD

# Editorials

## A Latter Day Missionary

Over a hundred years after the first group of New England missionaries came to Hawaii, a man from Boston arrived on a different type of mission. His was as important in its way as were those of earlier times. And this man appears to those who see him at work today as zealous in his vocation as were those earlier men.

Dr. Leo Bernstein, graduate of Tufts College in science and in medicine, and of Harvard University in public health, is the new director of the Hawaii State Department of Health, by virtue of ability, hard work, steadfastness to the principles of his profession, and the experience of twenty years with public health problems in the Territory and the State.

He has brought a new gospel to Hawaii—that in public health, "we do not have to do the entire job, but we need to see that the job is done."

Dr. Bernstein does his fair share of the job. As a stimulus to others to use more efficiently our resources for better community health, he takes second place to no one, not even his predecessor, Richard K. C. Lee.

Those physicians who choose public health for a career engage in a type of practice that includes many disciplines, both old and new to medicine. Sometimes it is difficult for "practicing" physicians to appreciate what in the health a public health officer is about, be it studying disease populations, talking to teen-agers about smoking and health, collecting mosquito pools, or running a psychiatric hospital. Is this practicing medicine?

Thoreau said, "If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured or far away."

A public health officer must be a student (if not scholar), a teacher, a policeman (sometimes), an administrator. A bit of clairvoyance helps. First and foremost, he must be a diplomat. (This latter quality is not always necessary, or even desirable, in some medical specialties.)

All of these, Dick Lee was and is. Leo Bernstein will be demonstrating his talents in these areas in the days ahead.

Hawaii is fortunate that there are still missionaries who come to her shores. This century's missionaries are messengers of the disciplines of agriculture, anthropology, engineering, medicine, and public health.

## All Out for Sabin Vaccine

Operation Swallow, for the statewide administration of Type I Sabin polio vaccine, begins October 14 on Oahu, Kauai, Hawaii, and Maui. Salk vaccine was a killed vaccine and presumably acted largely by protecting vaccinated individuals against paralysis; Sabin vaccine is a live vaccine and supposedly immunizes those who take it against the disease. It will also "spill" from vaccinated persons to unvaccinated, so that if most of the people can be vaccinated with it, the few that remain will "catch" it too, and be protected. This may virtually or even completely eradicate poliomyelitis from our state.

The three types of Sabin vaccine must be given in proper sequence, since some sequences are wrong and interfere with development of immunity. Accidental inoculation of persons not participating in the program could make it difficult to vaccinate them at all. Everyone should participate to be protected against this effect.

The vaccine will be given orally in a mass program centering on the various schools, supervised by a physician at each center who will donate his time to the program. Swallow II will follow Swallow I six weeks later, on December 2; Swallow III will take place on January 13.

You may safely reassure patients regarding the safety of Sabin vaccine; many hundred thousand doses have been given in the U.S. so far, and more than 70,000,000 persons abroad have been vaccinated, with good results and no ill effects. Urge your patients to participate!

# Fourteen Years of Indecision

In 1948 Dr. Steele Stewart and his fee schedule committee proposed a relative value schedule for Hawaii to be used in establishing fees for the HMSA. A fee survey was made and the results converted into a relative value study. It was proposed that this relative value study be used as the basis for a fee schedule for HMSA, a schedule which could be easily changed with changing economic conditions by merely adjusting the conversion factor. This idea was presented to the physicians of Hawaii and was rejected. The printed galley proofs were passed on to a San Francisco physician for what they might be worth.

In 1956 the California Medical Association came out with a "new" concept in establishing a basis for fee schedules that would be meaningful and realistic. The CMA's method of doing this was by the use of their "relative value study." California developed its relative value study by surveying physicians' fees and converting them into unit values . . . sound familiar??

Today the physicians of Hawaii are still struggling over fee schedules and relative value schedules without much success or unanimity of opinion. Many physicians strongly feel that there should be no restricting fee schedules, that they should be allowed to charge whatever they want or the traffic will bear, and that there should be no third party involved in the practice of medicine. Philosophically it is hard to disagree with this concept, but from a practical standpoint it is impossible to practice medicine in a vacuum. The public demands to know what doctors' fees are, that they be realistic, and that insurance be available to insure against these fees. Never let it be forgotten that public demands will not go long unfulfilled.

When we stop to think of the rapid growth in health insurance, service plans, and governmental medical care programs in the past few years, we realize that it is absolutely necessary that a firm, stable basis for fees be established. The doctors must be active and enthusiastic partners in this change, and work together to develop a method for establishment of these schedules. At the present time the best method for doing this is through the employment of a "relative value study" . . . the very thing that we started fourteen years ago and never took advantage of.

We must all work together as doctors in the "practice of medicine" and decide on what standards we are going to use. These standards must be adopted, knowing full well that any individual or small group of physicians could find some items not to their liking. The profession has pointed out irregularities and inadequacies in every fee schedule or relative value study yet produced. Each individual physician must be willing to sacrifice some of his individuality and work for the total practice of medicine if we wish to stave off complete third party control. It is no longer a question of who is going to pay the bill for medical care, but how it is to be paid. In order for medicine to have any say in this we must agree to a method of establishing these payments—a method that is fair to both the doctor and the patient. In the absence of any equitable method of establishing fees for contractual programs, confusion, disappointment with health insurance, and economic injustice for physicians, the patients, and the insurance companies will continue to be the rule.

Again, the relative value study has proven to be the best solution to this problem. A relative value study must be agreed to for a definite period of time, with resurveys at periodic intervals to make changes as new procedures are introduced, others become obsolete, and new methods of doing procedures increase or decrease the amount of skill or time required. To make constant changes in relativity leads to more confusion than having no standards at all. Levels of fees, however, are easily accomplished by an adjustment in the conversion factors.

Now is the time when we must all work for the common cause. Let's not wait another fourteen years, for who knows what may happen by then?

George H. Mills, M.D.

HAWAII MEDICAL JOURNAL

# In Memoriam - Doctors of Hawaii

This is the fortieth installment of In Memoriam—Doctors of Hawaii.

## E. Cook Webb

Dr. E. Cook Webb, homeopathic physician, arrived from California aboard the "City of New York" on May 17, 1880. Prior to coming to the Islands, he was Chief of Staff at the Homeopathic Hospital on Ward's Island, New York. His business card first appeared in the June 12, 1880, issue of the *Advertiser* and gave his address as No. 60 Fort Street and noted that special attention would be given to diseases of women and children. Before long he had an active practice which included members of the royal family.

DR. WEBB

In 1881 Dr. Webb was one of five doctors called to testify before a special committee of the Privy Council regarding the sanity of an Hawaiian man accused of murder. Doctors McKibbin, Hoffman, McGrew, and Brodie all agreed that the accused was sane, but Dr. Webb considered him insane at the time of the crime and testified that in the two years previous to his coming to Hawaii he was in almost daily contact with 1,400 insane patients.

In February, 1882, the doctor left, intending to settle on the mainland, but by November he was back and had his office and residence on the corner of Richards and Hotel streets. Dr. Webb practiced in Honolulu until April, 1883, when he left a second time. Returning in October, 1884, he was accompanied by his wife. During his absence, he not only embraced matrimony but found time to take additional medical work, and on his return he announced he would specialize in diseases of the kidneys and urinary organs. Shortly after his return he was appointed Inspector of Schools to take the place of Dr. Parker, who had resigned.

By 1885 Dr. Webb was a government physician with no private patients and in charge of the Insane Asylum for which he received a salary of $125 a month. He also served as physician for the branch hospital at Kakaako for which he received no additional pay. At a legislative hearing dealing with finances he was credited with reducing the amount spent for drugs from the $2,000 per quarter expended by his predecessor to $300 a quarter.

In August, 1887, a three-man committee was chosen to investigate charges of improper relations between the keepers and the female patients at the Asylum, mistreatment of patients by the attendants, and other irregularities. The committee's report was made public in September and, while no misbehavior on the part of the attendants was discovered, they did find that in some cases the keepers did not take the proper care of the patients. The committee also reported "very poor" management in every department of the Asylum but felt this was largely the fault of the government in giving no instructions to either the manager or the attending physician as to their duties and their relationship to each other. The committee listed a number of changes to remedy the situation, chief of which was a full-time medical superintendent to live on the premises and to have full control over the officers under him.

Shortly thereafter, Dr. Webb resigned and he and his wife left the Islands on February 11, 1888, and nothing further is known about him.

During his bachelor days the doctor was often a guest at social events at Iolani Palace, and after his marriage he and Mrs. Webb frequently attended court affairs.

## Alex H. Bailey

Alex H. Bailey was born in Placer County, California, in 1855, the son of Dr. and Mrs. F. E. Bailey.

At the age of three he moved with his family to Santa Cruz, California, where he was educated in the public schools. After studying in his father's office, he attended Cooper Medical Institute for two years, and in 1883 he graduated from the Hospital College of Medicine at Louisville, Kentucky.

*continued page 54*

# This Is What's New!

• **Aspiration biopsy** for diagnosis of **breast cancer** is a harmless procedure as far as spread of cancer cells goes. Of a group treated at Memorial Hospital, New York, as many were alive 15 years after aspiration biopsy as after surgical excision or incisional biopsy. (*Cancer* [July-Aug.] 1962.)

• **Tetracycline fluoresces** in ultraviolet light. In the past year or so, this fact has been utilized to assist in the **diagnosis of gastric cancer.** Orthopods now report that bone infarction, such as that preceding aseptic necrosis of the femoral head, can be early recognized by lack of fluorescence due to decreased amount of the supravital tetracycline stain. Other workers found more intense tetracycline fluorescence in certain bone neoplasms, indicating active calcification. (*Proc. Ortho. Research Soc.* [Jan. 26-27] 1962. Abstracted in *J. Bone & Joint Surg.* [July] 1962.)

• Sloan-Kettering cancer chemotherapists blame much of the apparent differences in **results of cancer treatment** at various centers to **poor classification.** They urge a standard classification as to pattern, that is, local or metastatic, and stage, that is, patient's symptoms and incapacity. They suggest that even apples are more precisely described than cancer. For example, pattern: winesap; stage: overripe. (*J. Clin. Dis.* [Mar.] 1962.)

• The *Medical Letter,* one of the best sources of information about new drugs, missed a major scoop when the editors did not report on the **fetus-deforming thalidomide** (due to their policy of not appraising drugs not sold in the United States). The editor reassures the reader, however, that if the drug were sold in the United States the *Medical Letter* would have stated "until longer experience has established the safety of the drug, older remedies known to be safe should be prescribed . . ." (*The Medical Letter,* Notes to Subscribers [Aug.] 1962.)

• **EHV** is the abbreviation used by Ann Arbor dermatologists to characterize a spectrum of related syndromes or diseases manifested by erythema, hypersensitivity, and vasculitis. EHV varies from mild **hives** to severe **necrotizing vasculitis** with deep ulcers, fever, and neurological signs, often with a fatal outcome. Causes, or perhaps more correctly, precipitating factors, are most commonly drug hypersensitivity, neoplasms, chronic infection, allergy to natural or foreign tissues, and collagen diseases. (*Am. Practitioner* [May] 1962.)

• The National Institute of Health has recently established a branch in Hawaii. This unit, known as the **Pacific Research Section,** is located at The Queen's Hospital and is directed by Dr. Leon Rosen.

Dr. Rosen and his staff plan to conduct epidemiologic investigations on **infectious diseases in Hawaii and in other parts of the Pacific area.** In contrast to the diagnostic laboratory and the communicable disease control services offered by the State Health Department and others, the Pacific Research Section will be concerned primarily with research problems. Initially, the Section will conduct studies on **eosinophilic meningitis** and on certain **virus diseases.**

Outbreaks of eosinophilic meningitis have been reported from at least four different areas in the Pacific since World War II, namely, Ponape, New Caledonia, Tahiti, and Sumatra. Dr. Rosen has conducted detailed studies of the disease in Tahiti where it has been estimated that over 5000 cases have occurred since 1958. The etiology and method of transmission of the disease, as it occurs in epidemic form, have not been established. Currently a nematode of rats is the prime suspect.

Six cases of eosinophilic meningitis have been observed in Hawaii since 1960. Because of the mild nature of the disease, and the necessity of doing a lumbar puncture to establish the diagnosis, it is believed that many unrecognized cases occur in Hawaii. Dr. Rosen and Dr. Gordon Wallace, his assistant, are most anxious to learn of any cases which occur in Hawaii. They believe that the solution to the etiology and epidemiology of the disease is most apt to be obtained by the epidemiologic investigations of all new cases. Their mailing address is

Pacific Research Section
P. O. Box 1680
Honolulu 13, Hawaii

and their phone number is 513-141. They will be happy to accept the charges on long distance phone calls pertaining to this program. ■

FRED I. GILBERT, JR., M.D.

# WESTERN CONFERENCE OF PREPAID MEDICAL SERVICE PLANS TO MEET IN SEATTLE, WASHINGTON IN OCTOBER

The Western Conference of Prepaid Medical Service Plans is composed of service plans in the Western Provinces of Canada and the Western United States.

HMSA, Hawaii's own community service prepaid medical plan association, has been a member of this Conference since September 1948.

Through this medium, HMSA has benefited both itself and other plans through interchange of ideas and experience.

Over the years, the Conference has become a dynamic force in Western medical economics. It has attracted participation by personnel from plans throughout the United States, Canada and Australia, thus spreading its influence beyond the confines of the Western area.

With concern for both day-to-day operations and future problems of prepayment, the Conference serves as a point of reference and assembly, open to physicians and administrators alike, for the exchange of information, ideas, and operational know-how. Conference members are aware that they must work as a team to forestall attempts by GOVERNMENT to take the initiative from them. Through combined efforts, plans to socialize medicine will be prevented.

President of the Western Conference of Prepaid Medical Service Plans for 1962 is Dr. John F. Frazer, a Honolulu physician.

In addition to Dr. Frazer, Dr. Allen B. Richardson will attend the October meeting as a physician-delegate. Dr. Richardson is Vice-Chairman of the HMSA Medical Committee.

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HAWAII MEDICAL JOURNAL

# Hawaii Medical Association

## *AMA Delegate's Report*

At the 111th Annual Meeting of the American Medical Association, June 25-29 at Chicago, the work of the House of Delegates was devoted primarily to reaffirmation of previous AMA positions on health care for the aged, professional discipline, medical ethics and medical education.

The election of the President-elect occasioned considerable interest. Dr. Edward R. Annis of Miami, Florida, defeated Dr. Raymond McKeown of Coos Bay, Oregon. Dr. Annis, outstanding spokesman for medicine in the campaign against the King-Anderson Bill, will succeed Dr. George M. Fister of Ogden, Utah, in 1963. Dr. Fister, a urologist, was installed as President at an impressive inaugural at which all the state association presidents were seated on the platform. Our President, Dr. Frederick L. Giles, made an impressive member of this group.

The House reaffirmed its strong support for the **Kerr-Mills program.** Continuing disapproval of King-Anderson type of legislation was evidenced by 17 resolutions opposing it. The main reasons for opposition are as follows:

1. The lack of need for such a plan.
2. It would provide inadequate care for all aged rather than complete care for those who need help.
3. Inherent in the use of the Social Security mechanism are governmental controls of medical practice, which would increase with expansion of the program.
4. Deterioration of the quality of medical care not only for the aged but for the population as a whole.

In accepting a report on the use of Federal and State tax funds to provide **voluntary prepayment health insurance** to help the aged in meeting the costs of medical care, the House approved the following policy:

1. The need for application of the prepayment or insurance principle to protect our people against the costs of medical care is fully recognized and applies to all ages rather than to the aged alone.
2. Persons financially able to prepay their own expenses are expected to do so and must be encouraged rather than compelled to do so.
3. Persons financially unable to adequately prepay their expenses may properly be assisted to the degree necessary by their families, their communities, their states, and if these fail, by the Federal Government—but only in conjunction with other levels of government.
4. The prepayment system should be devoid of governmental controls.
5. Dignity and self-sufficiency for the individual should be upheld.
6. The protection offered must be reasonably comprehensive rather than token in character.

The House continued to assert its authority relative to **the Board of Trustees** by adopting a report which recommend that four members be added to the Board, making a total of 15. This will be done by electing three new members and including the immediate past president of the Association. The term of office was lowered from five years to three with the terms limited to three, for a total of nine years' service.

**Medical education** continued to receive much attention from the House which accomplished the following:

1. Declined to approve an examing Board of Abdominal Surgery. In accepting the special report on this subject, the House also stated its disapproval in principle of establishing new specialties based largely or wholly on an arbitrarily defined anatomical region of the body.
2. Recommended that the Council on Medical Education and Hospitals into separate Councils for graduate and undergraduate training; also refused to specify private practice as a requirement for membership on the Council.
4. Encouraged development of two-year internship programs.

In the field of **medical discipline** the House implemented one of the major recommendations of the Medical Disciplinary Committee (June, 1961) by approving a change in the bylaws so that Section 1 (B), Chapter IV, will now read:

"In addition to such disciplinary action as may be taken under the constitution and bylaws of the component society and constituent association to which the member belongs, or when a state medical association to which a member belongs requests the AMA to take disciplinary action, or when at the request of the American Medical Association the state association to which the member belongs consents to disciplinary proceedings by AMA, the Judicial Council, after due notice and hearing, may censure him, or may suspend or expel any member of the American Medical Association from AMA membership only for an infraction of the Constitution or these Bylaws or for a violation of the Principles of Medical Ethics."

In considering a conflict between the American College of Surgeons and the AMA relating to **ethical practice,** the House declared that the adoption and interpretation of The Principles of Medical Ethics is the prerogative and duty of the AMA.

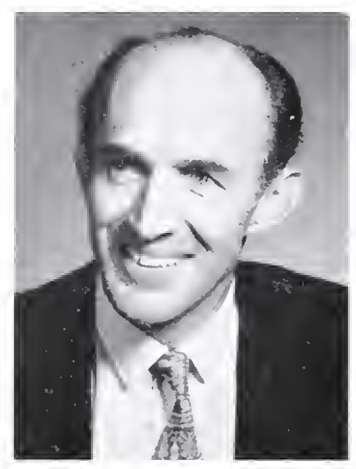
In **miscellaneous actions** the House **ruled** that physician **ownership of pharmacies** is not unethical unless it is shown to be contrary to the best interests of the patient or the medical profession.

Reaffirmed its opposition to compulsory **cov-**

*continued page 72*

HAWAII MEDICAL JOURNAL

# *New Members*



**Hans W. Graumann, M.D.**
45-939 Kamehameha Highway
Kaneohe, Oahu
Radiologist
University of Berlin Medical School, 1937
Internship—Charité Hospital, University of Berlin
Residencies—Charité Hospital, University of Berlin
The Queen's Hospital, Honolulu

**David D. Bronder, M.D.**
Kahuku Clinic
Kahuku, Oahu
General Practice
University of Nebraska Medical School, 1952
Internship—Madigan Army Hospital, Tacoma, Washington

**Francis M. Ikezaki, M.D.**
1697 Ala Moana
Honolulu 16, Hawaii
Internal Medicine
University of North Dakota, University of Kansas, 1958
Internship—The Queen's Hospital, Honolulu
Residencies—Kern County General Hospital, Bakersfield
San Diego County General Hospital, San Diego

**Maurice L. Silver, M.D.**
1441 Kapiolani, Suite 605
Honolulu 14, Hawaii
Neurological Surgery
Loyola University School of Medicine, 1945
Internship—Illinois University Hospitals
Residency—John Hopkins University Hospital

**J. Kendall Wallis, M.D.**
Maui Mental Health Service
Waiakoa, Maui
University of Pennsylvania Medical School, 1933
Internship—Pennsylvania Hospital
Residency—Pennsylvania Hospital

**Jerome L. Tucker, M.D.**
1441 Kapiolani, Suite 712
Honolulu 14, Hawaii
Ophthalmology
Tulane University School of Medicine, New Orleans, 1952
Internship—Baylor University Hospital, Dallas
Residencies—Baylor University Hospital
San Francisco VA Hospital

# County Society News

**Winfred Y. Lee, M.D.**
1481 South King Street
Honolulu 14, Hawaii
Internal Medicine
Northwestern University Medical School, 1955
Internship—Passavant Memorial Hospital, Chicago
Residencies—Passavant Memorial Hospital, Chicago
Cook County Hospital, Chicago

**Dorothy Jane Whittaker, M.D.**
1697 Ala Moana Boulevard
Honolulu 15, Hawaii
Anesthesiology
University of Cincinnati Jewish Hospital
Residencies—Vanderbilt University Hospital, Nashville
Strong Memorial Hospital, Rochester, N. Y.
Grace New Haven Hospital, New Haven, Conn.

## Hawaii

The July 27, 1962, meeting was held at the Hilo Hotel. Guests present were Drs. Morris Shaffer and Margaret Smith plus Messrs. Henry Minette and G. Ludwig.

A movie on external cardiac massage was shown before the business meeting began. A request for suggestions from the Hilo District Committee of the Boy Scouts resulted in an unanimous vote that Boy Scouts be required to take their physical examinations at the beginning of the summer months, one a year, instead of before each activity, and that a special form be utilized by the doctors in certifying each boy.

A letter from HMSA advising that Dr. Verne C. Waite had been chosen by them to replace Dr. Robert Faus when he retires was read. Approval of Dr. Waite for the position of Medical Director of the HMSA was given unanimous approval.

A discussion followed on the proper utilization of excess treasury funds. Suggestions were made to use this for a fund for families of deceased members, group insurance for all members, or a scholarship. No action was taken.

The Society was asked to submit names to the PTA of prospective candidates to run for the School Advisory Council. No immediate names were available.

The HMA President, Dr. Giles, suggestion that a Political Action Committee be formed was discussed. No action was taken.

It was agreed that only those people with legitimate business be allowed in the medical library.

A letter from the Tuberculosis Society was read in which it was stated that the five-year testing study had been completed and they have reached the stage of treatment. They asked the Society to set a policy regarding treatment of converters. The letter also urged that physicians tuberculin test children under five. It was voted to go along with recommendations of therapy formulated by the Medical Advisory Committee of the Tuberculosis Society.

The Scientific program was devoted to a discussion of the epidemiology of salmonellosis and parasitic infections in man from animals. The scientific session was carried over until the next day and further discussion were held between 7:00 and 9:20 A.M.

## Honolulu

Prior to the April 3 meeting the film "Gastrointestinal Cancer: The Problem of Early Diagnosis" was shown through the courtesy of the American Cancer Society. One new member, Dr. Donald T. Smith, was welcomed into the Society. Dr. Chew Mung Lum reported that the Medical Care Plans Committee was in the process of reviewing the contract between the Society and the HMSA and asked that any doctor who had any comments on this subject join the committee in its discussions. HMA President, Dr. J. A. Burden, addressed the membership on important matters concerning the medical profession.

At this business meeting new fees were adopted in the anesthesiology and ob-gyn schedules. Dr. Liljestrand reported on the current activities of the Legislative Committee, and Drs. Hunter and Mills spoke on the proposed National Blue Shield's plan for covering the over-65 population on a uniform, nation-wide basis.

More than 180 members attended the May 22 meeting

*continued page 56*

# Book Reviews

## Drug Therapy

*By Frank C. Ferguson, Jr., M.D., 411 pp., $7.50, Lea & Febiger, 1962.*

A GOOD handbook. It attempts to select best compounds for use, and gives brief pharmacological description of the drugs described. The drugs are listed by generic and representative trade names and are compared under the broad systems where they are used.

A. M. BRAULT, M.D.

## The Heart in Industry

*Edited by Leon J. Warshaw, M.D., 677 pp., $16.00, Paul Hoeber, 1960.*

THE WHOLE scope of cardiology in relation to industrial medicine is presented, from the basic cardiac physiology to its clinical application and the problem of workmen's compensation.

Specialists in cardiology and general practitioners can well profit from the experiences of the many authors who contributed their extensive personal experience in the handling of cardiacs in the acute as well as the recovery and rehabilitation stages.

COOLIDGE S. WAKAI, M.D.

## Physical Diagnosis, 6th Ed.

*By Ralph H. Major, M.D., and Mahlon H. Delp, M.D., 355 pp., $7.50, W. B. Saunders Company, 1962.*

THE SIXTH edition of this popular text on physical diagnosis begins with a brief historical account of outstanding physicians and their contributions to this science. The authors outline the order and methods of taking a good medical history and completing a thorough physical examination. The various elements of physical diagnosis such as inspection, palpation, percussion, and auscultation are discussed in detail. The book is well illustrated with an excellent selection of clinical cases which attests to the vast medical experience of the authors and their collaborators.

The book discusses in detail all elements essential to good physical diagnosis. It consists of 355 pages, well illustrated, with a well-prepared reference index.

HENRY C. GOTSHALK, M.D.

## Treatment of Injuries to Athletes

*By Don H. O'Donoghue, M.D., 649 pp., $18.50, W. B. Saunders Company, 1962.*

DOCTOR O'DONOGHUE'S book on athletic injuries is certainly one which all team physicians should make a part of their library. A most specific reference type of text, it is well illustrated and in great detail. The introduction includes a rather important discussion on the benefits and risks of competitive athletics and I must say Dr. O'Donoghue makes a strong case in favor of competitive athletics.

Dr. O'Donoghue is Professor of Orthopedic Surgery at the University of Oklahoma Medical School and also serves as Team Physician under the wonder boy of modern coaching, Bud Wilkinson.

The book is well written and superbly organized under an excellent index. It should be a must for all Departments of Athletics. It seemed to me that its price is a bit on the expensive side.

JAMES G. MARNIE, M.D.

★ means highly recommended.

## ★Clinical Laboratory Diagnosis, 6th Ed.

*By Samuel A. Levinson, M.D., Ph.D., F.A.C.P., and Robert P. MacFate, Ch.E., M.S., Ph.D., 1274 pp., $15.00, Lea & Febiger, 1961.*

THIS COMPREHENSIVE text is recommended as a reference and reading book for large and small clinical laboratories. It is of unquestioned value for pathologists, practicing physicians, and medical technologists. Its value lies in its being up to date, complete, and well organized. In addition to the step-by-step technical aspects of lab tests, the principles underlying them are explained. Clinical interpretations are presented.

Besides standard chapters on parasitology, hematology, bacteriology, etc., the book's twenty-six chapters range from pediatric procedures to new tests using radioisotopes. This new sixth edition has been extensively rewritten. In the chapter on hematology, emphasis has been placed on electrophoresis, hemoglobin abnormalities, and altered clotting mechanisms. The chapters on Blood Banking as well as Legal Medicine and Toxicology have been completely revised. Chapters on Viral and Rickettsial Disease and also Medical Mycology are new.

RAID CHAPPELL, M.D.

## Clinical Pathology, 3rd Ed.

*By Benjamin B. Wells, M.D., Ph.D., 541 pp., $9.00, W. B. Saunders Company, 1962.*

INCREASING emphasis on laboratory medicine is evidenced in recent examinations for certification in many specialties. This is logical, since a clinician is often judged by the way he uses the laboratory. He should evaluate on one hand the laboratory, from the standpoint of accuracy and dependability, and on the other the tests, as to how and when to use them and of course, as to their limitations. This book admirably emphasizes these points.

I would recommend this book to the teachers in medical schools, rather than the students or practitioners. The teachers need a source of a well-organized, concise presentation. They can then fill in the details and add the bibliography. Once again, the medical students come through. They help to educate their teachers.

PAUL Y. TAMURA, M.D.

## ★A Textbook of Obstetrics

*By Duncan E. Reid, M.D., 1087 pp., $18.50, W. B. Saunders Company, 1962.*

THIS TEXTBOOK of obstetrics by the Professor of Obstetrics and Chairman of the Department of Obstetrics and Gynecology of Harvard University Medical School is without doubt an outstanding contribution to the specialty of obstetrics. It presents the experiences and convictions of those in a respected medical center, the Boston Lying-In Hospital. The author presents clear and concise methods of handling normal and abnormal obstetrical conditions. Where there are several points of view regarding a problem, these are presented, but the preference of the author is emphasized. This approach creates less confusion for the student in obstetrics and aids materially in handling difficult clinical problems.

I do not agree completely with some of the practices advocated by the author, but I do agree that the ultimate purpose of good obstetrical practice is to reduce maternal and perinatal mortality. He writes "wherever the maternal mortality and the death rate in the first year of life are comparatively low, one can rightfully assume that medical services generally are superior and the eco-

*continued page 58*

# Notes and News

## Names in the News

**Dr. Nils P. Larsen's** home and art collection suffered severe damages when fire consumed his Diamond Head home.

**Dr. Fred Gilbert** and former local medico **Dr. Dorian Paskowitz** were teamed in an around Oahu surf safari.

**Dr. Pershing S. Lo** was again favored with unwanted publicity. He was accused of assault and battery in an altercation with a local businessman.

**Dr. Clarence Trexler** chaired the recent meeting of the Pacific Coast Oto-Ophthalmological Society which met here at the Princess Kaiulani recently.

Recipient of grants for local research for heart and circulatory diseases were **Drs. L. T. Chun** and **Joseph Stokes III.**

**Dr. Richard You** looked like a great prophet when he predicted an upset in local boxing circles. Incidentally he was correct!

Preliminary report by **Dr. Norman R. Sloan** (survey of 38,103 people tested) showed pure Hawaiians having 6½% higher rate of diabetes than Caucasians.

**Dr. Niall Scully** returned home, after a year doing heart surgery at the Cleveland Clinic, with a new son. Sean has five older sisters.

The recent crash of the CPA plane at the Honolulu airport had **Dr. Alvin Majoska** prominently mentioned. Also his interest in yachts.

Roosevelt High class of '42 distinguished list included **Drs. Robert P. C. Ho, Alma Leong Chun, Rowlin Lichter, Ed Furukawa,** and **J. M. Ohtani.**

**Dr. Thomas Min** et al addressed a clergy seminar on alcoholism recently.

**Dr. Dorothy Natsui** addressed the Kuakini Hospital Auxiliary on "What is Your Stress Quotient."

The "Medicare" issue reached its climax in July when a Senate amendment to force a vote was defeated. Many physicians contributed their time to educate the people in this State to the facts of the issue. Among those who did yeoman work were **Drs. Shigeo Natori** and **Tsuneichi Shinkawa,** whose many efforts on the language programs proved very effective.

**Drs. Ralph B. Cloward** and **Donald T. Smith** were prominently mentioned in the Jackie Burnett case.

**Dr. F. J. Pinkerton** was given much credit for the new Queen's Audiology Center.

**Dr. Nils P. Larsen** was widely quoted on his theory of "The Filipino Mystery Deaths." His explanation "death by dream shock." **Dr. Alvin Majoska** does not buy this!

**Dr. Richard K. B. Ho** called for a State ban on the use of toxic castor beans for jewelry.

**Dr. David Katsuki's** criticism of the use of commandeered city ambulances in a cockfight raid made headlines and snappy reading.

A special Senate committee to study Kerr-Mills implementation showed that programs were considered "adequate" in Hawaii and only two other states, North Dakota and Massachusetts.

## Congratulations to . . .

**Dr. Herbert M. Nam,** who is the newly elected president of the Korean Chamber of Commerce. Others elected to that group were **Drs. Philip Lee,** vice president, and **Anna Chung,** secretary.

**Dr. Kwong Y. Lum,** the new President of the Hawaii Psychiatric Society.

**Dr. Leo Bernstein,** who was sworn in as the State Director of Health in the Governor's office.

**Dr. Edward W. Colby,** from New Hampshire, who has been appointed to the new post of Executive Officer of the Special Health Services Division, State Health Department.

**Dr. David Lee Pang,** President of the Hale Nani Corp., for the opening of his new rehabilitation and convalescent facility.

**Dr. Andrew C. Ivy, Jr.,** a director of the new Island Federal. Need a loan? See Andy.

**Drs. C. E. Fronk** and **R. K. Uyeno,** directors of the new Hawaiian International Finances, Inc.

**Dr. Joseph Stokes III,** recently appointed Director of Medical Education at The Queen's Hospital.

**Dr. Richard K. C. Chang,** the first local physician to be appointed civilian consultant in gastroenterology and internal medicine to the U. S. Air Force.

**Dr. Vernon K. S. Jim,** who was certified by the American Board of Plastic Surgery in May.

**Dr. Thomas K. Oshiro,** newly elected Fellow of ACOG.

## Travel News

Having a grand time in Europe this summer were **Drs. Raymond Uyeno, Homer Benson, Gilbert Halpern,** and **Andrew Ivy.**

**Dr. Harold M. Johnson** had a wonderful vacation in Seattle and Banff.

Ditto the **Isami Mirikitanis** and **Robert Wongs.**

**Dr. John Sanders** did a lot of fishing this summer at Estes Park, Colorado.

**Dr. W. T. Ohta** and family saw much of the country from East to West coasts.

The **Iaconettis** spent time in the West Coast after attending the golden wedding anniversary of Dr. Iaconetti's parents.

**Dr. James Fleming** attended his son's wedding in Vancouver, B. C.

## Controversies

Controversial, headline-making medical topics have given local physicians much opportunity to enhance public knowledge and their P.R. Among the subjects "The Saskatchewan Strike," "Medicare controversy," "Thalidomide," "Poisoning," and "Enovid."

The doctors' strike against Saskatchewan's compulsory medical care plan caused local papers to get comments by our physicians, varied in their reactions to the validity of the Canadian doctors' stand, but united in putting healing before politics. Among those making comments were **Drs. Philip M. Corboy, Masato Hasegawa, Andrew Ivy, Joseph Stokes, Rodney West, Fred Gilbert, Duke Cho Choy, Henry Gotshalk, Samuel Allison,** and **Joseph Strode.**

On "Medicare" **Drs. O. D. Pinkerton** and **Fred Giles** blasted Representative Tom Gill on his statement that HMSA's Plan 65 would fail. **Dr. Rodney T. West,** President-elect of HMA, made it known that Hoju-kai followers in a recent march for the King-Anderson bill were being misled. Ye editor was glad to see a comment by **Dr. James E. Mitchell** of Kona in the *Star-Bulletin* on this subject. One alleged "physician for the Kennedy Plan" was either too scared or embarrassed to sign his name to his comments. The defeat in the Senate of the King-Anderson bill brought rejoicing comments from **Drs.**

**Fred Giles** and **O. D. Pinkerton** and. of course. groans by the opposition.

Thalidomide publicity caused **Drs. Fred Giles** and **Leo Bernstein** to make public statements on drug experimentation.

"Birth Control Pill—Enovid—and its possible effects" were commented on by **Drs. Fred Giles, Charles K. Yamashiro, David A. Sinclair, H. James Lambert, Thomas K. Oshiro, Lyle Bachman, Ethel O. Oda, Robert G. Hunter, Elizabeth Yin Ying Wang,** and **Richard Y. Sakimoto,** plus one more who asked not to be identified.

## New Affiliations

The Medical Group has added three new associates—**Drs. R. Bruce Joseph,** otolaryngology; **Charman J. Akina,** internal medicine; and **Norman Y. Nakamura,** orthopedics.

**Dr. David Tien** announced the opening of his office at the Doi Building in Wahiawa.

Pediatrician **Roy M. Kaye** is now located at 1441 Kapiolani Blvd.

**Dr. Keith F. O. Kuhlman** has relocated at the Pali Medical Bldg.

**Dr. Wilbur S. Lummis,** former Navy physician, has announced his association with **Dr. John Devereux** at 1224 Punahou St.

**Dr. M. H. Lichter** has moved to roomier quarters in the Alexander Young Bldg.

**Dr. Denis J. Fu,** pediatrician, opened offices at the Sach Building on 12th Avenue.

The Kaimuki Professional Bldg. is now **Dr. Steven Tyau's** new headquarters.

**Dr. Herbert M. Nakata,** pediatrician, joined the Central Medical Clinic at 1481 So. King St.

Psychiatrists **Pershing S. Lo, K. Y. Lum,** and **S. N. Cahoon,** and associates, have moved to 1259 So. Beretania St.

**Dr. Francis H. Soon,** obstetrician, has joined Dr. Edmund L. Lee at the Professional Center Building.

**Dr. Herbert M. Nam** is now located in the Gaspar Building.

**Surgeon Mor J. McCarthy** has relocated at 9 Maluniu Avenue in Kailua.

**Dr. Miller M. Howell,** formerly of Minnesota, has arrived to take over as the Hana, Maui, physician.

Welcome Home! **Dr. Raymond Dusendschon,** recently returned from Cincinnati after studying industrial medicine at Kettering Johnston.

New members of the Chock-Pang Clinic are **Drs. Richard K. S. Pang,** thoracic surgeon, and **Hing Hua Chun,** internist.

**Dr. Charles M. Kimura,** pediatrician, is now headquartered at the Kalihi Medical Center.

Welcome relief to **Dr. Harry L. Arnold, Jr.,** at Straub Clinic is his new associate **Dr. Michael Schiff** from the dermatology department of Dartmouth's Hitchcock Clinic.

## Hawaii Doctors in Print

**Dr. Harold M. Johnson's** article on "Lichen Planus" appeared in the 1962 issue of *Conn's Current Therapy.*

## Notice of Meetings

The 1962 scientific session of the American Cancer Society will be held at the Biltmore Hotel in New York on October 22 and 23. ■

# *Correspondence*

### Write Your Senators

To the Editor:

Recently a frightening development has occurred relating to American foreign policy and proposals for the direction of its future course. These proposals are embodied in a paper by Walt W. Rostow, an administration advisor working with the State Department.

We feel that these proposals are potentially disastrous if adopted and incorporated as the course of our foreign policy. We feel that every American should do everything within his power to prevent the adoption and extension of these policies by our State Department and thus we are soliciting the aid of patriotic Americans.

In general these policies are based on the premise that Communism is losing its influence on a world wide scale and that Communism has changed, its leaders no longer necessarily being dedicated to the principle of world conquest. *Nothing could be further from the truth!* The Rostow proposals bear a marked similarity to those in the "Liberal Papers" a document based largely on appeasement of Communism and embodying such features as disengagement (removal of nuclear weapons) from Europe and NATO Bases, the demilitarization of Quemoy and Matsu, admission of Red China to the United Nations with the eventual elimination of Nationalist China from this body, the sharing of our North American defense DEW line with Russia, the sharing of space secrets, and so forth, in a step by step process whose end result can be only the weakening of the United States, placing us at the mercy of the virulence of the worldwide, expanding Communist conspiracy.

We urge that each concerned, patriotic American write his support to Senator Everett Dirkson in his desire to have Mr. Rostow appear before the United States Senate and explain these proposals and send carbon copies of the letter to the two United States Senators from his state. Write to Hon. Everett Dirksen, Senate Office Building, Washington 25, D. C.

[s] Mrs. Royal Shields
Eva V. Burnham, *Chairman*
Committee for Constitutional Principles

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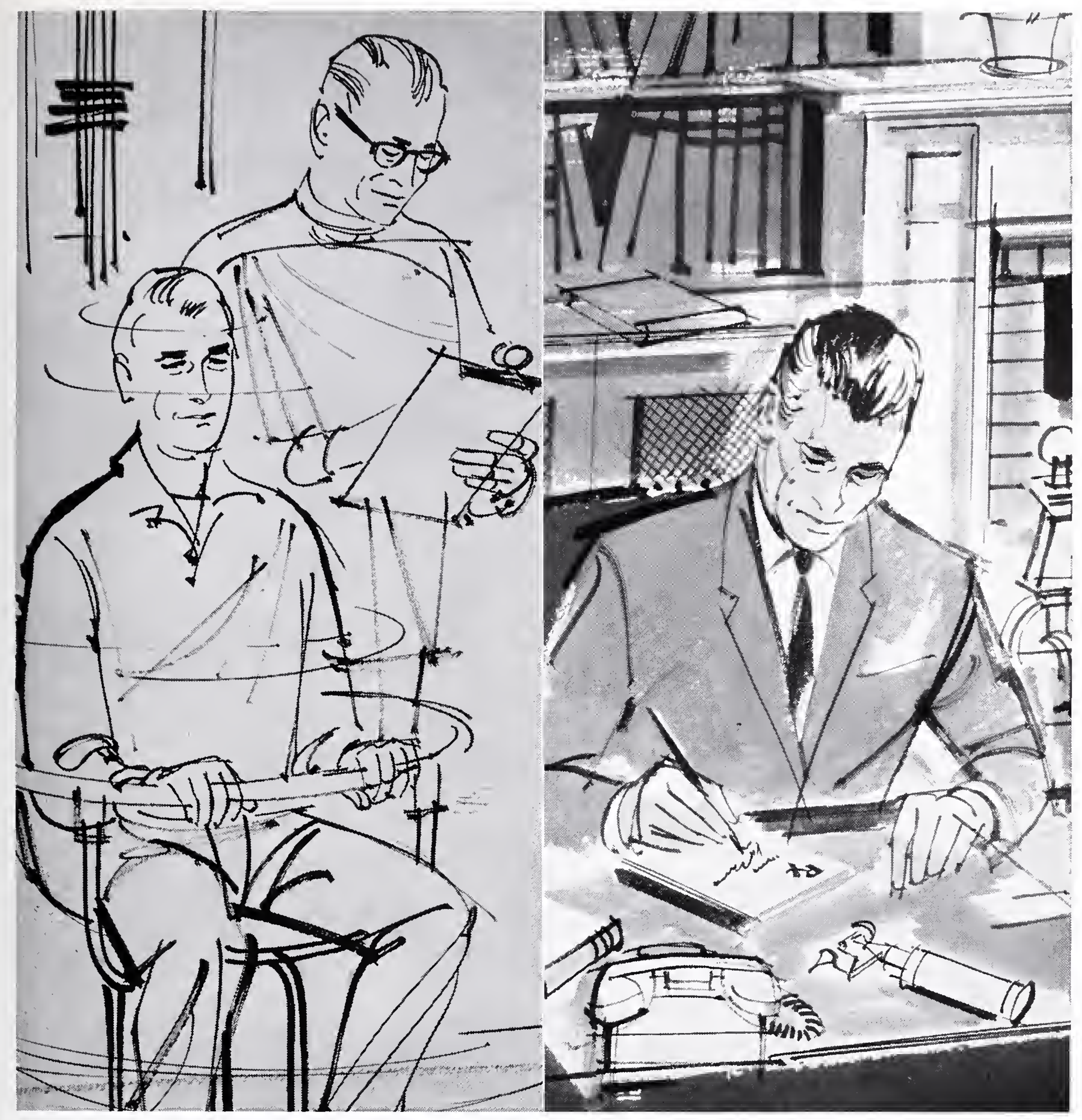

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SEARLE
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# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

BERYL UYEHARA, *Editor* MAX BOWMAN, *Associate Editor*

## *Lab News Briefs*

- Beryl Uyehara has left The Queen's Hospital to work in the New Pathologists' Medical Cytology Lab which boasts that their microtome is never idle one minute.
- Leslie Nakashima has made a change to the Dickson-Bell Medical Center for rea$on$ of his own.
- The lab at St. Francis is bustling with activity in preparing the most up-to-date techniques. Dr. Paul Tamura, who has recently been appointed as Pathologist, is the tonic behind this excitement.
- The finale of a long, hard grind at the various training hospitals will soon terminate for all students with a letter bearing the inevitable word "PASSED." Good luck to you all from HSMT. We hope that you as Medical Technologists will endeavor to strive for high standards and be proud of your achievements. Be worthy members of your profession.

## *An Improved and Rapid Method of Bone Decalcification*

Trifluoroacetic acid has been found to possess a rapid decalcifying action with minimal change in the staining reaction. No previous fixation of bone is necessary. A simple 10% solution by volume of the acid is all that is needed.

The soft bones and cancellous bones are usually adequately decalcified with the routine surgical specimens. Dense bones and teeth may take as long as two to three days. This comparatively rapid decalcification of teeth is particularly noteworthy. Washing out the acid after decalcification takes only a few minutes.

Trifluoroacetic acid is somewhat more toxic than acetic acid, when taken orally. It is as strong as hydrochloric acid, and stronger than trichloroacetic acid. It resembles glacial acetic acid in appearance. In full strength it is corrosive to the skin and if it comes in contact with the skin, should be washed off and neutralized with mild alkalis such as ammonia or sodium bicarbonate. It is also corrosive to metal containers. However, we have used stainless steel capsules and containers for years with no deleterious effects.

We make up a 10% solution in water and store it in glass bottles indefinitely. We reuse the material until the decalcifying time becomes prolonged, when it is discarded. Some cellular debris which collects at the bottom may be separated by mere decanting. No calcium precipitation has been noted.

SUMMARY

A 10% trifluoroacetic acid has been found to be a rapid decalcifying agent. The staining properties of the tissue remain excellent. Trifluoroacetic acid is obtainable from Matcson, Coleman & Bell, and Scientific Products.

REFERENCE

Rosbash & Leavitt—Decalcification of Bone with Trifluoroacetic Acid. Am. J. Clin. Path. 22:914, 1952.

DAVID O. ROSBASH, Ph.D., and
DANIEL LEAVITT, M.D.

## *Report on the 1962 North American Conference*

The Second North American Conference of Medical Technologists was held the week of June 16-23, 1962, in Washington, D. C., with headquarters at the Sheraton-Park Hotel. Having just returned, I can truthfully say it was the most exhausting week I have ever experienced.

Nevertheless, I'm more than willing to return to any and all national conventions of the ASMT that time and money will permit. It may have exhausted me, but it was also exciting to visit with so many friends and former co-workers. Judith Ramsey (now in Virginia) and Lydia Martens (now in Minnesota) were there and sent their best wishes to all their friends. I even got to see Sister M. Edward and Yvette LaPointe Ward of Ottawa, and Barbara Best Motyl of Edmonton, all co-workers of mine way back in '53-'55. Yvette, who was always the "little dickens" in the lab, has matured enough to have won the Fisher Award of Canada. Later, at a cocktail party given for the Canadians, Yvette proved she hadn't lost any of her sparkle. Ilene Kemp and Margaret Rutherford were there, names well known in the CSLT. Speaking of our neighbors from the North, their total registration was approximately 184. The last I heard, the total count for the joint convention stood at 2,084.

Our Hawaii Extension of the 1961 Convention must have pleased all those able to attend. Everywhere I went, people would stop me to say how much they enjoyed coming to Hawaii and they mentioned without fail the scientific portion. Our

members have the right to feel a little proud in helping to create such a lasting memory. Congratulations go especially to the various committee chairmen. Among those who stopped and said "Please say hello to .............. for me" were Ellen Anderson, "Patsy" Bering, Barbara Isabel, Jean Anderson, Virginia Sitter, Thelma Woods, Marian Tulley, Marion LaMarche, Marie Heinan, and some whose names I may have forgotten.

I quite agree with the Barbara Tanigawa statement made last year concerning the cocktail parties put on by the exhibitors. To tell the truth, it was one way of getting a little relaxation after each mentally exhausting day. It was also a very good way of getting to meet people, and to hear about the candidates for office. The candidates or their friends were politicking at all the informal gatherings. It was impossible to visit with friends during the business day, if one wanted to get the most out of the convention. Each person goes his own way, picking the lecture, etc. of his choice. When I first looked at the workshop schedule, I wanted to take three or four of them, but the hours conflicted with so many of the lectures and papers to be read.

As soon as we registered at the desk in the hotel lobby, we were given a lovely red plastic pouch containing the official program, the June *ASMT News,* badges, tickets, etc. The fact that the June issue of the *ASMT News,* containing many very important committee reports, does not get into the delegates' hands before the convention, upsets a good many people. Questions asked of the committees should come before the Advisory Council. How can anyone digest the June issue and read over the official program before the Advisory Council meeting, held the morning before the convention opens? Either one attending the Council should arrive a day ahead, or the reports should be sent out sooner.

At the Council meeting held Sunday we were given the agenda for the House of Delegates, and the Committee Chairmen went over their reports. Time was allowed for discussion. One concrete suggestion came from the Finance Chairman, Mr. Freedman. He suggested that the Finance Chairman serve a three or four year term of office. As it now stands, his term of office is up, just as he "gets the hang of things." After studying the budget, especially the convention account, I feel it was a good suggestion and hope a change is made. The individual state resolutions were either withdrawn or referred back to committees, with the exception of the California Resolution.

Mr. Amy of the CSLT was perhaps the most interesting of the opening ceremony speakers on Monday morning. On bleeding problems, he stressed: (1) The need of good individual quality control for reproducible results, (2) siliconized glassware, and (3) standardization of nomenclature of the factors in the prothrombin time studies, which are now named Factors 1 to 12.

During the Monday afternoon keynote address, the President of the A.M.A., Dr. Leonard W. Larson, strongly urged the M.T.'s to seriously consider having one or two more categories under the ASMT because of the acute shortage of registered M.T.'s. His very inspiring address probably helped the delegates at the House to at last make a decision concerning the Asst. Lab. Tech. program. After the keynote speaker, we all made dashes for the lectures of our choice. My choice was to hear Dr. K. M. Brinkhous speak on bleeding disorders. He listed the nine tests always done by his group when consulted about a bleeding problem. They do *not* use the Thromboplastin test, but the following: (1) Clotting time, (2) bleeding time (Ivy), (3) tourniquet test, (4) platelet count, (5) clot retraction, (6) prothrombin time, (7) prothrombin consumption (Iowa-2 stage), (8) thrombin time, and (9) partial thromboplastin time (PTT) (Landell, *et al*), 0.1 ml. citrated plasma, 0.1 ml. partial thromboplastin, 0.1 ml. 0.02M CaCl2, Normal = 70 sec plus or minus 10 sec.

Mrs. Nancy Meagher of the Ottawa Civic Hospital spoke on myeloproliferative disorders. It was mostly a checklist of the disorders in which the bone marrow cells have proliferated into the blood stream, confusing both the physician and technologist. She mentioned the pre-leukemic stage which is now recognized.

On Tuesday morning, I saw "Hemo, the Magnificent," while waiting to hear Dr. Karl Habel of N.I.H. speak on "The Practical and Basic Application of Modern Virology." He gave a brief history of virology, including the great change that took place when Enders developed the tissue culture technique in 1950. Research up to that time had been hampered by the price of monkey, $50.00 each. Over 70 types of virus have been found to cause encephalitis. Over 400 different viruses have been isolated, though some are nonpathogens. Virus work for the future, he felt, would deal mostly with the biochemical aspects and trying to control them by mutation, using chemotherapy.

Dr. Leanore Haley spoke Tuesday afternoon on the collection and processing of clinical material for mycological studies. She started with the hairs on the head, and went right through the body down to the toenails. Her opening statement brought down the house. It went something like this: "Any hair that you have to pull to get out, you might just as well leave there. It's perfectly normal." Her lecture will probably be published soon. It contained a wealth of information. (She is also writing a book.) One thing that ought to be mentioned is her use of the milipore membrane filters. She used them for digested sputum culturing and for blood cultures. I believe she also mentioned them in connection with a 24-hour urine culture for TB.

The next paper was read by Mrs. Anne Morgan Vance on the proper collection and preparation of slides for cytological studies. She advocates three smears on one slide from the vagina, the cervix, and the endocervix. She mentioned a product that she advocates for use after proper fixation, called "Cytodrifix" and especially recommended it if the slides are to be mailed.

After this paper, I attended the Recruitment and

Vocational Guidance Committee Conference. The notes on this section have been given to our new Recruitment Chairman.

The opening greetings on Wednesday were given by the Honorable John E. Fogarty of Rhode Island, after which I attended a paper reading by Carolyn Slater. Her work (co-authored by Martha Ann Mitchell) won an award and is to be published soon. Their effort was an agglutination test to differentiate the leukemoid state from leukemia.

I changed lecture halls again to get in on the latter part of a talk on leprosy by Dr. C. H. Binford, Chief, Leprosy Branch, Armed Forces Institute of Pathology. An interesting observation by him is the predilection of the leprosy organism for the cool parts of the body, mainly the ears and testicles. The nerves affected are always close to the skin surface. Dr. Binford and his co-workers have isolated four organisms from leprosy patients and have them growing. He doubts that they are M. leprae, but there is that possibility; hence, much research is being done on them.

On Wednesday afternoon, bus tours left at 1 P.M. for the Institute trips. I had decided on the N.I.H. at Bethesda, Maryland. This I thought was my chance to see a little sunshine, but alas, it poured rain the whole afternoon. The trip was still worthwhile. Our group of 300 was given a 15 minute movie to acquaint us with the set-up. We were then divided into three main groups, then each group subdivided into smaller units. Each unit saw just one portion, but it was well done.

Thursday morning I was off to attend "Executive Training and Administration Seminar—Approaches to Effective Supervision." It turned out to be a workshop type of meeting.

The House of Delegates started Thursday afternoon and carried through to Friday. There were present 352 delegates. It started out routinely with committee reports, then got progressively more interesting as the voting took place. It came to me as a surprise that not only was there to be the election of officers, but that nominations had to come from the floor for the Nomination Committee (seven to be elected) and for the Education and Research Committee (four to be elected).

The discussion on the proposed amendments to the Bylaws was very heated and the House was so split that a "division" was called for on almost all votes. There were no changes in the active membership sections. The affiliate membership proposals lost, with the exception of b. (line 5, page 7a) of the April, 1962, Macro Reports. Although it was carried, we were not told until Friday when the parliamentarian explained that it was the votes cast, not delegates present, that determined the success or failure of a vote. The Alternative Privilege Clause for Affiliate members was carried as stated on line 30, page 7a, April, Macro Reports. Under Student Membership, section b. and c. were added and the Advancement clause carried. The clause adding Associate Members was carried with their privileges the first of the two stated. This will mean dues of $12.00 per year.

Two other matters were decided at the House of Delegates that will affect each of us. The Laboratory Assistant Program was passed with the words "Certified" voted upon to be added to the title. It was agreed that the same teaching supervisor could hardly be expected to train two sets of students. Each requires a different approach, and should not attend the same classes. The actual working plans remain to be formalized. Since many of the pathologists have stated that they were going ahead with or without our cooperation, it seemed the only sensible course to take. At least we will have a voice in the planning of the program. Although the feelings were strong during the discussion, the whole House breathed a sigh of relief to have accomplished something that had been facing us for a long time. The Certified Laboratory Assistants (ASMT) will be with us in the near future. The other important matter decided upon was the selection of Miami Beach, Florida, as the site for the 1967 Convention.

Leaving for the airport on Saturday morning, I realized that I was seeing the sun again. Except for the trip to N.I.H., I hadn't left the hotel at all during the day. I did get to see many of the lovely government buildings and monuments while riding in taxis to and from various restaurants in our nightly forage for dinner. The hotel meals were expensive and the food didn't compare with O'Donnell's or the Watergate Inn. While the lectures and meeting took up every hour during the day, we did enjoy ourselves in the evening. I found myself quite attached to the wonderful delegation from Wisconsin. It usually took two taxis to cart us wherever we had decided to eat each night. On Monday evening I was invited to attend the Presidents' Dinner in Masaji's place. The Coleman Instrument Company has been giving this dinner each year.

The Awards Dinner on Thursray went off like clockwork. How 2,000 persons could be served so efficiently is a mystery to me. The whole affair lasted until 11 P.M., but there wasn't a single lag in the program. Our sparkling master of ceremonies was the Special Assistant to the President, the Honorable Brooks Hays.

My over-all impression of the convention was that it was excellent. It was indeed a privilege to have heard such noteworthy persons as Dr. Haley, Dr. Habel, and Mr. Brooks Hays. Thank you for giving me the opportunity to attend. Our plan of sending the President-elect each year seems such a good idea. Delegates from other states were aghast that Hawaii could raise money with ease for such a wonderful project. Many of the delegations were *completely* financed by their pathologists or their hospitals. The fact that our Society has undertaken the burden impressed many.

During the coming year, I would like to see each of you working on some committee. Only if we all work together can we go forward. I pray that with your help I may be a worthy president. ■

ELIZABETH J. HUGHES, MT (ASCP)
*President*

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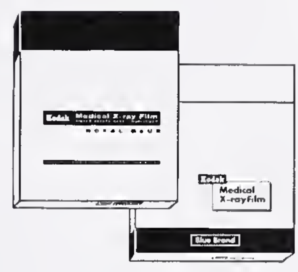

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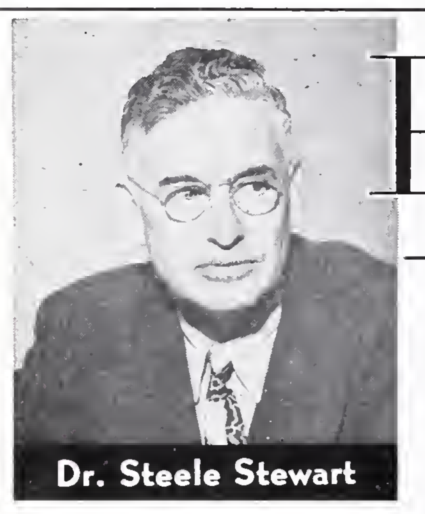
*In Memoriam* continued from 40

Following graduation, Dr. Bailey came to Kahului, Maui, to join his father who was in practice there. Upon his father's departure in July, 1884, the younger Bailey continued to practice in Kahului and succeeded his father as government physician for the Makawao District.

Dr. Bailey married Miss Mollie Nelson of New Hampshire sometime in 1883. Four years later she died (probably late in December, 1887), leaving a baby daughter.

In April, 1888, Dr. Bailey left for Santa Cruz but returned to Maui in December of the same year to settle his business affairs. Leaving the Islands for the last time in the spring of 1889, he settled in Santa Cruz where he was in practice until his death.

Dr. Bailey died in Santa Cruz on August 24, 1897. ■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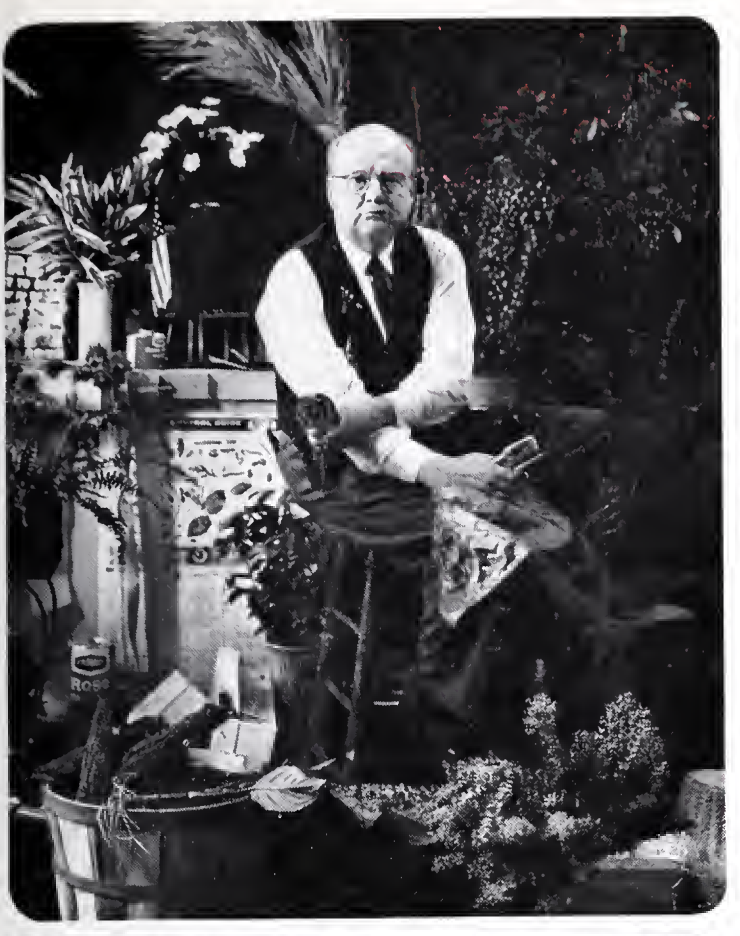

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## *County Society News* *continued from 45*

and heard their elected floor leader, Dr. George Mills, report on the actions taken by the HMA House of Delegates. After Dr. Robert Hunter presented a summary of the National Blue Shield plan, it was voted to approve the action of the House of Delegates in its decisions relative to a fee schedule for the National Blue Shield plan, the request that HMSA develop a local plan for the over-65 person, that all physicians bill their normal fee on all claims and make adjustment after the insurance payment is received, and that the HMSA be requested to undertake plans to convert to the 1960 HMA relative value study as a basis for their fee schedule. The first reading of a change in Section 2, A. (2) (a) of the by-laws, relating to the status of members who are out of the State for a period of at least one year, was presented by Dr. Kobayashi.

### Kauai

The July 3, 1962, meeting was held in the Wilcox Hospital Library. Two guests were present: Drs. Evora and Herter. The proposed oral vaccine program was discussed and it was agreed to go ahead with this, coordinating the dates with those proposed by the HMA. It was voted to delete the footnote applicable to procedures #0101, 0125, and 0130 of the HMSA fee schedule and to establish a flat fee of $15.00 for minor surgery. The HMA was granted authorization to negotiate with staff members of the HMSA. A movie on skin cancer was shown.

On August 7 a dinner meeting was held at the Kauai Surf. Hosts and hostesses were Dr. and Mrs. Spencer, Mrs. Kido, and Mrs. Sheehan. Guests included Drs. Evora, Cruz, Herter, and Kidder as well as Messrs. and Mesdames Cooper and Bryant plus Rev. Caufman and Father Van. At this meeting it was voted to approve of


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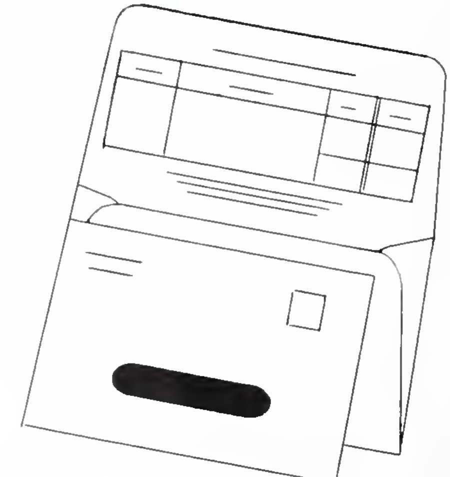

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Dr. Verne Waite as medical director for HMSA on a six- to twelve-month temporary basis. The proposed revision of the bylaws was distributed, and Dr. Frank Spencer spoke on the growth of the cytology laboratory.

## Maui

Members of the Woman's Auxiliary were invited to the June 21, 1962, meeting, which was held at the Wailuku Hotel. Other guests present were Drs. H. Anderson, B. Strothers, George Ewing, Rene Joycuse, and Dr. and Mrs. P. Ward.

Dr. Ewing spoke on the Bureau of Crippled Children's Convulsive Disease Program. Dr. J. Kendall Wallis was welcomed into the Society. The President discussed the new HMSA Plan 65 and pointed out the differences between it and the National Plan, a full service plan for the lower income groups.

A motion was passed to show medical films at every other monthly meeting, unless the films were to be replaced by a speaker on the program.

No action was taken on the letter from HMSA which requested that when other than the minimum fee was charged for minor surgical procedures, that the charge be accompanied by a short letter from the physician describing why he was requesting more than the minimum fee.

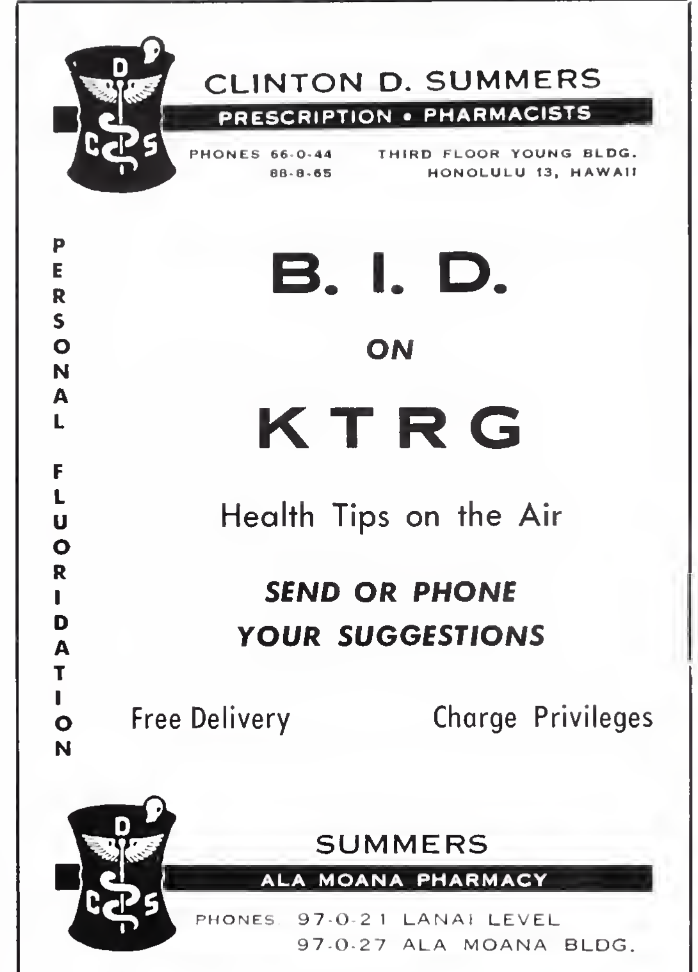
A motion was passed which put the Society on record as approving Plan 65 of the HMSA.

Dr. Andrews was made chairman of the newly formed Ethics Committee.

Various procedures in connection with unattended deaths were discussed. This problem will be taken up with Chief Lane at a later date.

Dr. R. J. McArthur, Chairman of the Polio Committee, recommended that "Operation Swallow" was not needed

*continued page 58*



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## County Society News continued from 57

on Maui, but the doctors should take advantage of the publicity. The report recommended that the entire operation should be carried out by the doctors in their offices as they so desire. The motion to accept this report was passed after considerable discussion. ■

## Book Reviews continued from 46

nomic standards high." This thought is worthy of serious consideration.

I would recommend this book to all physicians practicing obstetrics.

GEORGE GOTO, M.D.

### ★ Current Therapy—1962

*Edited by Howard F. Conn, M.D., 790 pp., $12.50, W. B. Saunders Company, 1962.*

THIS EDITION is the 14th annual publication of this multi-authored book. Rather large print in two wide columns to a page makes it easy on the reader's eyes.

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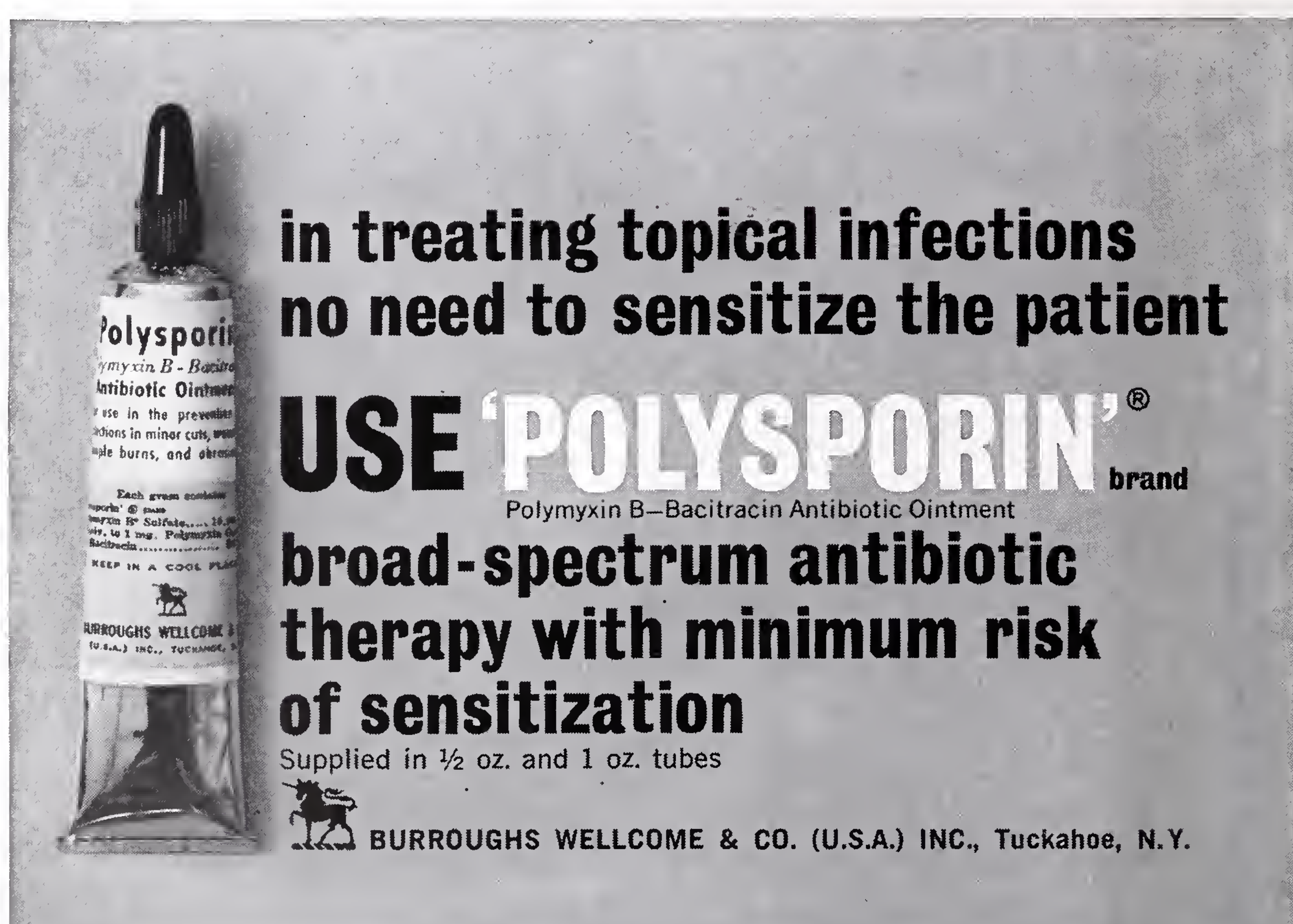
Of all the books in my personal library, this is the one most frequently borrowed by my practicing colleagues. The new edition is no exception. It disappeared from my desk the first day I received it and had been re-borrowed several times before I had completed reviewing it.

F. I. GILBERT, JR., M.D.

continued page 63



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1. Ford, R. A., and Blanchard, K: Journal-Lancet 78:185, 1958.

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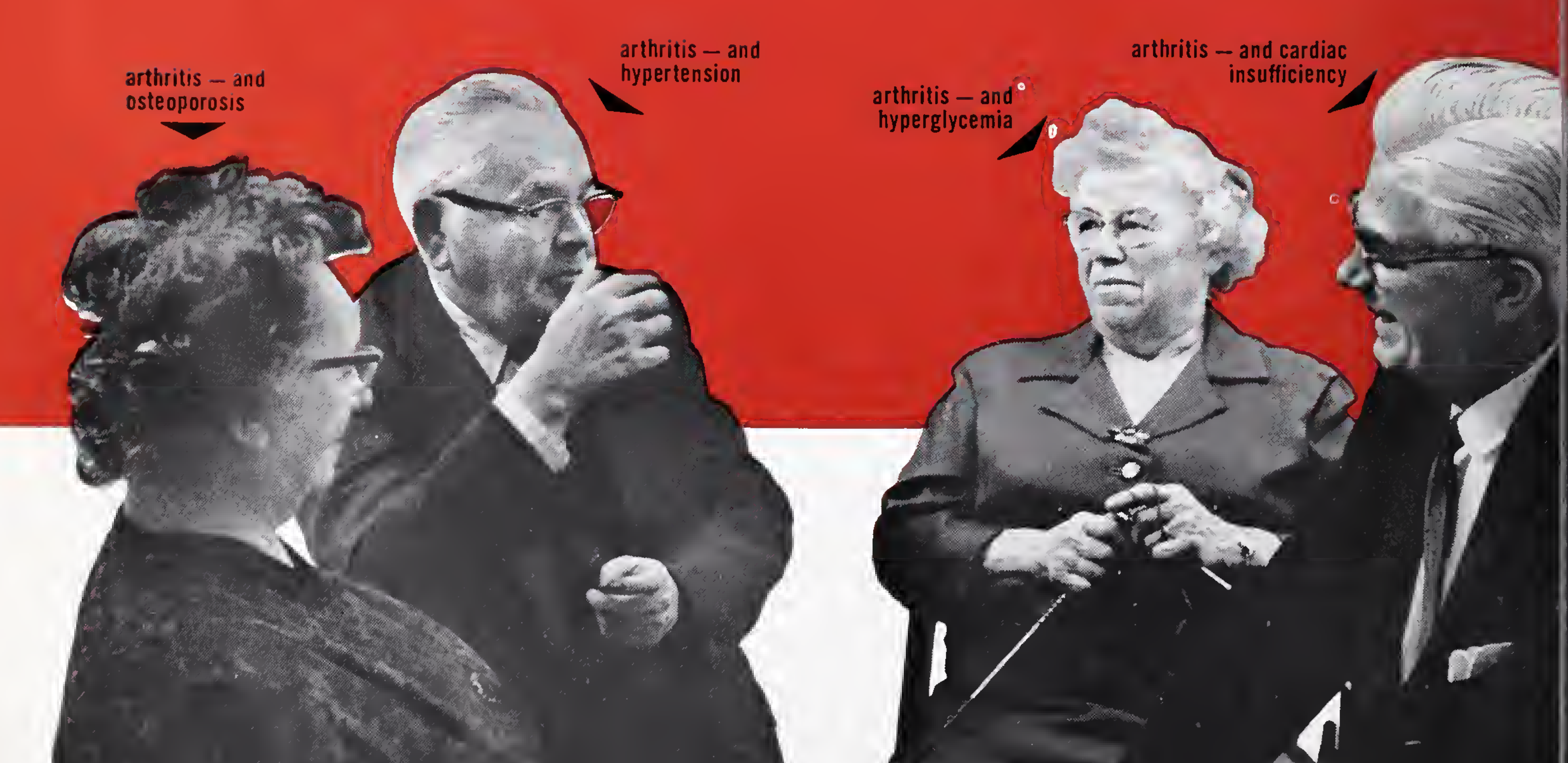

**Current Gastroenterology**

*Edited by Gordon McHardy, M.D., 674 pp., $16.50, Paul B. Hoeber, Inc., 1962.*

THIS VOLUME is based on a postgraduate course in gastroenterology, given by the American College of Physicians. It brings out all the latest developments in the field plus giving a brief summary of basic principles. Special emphasis is given to duodenal ulcer and pancreatic disease. The newer medications used both for benign and malignant diseases are discussed along with agents useful in the parasitic diseases. Intestinal biopsy and new techniques and instruments used in gastroscopy are evaluated. This book will be of help to men interested in general practice, surgery, or gastroenterology.

R. M. DEHAY, M.D.

**Annals of the New York Academy of Sciences, Vol. 99, Art. 2**

*By Walter E. Tolles, Consulting Editor, pp. 231-334, The New York Academy of Sciences, June, 1962.*

VERBATIM report of a conference on applications and methods of counting and sizing in medicine and biology.

**Annals of the New York Academy of Sciences, Vol. 93, Art. 7**

*By C. Alan B. Clementson, Lilian Blair, Albert B. Brown, pp. 277-300, The New York Academy of Sciences, April, 1962.*

THREE MEMBERS of the University of Saskatchewan's Department of Obstetrics and Gynecology discuss capillary strength and the menstrual cycle.

*continued page 66*

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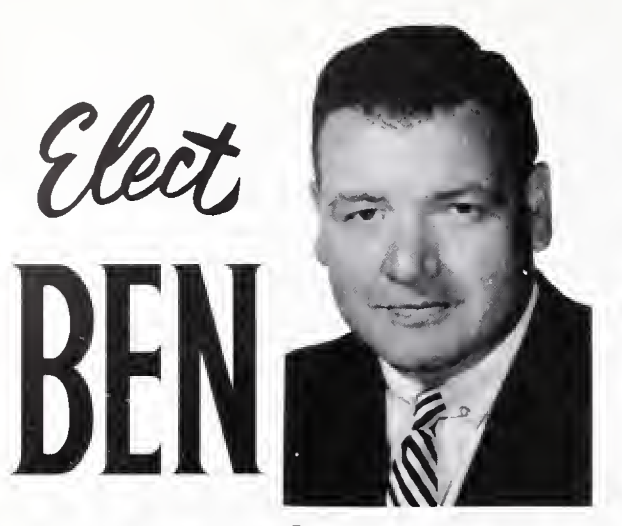


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*Book Reviews* *continued from 63*

**Psychological Development in Health and Disease**
*By George L. Engel, M.D., 435 pp., $7.50, W. B. Saunders Company, 1962.*

A TEXT for students or psychiatrists.

**★The Immunology of Rheumatism**
*By Jerzy B. Kwapinski, M.D., C.Sc., and Marshall L. Snyder, Ph.D., 255 pp., $9.00, Appleton-Century-Crofts, 1962.*

FOR rheumatologists. Fascinating, but deep.

**The Nature of Psychotherapy**
*By Walter Bromberg, B.S., M.D., 108 pp., $4.50, Grune & Stratton, 1962.*

PHILOSOPHICAL.

**Psychoanalytic Education**
*Jules H. Masserman, M.D., Editor, 332 pp., $9.75, Grune & Stratton, 1962.*

FOR psychiatrists.

**Practical Anesthesiology**
*By Joseph F. Artusio, Jr., M.D., and Valentine D. B. Mazzia, M.D., 318 pp., $7.75, The C. V. Mosby Company, 1962.*

ANESTHESIOLOGISTS would be interested and informed by this beautifully printed, well illustrated little volume.

**★Life in the Ward**
*By Rose Laub Coser, 182 pp., $7.50, The Michigan State University Press, 1962.*

RESIDENTS ought to read this, and nursing supervisors would find it informative too.

*continued page 70*

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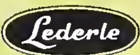

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1. Smith, C. H.: Blood Diseases of Infancy and Childhood, St. Louis, C. V. Mosby Co., 1960, p. 159.
2. Guest, G. M., and Brown, E. W.: AMA J Dis Child 93:486 (May) 1957.

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## Book Reviews continued from 66

**Annals of the New York Academy of Sciences, Vol. 93, Art. 10**

*By Jacob Feld, pp. 351-456, The New York Academy of Sciences, May, 1962.*

A CONSULTING ENGINEER reports on radio telescope structures.

**Annals of the New York Academy of Sciences, Vol. 93, Art. 9**

*By J. C. Houck and Y. M. Patel, 331-350 pp., The New York Academy of Sciences, May, 1962.*

THIS paper is on "The Collagenolytic Activity of Pancreas."

**The Surgical Clinics of North America, Vol. 42, No. 3**

*Kenneth W. Warren, M.D., Guest Editor, pp. 567-832, W. B. Saunders Company, June, 1962.*

A LAHEY CLINIC symposium on surgery of the endocrine glands.

**The Medical Clinics of North America, Vol. 46, No. 4**

*Pp. 885-1154, W. B. Saunders Company, July, 1962.*

A MAYO CLINIC number which presents 24 papers on medical considerations in surgical disease.

**Self-Hypnosis: A Conditioned-Response Technique**

*By Laurance Sparks, 255 pp., $5.75, Grune & Stratton, 1962.*

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1. Dupler, D.A., Greenwood, R.J., and Connell, J.T.: J.A.M.A. 174:123 (Sept. 10) 1960.
2. Hobbs, L.F.: To be published. 2/3026MB

C I B A
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*Hawaii Medical Association* *continued from 43*

**erage of physicians** under the Social Security Act.

Learned that the Board of Trustees has instructed the Council on Drugs to conduct a study on the relationship of **tobacco and disease.**

Encouraged the use of **seat belts** in automobiles.

Decided against making an independent study of the goals and methods of **voluntary health agencies.**

Endorsed a resolution on employment of the **handicapped.**

**Approved** the scheduling of future AMA meeting as folows: Annual Meeting—1966, Chicago; 1967, Atlantic City, and 1968, San Francisco. Clinical Meeting—1965, Philadelphia, and 1966, Las Vegas (with no argument at all!). ■

RICHARD D. MOORE, M.D.
*Delegate*

## *Alternate Delegate's Report*

It was a privilege to participate in the 111th American Medical Association meeting in Chicago this year as alternate delegate from Hawaii. This was an impressive meeting.

It was extremely reassuring to see the enthusiasm and willingness of the officers and the delegates to work hard for long hours in an attempt to resolve the many diverse and complex problems presented to them from all sections of the country.

It is interesting to note that although we are proud of tradition in the American Medical Association, when necessary and for the benefit of the group, this tradition may be altered. This was exemplified in the election of Dr. Edward Annis as President-elect, since he had not come up through the ranks and had no experience in the administration of the AMA.

I was impressed by the fact that in spite of all the modern means of communication and transportation, in Hawaii we lack a certain amount of up-to-date knowledge, and consequently as a group are not continuously well enough informed. This may be resolved to a degree by the Hawaii Medical Association's providing more funds for more frequent attendance at various AMA meetings. Likewise, the AMA may send representatives to Hawaii more frequently to keep us up to date with first-hand information on medical politics, economics, legislation and general policies. We have made a remarkable beginning in opposing anything that violates the principle of free medicine, and we must be well informed in order to continue this opposition. ■

GEORGE H. MILLS, M.D.
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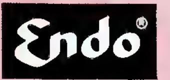


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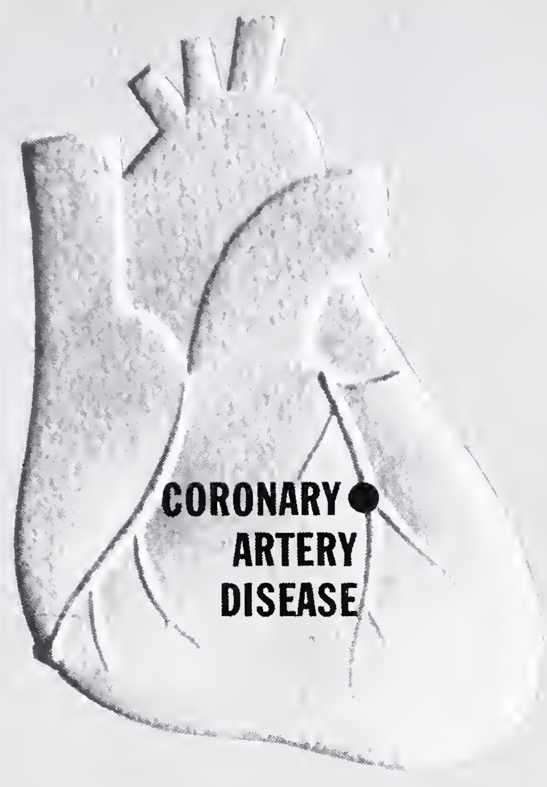


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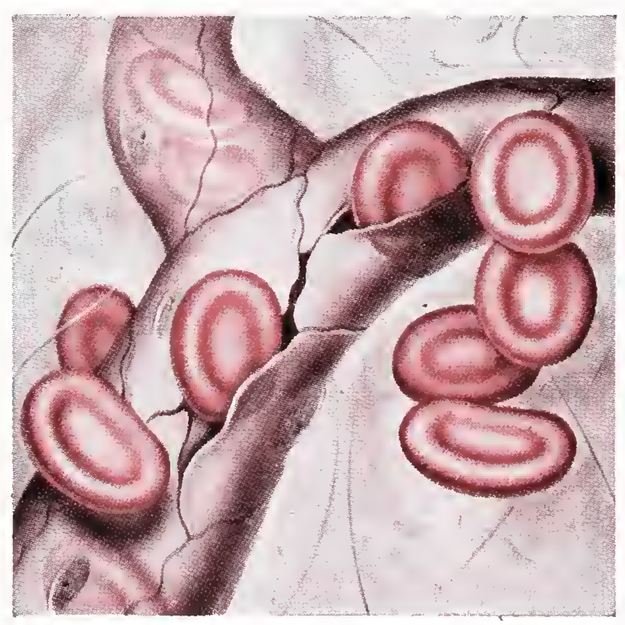

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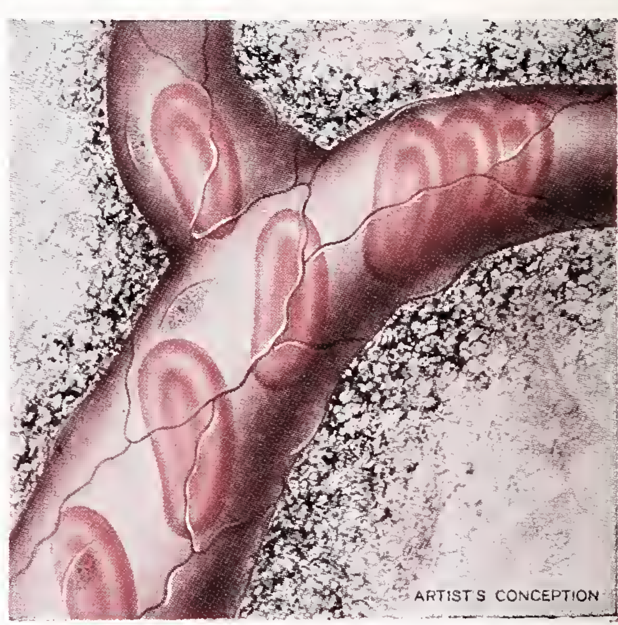


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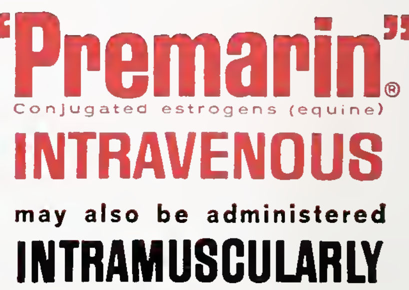

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*REFERENCES: (1) Roseman, E.:* Neurology **11***:912, 1961. (2) Bray, P. F.:* Pediatrics **23***:151, 1959. (3) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (4) Crawley, J. W.:* M. Clin. North America **42***:317, 1958. (5) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (6) Ibid.:* Postgrad. Med. **20***:584, 1956. (7) Merritt, H. H.:* Brit. M. J. **1***:666, 1958. (8) Carter, C. H.:* Arch. Neurol. & Psychiat. **79***:136, 1958. (9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, p. 37. (10) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1956, p. 187.*

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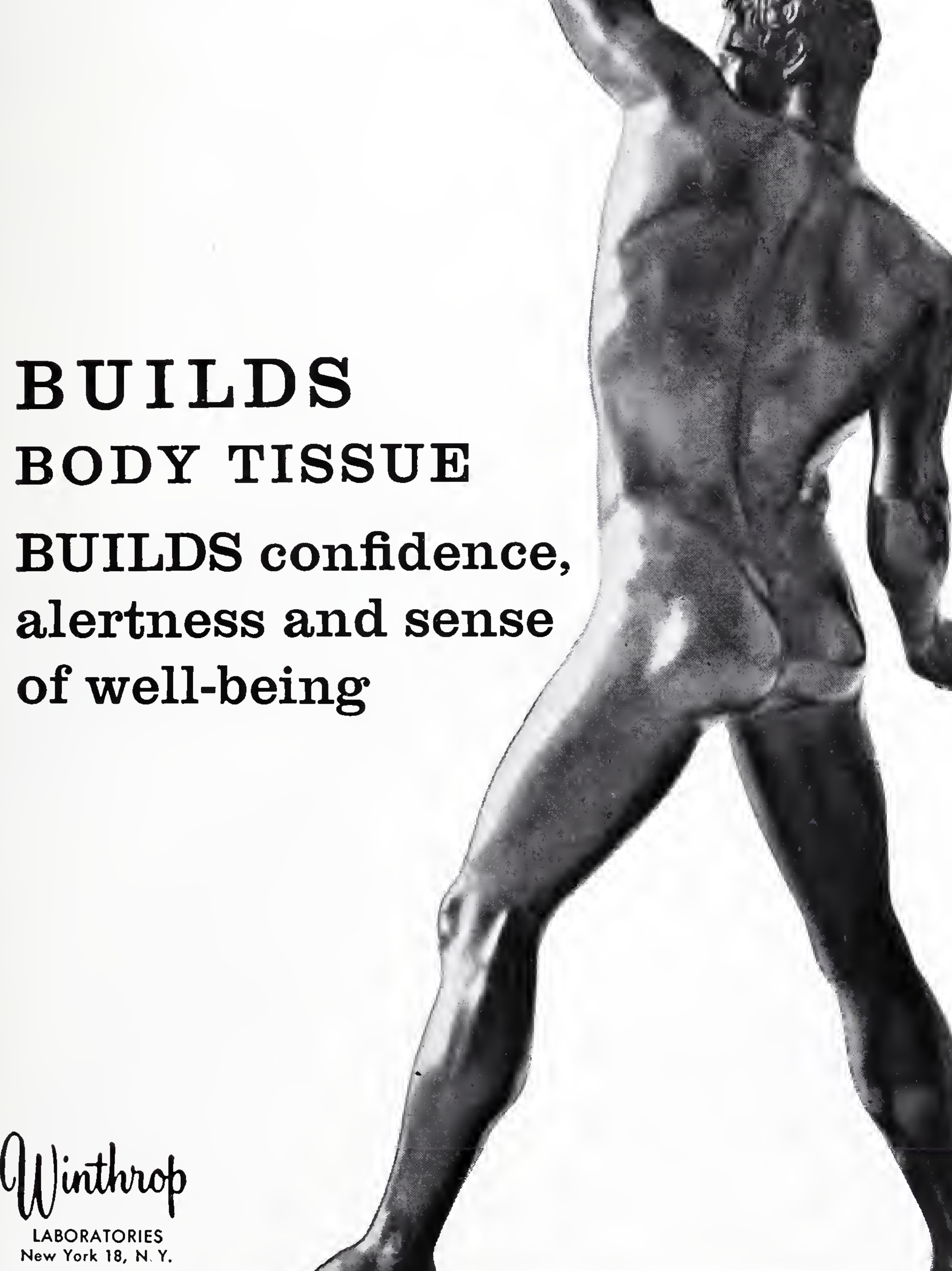

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**Boutonneuse fever** is a tick-borne, acute, febrile disease often affecting children. The bite site becomes a small, necrotic ulcer. A striking macular or maculopapular eruption develops on the trunk, palms and soles. Onset is sudden, with chills, high fever, violent headache and lassitude. The high temperature—up to 103° F.—characteristic of both boutonneuse fever and bronchopneumonia, drops rapidly following initiation of Terramycin therapy.

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capsules • syrup • pediatric drops
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# Reports & Snorts

**Thalidomide was distributed for trial to 1,231 American physicians; 1,073 had been reached by August 3, and 67 had some left, which was impounded.**

• • •

Natural background radiation was increased by from one-tenth to one-quarter by all the atomic tests conducted during 1961, according to the Federal Radiation Council.

• • •

The American Board of Pathology has certified 4,000 physicians in one or more of the seven classifications (!) of pathology since its founding in 1936, and estimates it must certify 6,000 more by 1970 if the U.S. is to have one for every 3,500 hospital admissions per year. The seven classifications are anatomic pathology, clinical pathology, forensic pathology, neuropathology, hematology, clinical chemistry, and clinical microbiology.

• • •

*Life Service Record, Spring Valley, N. Y., will microfilm a patient's medical history on a plastic pocket card for $2. It can only be read with a microfilm viewer or a projector. Write for forms.*

• • •

"Enough Rope" Department: Royal Lee (Vitamin Products, Milwaukee) was finally convicted in a Federal Court of distributing misbranded and fraudulent preparations and enjoined from making any more false claims. Regrettably, his one-year prison term was suspended and only his firm was fined, and then only $7,000. Its annual income is estimated at $3,000,000. The advertising he gets out of this trial will be worth easily 10 times the amount of the fine. Incidentally, he is a noteworthy opponent of water fluoridation—also of milk pasteurization and vaccinations, on the ground that they cause cancer.

• • •

*The giant economy 10-ounce size jar of Maxwell House Coffee only costs one-sixth more per ounce than the little six-ounce jar. The Food and Drug Administration will arrange to have this corrected.*

• • •

**If MEDICO and CARE, now merged, were to be renamed MEDICARE, we would have three "Medicare" programs, or two programs and one program, and confusion would reign supreme. CARE used to mean Cooperative for American Remittances to Europe. Now it means Cooperative for American Relief Everywhere. It's moving out of Europe, gradually, and into Asia, Africa, and Central America.**

*American pharmaceuticals have had an over-all decline of 7% in prices from 1949 to 1959. Any other products care to try to match that record?*

• • •

**Look for Saunders' ad on page 000 in this issue for three practical new volumes on pain syndromes, office procedures, and office psychotherapy. If you inquire, *mention our journal!***

• • •

*Collins of Cook County and Rovenstine of Bellevue (*Arch. Surg. *84:680, 1962) believe Carbocaine (Winthrop) is as much better than lidocaine (Xylocaine) for nerve blocks as lidocaine was better than procaine.*

• • •

**Saunders has published a new edition of Todd & Sanford, advertised elsewhere in this issue; also a new Parsons & Sommers (Gynecology) and Wolff on electrocardiography.**

• • •

"Your Baby's First Year," a picture pamphlet for beginning parents, is available for 15¢ from the Superintendent of Documents, U. S. Govt. Printing Office, Washington 25, D. C.

• • •

*An Indian chief is reported to have married three squaws and bedded them on a hippopotamus hide, a bear hide and a deer hide. The squaws on the deer hide and the bear hide each had a baby boy; the one on the hippopotamus hide had twin boys. This happened because, as in any right triangle, the squaw on the hippopotamus is equal to the sum of the squaws on the other two hides.*

• • •

**The FDA warns that Liefcort, a home-made hormone mixture being brought into the U.S. from Quebec for treatment of arthritis, is potentially dangerous; severe uterine bleeding is one of its possible effects.**

• • •

*Feeling left out of things? There is an American Association for Automotive Medicine. Dr. Suzanne Snively, 761 Laurel Drive, Sacramento, California, can tell you all about it.*

• • •

The American Industrial Health Conference is scheduled for March 18-21 in Washington, D. C. 55 East Washington St. in Chicago is the place to inquire.

• • •

*Inquire at the HMA office if you'd like to read a paper before the American Thoracic Society at Denver next May. Abstracts are due before January 4—and original and 7 copies.* ■

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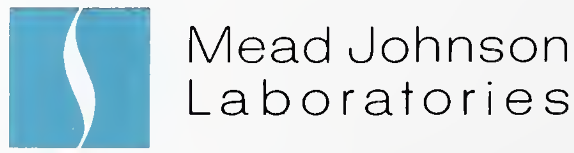


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**References:** (1) Shaw, J. H., in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, ed. 2, Philadelphia, Lea & Febiger, 1960, pp. 574-580. (2) Statement on Fluoridation of Public Water Supplies, by the House of Delegates of the American Medical Association, Philadelphia, December 3-6, 1957. (3) Accepted Dental Remedies, ed. 27, Chicago, American Dental Association, 1962, pp. 137-139. (4) Arnold, F. A., Jr.; McClure, F. J., and White, C. L.: Dent. Progress 1:8-12 (Oct.) 1960. (5) Muhler, J. C.: J. Am. Dent. A. 61:431-438 (Oct.) 1960. (6) Holt, L. E., Jr.; McIntosh, R., and Barnett, H. L.: Pediatrics, ed. 13, New York, Appleton-Century-Crofts, 1960, p. 350. (7) Council on Dental Therapeutics, J. Am. Dent. A. 56:589-591 (April) 1958.

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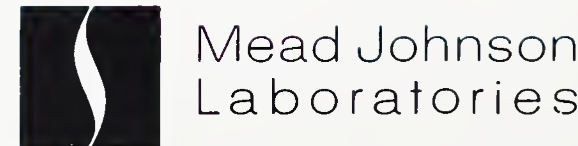


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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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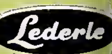

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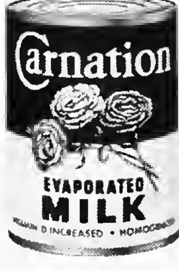


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1. Smith, C. H.: Blood Diseases of Infancy and Childhood, St. Louis, C. V. Mosby Co., 1960, p. 159.
2. Guest, G. M., and Brown, E. W.: AMA J Dis Child 93:486 (May) 1957.

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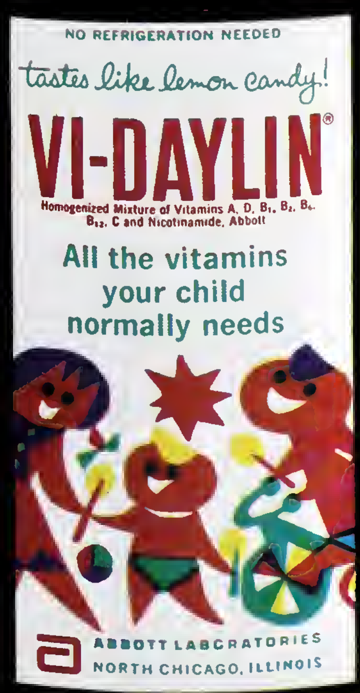


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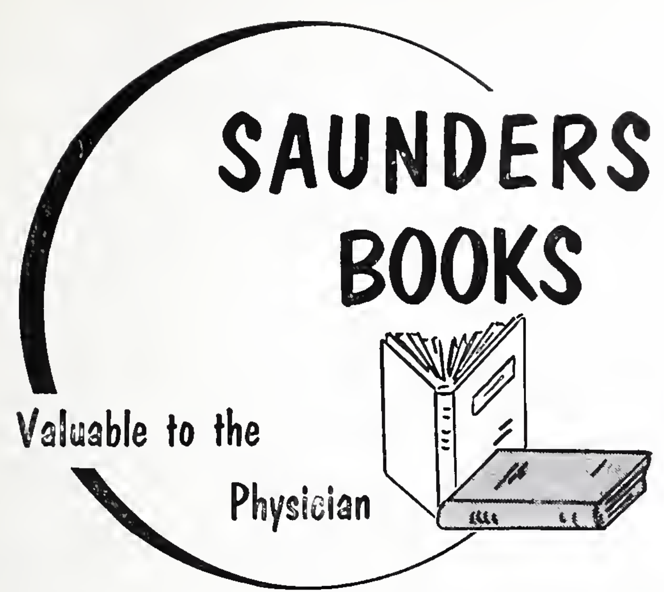
(an unsolicited testimonial from an actual letter)

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*By and large, you're healthy—as well as lucky—*

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# Finding and Planning Implications From the Hawaii Health Survey

CHARLES G. BENNETT,* B.S., M.A., *Honolulu*

• *Oahu residents are more prone to have asthma or hay fever, diabetes, high blood pressure, home accidents, and respiratory and digestive disorders (the latter includes tooth decay), and (up to age 65) are more apt to have seen a doctor, than are their mainland counterparts.*

*But they're only half as likely to have sinusitis, arthritis, heart disease, peptic ulcer, a hernia, an auto accident, or any infectious or parasitic disease. They have also spent one-third fewer days in bed, for any cause, than people of corresponding ages on the mainland.*

THE HAWAII Health Survey was a joint project of local and federal agencies. Results were based on a random sample of 3,300 households. Included were 12,500 individuals living on the Island of Oahu, which is, in census terms, the Honolulu Metropolitan Statistical Area. Only the civilian noninstitutional population was included.

Information was obtained by interviews with one or more members of each household. Interviewing was carried on for one year between October, 1958, and September, 1959. The interview questionnaire, instructions, and procedures were identical with those used in the National Health Survey on the mainland. For that reason, comparable data for the mainland as a whole and by regions are available from reports of the U.S. Public Health Service.

* Assistant Executive Officer, Research, Planning and Statistics Office, Hawaii State Department of Health. This paper was presented at the annual meeting of the Hawaii Public Health Association, November 6, 1961. Received for publication April 23, 1962.

DAYS OF DISABILITY

Figure 1 shows the estimated average number of restricted-activity days, bed-disability days, and work-loss days per person per year for the population of Oahu compared to the population of the mainland as a whole.

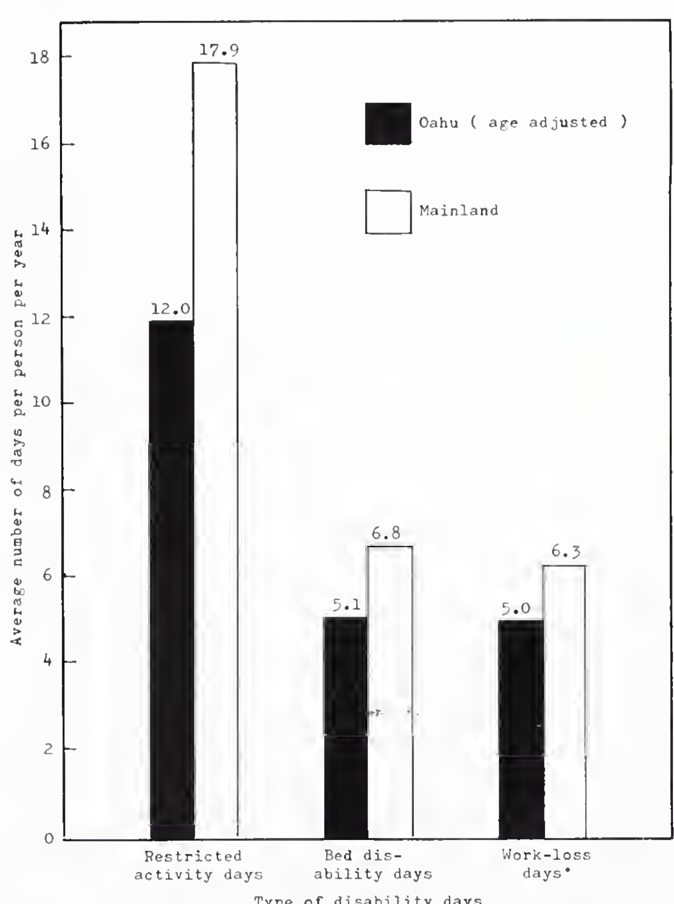


FIG. 1—*Average number of disability days per person per year by type of disability day: Oahu, October 1958–September 1959, and mainland, July 1957–June 1959.*

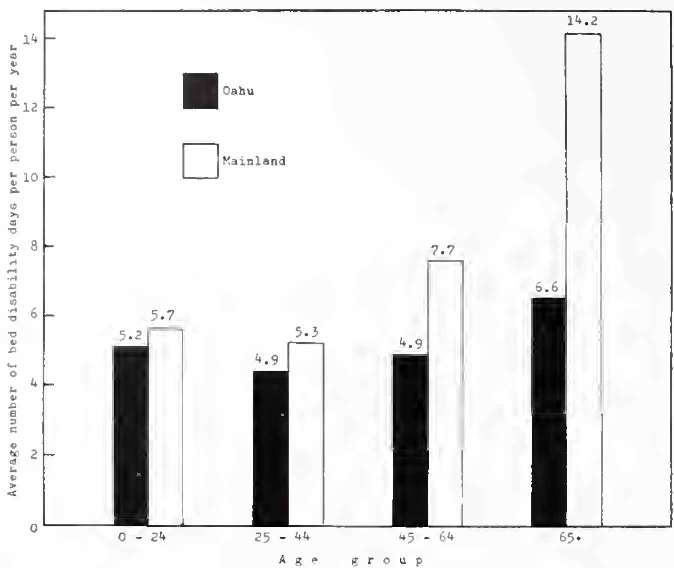


FIG. 2—*Average number of bed disability days per person per year by age: Oahu, October 1958–September 1959, and mainland, July 1957–June 1959.*

A restricted-activity day was defined as a day when a person cut down on his usual activity for the whole of that day on account of illness or injury. On a bed-disability day, a person stayed in bed either all or most of the day because of illness or injury. A day was counted as lost from work if a person would have been going to work at a job or business that day, but instead lost the entire workday due to illness or injury. Restricted-activity days, as might be expected, include both bed days and work-loss days.

For comparing the general health level of areas or groups within a single area, these three types of disability days appear to be an excellent yardstick. They are a kind of common denominator for all types of morbidity.

The recall period was only two weeks. Tests have indicated that a longer period results in less accurate information. Each week's interviewing constituted a random sample of all families on Oahu. The results of 52 samples were then added together to get the total number of disability days for the survey year.

The average number of restricted-activity days per person was 49.2 per cent higher on the mainland; bed-disability days were 33.3 per cent higher; and work-loss days 26.0 per cent higher. These data suggest that the level of health in Hawaii is superior to that in the country as a whole.

Hawaii has the youngest population of any state except Alaska. Since older people are generally more prone to illness and disability than younger people, one might expect from this fact alone that disability days here would be less than on the mainland. However, the Oahu averages indicated in Figure 1 are age adjusted—i.e., the age distribution on Oahu was assumed to be exactly the same as on the mainland and the averages were computed on that basis. Crude or unadjusted averages were even lower than shown in the chart.

This relatively high level of health in Hawaii did not happen by chance—especially with our subtropical setting. The medical profession, the Health Department, and voluntary health agencies have all had a part in bringing about and maintaining this above-average record.

### *$7,000,000 Lost*

However, relatively good health is no reason for complacency. There is still plenty to do. For example, health survey statistics show a work loss of approximately 733,000 days during the survey year among the working population due to illness and injuries. By a conservative estimate, the monetary value of these days lost from work amounted to at least $7,000,000. It is also estimated that the sick people concerned paid out at least another $5,000,000 for medical and hospital care. In a rather small community, $12,000,000 is a considerable sum; furthermore, it pertains only to our most able-bodied people.

Figure 2 indicates the average number of bed-disability days per person per year by age groups. Each Oahu age group had fewer bed days, but the difference was most striking at ages 65 and over, where the mainland average was more than double.

### *Select Group of Aged*

Other data of the survey also show the health level of persons 65 and over to be remarkably high compared to mainlanders of the same age. This may be due in large measure to the fact that the majority of old people here came as immigrants to work on the sugar and pineapple plantations. Only the most able-bodied were thus encouraged or helped to come. Therefore, our aged people today are a select group.

The next younger group, 45 to 64, do not appear so healthy in comparison to the mainland and to younger groups. It can be inferred from this that the group aged 65 and over of the near future may have greater health problems than exist today.

## INCIDENCE OF ACUTE CONDITIONS

Despite the fact that the Oahu population experienced fewer disability days of the various types, incidence rates for acute diseases were higher than mainland rates among each Oahu age group, except 65 and over. This apparent discrepancy can be explained by the fact that disability days connected with acute disease were fewer in number in Hawaii—in other words, these conditions appeared to be less serious here, or perhaps the people here were less inclined to restrict activity or go to bed on account of illness.

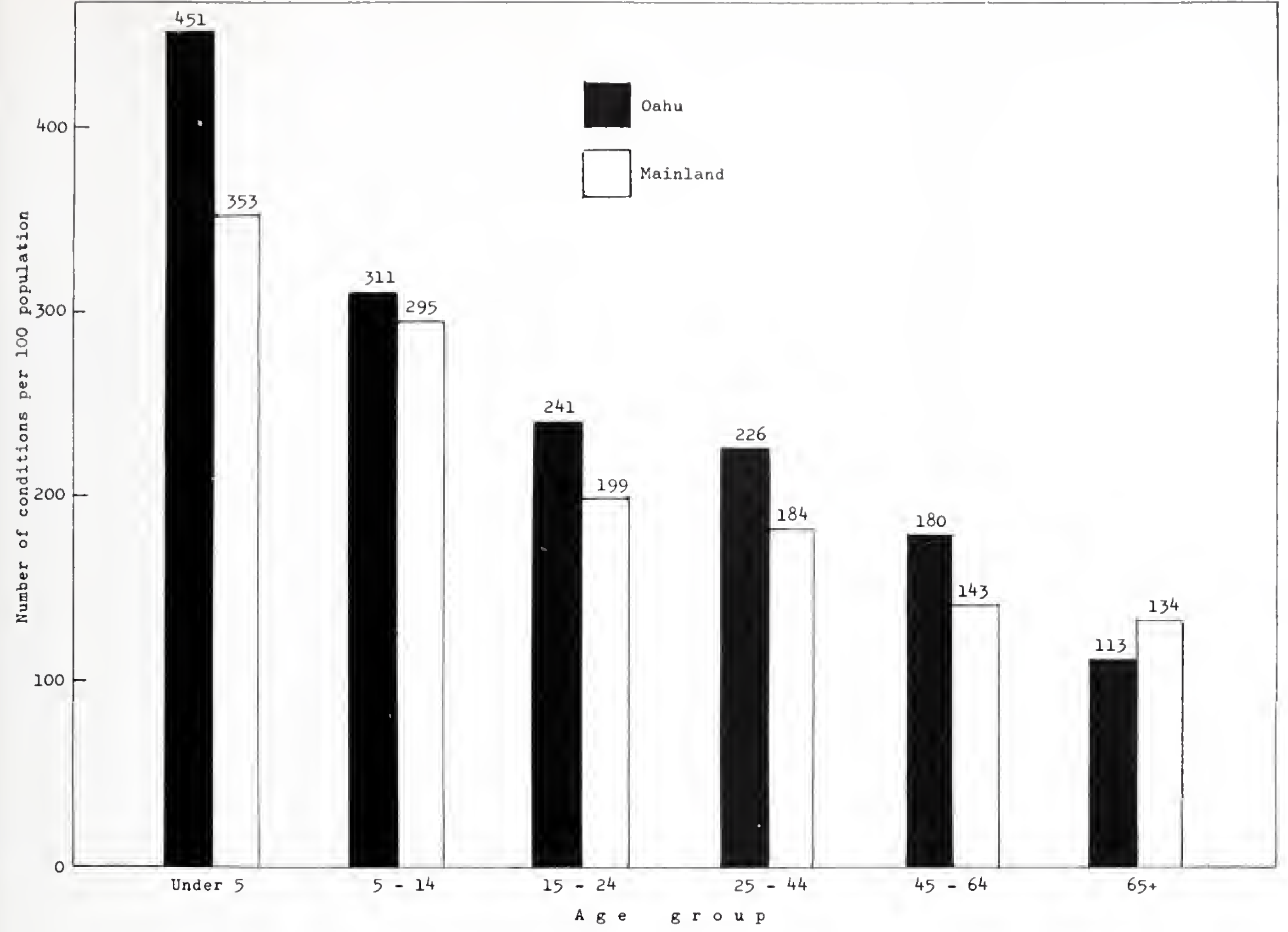


FIG. 3—*Annual incidence rates for acute conditions by age: Oahu, October 1958–September 1959, and mainland, July 1958–June 1959.*

Second, as will be shown later, the prevalence of chronic conditions was considerably less here than on the mainland.

Chronic conditions were sought by means of predetermined lists of chronic diseases and impairments. These lists were presented on cards to the family member being interviewed. A further qualification was that any chronic condition (to be so listed) must have been present for more than three months prior to the week of interview.

All conditions not classed as chronic were considered to be acute, but were recorded only if the person involved had had to restrict his usual activity, or had seen a doctor.

Figure 4 includes an estimated 1,265,000 acute conditions on Oahu and 368,000,000 on the mainland, broken down into six broad categories. (Generally, data from the survey must be presented only in broad categories. This is because estimates were based on a relatively small sample. If too much detail is shown, the number of sample cases becomes too small to be reliable.) Rates for Hawaii in Figure 4 were age-adjusted on the mainland population; otherwise, they would appear to be somewhat higher.

The infectious and parasitic group included such conditions as the common childhood diseases, acute venereal diseases, salmonella infections, streptococcus throat, acute encephalitis, etc. Apparently, Hawaii has done a fine job of controlling such conditions. Our rate per 100 population was only half that of the mainland.

### U.R.I. COMMONER HERE

The incidence of upper respiratory conditions, mostly the common cold, was greater in Hawaii. The incidence of other more serious respiratory conditions, such as influenza and acute bronchitis, was also moderately higher here.

Disturbances of the digestive system likewise were more common on Oahu. Since the category included acute dental conditions, this may be the main reason for the higher rate. Other studies have demonstrated that Hawaii's people have poor teeth.

The greatest difference occurred for injuries resulting from accidents. Our rate was 56 per cent higher than on the mainland. Figure 5 gives some indication as to how these injuries came about.

This figure refers to the number of persons in-

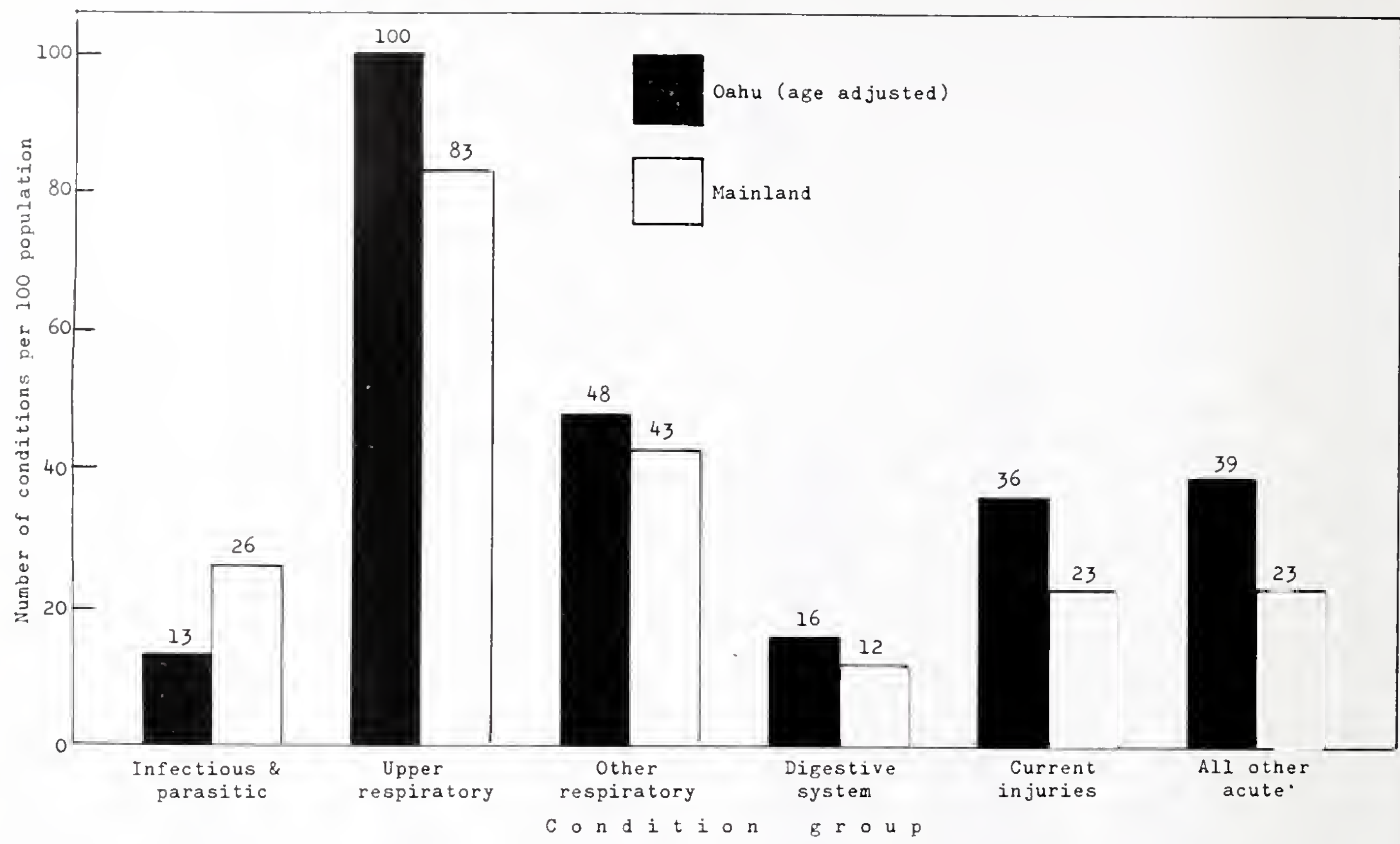


FIG. 4—*Annual incidence rates for acute conditions by condition group: October 1958–September 1959, and mainland, July 1958–June 1959.*

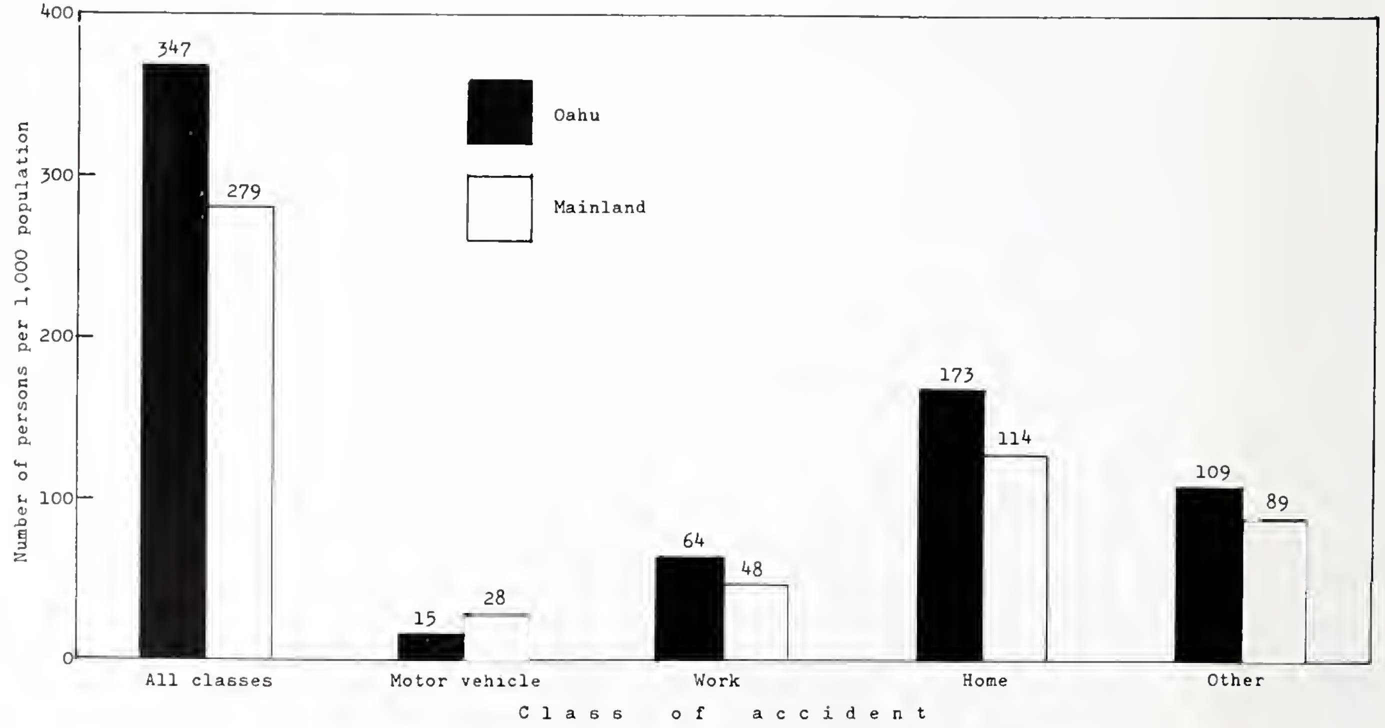


FIG. 5—*Number of persons injured per 1,000 population per year by class of accident: Oahu, October 1958–September 1959, and mainland, July 1957–June 1958.*

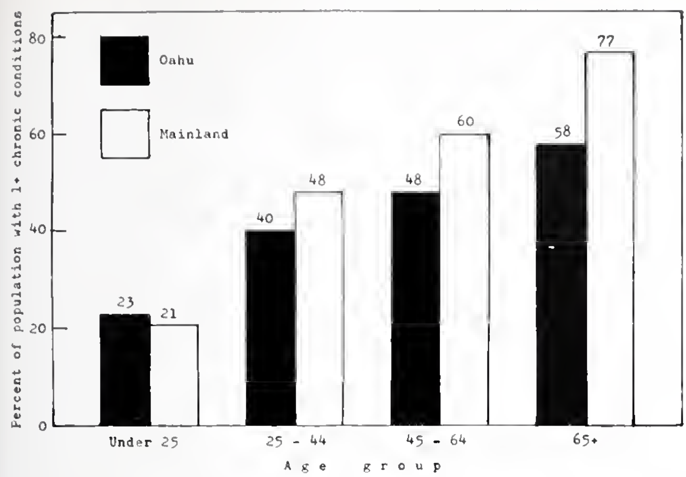


FIG. 6—*Prevalence of chronic conditions by age: Oahu, October 1958–September 1959, and mainland, July 1957–June 1959.*

jured rather than to the number of injuries. There is a minor difference because a person may sustain more than one serious injury in a single accident.

*More Work–Home Accidents*

The Oahu accident rate, referring to number of persons injured, was lower for accidents involving motor vehicles, but higher for accidents while at work, home accidents, and "other" classes of accidents. The "other" category includes mostly various kinds of mishaps in public places, but a few with origin unspecified.

Our rate involving motor vehicles is lower, probably because we have fewer speedways. The number of persons injured in motor vehicle accidents was only 4 per cent of all persons injured during the survey year. However, the number of resulting bed-disability days from motor vehicle accidents constituted 19 per cent of all bed-disability days due to accidents. From this it is evident that motor vehicle accidents are generally more serious than the other types of accidents.

Why Hawaii should have higher rates for work accidents, home accidents, and accidents in public places is not clear. Extensive outdoor living in a benign climate the year around may be a factor. Whatever the reasons, the data should serve as a guide to health agencies and others interested in reducing all kinds of accidents.

CHRONIC CONDITIONS LESS COMMON

In each age group, except under 25, the percentage of people having one or more chronic conditions was smaller on Oahu. As usual, the difference between Oahu and the mainland was most pronounced in the age group 65 and over, with our old people much better off with respect to chronic conditions.

Figure 7 shows rates per 1,000 population for a selected group of the more common chronic diseases.

*Hay Fever, Asthma High*

Asthma and hay fever, considered together as a single category, constituted the most frequent

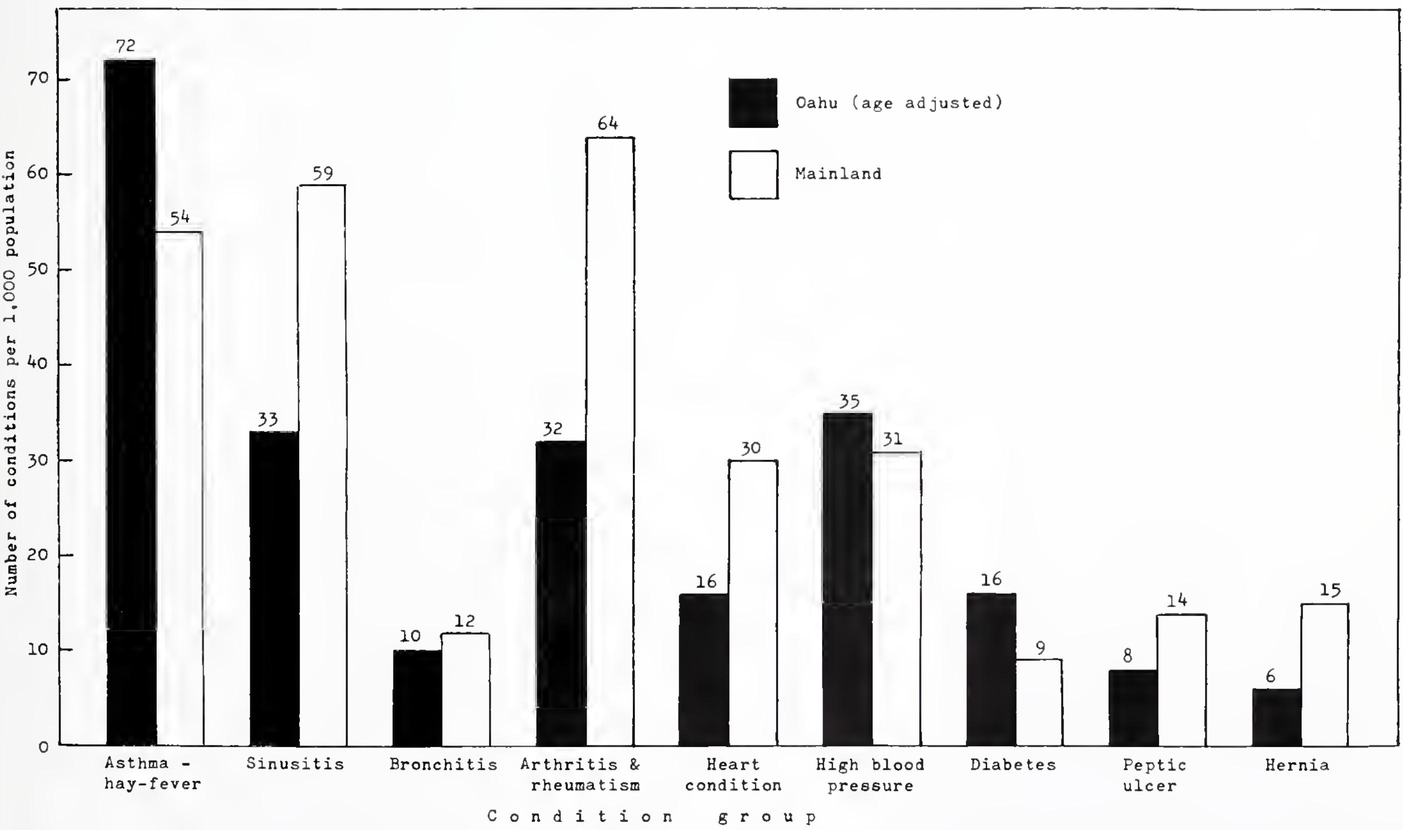


FIG. 7—*Prevalence rates for chronic conditions by condition group: Oahu, October 1958–September 1959, and mainland, July 1957–June 1959.*

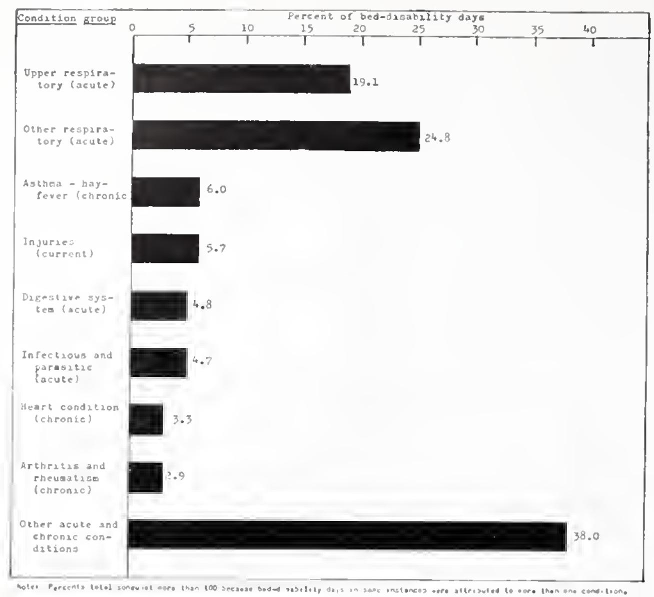


FIG. 8—*Percentage distribution of bed-disability days by condition group: Oahu, October 1958–September 1959.*

chronic condition reported on Oahu. (For several reasons, it was not practical to present statistics for the two conditions separately.)

Although the Hawaii rate was 33 per cent higher than the mainland average rate, recent data by regions from the National Health Survey show the rate for the western states as a whole, including Rocky Mountain and Pacific states, to be about the same as for Oahu.

Nevertheless, these types of allergic conditions constitute an extensive problem in Hawaii. During the survey year, about 36,000 persons on Oahu were so affected; more than half were under 25. The University of Hawaii, the State Health Department, and the medical profession at present are developing a cooperative plan of research in an effort to pinpoint what may be causing allergic conditions among us.

Sinusitis, arthritis and rheumatism, heart conditions, peptic ulcer, and hernia were much less prevalent on Oahu than on the mainland. On the other hand, the high blood pressure rate was moderately higher on Oahu and the diabetes rate 78 per cent higher.

*Diabetes Rate High*

This relatively high diabetes rate is probably due, at least in part, to diabetes detection campaigns that have been carried on during recent years. However, Dr. Norman Sloan of the Health Department's Adult Health Branch feels that we do actually have a higher rate than do most places on the mainland.

*In Bed with a Cold*

About 45 per cent of all bed days reported in the survey were due wholly or in part to chronic conditions. On the other hand, 70 per cent were due wholly or in part to acute conditions. These two percentages add up to more than 100 per cent because sometimes the same bed days had to be attributed equally to several conditions that one individual might have. Nevertheless, they indicate that acute conditions are much more important as a source of bed-disability than chronic conditions.

It is evident that acute respiratory conditions are the outstanding cause of bed-disability. Although heart conditions are shown in vital statistics as the leading cause of death, it is interesting to note that they produce far less disability in the population as a whole than does the common cold.

THE USE OF PHYSICAL SERVICES

In each age group, except 45 and over, Oahu averaged a greater number of physician visits per person per year than on the mainland. Our highest average was for children under five. The highest average on the mainland was for those 65 and over. As might be expected from previous charts on the health of our aged people, their number of physician visits was relatively low—in fact, the average number of visits was lower than among any other age group (Figure 9).

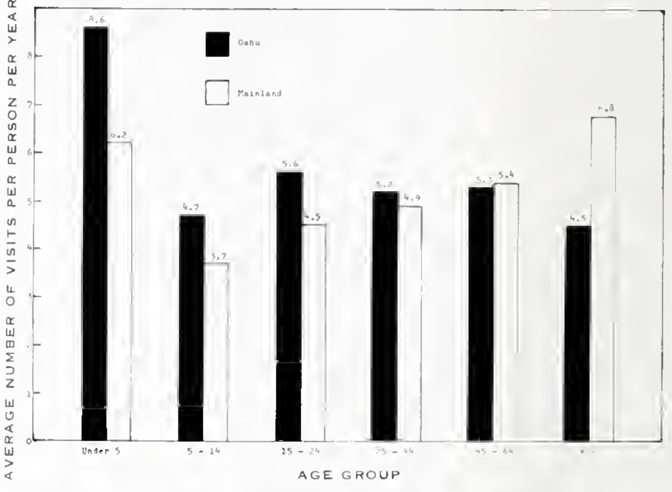


FIG. 9—*Average number of physician visits per person per year by age: Oahu, October 1958–September 1959, and mainland, July 1957–June 1959.*

A physician visit was defined as consultation with a physician in person or by telephone for examination, diagnosis, treatment, or advice. Although the service rendered may have been carried out by a nurse or other person acting under a physician's supervision, the contact was considered a physician visit.

Figure 10 indicates the percentage of acute conditions causing restricted activity which were attended by a physician. The survey criteria for an acute condition specified reduced usual activity or a visit to a physician. Therefore, only conditions involving restricted activity were used in the figure. We already know that all other conditions not in-

volving restricted activity were recorded only if seen by a physician.

For every acute condition group shown, except that involving the digestive system, the percentage of conditions receiving medical attention is greater in Hawaii. This appears to be good evidence that the Oahu population does make greater use of the medical profession than is generally done on the mainland. The accessibility of physicians, a favorable economic situation, and health consciousness are probably factors influencing the greater frequency of physician visits in Hawaii.

That a slightly lower percentage of digestive system conditions are attended by a physician in Hawaii may be due to the fact that acute dental conditions were allocated to the digestive category. Oahu people, having a higher dental decay rate than the mainland, went to the dentist instead of the physician.

### HOSPITALIZATION

A hospital episode was defined in the survey as any continuous period of stay of one or more nights in a hospital as an inpatient. The data presented here refer only to episodes in short-stay hospitals.

A hospital discharge was recorded whenever a member of the family being interviewed was reported to have been discharged from a hospital during the 12-month period prior to the interview week. For short-stay hospitals, the number of discharges in a year approximate the number of admissions.

Since all survey data refer only to persons who were alive at the time of interview, the hospital experience of persons who died in the year prior to the interview period was not counted. Understatement of hospital experience due to this procedure is greatest relating to older persons and various disease groups where mortality rates are high. This deficiency in National Health Survey data is now being corrected by a nationwide study on the hospital experience of deceased persons.

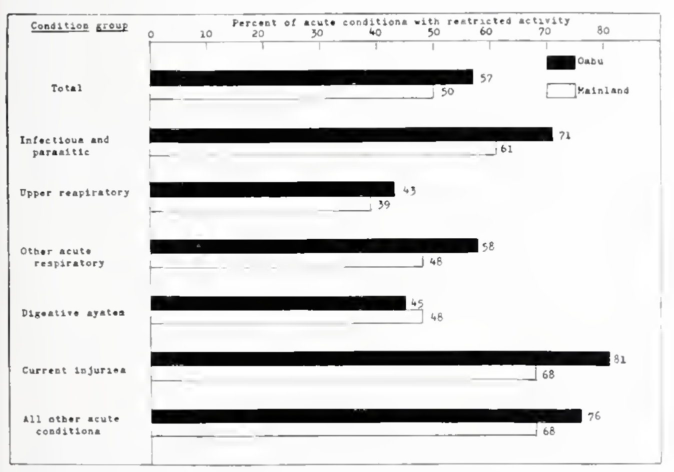


FIG. 10—*Percentage of acute conditions with activity restriction that were medically attended: Oahu, October 1958–September 1959, and mainland, July 1958–June 1959.*

According to the data we have, the discharge rate from Oahu short-stay hospitals was somewhat higher than that from similar hospitals on the mainland for each age group except 65 and over (Figure 11). Our rates were especially high, compared to the mainland, at ages 15 to 24 and 25 to 44. Probably this is connected with the birth rate, which is higher on Oahu than on the mainland as a whole; consequently, a larger proportion of women on Oahu went to the hospital to have babies.

It is worth noting here that the Oahu birth rate is especially high, due largely to military families. They are here for a few years, have babies, and are replaced by other young couples who likewise have children. Thus, we have a constantly replenished reservoir of young, fecund, married people.

Despite the marked differences in hospital usage by age shown in Figure 11, the average rate including all ages was only about 6 per cent higher for our population. Therefore, apparently we do use hospitals to a greater extent than on the mainland, but only moderately so.

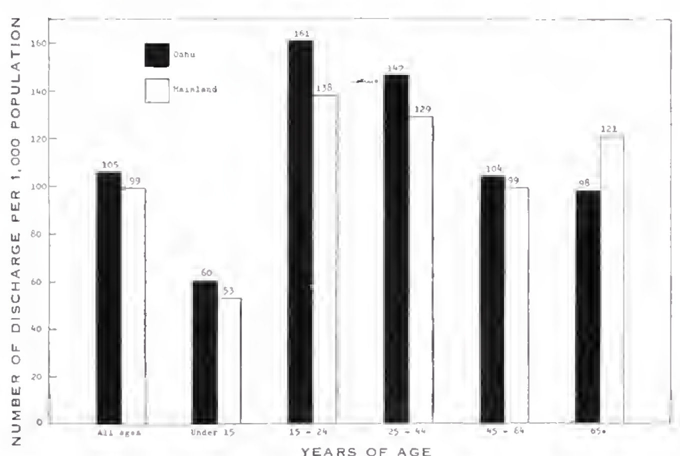


FIG. 11—*Hospital discharges from short-stay hospitals per 1,000 population by age: Oahu, October 1958–September 1959, and mainland, July 1957–June 1958.*

Average length of hospital stay considering all ages together appeared 15 per cent higher on the mainland. However, this higher mainland average was confined to ages 15-24 and 25-44. (Figure 12). At younger and older ages, the Oahu average was higher. Here again, probably the birth rate was involved. We had a higher proportion of women going to the hospital for childbirth and they stayed a shorter length of time than other types of cases.

Although persons 65 and over had a relatively low hospitalization rate, as shown in Figure 11, their average length of stay was much longer than on the mainland. However, as pointed out above, hospital discharge data of the survey relating to older people is probably especially deficient be-

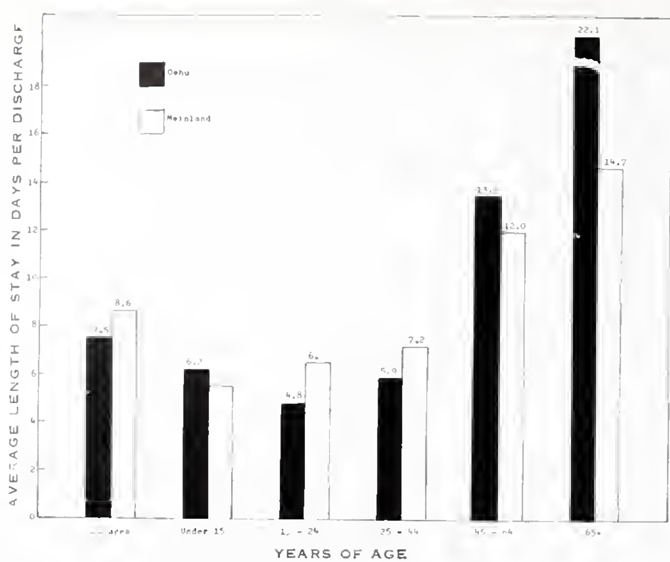

FIG. 12—*Average length of stay per discharge from short-stay hospitals by age: Oahu, October 1958–September 1959, and mainland, July 1957–June 1958.*

cause hospitalizations of deceased persons were not included.

Figure 13 indicates that a much lower percentage of hospital discharges on Oahu than on the mainland had hospital insurance. At least a partial explanation is that military dependents constitute a certain proportion of our civilian population (about 15%), and therefore figured in the survey sample. At the time of the survey, they had a "medicare" program available and by definition this was not classed as hospital insurance. Care provided free of charge in a veterans' hospital, care through welfare programs, and other free care were also excluded from the insurance category.

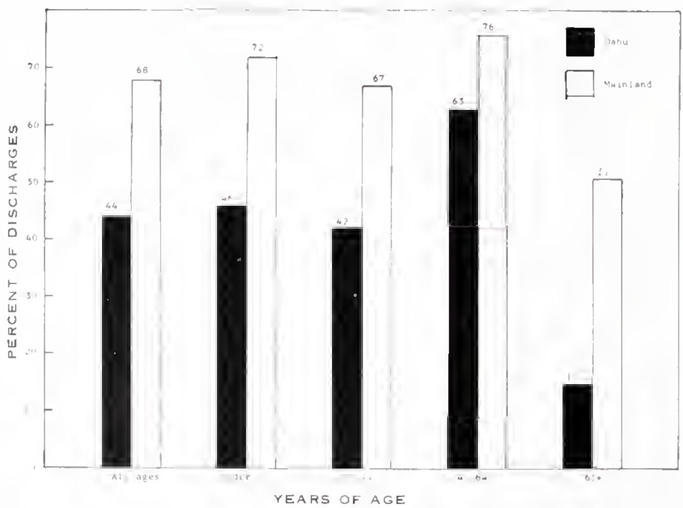

FIG. 13—*Percent of discharges from short-stay hospitals reported with hospital insurance by age: Oahu, October 1958–September 1959 and mainland, July 1958–June 1960.*

Figure 14 shows the percentage of "usually working" persons 17 years of age and over with hospital insurance. To a large extent, this excludes military dependents, few of whom are gainfully employed. Although Oahu and mainland percentages are now more similar, both working men and

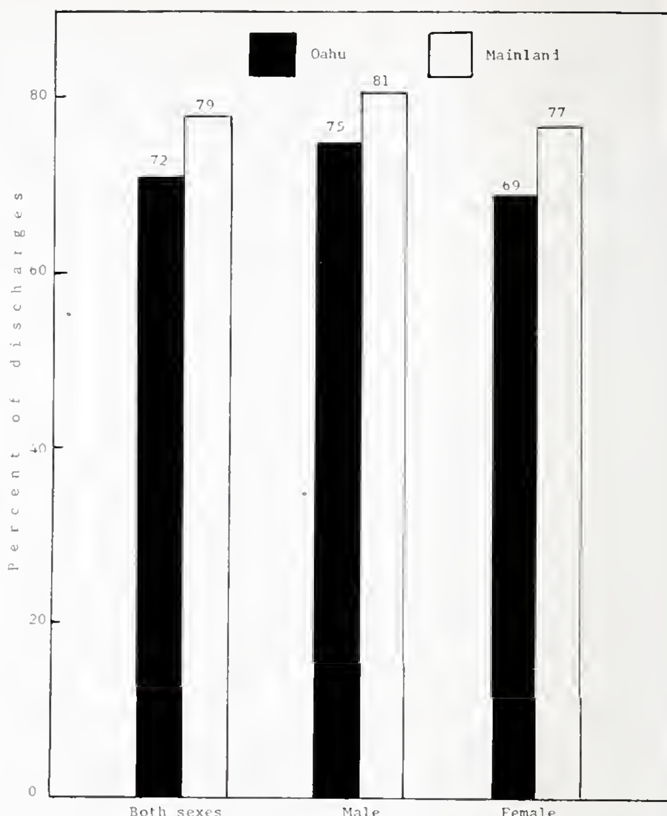


FIG. 14—*Percent of usually working persons discharged from short-stay hospitals reported with hospital insurance: Oahu, October 1958–September 1959 and mainland, July 1958–June 1960.*

working women on Oahu appeared somewhat less likely than their mainland counterparts to have hospital insurance.

## SUMMARY


On the basis of the number of restricted-activity days and bed-disability days per person per year (age adjusted), the level of health on Oahu is better than that in the United States as a whole. As indicated by health survey data, the aged 65 and over on Oahu appeared remarkably healthy compared to the same age group on the mainland.

The Oahu population has a relatively high incidence of acute conditions and a low prevalence of chronic conditions. Respiratory conditions and accidental injuries are the major causes of acute morbidity. Respiratory conditions were wholly or in part responsible for 44 per cent of all bed-disability reported during the survey year. Asthma and hay fever had by far the highest prevalence among chronic conditions.

Except the age group 65 and over, the people of Oahu visit a physician more frequently than mainland residents. The highest rate of visits during the survey year was for children under five. Again excepting the aged group, Oahu residents use hospitals somewhat more than mainlanders. At least to some extent, this is due to a higher birth rate. (Nearly all Oahu births occur in hospitals.) The proportion of persons with hospital insurance is low compared to the mainland. ■

*On Oahu, 97% fifth-graders have decayed teeth— averaging 7.2 of their average of 10 permanent teeth each!*

# Dental Findings: High Caries Rate

## School Health Services Evaluation Study

MANUEL C. W. KAU, D.D.S., and
KATHERINE J. EDGAR, M.D.,* *Honolulu*

• *Multiphasic screening of 1,064 fifth-grade children on Oahu showed that 20 per cent had major adverse conditions; 97 per cent had dental caries; of their average complement of ten permanent teeth, seven were decayed (or missing, or filled). Half the adverse conditions recorded were unknown to the parents until reported to them by the school. In 56 per cent of cases, parents took no corrective action. Lack of finances was cited only half as often here as it was in a mainland study, as a reason for inaction.*

MOUTHS of 1,064 fifth-grade children in Honolulu public schools were examined by Dr. Masaichi Oishi in 1958, as one phase of multiphasic examinations. The dental section of the School Health Services Evaluation Study[1] was under the guidance of Dr. J. R. Robinson.† Examinations were made with mouth mirrors, explorers, and a dental spotlight. Compressed air was also available.

The fifth-grade children examined in this study may be considered to be in a period of dental development frequently referred to as the "mixed dentition" stage. While these children usually will have eight anterior and four permanent molar teeth, the bicuspid positions frequently are occupied by primary or deciduous teeth.

### ADVERSE CONDITIONS RECORDED

Adverse dental conditions that were more than minor were recorded for both primary and permanent teeth and cannot be separated. Any oral condition that was in the opinion of the examiner a more than minor health hazard to the child was recorded as an adverse dental condition.

The DMF rate is the most commonly used yardstick to measure dental caries attack rates. This rate specifies the number of teeth that are decayed, missing, or filled. Since the missing and filled teeth have usually been decayed, the DMF rate is considered to indicate the number of teeth that have been attacked by caries.

In doing the examinations, the examiner was instructed to consider any tooth with a cavity, apparently resulting from dental caries, as a decayed tooth. Where a cavity existed in a filled tooth, only a decayed tooth was recorded.

### FINDINGS

Among 1,064 students examined, 217 (20%) had 236 dental conditions that were more than minor (Table 1). Adverse conditions due to dental caries affected 13 per cent of the students.

TABLE 1.—*Per cent of students with four types of adverse dental conditions among 1,064 students.*

| ADVERSE CONDITIONS | NUMBER OF STUDENTS | PER CENT OF STUDENTS |
|---|---|---|
| Decayed | 137 | 12.9 |
| Malocclusion | 94 | 8.8 |
| Gingivitis | 4 | .4 |
| Debris | 1 | .1 |

A previous study[5] shows that Hawaii's children in this age group have, on an average, .08 primary teeth per child indicated for extraction. In the present study, .13 adverse decay conditions per child were found, encompassing the primary and permanent dentition. The difference of .05 may be attributable to adverse conditions of the permanent teeth. While this figure is low, it indicates that difficulties in the permanent dentition have already begun even before the eruption of the full complement of permanent teeth, exclusive of third molars or wisdom teeth.

Further evidence that dental caries begins to destroy the permanent dentition at an early age is found in the DMF rate (Table 5). The average number of teeth missing (extracted) per child at this early age has already reached .2.

Clinical malocclusion is estimated to occur in

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the United States in approximately 50 per cent of the population below 14 years of age.[2,3] In this study 94 of the 10-to 11-year-old children, or 8.8 per cent, were found to have adverse malocclusion. Apparently, a large number of malocclusions were determined by the examiner to be minor. Of the 94 malocclusions, 25 were under orthodontic treatment. Of the 137 carious teeth which were other than minor health hazards, 35 were under treatment.

### GINGIVITIS RARE

Gingivitis and unclean teeth were recorded as adverse for .4 and .1 per cent, respectively, of the sample children. The infrequency of these conditions is probably due to the transitional stage of the teeth of fifth-grade children. Many permanent teeth are found to be partially erupted or unerupted at this stage and oral hygiene is easier to maintain. Good oral hygiene and fewer periodontal or gum conditions are positively correlated.[4]

TABLE 2.—*Percentage distribution of 236 adverse dental conditions.*

| ADVERSE CONDITIONS | NUMBER OF CONDITIONS | PER CENT OF ADVERSE CONDITIONS |
|---|---|---|
| Decayed | 137 | 58.1 |
| Malocclusion | 94 | 39.8 |
| Gingivitis | 4 | 1.7 |
| Debris | 1 | .4 |
| TOTALS | 236 | 100 |

Of four children with severe gingivitis, only one was receiving treatment.

Table 2 shows the percentage distribution of 236 adverse conditions found. Of the adverse dental conditions, 58 per cent resulted from dental caries. Malocclusion accounted for 39 per cent, while 2.1 per cent were due to gingivitis and unclean teeth. As expected, dental caries constitutes the most prevalent dental problem among fifth grade children.

Data on caries attack rate, as distinguished from adverse dental conditions of all types in the mouth, was also collected. Of the 1,064 children, 1,032, or 97 per cent (Table 3), had teeth that had been previously attacked by caries. Only three per cent of the fifth-grade children escaped the ravages of tooth decay.

TABLE 3.—*Distribution of all children examined by the number of permanent teeth attacked by caries.*

| NUMBER OF TEETH ATTACKED BY CARIES | NUMBER OF CHILDREN EXAMINED | PER CENT OF ALL CHILDREN |
|---|---|---|
| 0 | 33 | 3.1 |
| 1-5 | 336 | 31.5 |
| 6-10 | 501 | 47.0 |
| 11-15 | 171 | 16.1 |
| 16-20 | 22 | 2.1 |
| 21-25 | 1 | .1 |
| 26-30 | 1 | .1 |
| one or more | 1032 | 96.9 |

### 70% OF TEETH ATTACKED

The average child had 7.2 teeth attacked by caries. This represents approximately 70 per cent of his erupted permanent teeth (Table 5). Of these decayed teeth, 4.3 were filled while 2.7 remained unfilled. These figures correspond closely to the DMF figures previously published as baseline DMF rates for Hawaii's children (Table 4).

As most of the dental examinations were completed during the last half of the school year, the decay rates from this study may be compared with those of the 11-year-old group in the 1958 baseline study.[5] Compared to similar studies on mainland children, the Hawaii decay rates are high.

Students with adverse dental conditions were investigated further in the study to determine whether the presence of these conditions was known to the parents or schools, or both, before the study was conducted.[1] It was found that 51 per cent of all adverse dental conditions were unknown to parents until they were identified at the

TABLE 4.—*Number of DMF (Decayed, Missing, and Filled) permanent teeth per person among children 5-16 years of age attending the public schools, State of Hawaii, 1958.*

| AGE AT LAST BIRTHDAY | NUMBER OF CHILDREN IN SAMPLE | DECAYED TEETH (D) | MISSING TEETH (M) | FILLED TEETH (F) | DMF TEETH |
|---|---|---|---|---|---|
| 5 years | 4,090 | .08 | — | .03 | .11 |
| 6 " | 5,044 | .41 | .01 | .30 | .72 |
| 7 " | 5,155 | .77 | .02 | 1.00 | 1.79 |
| 8 " | 5,301 | 1.02 | .07 | 1.69 | 2.78 |
| 9 " | 5,212 | 1.29 | .11 | 2.35 | 3.75 |
| 10 " | 5,295 | 1.68 | .19 | 3.25 | 5.12 |
| 11 " | 4,455 | 2.06 | .30 | 4.12 | 6.48 |
| 12 " | 2,582 | 2.78 | .44 | 5.23 | 8.45 |
| 13 " | 2,858 | 3.10 | .61 | 6.59 | 10.30 |
| 14 " | 2,037 | 3.40 | .74 | 7.22 | 11.36 |
| 15 " | 2,244 | 2.86 | .98 | 8.80 | 12.64 |
| 16 " | 1,278 | 3.32 | 1.45 | 8.59 | 13.36 |

TABLE 5.—*Average number of permanent teeth attacked by caries among 1,064 fifth-grade school children.*

| | NUMBER OF TEETH | AVERAGE NUMBER PER CHILD |
|---|---|---|
| Decayed | 2896 | 2.7 |
| Missing | 206 | .2 |
| Filled | 4606 | 4.3 |
| DMF TOTAL | 7708 | 7.2 |

TABLE 6.—*Distribution of adverse dental conditions by awareness of these conditions.*

| | TOTAL FOR ALL TYPES OF DENTAL CONDITIONS | PER CENT OF ALL TYPES OF DENTAL CONDITIONS |
|---|---|---|
| Not known to school or parent | 58 | 24.6 |
| Known to parent only | 28 | 11.9 |
| Known to parent and school before school examination | 11 | 4.6 |
| Identified at school and reported to parents | 121 | 51.3 |
| No information on above | 18 | 7.6 |
| TOTAL | 236 | 100 |

school and had been reported to parents (Table 6). Twenty-five per cent were not known to either school or parents; 12 per cent were known to parents only.

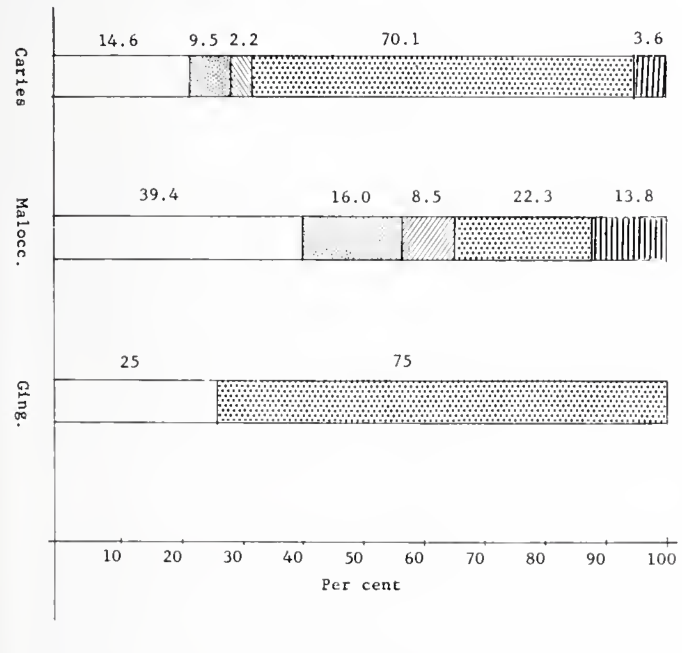
By specific conditions, 70.1 and 75 per cent (Chart 1) of the adverse (more than minor) dental caries and gingival conditions were identified in schools and reported to parents who had no previous knowledge of the existence of these conditions.

### HYGIENE PROGRAM

The high per cent of dental caries and gum conditions that were identified at school and reported to parents are due to an extensive dental hygiene program provided by the State. Dental hygienists enter into nearly every public school and some private schools each year to inspect the teeth of students, apply topical fluorides to teeth, and assist in dental health education.

Only 23 per cent of the adverse malocclusions were identified at school and reported to parents. The lack of a clear definition of adverse malocclusion is probably responsible for the low percentage of these conditions identified by dental hygienists.

To obtain information on the correction status of adverse dental conditions, the parents were asked if the known conditions were being corrected or if there was a specific reason why they had not been corrected. Information on the treatment status of 160 adverse conditions was received (Table 7). Of 160 cases with adverse conditions, 39 per cent had not tried to obtain treatment; no reason was given for this inaction. Thirty-eight per cent were being treated at the time of the examinations. Of those who gave reasons why no action was taken, 17 per cent cited lack of finances. This figure is low compared to the nationwide figure of 33 per cent found to defer needed dental care because of lack of finances, according to a Health Information Foundation research project.[6] Lack of facilities for treatment was not a reason for lack of care.



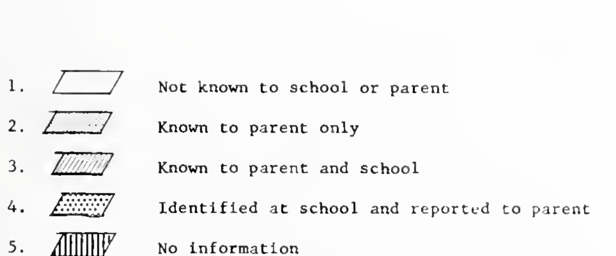




CHART 1.—*Percentage distribution of school's and parents knowledge of the presence of adverse dental conditions.*

TABLE 7.—*Distribution of 160 adverse dental conditions by treatment status.*

| TREATMENT STATUS | TOTAL FOR ALL TYPES OF DENTAL CONDITIONS | PER CENT OF ALL TYPES OF DENTAL CONDITIONS KNOWN TO PARENTS |
|---|---|---|
| *Correctable condition* | | |
| A. No action taken—reason not given | 63 | 39.3 |
| B. No action on doctor's advice | 9 | 5.6 |
| C. No action due to lack of finances | 27 | 17.0 |
| D. No action due to lack of facilities | 0 | 0 |
| Treatment terminated incompleted | 1 | .6 |
| Presently being treated | 60 | 37.5 |
| TOTAL | 160 | 100 |


### SUMMARY

As part of the multiphasic screening of a representative sample of 1,064 fifth grade children on Oahu, oral examinations were performed by a dentist.

Data on adverse dental conditions, other than minor, were tabulated separately from data on caries attack.

Of the students examined, 20 per cent had adverse conditions that were other than minor.

Dental caries attacks were evident in 97 per cent of the children. The average child had 7.2 decayed, missing, or filled teeth.

Of the adverse dental conditions found, 51 per cent were unknown to parents but were identified at school and reported to parents. ■


### REFERENCES


1. Edgar, K. J., and Spicer, R. A.: A preliminary report; school health services evaluation study, HAWAII MED. J. 19:299-304 (Jan.-Feb.) 1960.
2. McCall, J. O.: A study of malocclusion in preschool and school children. Dental Items of Interest, 66:131, 1944.
3. Orthodontic Treatment. Consumer Reports, 22:434 (Sept.) 1957.
4. Greene, J. C., and Vermillion, J. R.: The oral hygiene index: a method for classifying oral hygiene status, J. Am. Dent. Assn. 61:172(Aug.)1960.
5. Kau, M. C. W., Robinson, J. R., and Bennett, C. G.: Dental caries among Hawaii's school children, J.A.D.A. 63:653 (Nov.) 1961.
6. Friedson, E., and Feldman, J. J.: The public looks at dental care, J.A.D.A. 57:325 (Sept.) 1958.

*A projected biological study becomes primarily a socio-psychological one, providing unexpected conclusions of public health interest.*

# Kohala Fluoridation Program

## Progress Report

F. L. TABRAH, M.D., and
B. M. EVELETH, M.D., *Kohala*

• *A voluntary program of fluoride tablet administration for the prevention of dental decay in a relatively isolated plantation community was begun in 1957. Following newspaper and direct-mail antifluoridation propaganda campaigns, and despite educational efforts within the community, participation had dropped to about half the children after two years, and about 12 per cent after three years.*

IN JUNE, 1957, the Medical Department of Kohala Sugar Company, Kohala, Hawaii, began a study of the effectiveness of fluoride tablet ingestion among the children of Kohala District, in an effort to reduce the high level of dental caries prevalent there.[1]

Kohala, on the northwest tip of the largest island in the Hawaiian chain, is a relatively isolated area. Most of the population works for the Kohala Sugar Company Plantation, which undertook the cost of the study. The remainder of the people are employed by scattered ranches, or are small shopkeepers or truck garden farmers.

The children attend one of three public schools in the area. The population is about 3,500 to 4,000 persons, with about 1,500 children under 12.

The population is quite stable, and when the study was begun few urban changes had come to the area. Water supplies are complex, and fluoridation is impractical because of the use of multiple sources. There are in Kohala one dentist, two physicians, a public health nurse, and a sanitarian. The area is served by a small but well-equipped county hospital for diagnostic services and in-patient care.

P. O. Box 98, Kohala, Hawaii.

### UPS AND DOWNS

During the early months of the Kohala caries prophylaxis program, it was accepted enthusiastically by much of the population, and about 90 per cent of the parents in the area used the tablets as provided. However, following the denouncement of fluoridation as a whole by a physician elsewhere on the island, and the rapid inflow of antifluoridation literature into the district, the program of daily fluoride ingestion rapidly waned to a coverage of about 12 per cent.

In December, 1958, in response to a request to the Hawaii State Health Department for assistance in public education, Miss Christine Ling of the Office of Health Education designed and conducted a study (1) to determine the number of children still taking fluoride, (2) to determine local differences in acceptance of the program, and (3) to sample attitudes toward the program. The following questionnaire was distributed through the Kohala schools:

(1) I live in..........................................................................
(2) I have............................children
(3) They are............................(ages?)
(4) Circle those taking anti-decay pills.
(5) Tell why you are or are not giving the pills.

The questionnaires, when completed, were mailed by the public health nurse to the Office of Health Education for analysis. The survey had followed almost immediately an intensive informational program on fluoridation, involving outside speakers, the film, "The Truth About Fluoridation," and numerous public lectures by Kohala physicians, the sanitarian and the public health nurse. All of this appeared to be well accepted by the community.

Replies to the questionnaire reflecting the status of the fluoridation program in May, 1959, after about two years of operation, revealed that a remarkable resistance to the program had developed, despite not one single instance of toxicity or any "overdosage" accidents.

Among 501 children under 13 years of age (roughly one-third the number under 13 years old in the district), only 52 per cent were taking the tablets regularly. Among 160 children under six years of age, 104 or 65 per cent were being given the tablets. Spotty areas of great resistance to the program seemed to be present in some plantation housing areas (camps), but no valid explanation could be found for this fact.

Following the public announcement of the above figures on fluoride ingestion, increased efforts were made to educate parents through PTA talks, posters, explanatory notes in the local weekly papers, and instruction of parents in well baby clinics.

### DAMNED BY ASSOCIATION

Concomitantly, a further flood of antifluoridation literature arrived in the district by individual mailings to every boxholder. Much of this literature flailed public water fluoridation, but was so worded that fluoridation by any method was condemned by association.

At the present time, the ingestion rate among children who should be taking daily fluoride tablets to carry out the original intent of our study is approximately 12 per cent, a figure determined by the dispensary output of tablets. Almost all of these are infants and preschool children.

It is too early to accurately ascertain any reductions in the DMF rate as a result of our program. Further, the number of children steadily taking fluoride has fallen so low as to be without statistical significance.

However, we are impressed with the number of individual parents who favorably compare the teeth of their children born since June, 1957, with those of previous siblings.

It may still be possible to collect these children into a group of perhaps 200 for re-examination for comparison with the untreated control group in the same area.

It must be concluded that, despite a social situation in which a "captive" population, served almost entirely by one medical facility, is offered effective dental decay prophylaxis by a simple means, at no expense, the program fails because of fear engendered by antifluoridationists, and because of the loss of interest that often accompanies any long-term procedure.

### CONCLUSION

Our opinion is that fluoridation on an individual basis, although perhaps effective for a few comprehending families, is a total failure from a public health standpoint. Similarly, the fluoride-containing vitamin supplements for infants that have recently come on the market can hardly be successful (except commercially) since most vitamin routines are sporadic after infancy, and our experience indicates that fluorides are not likely to be continued separately during childhood. ■

[1] Tabrah, F. L., and Eveleth, B. M., Fluoride tablets for dental decay, preliminary report, HAWAII MED. J. 17:241-243 (Jan.-Feb.) 1958.

*Is appendicitis a dying disease, and appendectomy a dying operation? Evidence suggests that this may be so.*

# A Twenty-Six Year Study of Appendectomies

NILS P. LARSEN, M.D., *Honolulu*

• *Appendectomies—both incidental, and for acute appendicitis—are being done far less often today than a decade or two ago, both in Hawaii and on the mainland. The reasons for this are obscure. It seems probable that appendicitis itself is less common; why, we do not know.*

On THE 27 sugar plantations in Hawaii, located on the four major islands, all morbidity and mortality are reported monthly to a center in Honolulu. The accompanying graph shows the change in rate of the appendiceal operations over the last 26 years. A comparison of the rates on each of the four islands is made. Half the people are Filipinos, the other half Japanese, with a smattering of all the other races of Hawaii. The rates are based on the number of cases per 100,000 population.

In 1902 the Prince of Wales was to be crowned King. A few days before this event, he was seized with severe abdominal pain. The best doctors in England were summoned to his bedside. They agreed on the diagnosis of perityphlitis (appendicitis). They also agreed on the treatment in vogue in England at that time: to keep the patient under opium and wait until an abscess points, at which time it should be lanced and drained. That took three weeks. The King recovered. That treatment cured 60 per cent of the cases.

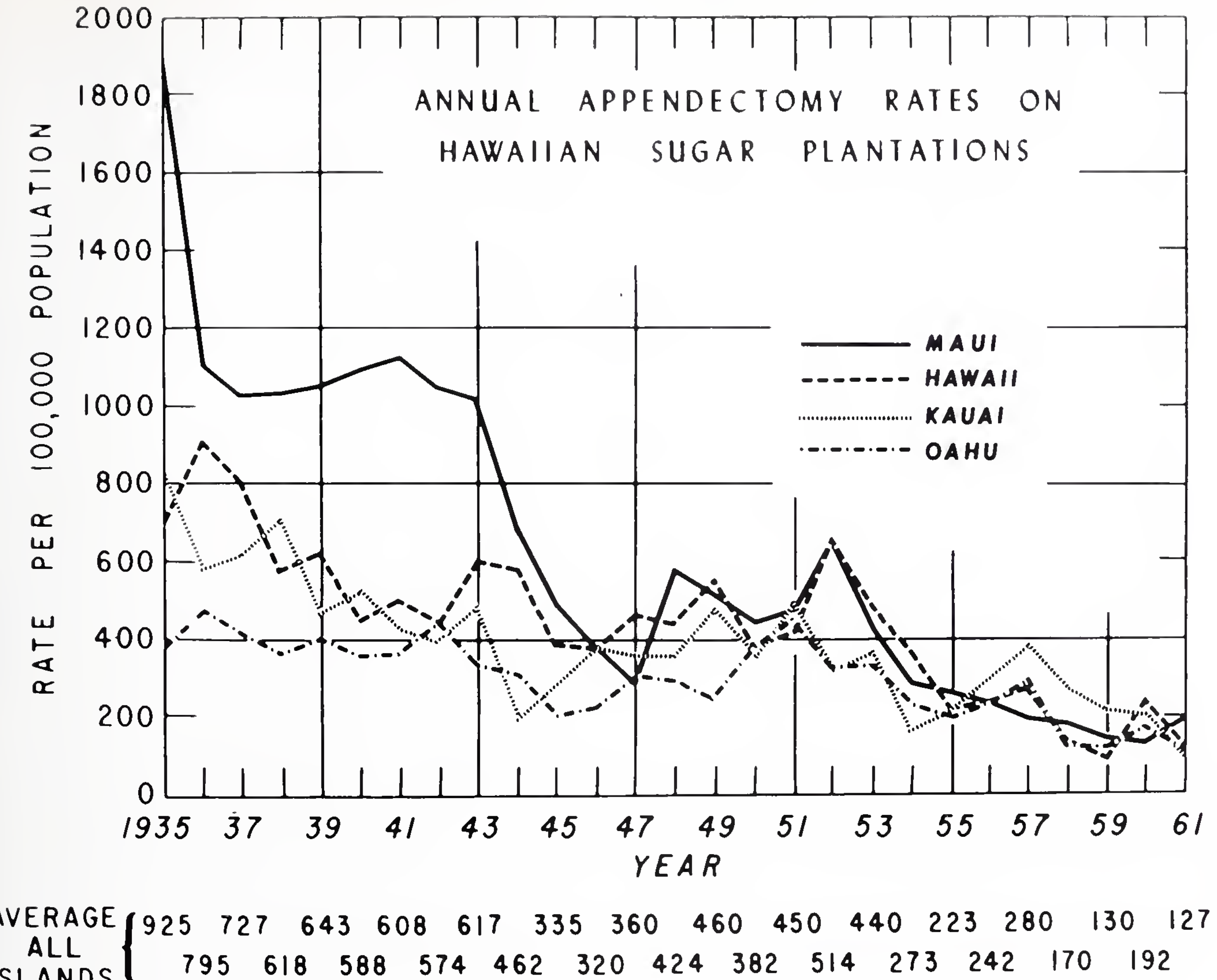
In 1962 the Prince of Wales was seized with abdominal pain. He was placed in an ambulance, driven fifty miles to London, and the appendix was removed within twenty-four hours of the onset of pain. That treatment cures 100 per cent of the cases. The change in the understanding and the treatment of acute appendicitis during those sixty years is well illustrated by what happened to these two heirs to the throne of England.

This condition has been written about for almost 100 years. By 1889, 2,500 books and articles had been published about various phases of this disease.[1] Yet, in 1936, 25,000 people in the U.S.A. still died of it.[2] In 1937, the Pennsylvania Medical Society conducted a complete statistical survey on 20,000 cases.[3] Their answers seemed so convincing they are worth repeating for this study. Of 9,061 cases (47%) admitted to a hospital during the first 24 hours, 124 (1.37%) died. Of 5,792 (30%) admitted during the second 24 hours, 223 (3.85%) died. Of 1,778 (9%) admitted during the third 24 hours, 105 (5.9%) died. Of 2,767 (10%) admitted 72 or more hours after onset, 206 (7.4%) died. Spreading peritonitis caused 92 per cent of the deaths. Of those who received no laxative, one out of 62 died. Of those who were given one laxative, one in 19 died. Of those who had received more than one laxative, one in 9 died.

The evidence was clear-cut. In the U.S.A., a campaign was conducted to warn people: (a) With the onset of abdominal pain, seek medical advice since delay is frequently the cause of death; (b) Don't take laxatives for abdominal pain, since tragedy often results from such treatment.

Since the mid-thirties, the number of operations and the death rate from appendicitis have steadily decreased. A summation of these two figures was put in graph form by *New Materia Medica* in 1959; it indicated a drop in operations and deaths of some 66 per cent.[4] The following reasons for the decrease were given: (a) improved medical diagnosis; (b) use of sulfonamides and antibiotics;

1527 Keeaumoku St.




(c) better nutrition; and (d) better education of the public regarding the disease.

Puestow[5] believed "the incidence of the disease has declined at about the same rate as the operations." Glenn,[6] in 1960 in reviewing this subject, wrote, "appendicitis was present but relatively rare in civilized countries until the end of the 19th century. From then until the middle thirties a pronounced increase in cases occurred but the rate is now on the wane." This opinion is verified by many studies, including the figures from the Navy, where there might well be reason to remove an appendix on suspicion.

The rate rose from 6 in 1916 to 14 in 1935. Since then it has decreased to 4 per thousand.[7]

### HAWAIIAN FIGURES

We believe the figures from the Hawaiian plantations throw further light on this problem. Figure 1 shows Maui with a rate in 1935 of 1,842 appendix operations per 100,000 population! Kauai had a rate of 827; Hawaii, 698, and Oahu, 375. Because of this great difference in rates on the different islands, an attempt was made to find the cause. We concluded that the reason was a difference in the philosophy as to what constituted a need for surgery. The doctors on Maui believed that for any abdominal pain the safest treatment was immediate surgery.

On Oahu, the doctors were proud of their diagnostic abilities. They believed the removal of a normal appendix indicated poor surgical diagnosis and judgment.

### U.S.A. "SERVICE STRIPE"

Another cause for the high rate, especially among the Filipinos, was their desire to have their appendix out before they returned to the Philippines. In the Philippines, it had been widely publicized that General Eisenhower, before he left for his post there, had had a prophylactic appendectomy. Hence, on coming to Hawaii, Filipinos had a chance to follow in the footsteps of General Eisenhower, and get a paid vacation besides. When they returned to their country, it was said, they proudly showed this "service stripe" from the U.S.A.

One of the Maui doctors (his plantation had

shown a rate of 2,400 the year before), when told he should be ashamed to have a rate twice that of the other doctors, replied, "I am not ashamed. My patients all get well. The other day I found 14 Filipinos standing on the back porch of my hospital. I said, 'What's the matter, boys.' They patted their right lower abdomens and replied, 'Boss, we got appendicitis.' I turned to the nurse and said, 'Prepare surgery!' I removed all 14. They recovered without any complications."

This attitude, however, led to complications on another plantation. That plantation's manager came into the doctor's office one day with 100 cards of laborers whose appendices had been removed. He said, "I do not object to an operation for appendicitis and I don't intend to tell my doctor how to practice medicine. But I do want him to be sure that an operation is necessary. This operation puts a man in the hospital for a week, off work for a month and he is no damn good for a year." The rate on that plantation dropped markedly during the following year.

### DRASTIC DROP

A summary of all plantation reports showed that the average appendectomy rate per year for the five years in the thirties (through 1939) was 472, with 42 ruptured, per 100,000 population. The same plantations for the five years in the fifties (through 1959) showed an average yearly rate of 209 operations, with 20 ruptured and no deaths. The drop for the 20-year period for this operation (based on an average of five years) for Maui was 83 per cent; for Hawaii, 75 per cent; for Kauai, 54 per cent, and for Oahu, 52 per cent. There have been no deaths from appendicitis since 1953. During the same period, the operations for "other major surgery" rose 19 per cent. That should indicate better, rather than poorer, surgeons. During the past four years, the total plantation rate for this operation has been under 200. For 1961, it was 127.

A questionnaire to seek the reasons for such a decrease was answered by 22 plantation surgeons. All answered that better diagnosis was one factor. Tissue committees and microscopic analyses, not available in the thirties, were also listed as factors. However, there were no tissue committees from 1935 to 1945, when the greatest drop occurred.

Eleven believed that the use of antibiotics had a bearing on the decrease, since the former urgency to operate to save a life was no longer so applicable. Six thought a change in diet had played a role, four that the wide use of vitamins may have helped by improving the general health. Another possible cause mentioned was the improvement in general health, due to better diet, shorter hours of work, and therefore less fatigue and better resistance.

The parasite problem was mentioned, but there were more workers with intestinal parasites reported in the fifties than in the thirties, hence it would seem the parasites hardly played a role.

That fewer Filipinos wanted their appendices out was also mentioned, as well as a change in the surgical attitude due to the arrival of younger and more recently trained surgeons. Surgeons no longer removed an appendix on request. It is interesting to note that though the difference in rates between the islands was large in the thirties, during the last ten years the rate has been nearly the same for all the islands.

### MAINLAND CONCURS

To check whether mainland surgeons had experienced this same amazing drop, we wrote to a series of mainland general hospitals. We had written to these hospitals and had on file their appendix operation rates for five years ending with 1937. Twenty hospitals sent us their five-year record ending in 1957. All the hospitals showed a striking decrease in the number of appendix operations. Four California hospitals reported a decrease of 77.3 per cent; four midwest (Indiana, Minnesota, Wisconsin) hospitals, 77.6 per cent decrease; three southern (South Carolina, Missouri and Georgia) hospitals, a decrease of 77.7 per cent; five eastern (Connecticut, Maine, Massachusetts) hospitals, 85.4 per cent decrease. From Texas, one hospital reported a decrease of 92 per cent.

In Honolulu, a general hospital, comparable to mainland hospitals, had a decrease of 80 per cent. These figures were based on the number of primary appendicitis operations per 100,000 admissions.

### REASONS FOR DROP

To find out if the Hawaii members of The American College of Surgeons agreed and had ideas as to the cause(s), of the decrease, a questionnaire was sent to each. Sixteen surgeons answered. A few of these had had twenty or more years of experience. Some had had too short an experience to give an opinion. Everyone agreed that if the diagnosis was definite (acute purulent appendicitis), immediate operation was imperative. A surgeon with extensive experience wrote, "I am sure there has been a definite decrease in the incidence of acute appendicitis, in both children and adults, during the past ten to fifteen years." A second surgeon wrote, "It does not seem likely to me that the rate of appendicitis . . . is really any less than it was before; it is just that we are being more careful in our decision to operate by reserving the operation for the patient who actually has organic disease of the appendix or those in whom a differential diagnosis is impossible."

All agreed that there were many cases of abdom-

inal pain with a doubtful diagnosis. In these, some felt antibiotics gave a safe opportunity to observe cases longer, in order to make a correct diagnosis.

However, others believed antibiotics should never be given in doubtful cases because their use might cloud the diagnosis. There is considerable difference of opinion on this score in the literature. Harrison,[8] Dietrick,[9] and Collins[10] believe antibiotics produce dangerous masking effects. They gave case reports to prove the danger of using antibiotics and one said, "It has been frequently more hazardous to administer antibiotics than to withhold these potent drugs."

On the other hand, Coldrey[11] recommended conservative treatment, having used this in 471 cases with only one death. These 471 cases all came to his attention more than 24 hours after onset. He gave, however, huge doses of antibiotics —e.g., six hourly injections of 250,000 units of penicillin plus 0.5 gm streptomycin; at times he used chloramphenicol, Terramycin, or other antibiotics.

### MORBIDITY REDUCED

All local surgeons responding to our questionnaire agreed that the antibiotics had helped to cut down the morbidity and the mortality in the treatment of the complications of appendicitis. Because of this aid, some mentioned, there was better wound healing in the complicated cases and that wound hernias postoperatively had disappeared.

Some felt that when the diagnosis was doubtful, and the symptoms were due possibly to acute lymphangitis, this condition might clear with antibiotics and thus progression to an obstructive appendicitis might be prevented. Two mentioned the fact that a tremendous number of appendices had been removed during the last thirty or more years incidental to some other operation, hence there were fewer appendices left to become inflamed. Though this would be done often during gynecological surgery, there is also a report of an examination of 27,718 men, 18 to 65, of whom 5,154 (18.5%) had abdominal surgical scars.[12]

Several mentioned the wholesome deterrent effect of a tissue committee. Kuakini Hospital of Honolulu[13] reports that, eight years before the tissue committee began to function, 30 per cent of the appendices removed were normal (microscopically). From 1958 to February, 1962, of 542 appendices removed, only 11 per cent were found to be not inflamed. The majority mainland opinion accepts up to 20 per cent normal appendices as possible honest diagnostic mistakes.[14]

One of our local surgeons[15] wrote, "Incidental appendectomies have probably numbered three to four times the number of inflamed appendices in the past ten years." He also mentioned that formerly, during his thirty years of practice, five to ten per cent of his appendiceal operations were for subacute or chronic appendicitis. These cases, he wrote, have disappeared. In the thirties and early forties, he added, he saw many more cases of acute appendicitis. At times, he would have as many as six cases in the hospital at one time. At present, a single case is uncommon. In the first twenty years of his practice, he operated upon 350 patients with acute appendicitis. During the last ten years, he had operated upon less than 100, even though his surgical experience and reputation were greater and there were now fewer "occasional surgeons."

### SUMMARY

There has been a marked drop in appendectomies since 1935, both on Hawaiian sugar plantations and in the general U. S. experience. A drop in acute appendicitis and in ruptured appendices has also been seen. Suggestive reasons for the drops are enumerated. ■

### REFERENCES

1. Klingensmith, William: Establishment of appendicitis as a surgical entity, Texas State J. Med. 55:878 (Nov.) 1959.
2. McKinney, Mark W.,: A study of surgical broth therapy for suppurative appendicitis, King County Hosp. Bull. 4:8 (Oct.) 1936.
3. Penn. Med. Soc.: Report of the first state-wide survey of acute appendicitis mortality, The Penn. Medical Jour. 43:1145 (May) 1940.
4. New Medical Materia: U.S.A. death rate from appendicitis, 1:20 (Oct.) 1959.
5. Castleton, E. B., Puestow, C. B., Sauer, D.: Is appendicitis decreasing in frequency?, A.M.A. Arch. of Surg. 78:794 (May) 1959.
6. Glenn, Frank, Thorbjarnarson, B.: Present status of appendicitis, N. Y. State J. Med. 60:15-20 (May 15) 1960.
7. Collins, S. D.: Surgical experience in selected areas of the United States Public Service, Monograph No. 38, Dept. of Health, Education, and Welfare, 1956.
8. Harrison, Paul: Appendicitis and antibiotics, Am. J. Surg. 85: 160 (Feb.) 1953.
9. Dietrick, R. B., Byrd, C. W., Lawson, J. A.: Adverse effects in acute appendicitis before diagnosis, Annals of Surg. 148:958 (Dec.) 1958.
10. Collins, D. C.: The dangerous masking effect of penicillin in acute perforative appendicitis with secondary peritonitis, Ann. West Med. and Surg. J. 5:2 (Feb.) 1951.
11. Coldrey, Eric: Five years of conservative treatment of acute appendicitis, Jour. Internat. Coll. Surg. 32:255 (Sept.) 1959.
12. D'alonzo, C. A.: Industrial medicine and surgery, J. Health Exam. in Industry 24:75 (Feb.) 1955.
13. Stemmermann, Grant N.: Personal communication with Grant Stemmermann, M.D., Head of Laboratories, Kuakini Hospital, Honolulu, Hawaii.
14. Thieme, E. T.: Appendicitis—a fifteen year survey, A.M.A. Arch. Surg. 70:207 (Feb.) 1955.
15. Yamauchi, Shoyei: Personal communication. (Oct. 23) 1961.

*"Purgation means perforation*
*In the appendix, meek and mild.*
*Food and drink annoy it, and*
*Cathartics drive it wild."*

—ANON.

*The disabling pain of gout may be relieved completely for the duration of any attack by an interspinous injection of procaine.*

# A Method for Instant Relief of Pain in Cases of Gout

FREDERICK LEET REICHERT, M.D.,* and
J. ALFRED BURDEN, M.D.†

• *In 10 patients, in various stages of acute gout, the injection of 2 or 3 cc of 2% procaine into the space between the spinous processes of the appropriate vertebrae resulted in immediate relief of pain, lasting throughout the attack.*

MOST OF the gouty patients seen at the Haliimaile Dispensary on the Island of Maui have been of Filipino ancestry, and have partaken freely of roast pork and wine.

Relief of their swollen joints can nearly always be obtained by the administration of colchicine 1/100 gr t.i.d., along with Benemid 500 mg b.i.d or t.i.d., for two weeks. In some cases prednisone has also been given. Usually the patients are on sick leave for about one to two weeks.

If the patient comes to the dispensary immediately after the first symptoms, relief from pain has been secured temporarily by the intravenous injection of 2 cc (1 mg) of colchicine. However, if pain has been present for 12 hours or more, the intravenous colchicine only partially relieves it, and then for only a day.

We have found that in ten patients in various stages of acute gout, pain was instantly relieved for that attack by procaine injections into the appropriate interspinous spaces.

### PROCAINE INSTILLED

For the upper extremity, deposits of 2-3 cc of 2 per cent procaine are placed in the potential bursae exterior to the dura between the spinous processes of $C_7$ and $T_1$, and $T_1$ and $T_2$. If injection of these two areas does not give complete relief of pain, the deposits of procaine are made between the spinous processes of $T_2$ and $T_3$, and if necessary between $T_3$ and $T_4$.

For the lower extremity, procaine injections between the spinous processes of $L_2$ and $L_3$, and $L_4$ and $L_5$, and sometimes between $L_5$ and $S_1$, will usually relieve pain in the knee, foot, or ankle.

Immediately after procaine injections, the patients have been surprised to find that they could move, freely and without pain, their swollen and seemingly immobile extremities. Freedom from pain continues until the inflammation of the joint subsides.

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The injected patients are warned that the taking of alcohol in any form will cause a return of their pain. Some have continued to drink despite this warning. Evidence of vitamin and mineral deficiencies have been found in some patients.

### VITAMINS GIVEN

To lessen the frequency of attacks, the gouty patient is put on a course of multiple vitamins and trace elements, using a multimineral tablet high in calcium, magnesium, manganese, and potassium. To ensure the absorption of vitamins and minerals, digestive enzymes, as bile salts and pancreatin, are also given before meals.

During repeat episodes of joint swelling, instant relief of pain may be secured by the interspinous procaine injections. The method of injection with illustrations has been reported previously.[1, 2]

Briefly a #26 gauge hypodermic needle, 1 to 3 cm long, is used to make the deposit of 2 per cent procaine, which seems to be the optimum strength. Other local anesthetic agents have been tried, but the 2 per cent procaine remains the most efficient.

### REFERRED PAIN

A network of blood vessels and many sympathetic nerve fibers are in the loose areolar tissue between the spinous processes external to the ligamentum flavum. Anatomically, the course of these or other connecting sympathetic nerve fibers to the extremity down into the digits has not yet been ascertained. It is a fact, however, that when the procaine injection is being made, transitory referred pain is felt radiating down the extremity. With the injection of 2-3 cc of procaine, instant and permanent relief has occurred throughout the attack of gout.

To prevent reactions, such as lightheadedness or faintness, that may be experienced with 2 per cent procaine, the patients just before injection are given 1 to 1½ gr of phenobarbital which reduces the toxicity of procaine about five times. Any patient known to be sensitive to procaine is given ½ gr of phenobarbital at 2 hours, 1½ hours, 1 hour, and ½ hour before the procaine injections are made.

To insure against the toxic effects of procaine, since pain depletes the adrenal cortex, 1 cc of Upjohn's adrenal cortex extract is given subcutaneously before employing procaine. If the patient tends to bruise easily, 10 mg of vitamin K (Synkavite) is given with the adrenal extract.

### SUMMARY

Ten patients with acute attacks of gout in the upper or lower extremities have been immediately, and for the duration of the swelling, relieved of pain by 2 per cent procaine injections in the appropriate interspinous spaces. Colchicine and Benemid are utilized to reduce the inflammation. Vitamins, trace elements, and multiminerals are given to reduce the frequency of attacks of gout. ■

### REFERENCES

1. Reichert, F. L.: Atypical neuralgia of the chest simulating angina pectoris, Am. Jour. Surg. 88:399 (Sept.) 1954.
2. Reichert, F. L.: Atypical neuralgias of the head. Headaches, so-called migraine and complications of whiplash injuries and the other cervical trauma, Am. Jour. Surg. 89:1213 (June) 1955.
3. Reichert, F. L.: Use of deep procaine injection for the relief of localized pain, Am. Jour. Surg. 91:699 (Apr.) 1956.

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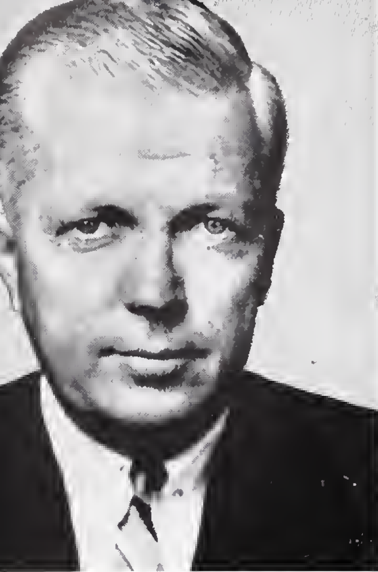
*One of mighty, fabled logger Paul Bunyan's more memorable remarks was that he didn't care if the man on the other end of his crosscut saw rode his end of the saw—but he didn't think he ought to drag his feet. Are you dragging* your *feet? Have you made a donation to AMA-ERF—the AMA Education and Research Foundation? Are you a member of your Chamber of Commerce? Physicians have a special responsibility to be good citizens. Don't let your profession down!*



# *The President's Page*

As this issue of the JOURNAL goes to press, the final days of the election campaign are ending. Our experiences during the past few months should give us a chance to evaluate the effect of our actions and to develop from this study, new modes of action or methods of action which would be more effective in future campaigns. We have two years until the next election to develop these plans, to accumulate the financial reservoir with which these plans can be implemented, and the results developed more to our liking.

During this campaign, a tremendous amount of apathy and lethargy has been noted among the medical profession in Hawaii and also in the medical auxiliary. Cooperative action in these groups fell far short of that required for effective action. If we are to see medical care maintained on a high level, we, as physicians, and we alone, are responsible. There is a movement on foot which we have seen gaining momentum over the years—to convert a personal profession into a mass technical action. We are at the present time undergoing in our country a revolution in medical and social aspects of our lives. That the changes brought about by this revolution are orderly and are based upon democratic processes is the result of the type of government and the mental and emotional stability of our population. This revolution elsewhere is much more ground-shaking and much more convulsive in its effects. This revolution has resulted in changes in the economy of the world. To maintain the necessary personal approach which our profession requires will necessitate tremendous effort on the part of each individual physician, the auxiliary, the nurses and all other individuals who recognize the importance of maintaining the individual's personality so that he will not be lost in the mass of humanity.

In this process we must be careful in the choice of methods which we use to educate the public as to the importance of this approach. Mass immunization programs must not be used to gain approval from the public.

Such mass immunization programs may lead us into a situation from which we may not be able to extricate ourselves. These mass immunizations are quasi socialized processes. Certainly, such programs enhance mass approval of the practice of medicine, and tend to subvert the importance of the personal approach. We must pay no attention, and hold ourselves above the smears thrown at us that we are a union group motivated by self-interest. We, as physicians, know this is not true. In every day of our working lives since we were medical students, our basic motive has been to improve the health of each individual and of our community and our country. We know that this improvement in health of our people and our community would not develop under this plan of socialized medicine because the bad aspects of contemporary medicine would be multiplied and compounded. We must be sure that, whatever medical care the people receive and in whatever form, it is properly constituted; that they receive the best medical care that we have now, and the best medical care that will be developed in the future. This cannot be obtained on an assembly-line basis. The quality of medical care will continue to improve and the distribution of high-quality medical care will also improve. In England, the quality of medical care to the individual is improving because the assembly-line type of medicine is evolving back to the personal approach. How is it doing this? By the growth of prepaid medical care plans and the capacity of the individual under these plans to choose his physician and pay him through insurance payment which he has chosen to meet his problems in the best way.

The ideals of medicine are not lost in the younger physicians. The younger physicians are learning in a new era where new problems are presented. They are men of high quality and they will meet these problems when they arise, just as the present physicians in our older generation are meeting the problems today.

HAWAII MEDICAL JOURNAL

# Editorials

## Regarding the "Swimming Pool" Disease

Tuberculoid skin lesions on the bridge of the nose following injuries sustained while swimming in a public pool were first reported from Stockholm in 1939 by Hellerström.[1]

As to the question of the probable etiology of the swimming pool granuloma I wish to refer to our report published in the *Acta Dermato-Venereologica*[2] and to further knowledge of atypical acid fast bacteria which has been acquired in the meantime through experience in clinics and laboratories in different parts of the world. This may be summarized as follows:

The histologic lesions are not specific for any well-defined mycobacteria, but may be caused by any acid fast bacillus of reduced pathogenicity. In some cases these bacteria may be as described by Linell and Nordén. In other cases[2] the causative organism is obviously very closely related to typical tubercle bacilli except for reduced pathogenicity: they are unable to cause a spreading infection or a typical lupus vulgaris. The extracorporeal habitat of the bacilli (swimming pool water) may perhaps explain the observed change in pathogenicity—which, according to our experience, may be reversible.

As the latest case we observed was localized to the elbow, I do not believe that differences in histology of the skin can explain the differences of the pathological lesions which seem to exist between Linell and Nordén's cases and ours.[3]

Sven Hellerström, M.D.

[1] Hellerström, S.: Contribution a la connaissance de l'infection tuberculeuse primaire de la peau et de la muqueuse, Acta Derm.-Ven. 20:276, 1939.
[2] Hellerström, S., Ericsson, H., and Lagercrantz, R.: Different types of swimming pool infections caused by mycobacteria, Acta Derm.-Ven. 36:249, 1956.
Hellerström, S.: Collected cases of inoculation lupus vulgaris, Acta Derm.-Ven. 31:194, 1951.
[3] Hellerström S.: Über Schwimmbadinfektionen durch Mycobacterien verschiedener Art, Hautarzt 10:473 (Oct.) 1961.

## Give Them *Today's Health*

It seems as though any season these days is "open season" on M.D.s! A favorite indoor, and outdoor, sport, likely for many seasons to come, will be giving one's own impression of how lousy doctors are, how self-interested, how money-mad, how careless for the feelings of the "little people." Might as well brace yourselves.

There are things, however, that we can do to fight back. We can live our lives to belie the liars and storytellers. We can take our rightful places in civic affairs, befitting our educational level, interests and native intelligence.

As another Christmas approaches, there's something more specific we each can do, to prove to our friends and patients, if we have to, that American doctors, singly, and as a group—as the A.M.A.—aren't "all bad."

Each of us has several friends, acquaintances, relatives, and business associates whom we'd like to have know more about us and our work—more, indeed, about themselves and what makes them tick (and sick!).

Your fine Association has provided you with a nearly ideal way of accomplishing all these things at once, in one neat package—or, rather, in twelve neat packages, one each month—a reminder throughout next year that you have thought of your friends, and that you want them to know you better, to understand what you're trying to do, and to know themselves better.

Your Christmas shopping is easily attended to. *Today's Health* has a special Christmas gift offer. For each $4.00 subscription, you can put your message monthly into as many homes as you want and can afford to, in the form of a fine lay magazine on medical and health topics, colorfully made-up and written for the layman.

Look over your Christmas list—young, old, middle-aged, large families or singletons—people you'd like to remember with a small but special gift, or as an adjunct to a larger gift.

Send them *Today's Health*.

You'll be doing them and yourself one big favor.

# Drug Amendments of 1962

The famous—nay, notorious—Kefauver hearings of the past two years, which have cost publishers of medical periodicals (and that includes *you,* dear reader!) thousands of dollars in lost pharmaceutical advertising, have culminated now in the Drug Amendments of 1962 to the Federal Food, Drug and Cosmetic Act, signed into law last month. Briefly summarized, they will have the following effects.

- Quality controls will be imposed on all drug factories.
- Substantial evidence of effectiveness will be required before a new drug can be marketed.
- A drug cannot be marketed (or continue to be marketed) if its labelling is thought by the FDA to be misleading and is not promptly changed.
- The Secretary of HEW can suspend approval of any drug immediately if he believes it hazardous to the public health.
- Clinical trial of new drugs will be very closely regulated, and consent to use of an experimental drug is to be obtained from the patient unless the investigator deems this not feasible or contrary to the patient's best interests!
- Much closer inspection of establishments manufacturing prescription drugs will now be required by law, and facilitated by injunction if need be.
- HEW may designate a standard "official" name for any drug.
- The "official" name of any prescription drug must appear on all labels in letters at least half as large as the brand name.
- The same requirement applies to advertisements of such drugs. Advertisements must also show the quantitative formula, if any, and a true and nonmisleading summary of side effects, contraindications and effectiveness of the drug.
- Batch-by-batch testing will now be required for 35 groups of antibiotic drugs instead of only 5, as at present.
- Physicians must be furnished, on written request to the manufacturer, true and correct copies of all required labelling material for prescription drugs.

Most of this takes effect in May, 1963, but any of it may take effect earlier under applicable regulations.

It is too early to evaluate the impact of all this. Perhaps at the moment we can just be grateful that the thalidomide tragedy and the frenzy of legislative overactivity stimulated by it left nothing worse—at the moment, anyway—in their wake.


**ANNOUNCING THE DATES**

**of the**

**Ninth Congress of the Pan-Pacific Surgical Association:**

**November 5-13, 1963**

**in**

**Honolulu, Hawaii**

***and the***

**First Pan-Pacific Mobile Educational Lecture Seminar:**

**November 13—December 10, 1963**

**in**

**New Zealand, Australia, Thailand, the Philippines, Hong Kong, and Japan**

HAWAII MEDICAL JOURNAL

# This Is What's New!

• Collectors of **hemoglobinopathy** now have two more abnormal hemoglobins to add to their list—**hemoglobin Zurich** and **hemoglobin M Kankakee.** The former was named after a Swiss family in Zurich that developed severe hemolytic anemia after exposure to various sulfonamides and Primaquine. In the Kankakee (Illinois) family, certain members appeared cyanotic from birth due to the presence of an abnormal hemoglobin. Defective construction of the globin portion of hemoglobin apparently led to the poorly reduced iron hemoglobin complex and consequently cyanotic Kankakeese. (*Blood* [Sept. 16] 1962.)

• Although most dermatologists recognize that no agent administered systemically has a specific effect on warts, two current text books of dermatology still advise **intramuscular bismuth** subsalicylate for treatment of **warts.** A recent report indicates that spunk water is still safer than, and as effective as, some kinds of bismuth. A boy, seven and one-half years old, became oliguric, with a blood urea nitrogen of 270 mg per cent, after receiving bismuth thioglycollate IM for small warts on the back of his hand. He managed to survive his acute **renal failure** and was discharged from the hospital, asymptomatic except for warts on the back of his hand. (*Arch. Derm.* [Sept.] 1962.)

• American Cancer Society studies indicate that approximately one-third of all high school students are regular smokers. The most important single factor in deciding on whether or not a **youngster smokes** is whether or not his **parents smoke.** (*A.M.A. News* [Sept. 17] 1962.)

• The **transplantation of a kidney** from one identical twin to another has been performed often enough to make it almost a standard procedure in severe bilateral kidney disease afflicting one of identical twins. The transplantation of kidneys from nontwins has been much more difficult, but success has been reported from various parts of the world. The kidney of a **near relative** with compatible ABO and Rh systems has been used after **irradiation** of the recipient with 430 to 460 rads. One recipient is now alive, two and one-half years after removal of both of his kidneys. The renal function of his transplanted kidney is normal. (*The Lancet* [Aug. 25] 1962.)

• **Medical writing** is often not only dull but uninformative. The most vigorous and eloquent acknowledgment of this should logically come from the great traditional medical centers. It does not. It comes from Calgary, Canada, and Iowa, U.S.A. **Bean of Iowa** and **Scarlett of Calgary** are among the leaders of the revolt against the literary effort of the incomplete physician. The neuter style of most American medical journals is described by Bean as stylistic eunuchoidism. To really appreciate what these people are driving at, read almost any article in a current medical journal or text and then read Osler's textbook description of neurasthenia. Or read Bean and Scarlett in the *Archives of Internal Medicine* and elsewhere.

• Peculiar and often criminal behavior has frequently been attributed to **psychomotor epilepsy.** Patients with psychomotor seizures were compared with patients with "ordinary" epilepsy, using a battery of psychiatric and psychological tests. It was concluded that the psychomotor epileptics had no more psychopathology than the ordinary epileptics. (*Arch. Neurol.* [Sept.] 1962.)

• The diuretic **chlorothiazide** is being used successfully to reduce the excessive urine volume in **diabetes insipidus.** Workers at Harvard and at Edinburgh attempt to explain this seeming paradox. The Harvard workers suggest that the chlorothiazide causes a sodium deficit with a smaller amount of urine reaching the distal nephrons and a subsequent smaller urine volume. The Edinburgh workers take the view that **reduction in water intake** after chlorothiazide is an important factor in diminishing the urinary output. (*Metabolism* [Sept.] 1962.)

• Taking their clue from William Hunter, who noted in 1784 that cyanotic patients obtained relief from faintness by **squatting,** San Francisco researchers have come up with an explanation. Squatting elevates arterial blood pressure, cardiac output, and central blood volume. Squatters with Fallot's tetralogy also have an **increase in arterial oxygen saturation** during squatting, whether at rest or after exercise. (*Am. Heart J.* [Sept.] 1962.) ■

FRED I. GILBERT, JR., M.D.

# On The Night Before Christmas . . .

AND all through the year, may you find happiness . . . success . . . good health . . . and the peace of mind that comes with freedom from worry.

## HAWAII MEDICAL SERVICE ASSOCIATION

**BLUE SHIELD PLAN FOR HAWAII**

**Member, Western Conference of Prepaid Medical Service Plans**

*(Advertisement)*

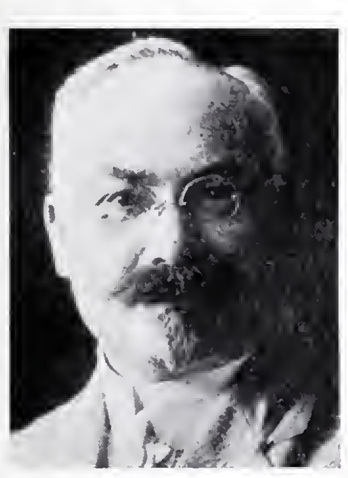
# In Memoriam—Doctors of Hawaii

This is the forty-first installment of In Memoriam—Doctors of Hawaii.

## Carl Keller

Carl Keller was born May 5, 1865, at Coblenz, Germany, son of Anton and Catharina (Nickening) Keller.

His education was received in the schools of Germany until he was 12 years old, and from ages 12 to 17 he attended school in France and Belgium. From 1882 to 1885 he was engaged in the wine business. In the following year, he entered the Empress Augusta Regiment of the German Army as a volunteer and was discharged as a petty officer in 1886. He then became an inspector of a military hospital until 1888. He attended the University of Rome from 1889 to 1891 and the University of Freiburg in Switzerland from 1891 to 1894.



DR. KELLER

In 1894 he was ordained a Catholic priest in the St. Louis, Missouri, diocese. His first parish was in Elston, Missouri, where he served from 1894 to 1900. From there he went to Krakow, Missouri, where he remained until 1908. Centaur, Missouri, was his parish until 1912, when he left the priesthood because of his adherence to modernism.

From 1908 to 1912 he studied at the University of St. Louis while serving as a priest, and in 1912 he was granted his medical degree.

Coming to Molokai November 1, 1912, Dr. Keller practiced there until March of the following year, when he went to Kauai. In June, 1914, he came to Honolulu to practice.

During World War I, he went to New York to offer his services to the Red Cross, but returned when he discovered that more than 2,000 physicians from all parts of the country had already registered.

Dr. Keller married Miss Mary Bryant at Honolulu on December 23, 1916.

About 1917 Dr. Keller left the Islands to settle on the mainland where his death occurred on May 12, 1933, at San Francisco, at the age of 67.

While in Honolulu, he was a member of the Honolulu Medical Society, Medical Society of Hawaii, American Medical Association, the Pacific Club, Phoenix Lodge, and the Hermansoehne Lodge.

## A. C. Buffum

On May 9, 1866, Dr. A. C. Buffum arrived in Honolulu aboard the "D. C. Murray" from San Francisco. In the *Pacific Commercial Advertiser* of May 19 his business card first appears and lists him as physician and surgeon with office and residence at the Aldrich House on Fort Street. The same issue carried the following news item: "Dr. Buffum, lately of California, in which state he has long been a resident and also a member of the Legislature, comes to reside among us and brings high credentials as to his skill as a physician and surgeon."

For the next five years Dr. Buffum carried on an extensive practice, and, while he treated both "foreigners" and "natives," most of his patients were Hawaiians. On Dr. McKibbin's resignation as port physician in January, 1869, the Board of Health appointed Dr. Buffum to that position. In September, 1870, the doctor had his office under Buffum's Hall on Hotel Street and advertised "a good assortment of drugs and medicines, perfumery, soaps, hair oils, brushes, combs, toilet powder, bird seed, cologne, etc. etc. which he sells cheap for cash."

The doctor actively supported the temperance movement by lecturing before various groups and as a member of Ultima Thule No. 1 Lodge of the Good Templars in which he held office. He was also a member of the I.O.O.F., Excelsior Lodge, of Honolulu.

Until March, 1871, Dr. Buffum was a respected member of his profession and of his community. In that month he was charged in Police Court with failing to comply with the law which required physicians to keep a record of their prescriptions and fined $250 and costs. His counsel noted an appeal to the Supreme Court where the following month he was again found guilty and his lawyer filed an

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# Book Reviews

## Missing Books

Please check to see if any of the following books are in your library. If so, please return them to the Hawaii Medical Library.

*Fundamentals of Nerve Blocking* by Vincent J. Collins, 1960.

*Practical Clinical Management of Electrolyte Disorders* by William J. Grace, 1960.

*Hypertensive Disease, Diagnosis and Treatment* by Sibley W. Hoobler, 1959.

*A System of Medical Hypnosis* by Ainslie Meares 1st Ed. 1960.

*Atlas of Obstetric Technic* by J. Robert Wilson, 1961.

*Fundamental skills in surgery* by Thomas F. Nealon, Jr., 1962.

*Anatomy* by E. Gardner, 1960.

### ★Pediatrics, 13th Ed.

*By L. Emmett Holt Jr., Rustin McIntosh, and Henry Barnett., 1395 pp., $18.00, Appleton-Century-Crofts, Inc., 1962.*

PEDIATRICS is the latest edition of one of the few outstanding pediatric textbooks. Holt and McIntosh, who have been revising the original Holt's *Diseases of Infancy and Childhood* since 1927, have added Henry Barnett as a third editor in the present edition. In addition, the contributing authors to this edition have increased to 81 persons.

The broad scope of pediatrics is covered in 41 major sections beginning with Growth and Development and ending with Accidents and Poisonings. The essays are written with much clarity. Each article is followed with specific references for the reader's perusal. Keeping pace with the more recent advances in mdicine, the editors have enlarged upon the sections on metabolism, heart, and the endocrine systems. There is a special section on the collagen diseases and the reticuloendothelioses. The text is filled with excellent pictures and diagrams of x-rays, EKG, microscopic sections of kidneys, and gross physical anomalies. This book is recommended as an excellent basic pediatric reference textbook.

CALVIN C. J. SIA, M.D.

### Clinical Biochemistry, 6th Ed.

*By Abraham Cantarow, M.D., and Max Trumper, Ph.D., 776 pp., $13.00, W. B. Saunders Company, c1962.*

BIOCHEMISTRY has made rapid advances in recent years in the elucidation of not only normal human functions but also pathological processes. The authors of this book have attempted to bridge the wide gap between the basic biochemical knowledge and clinical medicine. The basic science is presented in a concise and clear fashion especially in diagrammatic forms to explain many of the observations or tests one encounters in clinical medicine. In attempting to cover such a broad field, it is easily understandable that they were unable to cover the various fields thoroughly. Additional references which are lacking would have helped if one is interested in pursuing the context further. However, it is an excellent text for undergraduate students of medicine or the progressive clinical practitioners who wish to familiarize themselves rapidly with the wide application of biochemistry to clinical medicine and surgery.

Y. TAKENAKA, M.D., Ph.D.

★ means highly recommended.

### Strabismus

*Symposium of the New Orleans Academy of Ophthalmology. Edited by George M. Haik, M.D., 369 pp., $18.00, The C. V. Mosby Company, 1962.*

THIS SYMPOSIUM on strabismus approaches the subject from an academic viewpoint, rather than from a clinician's. This makes dull reading, although it is thorough in its coverage. The illustrations are excellent and numerous. The bibliography seems in my opinion to be overlimited and not comprehensive enough.

The round table discussions bring in a fresh approach to solutions of muscle problems, although they do not cover the subject with completeness; obviously they were planned to limit such discussion.

This volume will be excellent for reference work; its cost seems excessive, however.

PHILIP M. CORBOY, M.D.

### ★Surgery of the Stomach and Duodenum

*Editors: Henry N. Harkins, M.D., Ph.D., F.A.C.S., and Lloyd M. Nyhus, M.D., F.A.C.S., 736 pp., $28.50, Little, Brown and Company, 1962.*

LITTLE can be added to the foreword by Sir Charles Illingworth summarizing this excellent gastroduodenal encyclopedia. The book is a well-organized, easily readable, complete comprehension of current surgical thinking on the subjects covered. Its authors are some 43 outstanding specialists representing all phases of gastroduodenal surgical problems, including Hawaii's dean of gastric surgery, Dr. J. E. Strode. The volume is up to date in context and objective in its approach, but includes specific preferences and recommendations of the editors, as well as the authors, and is spiced with comments after each chapter from world authorities. Its teaching and reference value is enormous.

FREDERICK B. WARSHAUER, M.D.

### Extracorporeal Hemodialysis Therapy in Blood Chemistry Disorders

*By John E. Doyle, M.D., 353 pp., $11.50, Charles C. Thomas 1962.*

RECOMMENDED to all practicing physicians, Dr. Doyle's succinct presentation makes reading easy. The use of hemodialysis in various abnormal states, including treatment of overhydration and the use of the dialyzer as an ultrafiltrant, is discussed. Dr. Doyle describes the various dialyzers on the market and the advantages and disadvantages of each. Again, this is done in such a manner that the extremely complicated theoretical basis of each dialyzer (i.e., formulas requiring half a page or more to describe the intricate physiological mechanisms) has been nicely omitted. Toxicology is briefly covered for each drug or toxic substance, and the references are quite complete.

NOBORU OISHI, M.D.

### Pediatric Diagnosis, 2d Ed.

*By Morris Green, M.D., and Julius B. Richmond, M.D., 541 pp., $13.00, W. B. Saunders Company, 1962.*

AS INDICATED by the title, this volume is a handy pediatric reference book, in outline form, designed to help in diagnostic problems in the pediatric age group.

It is useful as a quick method to check yourself out

*continued page 148*

# Hawaii Academy of General Practice

Although the general practitioner of medicine has not aimed at formal certification as such, in an age of certified medical specialists, he has formed an association with those of his colleagues who aim to raise the standards within the field.

This association is unique in that it specifies only the basic requirements for initial membership—those of graduation from an accredited medical school, licensure, membership in county and state medical societies, one year of internship plus two-to-three years of further training or experience.

### APPROVED STUDY REQUIRED

The association goes on to require a specified number of hours of approved postgraduate study each three years, or membership will be forfeited. No medical specialty has this requirement.

The American Academy of General Practice aims at building in an incentive to keep physicians from sliding gently but inevitably down the groove to stagnation.

Statistics have indicated the growth of specialism during the past 30 years. The factors involved in this trend are undoubtedly mutliple. A major one is the infinitely greater amount of medical knowledge in the books today. The medical graduate of 30 years ago hung up his shingle with a humble realization that he knew very little about anything; but then, neither did a specialist!

Today's graduate may also step out of medical school, appalled at the prospect of coping with his first patient, but for a different reason. It is natural to expect, therefore, that he will soon narrow his interests and attempt to gain mastery of a specialty.

### FIGHTING THE TREND

The generalist of yesteryear needed only intestinal fortitude to bolster his sense of his own ignorance. Today, the man who dares consider the prospect should be congratulated for superior courage.

What, then, might be the prospect facing such a neophyte with the courage required? Perhaps he sees a vista before him, an ever widening path of experience in human relations, of medical counseling and medical management. He sees patients on all sides, eager and anxious to have a family medical friend. He is able to help and advise with the wisdom he derives from the modern wealth of literature that has smoothed the path of error before his tread. He should also realize that he will be able to call on a team for assistance. Thus the burden of responsibility, that rested so heavily on the solo country doctor of the older generation, is something that the younger man can now share.

The path is, however, beset with man-made discouragements too. Primarily as a result of economic pressures, many of the specialties have shut doors in the face of the generalist. He faces the discouraging prospect of not being allowed to enter into the workshop of medicine—the hospital.

### IS IT FAIR?

Under the somewhat spurious guise of maintaining high standards, and the pious sentiment that "guild members" can do no wrong, many of the specialties are attempting to restrain the younger man eager to gain a partial knowledge and experience. It is understandable that much of this is in reaction to the unscrupulous and ambitious practitioner who spoils it for the rest. However, men have a tendency to shy away from direct confrontation of a nasty issue by passing new and sweeping restrictive rules and regulations in an unfair manner.

The AAGP is a growing, vigorous association whose very growth in size and stature (second only to the AMA in number of members) is a mute denial of the cliché that the GP is becoming extinct.

The organization recognizes the forces of medical economics currently in effect. It is trying honestly and honorably to bring about the resolution of problems of the GP by using rational arguments and promoting commonsense attitudes to dampen the swing of the pendulum from one extreme to the other.

The common aim of the medical profession is for the welfare of the patient. The AAGP represents an effort to make the GP assume his proper position on the team that will continue to accomplish that purpose. ■

J. I. FREDERICK REPPUN, M.D.
*Secretary*

# Notes and News

## Change of Scene

The Park Center Building in Kaimuki is the new location for both **Dr. Roy T. Tanoue** and **Dr. Toru Nishigaya.**

**Dr. Rogers Lee Hill** has temporarily retired from active practice and will reside on the Mainland.

## New Shingles

**Dr. Hing Hua Chun** and **Dr. Richard K. S. Pang** have joined the Chock-Pang Clinic. Dr. Chun is an internist and Dr. Pang a surgeon.

The Medical Group has two new associates, **Dr. Kasuo Teruya**, an otolaryngologist, and **Dr. Ghim L. Yeoh**, a radiologist.

**Dr. Francis H. Soon** has joined **Dr. Edmund L. Lee.** Dr. Soon will limit his practice to obstetrics and gynecology.

**Dr. John A. Harbinson**, pediatrician, who has been associated with both Children's and Leahi hospitals, is now in private practice at 1507 So. King St.

**Dr. Douglas B. Bell II**, has completed his residency training in internal medicine and joined his father's group, the Dickson-Bell Medical Center.

The Medical Arts Building was chosen by **Dr. Roy Isao Iritani** when he started his practice of general surgery.

**Dr. Walter F. Char** chose the 1441 building. His practice is limited to psychiatry.

## Names in the News

**Dr. J. I. F. Reppun's** plea for a more solid program of work, schooling and recreation for the children at Koolau Boys' Home and more recreational facilities for young people generally appeared in the morning paper.

**Dr. Frederick L. Giles** presented awards to the three top winners of the 1962 AAPS Essay Contest. The Council voted to continue this project in 1963.

**Dr. John C. Milnor** announced that the Vocational Development Center is able to accommodate several more retarded teenagers and adults.

The so-called "Medicare" program received many brickbats in the local press. Only one physician defended the Administration's scheme to tie health care into the Social Security system, and he didn't sign his name. The HPLGG's advertisement asking anyone over 65 to fill in a coupon brought in only two answers, which are now being checked.

Local doctors were asked to comment on the Finkbine abortion issue. **Dr. Bachman** advocated a review of the laws. **Dr. Masato Hasegawa** implored the lawmakers "Don't give us the power to kill. Our job is to keep people alive." **Dr. John M. Felix's** letter to the editor pointed out the psychic trauma involved.

Three large public health projects were sponsored by the doctors of the Hawaii Medical Association. Free glaucoma tests were given 1,753 Oahu residents in a two-day clinic in August when 18 ophthalmologists, 48 nurses, and nine Lions Clubs cooperated in setting up registration booths and screening stations. The Annual Diabetes Detection Week again used the services of the Department of Health's Clinitron for a week-long screening program. Operation Swallow was the first statewide mass immunization program using oral vaccine and the first Swallow brought more than 75% of the population to the clinics set up throughout the state. This tremendous program was sponsored by the HMA and spearheaded by each individual county medical society. The HMA's public announcement thanked the many volunteers from professional, civic, and lay groups that cooperated in making the program a success.

HMA doctors were asked by a reporter to comment on the health of Hawaii's press for the *Star-Bulletin's* 50th Anniversary. **Drs. O. D. Pinkerton, Nils P. Larsen, Frederick L. Giles**, and **John M. Felix** praised the press's influence in health education.

The press's attack on the drug industry drew fire from the medical profession. **Dr. S. F. Stewart** took time off from planning global tours for his customers to set the editors straight.

**Dr. Victor M. Mori** represented the Japanese founding group at the Nuuanu YMCA groundbreaking ceremonies.

Two articles written during October told of the help Hawaii residents are receiving at the Rehabilitation Center, which is under the able direction of **Dr. R. Frederick Shepard.**

Local doctors expressed different philosophies when reporters questioned them on whether a doctor should tell a patient he has a terminal disease.

Eddie Sherman in a recent column suggested a testimonial dinner for **Dr. Richard You** for all the time he has devoted to helping athletes and athletics.

**Dr. Harry L. Arnold, Jr.**, was called upon to testify in court. He said a plaintiff's burns were caused by having a permanent wave, but were superficial.

Also in court recently were **Dr. J. Robert Jacobson,** who testified that the defendant in a murder case was not acting under pressure of a mental disorder. **Drs. Winfred Y. Lee** and **Thomas Bennett** were called upon to testify in another murder case.

**Dr. Richard K. C. Lee** was asked to assist Guam in training workers in the medical field.

## Visitors

**Dr. Malcolm Todd** addressed a meeting of the Hawaii Physicians League for good Government and told them that physicians must take steps to protect the health of Americans by helping to elect a Congress which will keep American medicine free of political controls.

**Dr. Harold B. Boyd**, from Tennessee, **Dr. Jeanne C. Bateman**, from George Washington, and **Dr. Francis M. Foster**, from Wisconsin, addressed a meeting co-sponsored by the Hawaii Academy of General Practice and Lederle Laboratories.

## Traveling Doctors

**Dr. Walter B. Quisenberry** returned from the 8th International Cancer Congress held in Russia, noting the international accord that there is more evidence of smoking-cancer ties.

**Dr. and Mrs. Frank S. Spencer** took in the Seattle Fair while they were on the mainland to attend the Pacific Coast Obstetrical and Gynecological Society's Annual Meeting.

**Dr. and Mrs. Verne C. Waite** will be in Atlantic City to attend the annual congress of the American College of Surgeons, and then continue on to New Delhi for the meeting of the World Health Association.

**Dr. and Mrs. Gilbert Halpern** enjoyed a two-month vacation in Europe.

The Kokua Samoa Project took many local doctors into the South Pacific during its final phase, including **Clagett Beck, Charles Judd, Carl Mason,** and **Donald Jones.** After **Drs. Scott Brainard, Unoji Goto,** and **G. J. Liese** return from their survey expedition, the only doctors that will be sent down will be those that are called in on consultation.

**Dr. B. A. Richardson** attended the Seattle meeting of the Western Conference of Prepaid Plans. This organization plans another Hawaii meeting in 1966.

**Dr. Edwin Willett** found a replacement, which enabled him to take a two-month vacation away from his practice on Lanai.

## In the Public Eye

**Dr. Edward Boone** addressed the Hawaii Pharmaceutical Association on civil defense. He said "You can be just as dead if you've been hit by a flying toilet seat as you can by a nuclear blast." He was asked to talk to the National Police Women's Association on Medic Alert. **Dr. Casimer Jasinski** also addressed the two groups, and appeared on KGMB and KTRG-radio, discussing Civil Defense.

**Dr. Thomas S. Min** spoke to an A.A. group on the relationship of medicine to alcoholism.

**Dr. Walter F. Char** accepted the Hui Pookela Alumnae Association's invitation to speak on "Emotional Problems in Children."

**Drs. John Stephenson, John Peyton,** and **Masato Hasegawa** answered questions on Operation Swallow on radio.

The Couples Club at Central Union Church heard **Dr. Robert A. Nordyke** discuss "Nuclear Medicine in the Space Age."

**Dr. Claude V. Caver,** Hawaii's counterpart to Dr. Annis, has talked before many groups and on radio and TV, on the "Medicare" controversy.

The new weekly TV series produced by the HMA's Health Education Committee started off with a program on Twentieth Century Medicine, featuring **Drs. O. D. Pinkerton, Thomas Fujiwara, Raymond Yap,** and **Richard D. Moore.** The program is called "Spotlight in Medicine" and is shown each Tuesday evening at 8:30 over KTRG.

## Social Lights

**Dr. and Mrs. Clarence E. Fronk** celebrated their 50th wedding anniversary in September. The same month marked the 25th wedding anniversary of **Dr. and Mrs. Samuel Allison.**

**Dr. Erida Reichert** became the bride of Howard Wesley Klemmer in a noontime ceremony at Stanford.

**Dr. George D. Oakley** and Patricia Nicholson Mundy were married in Kawaiahao Church.

The wedding of **Dr. and Mrs. Toru Nishigaya's** daughter, Jean, to **Dr. Walter Yokoyama** was attended by 700 guests.

**Dr. and Mrs. Ralph Cloward** travelled to Salt Lake City for the marriage of their daughter, Kathleen, to James Michael Sattler.

**Dr. A. S. Hartwell** has played the role of father of the bride twice in the past few months. His daughter, Mary Foster, became the bride of Lt. (jg) William Truesdell in September and his daughter Cordelia, now Mrs. Charles Puttrammer, was married in July.

**Dr. Fred Gilbert's** wife, Helen, Mills College alumna, was one of the fifty artists selected for its Art Exhibit.

**Dr. and Mrs. K. S. Fong (Lucy Ma)** entertained 1,200 guests at their Diamond Head home, for the benefit of the Cancer Society.

**Dr. and Mrs. Marquis Stevens'** daughter, Suzy, was married to Gerold C. Wunderlich, Jr. in Rochester, New York, in September.

## Congratulations to . . .

The doctors and doctor's wives who were nominated in the primaries to run for the School Councils of their individual counties. These included **Dr. Richard E. Ando, Mrs. Richard Chang (Dr. M. J. Bradshaw), Mrs. C. A. Wyatt, Dr. James Fleming, Mrs. Frank Tabrah,** and **Dr. Vernon G. Boido.**

**Dr. Grover H. Batten,** who was elected President of the American Cancer Society's Oahu unit.

**Dr. David Lee Pang,** president of Hale Nani, Hawaii's newest 100-bed convalescent home.

**Dr. Verne C. Waite,** who has taken on Dr. Faus's duties as Medical Director of the HMSA, and at the same time retains his private practice.

**Dr. Robert B. Faus,** after almost twelve years of continuous service, has reached the mandatory retirement age at the HMSA, but will continue on in private practice at his long-time location in the Young Hotel Bldg.

**Dr. Leon Rosen,** who is heading the new Pacific Research Section of the National Institute of Allergy and Infectious Diseases, housed in The Queen's Hospital.

**Dr. Noboru Oishi,** who was certified by the American Board of Internal Medicine last September.

**Dr. Charles L. Wilbar, Jr.,** formerly of Hawaii and now Secretary of Health of Pennsylvania, on his election to the presidency of the Association of State and Territorial Health Officers.

## Condolences to . . .

**Dr. R. J. McArthur,** whose son was killed in a mainland automobile accident.

**Mrs. J. I. F. Reppun,** whose father, Dr. Charles Frederick Engle, died in August.

The family of **Dr. Emil Bogan,** pathologist and Director of Laboratories and Research for Leahi Hospital for the past year, who died suddenly on September 19 as he was returning to Hawaii.

## Hawaii Doctors in Print

**Drs. R. A. Nordyke, R. G. Rigler,** and **W. S. Strode** were co-authors of an article on "Radioisotope Renography" which appeared in the August issue of the *American Journal of Roentgenology.*

"Insulin in Blood" was the title of **Dr. Donald F. B. Char's** article in the September issue of the *American Journal of Diseases of Children.*

**Dr. Winfred Y. Lee** collaborated on an article on "Studies of Thyroid and Sympathetic Nervous System Interrelationship" which appeared in the September issue of the *Journal of Clinical Endocrinology and Metabolism.*

## News

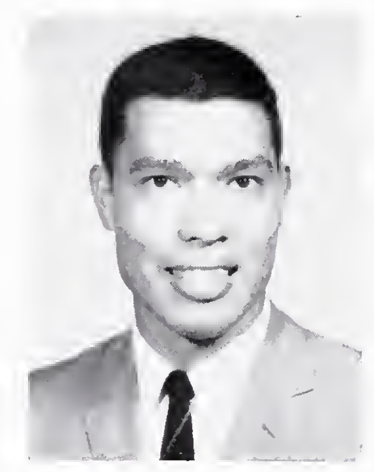
The American Thoracic Society's deadline for filing applications for 1963 grants has been set for December 15, 1962. ■

**Use Christmas Seals**

**Fight TB and Other Respiratory Diseases**

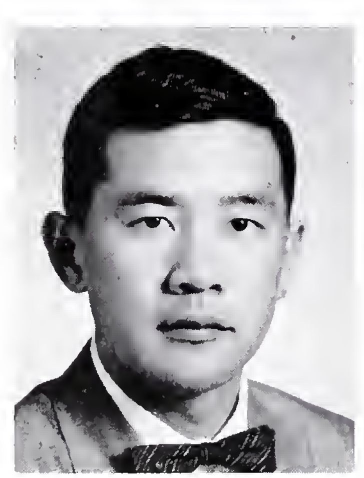
# New Members

**John A. Harbinson, M.D.**
1507 South King Street
Honolulu 14, Hawaii
Pediatrics
University of Toronto Medical School, 1952
Internship—St. Michael's Hospital
Residencies—Leahi Hospital, Children's Hospital

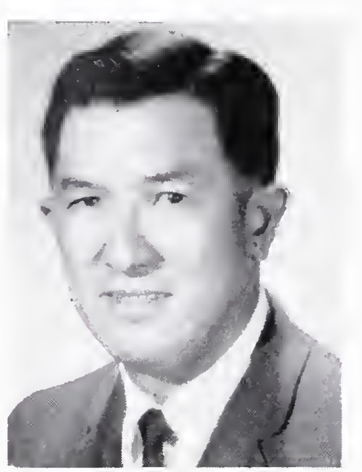


**Charman James Akina, M.D.**
133 Punchbowl Street
Honolulu 13, Hawaii
Internal Medicine
Stanford University School of Medicine, 1958
Internship—Kings County Hospital
Residencies—Veterans Administration Hospital, The Queen's Hospital

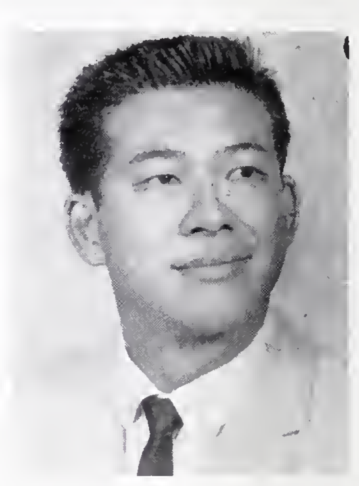
**Roy M. Kaye, M.D.**
1441 Kapiolani, Suite 610
Honolulu 14, Hawaii
Pediatrics
University of Berne, Switzerland, 1959
Internship—Albany Hospital
Residencies—Albany Hospital and Children's Hospital



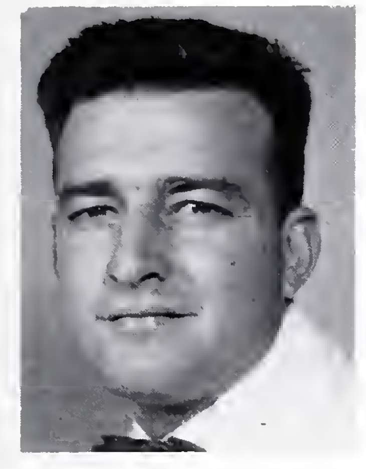
**Robert Kim, M.D.**
1481 South King Street
Honolulu 14, Hawaii
Dermatology
University of Oregon Medical School, 1955
Internship—Walter Reed Army Hospital
Residency—Mayo Clinic



**Philip Tong Chu, M.D.**
1697 Ala Moana Boulevard
Honolulu 15, Hawaii
General Surgery
Pennsylvania Medical School, Medical Department of St. John's University, Shanghai, China, 1944
Internship—St. Luke's Hospital, Shanghai
Residencies—Jefferson Medical College Hospital, Doctor's Hospital, and State University of New York Upstate Medical Center



**Denis Jackson Fu, M.D.**
1126—12th Avenue
Honolulu 16, Hawaii
Pediatrics
Tulane Medical School, 1959
Internship—Charity Hospital
Residencies—Charity Hospital and Children's Hospital



**Douglas B. Bell, II, M.D.**
1441 Kapiolani Boulevard
Honolulu 14, Hawaii
Internal Medicine
University of Rochester Medical School, 1955
Internship—Baltimore City Hospital
Residency—University Hospital, Madison, Wisc.

**Charlotte T. Kutsunai, M.D.**
581 Paikau Street
Honolulu 15, Hawaii
Anesthesiology
Northwestern Medical School, 1959
Internship—Los Angeles County General Hospital
Residency—Los Angeles County General Hospital

**Hing Hua Chun, M.D.**
1374 Nuuanu Avenue
Honolulu 17, Hawaii
Internal Medicine
Northwestern University Medical School, 1956
Internship—Philadelphia General Hospital
Residency—Philadelphia General Hospital

**Richard K. S. Pang, M.D.**
1374 Nuuanu Avenue
Honolulu 17, Hawaii
Surgery
Tulane University Medical School, 1956
Internship—Charity Hospital of Louisiana
Residency—Baylor University Affiliated Hospitals

**Milton Moore Howell, M.D.**
Box 98
Hana, Maui, Hawaii
General Practice
University of Rochester Medical School, 1952
Internship—U. S. Public Health Service Hospital, Baltimore, Maryland

**Michael Schiff, M.D.**
1000 Ward Avenue
Honolulu 14, Hawaii
Dermatology
Boston University Medical School, 1956
Internship—Tripler U. S. Army General Hospital
Residency—Hitchcock Clinic, Hanover, N. H.

HAWAII MEDICAL JOURNAL

# Hawaii Medical Association

## MINUTES OF THE COUNCIL MEETING

**September 26, 1962—6:00 p.m.**
**Oahu Country Club, Honolulu**

### PRESENT

Dr. Frederick L. Giles, presiding; Drs. Allison, Andrews, Burden, Ito (for Dr. Benson), Lum, Miyamoto, Nishijima, Richert, Wade, and West, plus Drs. Toru Nishigaya, Richard D. Moore, and Messrs. Hugh Lytle and Howard Pearce.

### MINUTES

The minutes of the January 30, 1962, meeting were approved as published.

### HMSA ADVERTISEMENT

The June 27, 1962, letter from Dr. George M. Ewing was noted. Mr. Pearce advised that Honolulu County had not taken any final action. Dr. Burden didn't feel that Dr. Ewing's letter was self-explanatory without knowing the contents of the letter which prompted this reply.

**ACTION:**

**It was voted not to publish Dr. Ewing's letter.**

### LETTER FROM HONOLULU DELEGATES

The President read the petition signed by 18 regular and alternate delegates from Honolulu County which referred to actions that took place at the annual meeting. It was noted that the request has no official standing since delegates are not officially constituted to make recommendations to the Council except when the House of Delegates is in session. The President asked for discussion of the contents of the petition.

Dr. Lum advised that the request was not to have a special meeting, but an expression that they want a survey and they wish to remind the Council that this has not been undertaken as mandated by the House of Delegates at the annual meeting. If the Council takes action to conduct the survey, there is no need for a special meeting of the House of Delegates. However, if the Council fails to conduct a survey, then they will request a special meeting.

After a lengthy discussion, Dr. Giles said that since the HCMS petition is not official, we have to continue to work as mandated by the House of Delegates and conversations should go on between the HMA and the HMSA to the point that the considerable number of subjects being discussed need interpretation in order to establish a sound schedule which will get the approval of everyone. Dr. Giles said he felt that a separate committee might very well be appointed for this project.

**ACTION:**

**It was voted that the Secretary note that the letter from the Honolulu County Delegates was duly read and discussed in this meeting and no**

*continued page 140*

HAWAII MEDICAL JOURNAL

# County Society News

## Hawaii

The August 17 meeting was held at the Naniloa Hotel. One guest, Dr. Vincent C. DiRaimondo, who discussed the clinical use of steroids, was present. It was voted to give the Polio Committee full authority to determine the dates of the campaign.

The September 21 meeting was held at the Hilo Hotel. Guests included Drs. Matthew and Thomas Durant, Professor of Medicine at Temple University. After the showing of a movie, "The Essentials of the Neurological Examination," Dr. Okumoto called the business meeting to order. Members were urged to attend the September 25 conference on the Rehabilitation of the Mentally Ill Adults at Hilo Hospital. A tape recorder was presented to the Society by the American Cancer Society, Hilo Unit, to be used at the Medical Library. In addition, the Society was advised that $200 had been made available by A.C.S. for the purchase of medical books, journals, etc.

The proposal that the Society offer a scholarship was deferred until after the completion of Operation Swallow. Dr. Mizuire asked for a replacement on the HMA Medical Care Plans and Fees Committee, but no volunteers were immediately available.

After a detailed discussion on Operation Swallow, Dr. Durant gave an extremely interesting talk on "Management of Congestive Failure."

The October 12 meeting was held at the Tropics Lanai and Drs. Price, Mathews, and Robert Aird were the guests present. There was a lengthy discussion on fees for radiology for the indigents. The Department of Social Services advised that the radiologist felt either his services should receive full compensation or they should be rendered free of charge. No decision was reached since Dr. Bracher was not present to present his views.

Dr. Jenkin was appointed chairman of the Diabetes Committee and authorized to purchase materials for the annual drive.

The Society decided to purchase an otoscope for the Peace Corps in Hilo.

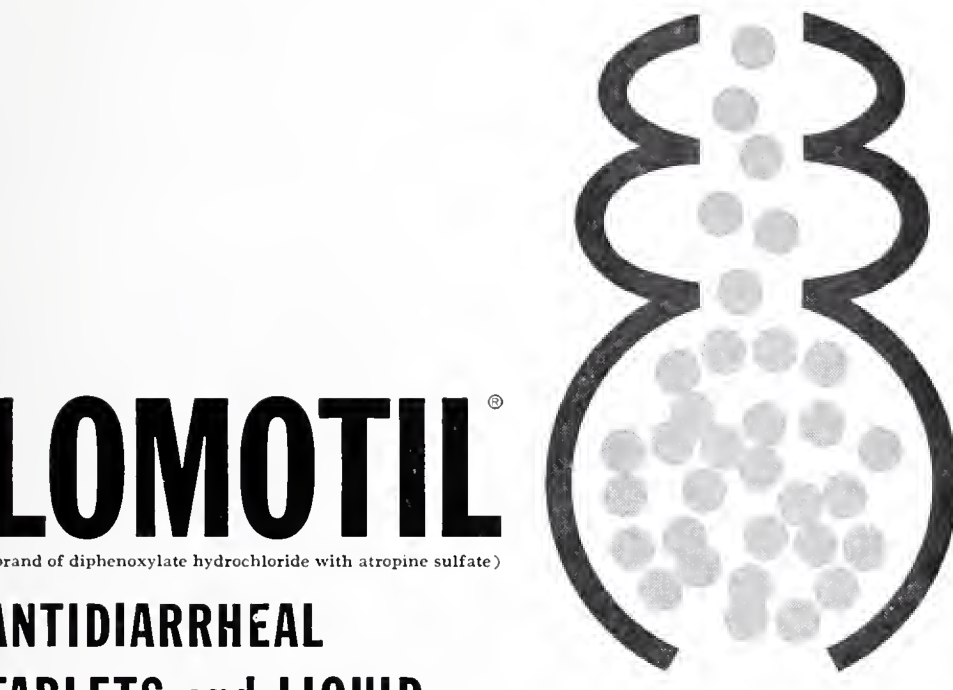
Dr. Aird, professor of neurology at the University of California, spoke on the pathophysiology of epilepsy, diagnostic precautions, and drug therapy.

## Honolulu

More than 180 persons were present at the September 4 meeting. A Community Chest film was shown and Dr. Joseph Nishimoto introduced as chairman of the Physicians Division for this year's drive.

Dr. Varian Sloan and three panelists outlined the format that will be followed for Operation Swallow. The program committee announced that it was still trying to get Ben Dillingham and Daniel Inouye to speak at the next meeting. New members Jerome Tucker, Carl Mirikitani, David Bronder, Hans Graumann, Winfred Lee, Patrick Walsh, Denis Fu, Mitsuo Tottori, David

*continued page 140*

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Roentgenographic studies by Demeulenaere[1] established that a single dose of 10 mg. of Lomotil slowed gastrointestinal transit within two hours and that it maintained its decelerating activity for more than six hours.

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Investigators have found the antidiarrheal action of Lomotil not only "excellent"[2] but "efficacious[3] where other drugs have failed. . . ."

**DOSAGE:** For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. For *children* daily dosages, in divided doses, range from 3 mg. (½ teaspoonful three times daily) for infants 3 to 6 months to 10 mg. (1 teaspoonful five times daily) for children 8 to 12 years. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. The recommended dosage schedules should not be exceeded.

**NOTE:** Lomotil is an exempt narcotic preparation.

Descriptive literature and directions for use detailed in Physicians' Product Brochure No. 81 available from G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kasich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.: Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961.

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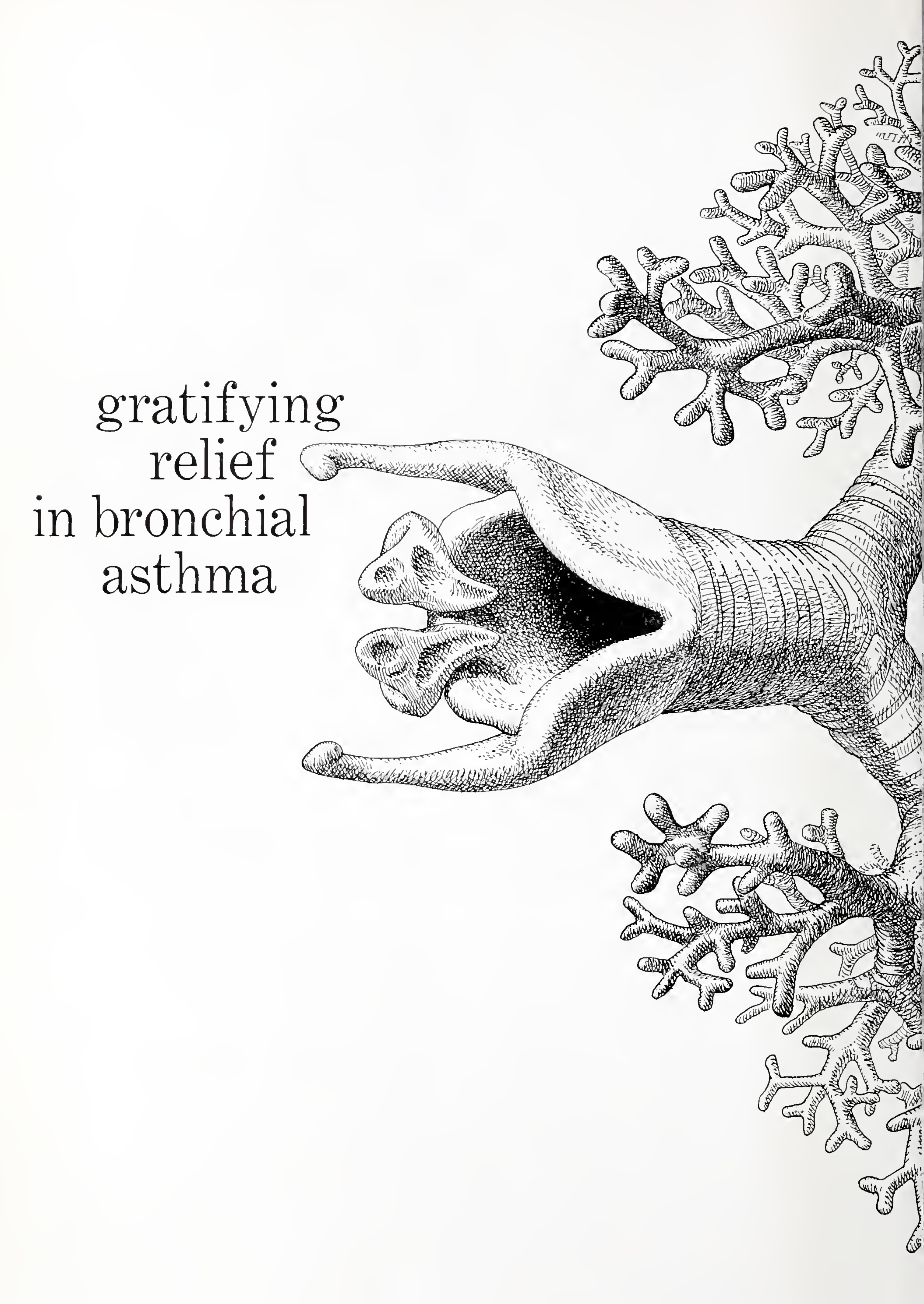
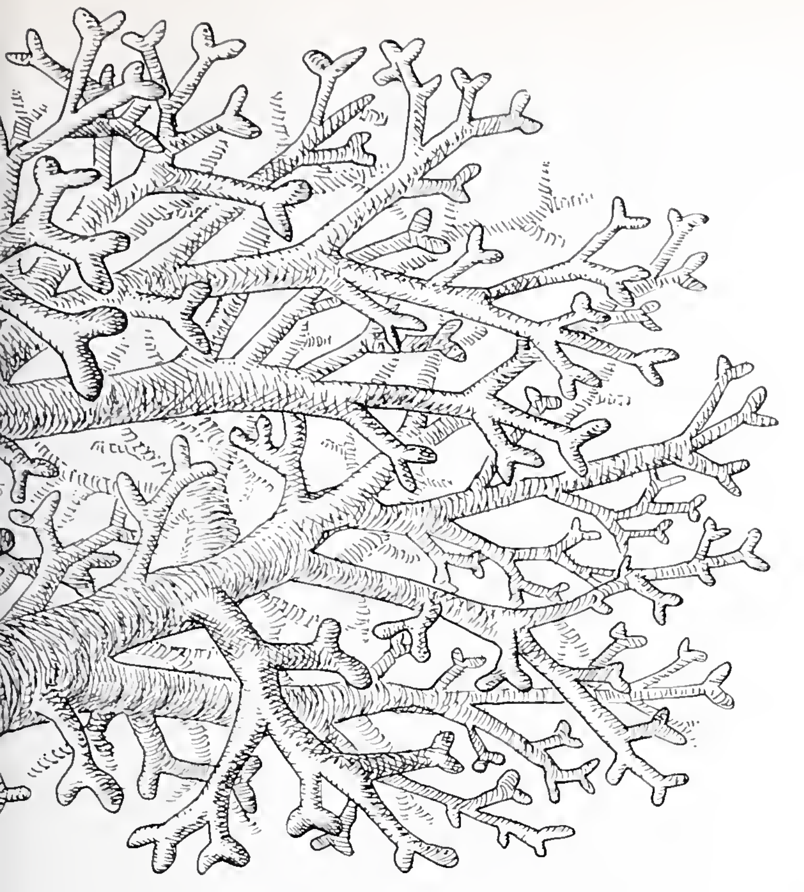

gratifying
relief
in bronchial
asthma



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# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

*Editor:* NELLIE CHEREVAS, St. Francis Hospital Laboratory

## *Local Lab News*

The annual picnic for the Medical Technologists and their families was held on September 30, 1962, at Haiku Gardens, Kaneohe. The grounds at the garden were so beautiful that everyone started hiking the trails as soon as they arrived. All were there by the time the buffet-style barbecued ribs *et al* were served. Good meals—lots of companionship—plenty of fun. Although the sun was overcast a good portion of the time, the weather was excellent. Dorothy Matsuo did a terrific job of organizing the games with prizes for the adults as well as the children. Impression: everyone had a good time. Attendance—42 adults, eight children between 5-10 years, and three under 5 years. Total 53.

**Clara Yuen,** former President of the H.S.M.T., is on a 20-day vacation in Honolulu. At present she is with U.C.L.A.

**Louise Wolfe,** our very avid orchid grower, decided for a change to enter her home-grown Hayden mango in a contest. Lo and behold, she won 1st prize.

**Dr. O. N. Allen,** professor of bacteriology at the U. of Wisconsin, and Mrs. Allen will be stopping by in Honolulu, November 25–December 11, on their way home from a trip to the Orient. He was professor of bacteriology at the University of Hawaii for a number of years back in the '30's. Some of his former students are looking forward to a dinner meeting for old time chitchats while they are in Honolulu and therefore would like to contact as many of the former students as possible. Those who are interested, please notify **Mr. Ralph Tanimoto,** Laboratories Branch, Dept. of Health, telephone 507-711, extension 734, or at his home, 744-507.

## *Note to All Technicians*

A portion of this publication is the voice of the Hawaii technologists, by which we hope to further our education, advance with the changing times, and above all share our knowledge so that each can put forth his best possible work. It is a growing trend that doctors have come to rely more and more on lab results, so we in turn must produce them, reliably and accurately. Any proven technique, scientific paper or even personal observations that would benefit other technicians will be published. Local news would be greatly appreciated. How about a word from the other Hawaiian Islands?

## *Carol McCue vs. Afghanistan*

Two years have elapsed since Miss Carol McCue bade us farewell for faraway Afghanistan, the mystic land of extreme temperatures and ancient cultures. Under the auspices of MEDICO, Carol has been appointed to set up a laboratory in its entirety, from the making of cabinets to the sterilization of a lancet. Each item has to be approved by the Afghan ministry. Fortunately she learned that a little *hoomalimali* can go a long way, and it has paid great dividends so far.

Her first day of work was a surprise. She hardly expected that the only equipment would be two blood-counting pipettes, a broken microscope (monocular at that), and two Afghan men who spoke little English.

Since that day, she has rolled up her sleeves and gone about industriously setting up a small modern laboratory to equal any in the United States. Carol has written letters about her problems and following are some excerpts:

Today is Juna (Friday), which is the Moslem Sunday, so we don't work. The weather is clear and sunny most of the time and the temperature range is from a warm 65° at noon to freezing at night. Mountains everywhere you look and climbing them is an ever exhilarating experience. On one occasion we came upon the ruins of an ancient China wall whose history has long been forgotten. Despite many modern conveniences, this is still a backward, isolated area, but one which has many appealing aspects i.e., bazaars, the modes of dress and customs of its people.

I live in a huge house with the rest of the MEDICO group including three doctors, their wives, two babies and one nurse. The two men servants do all the cooking and dishwashing, which is a real treat! Early each morning we gather around the table to have language classes by our interpreter. Our pump freezes quite regularly, which means no water until it gets repaired. Oh, the trials and hardships of overseas living! Only other hardship is the lack of heating in the hospital, and for economy's sake it is turned on faithfully every 3rd of December. In the meantime we FFFRREEEEZE. The other day I got all excited when a couple of repairmen came into the Lab to tinker with the radiator and I asked them if the heat would come soon. They answered "Insha Allah" (God be willing). To my amazement the very

next day they walked off with our radiator! So I'll continue to wear my sweater at work, and, "Insha Allah," I won't freeze to death. Back in our nice cozy home we are having a before-dinner drink. (Ohhhh, the hardships, tribulations, hic.) We are as usual, having boiled potatoes and mutton (small and tough as elephant hide).

I attended a Moslem funeral service and the custom is such that only the men are present at the actual funeral and burial. The following day prayers were held at the decedant's home, and all the female hospital employees went. We sat on the floor while a boy chanted a requiem. Suddenly, the close relatives threw their veils over their faces and began to wail morbidly. This sobbing and weeping went on for about 20 minutes, then stopped just as suddenly. Then, curiously enough, an old woman began to smoke a water pipe. This was a very unusual experience for me.

Yuri Gagarin, the Russian Cosmonaut, is still making public appearances and the day his open car drove down the main street, all school children and government employees were ordered to wave Afghan and Russian flags. It was indeed odd to see women lined on one side of the street and men on the opposite side. One of the male lab techs managed to get me a souvenir, which remains concealed in my room.

My first day at the laboratory made me realize the enormity of my undertaking. The equipment was pathetically inadequate—either it was broken or very out-dated. First I assembled a blood tray. The few needles on hand, I understand, were usually boiled a few minutes before re-use. I spent the first two weeks ordering supplies from the U.S. which will take four to five months to get here.

I plan to set up Chemistry, Bacteriology and Serology. This week I redesigned the layout on paper and made a formal request for furniture to be approved by the Afghan government. I designed the lab furniture right down to the drawer specifications. It's really interesting and fun to do business with the cabinet maker. The two Afghan techs seem rather well trained and are exceptionally sharp on parasitology—no wonder, almost every stool examined has *Ascaris*.

I've worked mostly on organization, keeping the lab neat, washing glassware and not reporting out 17 gm Hgb with a 3.7 mil. RBC without checking something. Today was a big day—we now have an American-made electric centrifuge. Some of our equipment has arrived and now I can start teaching the boys chemistries.

It is now August, and this month finds me doing lab statistics. For July we have done 1,520 tests. I know this is nothing compared to the amount of work you folks put out, but in my more disagreeable moods I give my "assistants" little lectures on how hard Americans work. Anyone who believes that lazy American bit ought to work overseas for a while.

There's the worst odor outside this window—someone's been dumping garbage on the hospital grounds, but if I close the window I'll suffocate—it's so hot. Meanwhile, out on the front lawn the cesspool is overflowing and running into the *jui* (ditch) along the street where people are washing themselves and their dinner vegetables. Needless to say there is lots of typhoid and dysentery here. I was sick a few weeks with dysentery and lost 14 lbs., but recovered fully.

Went to Pakistan where it was lovely and warm. The state of Sirat was beautiful, so green, and blossoming fruit trees everywhere. Kabul is so stark and arid, our mountains don't have a blade of grass on them, let alone trees. There's an active social life in the American community here, lots of dinner invitations. There's no other place to go except one restaurant and one cinema.

Still no equipment from the U.S. If you can get the H.S.M.T. to accumulate any old stuff, I would thank you from the bottom of my heart. Also it would have great propaganda value and you all would be doing your part to win the cold war. How's that for a sales pitch? Say hello to the old gang for me. Would love to hear from all of them.

Miss McCue's perseverance and determination in bringing scientific education to a deprived country is indeed praiseworthy. Well, how about it, members? Let's give this technician a hand at setting up this much-needed laboratory. Any unwanted chemicals, stains, pipettes or old equipment. Please contact Editor by phone. Mahalo for your kokua.

## *Eosinophilic Meningitis**

Since March, 1958, many hundreds of cases of an unusual type of meningitis of unknown etiology have occurred on the island of Tahiti in French Polynesia. Since the most characteristic feature of this meningitis is a pleocytosis, consisting in large part of eosinophils, the disease was called eosinophilic meningitis. The most common symptoms were headache, stiffness of the neck and back, and many different types of paresthesias. The latter occurred in localized areas of various sizes and shapes on the head, body, or extremities. Patients had either no fever or low-grade fever of short duration. Approximately 5 per cent of individuals also had unilateral facial paralysis. Several patients with meningeal signs had a unilateral paralysis of the external rectus muscle of the eye. The onset of the disease was either relatively sudden or insidious, and its duration varied from several days to several months. The course of the disease appeared to be unaffected by treatment with various antibiotic, antihistaminic, or antiparasitic drugs.

### LABORATORY FINDINGS

*Cerebrospinal fluid*—The great majority of patients with both pleocytosis and eosinophils had 100 or more cells per $mm^3$ and more than one half had 500 or more cells. In 85 per cent of patients, eosinophils accounted for more than 25 per cent of the cells present. In those patients who were followed with serial spinal taps, the number of cells was noted to decrease gradually to a normal level over a period of several months. Cultures of c.s.f. on media suitable for aerobic, anaerobic or acid-fast bacteria and for fungi were uniformly negative. The c.s.f. protein was either normal or only moderately elevated, and the amounts of chlorides and sugar were within normal limits. Serologic tests for syphilis were uniformly negative.

*Blood*—The only abnormality noted in the peripheral blood of patients was an eosinophilia ranging up to 49 per cent of the leucocytes. It should be noted that peripheral eosinophilia is very prev-

* H.S.M.T. had the honor of hearing Dr. Leon Rosen relate his most interesting research on an unusual entity, eosinophilic meningitis. The disease has occurred mainly in the Pacific area, including the Hawaiian Islands. The etiology of eosinophilic meningitis is unknown, but several hypotheses have been proposed. Dr. Rosen, head of the newly organized Pacific Research Section of the National Institutes of Health, and his staff are currently conducting research on certain virus diseases and on eosinophilic meningitis. The following is a resumé of the clinical aspects and laboratory findings of the latter disease.

alent among residents of French Polynesia and is generally attributed to their infection with intestinal nematodes and Wuchcreria. Approximately one fourth of the patients with eosinophilic meningitis had a normal blood level of eosinophils.

*Feces and Urine*—essentially negative.

*Serology*—Examination of sera with antigens for a number of arthropod-borne viruses, enteroviruses, Leptospira, and other microbial agents gave no indication of the etiologic agent.

The disease did not appear to be transmitted from person to person or from one geographic area to another. The incubation period was estimated to be between two to four weeks. Although the etiology of eosinophilic meningitis was not determined, the sum of the clinical and epidemiologic evidence suggested the hypothesis that the disease was caused by a helminthic parasite.

As part of the study of eosinophilic meningitis in the Pacific area, postmortem material was examined from two mental patients who died in Hawaii with an eosinophilic meningoencephalitis. A number of young adult nematodes, identified as Angiostrongylus cantonensis, a rat lungworm, were found in the brain and meninges of one patient. Foreign material in the brain of the second patient and a cellular reaction similar to that observed in the first case suggested that this person also may have been infected with the same parasite. Because of the mental condition of both patients, and the presence of other pathology, it was not possible to decide how much, if any, of their symptomatology might have been caused by the parasitic infection. The possible relationship of A. cantonensis to the other cases of eosinophilic meningitis seen on the Hawaiian Islands, Tahiti, and other islands of the Pacific is currently under study.

Because of the obscure nature of the disease as well as our lack of information concerning its etiology, it may be more prevalent than we think. It would be of great help if any medical technologist in the Hawaiian Islands would immediately pass on information regarding c.s.f. counts containing eosinophils. Such information would greatly assist the researchers and consequently help many sufferers, which is the end to which technology is dedicated. Dr. Rosen or his assistant, Dr. Gordon Wallace, may be contacted at the following address: Pacific Research Section, P. O. Box 1680, Honolulu 13, Hawaii, Phone 513-141. Charges on long-distance phone calls concerning eosinophilic meningitis will be accepted by the Pacific Research Section.


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*In Memoriam* continued from 123

appeal to the full bench, but before this took place Dr. Buffum had left the Islands.

The doctor's troubles came as the result of medication prescribed by him for an Hawaiian woman. According to a letter appearing in the *Advertiser* March 18, 1871, he was called to treat a woman suffering from a cough, and, after making a house call at 8 P.M., he left some white powders to be taken. The patient's husband gave his wife the powders as ordered and by the following morning when Dr. Buffum arrived she was unconscious. The doctor administered castor oil and salts and, although "neither produced any effect," he stated she was "all right, *aole pilikia*" and left. The patient continued to sink and died that evening. The next morning when the doctor arrived he found people "wailing over her corpse." In court the prosecution contended that the white powders given by the doctor were "morphia."

On April 18, 1871, the Board of Health issued the following statement: "After examination by the Board of Health it appears that Mr. A. C. Buffum does not possess the requisite professional qualifications to practice as a physician and surgeon, and his license is revoked." This was signed by Ferd. W. Hutchison, Minister of the Interior, Ex-Officio President of the Board of Health (also a doctor).

*The Pacific Commercial Advertiser* stepped into the fray at this point with an editorial that reminded its readers that the members of the Board of Health who granted Dr. Buffum's license were F. W. Hutchison, W. Hillebrand, M.D., T. C. Heuck and W. P. Kamakau and wondered how the present Board made up of the same four men (with one additional member) could have been so completely mistaken about his qualifications. A second editorial stated that it was being said "by whose who profess to know" that Dr. Buffum's license was granted without a formal examination on the presentation of his medical school diploma and went on to denounce the Board's method, or lack of method, in granting licenses.

However, none of this helped Dr. Buffum, who had left on the "D. C. Murray" for San Francisco on April 21, 1871. The *Advertiser* commented on his departure as follows: "—we learn that Dr. Buffum left for San Francisco. So it appears that the action of the Board of Health has resulted in professional ostracism."

But the last and saddest report of the doctor appeared in the June 12, 1875, *Advertiser:* "We learn that Dr. A. C. Buffum, formerly of this city but for several years past residing at San Francisco has become insane and has been sent to the Asylum at Stockton."

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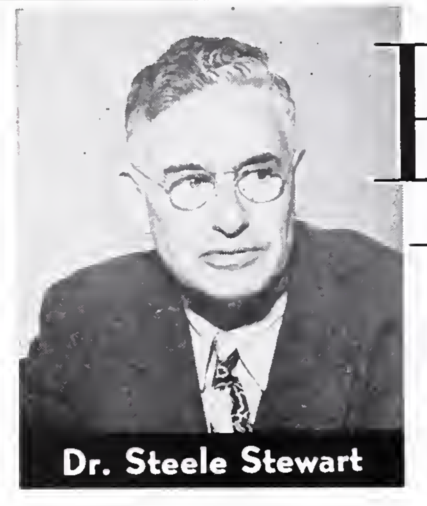


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*County Society News* *continued from 130*

Tien, Maurice Silver, Dorothy Whittaker, Francis Ikezaki, Roy Kaye, and Philip Chu were introduced.

Dr. Pinkerton announced that the proposed fee changes in the Workmen's Compensation Schedule as circulated to the membership had been submitted. There will be a public hearing on this and the president urged any physician interested to attend. Dr. Pinkerton advised that a meeting of the HPLGG would be held immediately after adjournment at which time Dr. Malcolm Todd would speak.

## Maui

Three guests were present at the August 21 meeting: Dr. Rene Joyeuse, and Messrs. Sanford Langa and Elmer Cravalho.

The first part of the meeting was devoted to a discussion of politics. Dr. Moran reported on the formation of the Political Action Committee and Dr. Howell told of his experience as a member of a similar body in Minnesota. Mr. Langa urged active participation in the forthcoming election and Mr. Cravalho suggested that instead of a straight party endorsement, individual candidates should be endorsed within either party.

Dr. Howell was welcomed as a new member of the Society. Dr. Rockett was welcomed back to Maui after having completed his surgical residence at Queen's. The Society endorsed Dr. Verne Waite as Medical Director of the HMSA.

A lengthy discussion folowed on whether or not Maui should participate in Operation Swallow. A motion to participate was defeated 7 to 6 and Dr. McArthur advised he would meet with the Polio Committee the following day and bring back a final recommendation to be circulated to the membership. ■

*Hawaii Medical Association* *continued from 130*

**action is needed; that the Council is taking action to carry out the actions of the House of Delegates.**

**SECRETARY'S REPORT**

The Secretary's Report was approved with one amendment. Approved was the recommendation that no retroactive action be taken on any waiver of dues granted in 1961 and that the waiver of dues for 11 members which was requested by their county societies in January be granted. The Secretary was instructed to call to the attention of the Honolulu County Medical Society, the irregularities that appear in its roster of inactive members. Additional action was taken on the change of status of two Honolulu members. All changes in membership requested by the counties were accepted, resulting in a total active membership as of August 31, 1962, of 607 members distributed as follows:

| | | |
|---|---|---|
| Unaffiliated | 1 | |
| Hawaii | 54 | ( 9) |
| Honolulu | 506 | (29) |
| Kauai | 11 | ( 2) |
| Maui | 35 | ( 4) |
| | 607 | (44) |

The figures that appear in brackets indicate the number of active members who have been granted waiver of dues.

Members whose dues have not yet been paid were granted a further extension of seven days beyond the date of the next notice the Secretary is authorized to send.

There was a lengthy discussion on the subject of waiver of dues. Dr. Allison suggested that a resolution

*continued page 142*


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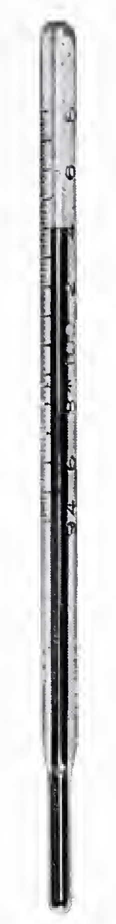

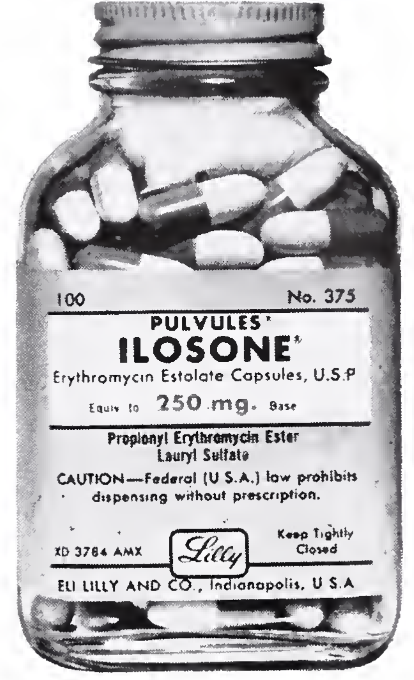

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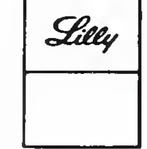


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*Hawaii Medical Association* *continued from 140*

might be introduced at the AMA requesting them to drop to 65 the age for waiver of dues. Mr. Pearce explained that there are certain Honolulu members who have been granted waiver of dues and then when the change in the bylaws went into effect, they were required to pay HMA dues. They had always been required to pay AMA dues if they were AMA members. Dr. Giles said it had created an unfortunate situation. The bylaw change affected nine members, all except one were AMA members. The one physician who was not an AMA member has declined to join that organization. Although the County reported him as having resigned from their Society, he advised the State Secretary that he had not resigned and if the County wanted to remove him from its rolls, that was its business. Dr. Giles asked Drs. Allison and Richert to work on problems of the above paragraph and make recommendations. It was noted that any change would require a change in the bylaws. After a recommendation is worked out, it will be submitted to the Bylaws and Parliamentary Committee.

ACTION:

**It was moved to accept the Secretary's report. Dr. Wade said that Kauai County had instructed him to present to the Council a request to refund to the two members who were dropped 50% of the dues they had paid. The motion was amended to include this recommendation and it was passed.**

### TREASURER'S REPORT

The Treasurer discussed the recommendations in his report. He said he felt that the percentage of members who had been granted dues waiver was too high. He felt we should stick with the AMA regulations. If men are still practicing until they are 70, they should pay dues until they are 70.(We have had a relatively young doctor population here and it isn't as young as it was.)

The request of the auditor for an increase of his fee to $500 was discussed at length. Dr. Richert said that the auditor had been underpaid for a number of years. He has demonstrated his willingness to come to meetings and spend a lot of time on Association affairs. As an addition to his report the Treasurer read a letter from Mr. Hough dated June 22, referring to exhibitors.

Dr. Richert advised that the HMA had an outstanding bill from the Drake Hotel covering Mr. Lytle's expenses which he incurred in attending an AMA meeting at our request.

ACTION:

**It was voted to approve payment of the Drake Hotel bill.**

Dr. Richert said that all in all the HMA is in pretty good shape. We have made a little money over the past year and the budget is being followed. The funds that were earmarked for Mabel Smyth Building improvements have not been used. Referring to the recommendation that the Physicians Benevolent Fund be withdrawn and placed in two different accounts, Dr. Andrews advised that the Maui Savings & Loan Company was insured. Other recommendations in the report included authorization to pay bills incurred by the Medical Care Plans & Fees Committee, purchase of a new typewriter and embossing machine, continuation of present handling of the PBF, payment of Mr. Lytle's expenses incurred in performance of duties performed at the HMA's request, development of a contract for Mr. Lytle, refund of Dr. Miyashiro's dues, waiver of all interns and residents registration fees at all annual meetings, and retention of Mr. Ajifu.

ACTION:

**It was voted to approve the Treasurer's report.**

### PERSONNEL COMMITTEE REPORT

The Treasurer read the Personnel Committee's Report

*continued page 144*

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which included recommendations for the 1962-63 salary adjustments for the Executive Secretary and the Association secretary, the employment of part-time help, and the payment of the Oahu Country Club dues.

ACTION:

**It was voted, with one dissenting vote, to approve the Personnel Committee report.**

**BOARD OF MANAGEMENT OF THE MABEL SMYTH BLDG.**

Dr. Nishigaya thanked the Council for inviting him to appear to present a report from the Board of Management. He outlined some of the problems that are currently facing the Mabel Smyth Building. The Hawaii Medical Association and the Hawaii Nurses Association are responsible for the maintenance of the building. If the building goes in the hole, it has to be supported by these two organizations. So far the HMA has been carrying the brunt of the burden and the building has not gone into the red. It is getting some competition to the Physicians Exchange. Some of the doctors have been using Radio Call Service. This type service is being considered by the Exchange along with intercepted service. The Exchange has received an offer from a firm that wishes to purchase it. He met with the man who made the offer, which was ridiculously low. Honolulu County has helped because the Board of Governors went on record as making the Exchange the official exchange for Honolulu. The auditor has expressed concern over the uses of the auditorium. The proposed remodeling of the basement has been talked about for two years. The plans were drawn up but Honolulu County has not reached a decision. In the meantime, the cost for the remodeling has gone up about $10,000. The different associations concerned are trying to iron out the legal technicalities. He asked for a discussion by the Council.

Dr. Nishijima asked about the results of the survey in which the Exchange asked what services the doctors wanted, and was advised that this was on file. Dr. West said the Exchange should have reevaluated its services sometime ago. Dr. Nishigaya explained that it would cost about $12,000 to put in intercepted service and they didn't feel enough people would want it. Dr. Nishijima asked how many doctors are using the different competitive services. Dr. Giles said the Mabel Smyth Building has been a symbol of the medical profession here and we should try to do all we can to help them develop. We owe them a great deal of support.

**AAPS ESSAY CONTEST**

Past participation in this contest was discussed. Mr. Lytle said it was a lot of trouble, probably more than worthwhile, but he would hate to see it discontinued under fire. The fact that these young people participate is a fine thing.

ACTION:

**It was voted that the HMA continue to sponsor the AAPS Essay Contest on a State level and the counties have the option to participate as they see fit.**

**SPONSORSHIP OF RADIO AND TV PROGRAMS**

The Council was advised that as a result of the telephone poll it had voted to permit sponsorship of the radio program. Mr. Lytle reported that the HMSA had offered to sponsor the programs and when the time came to sponsor the Dr. Annis film, they decided against this action because of a problem which might develop with the ILWU. The HMA wanted this program on prime time, but there was no budgeted allowance. However, this was accomplished because of the donations made by the individual doctors. Both Mr. J. R. Veltmann and Mr. Hugh Lytle contributed $25 of their own funds towards paying for the TV time. There is no

*continued page 146*

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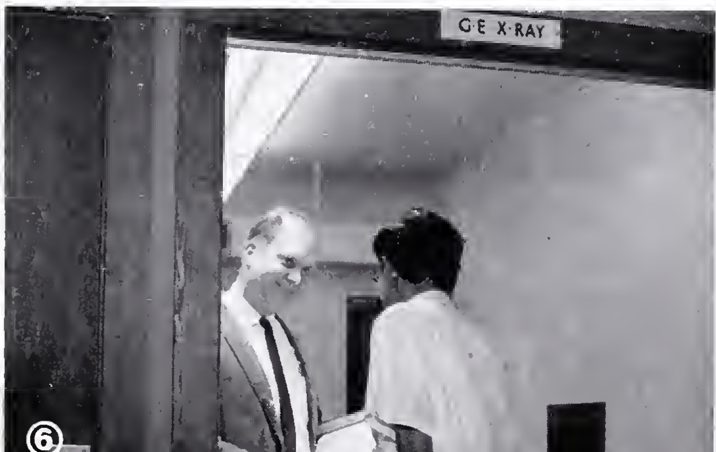

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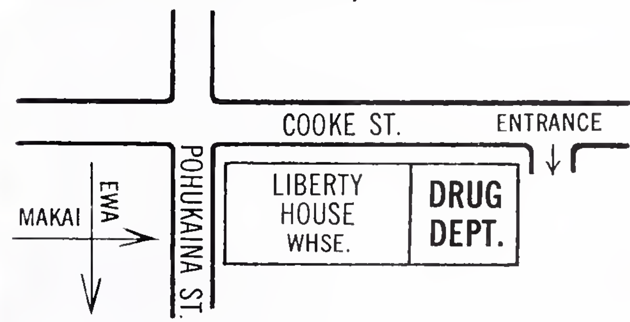


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one at the present interested in sponsoring either the radio or the TV program. The Bankers Association was approached on the radio program but turned it down. KGU is now working on some other plans including Dairyman's. The TV program time is free. It is attracting attention wherever KTRG can be seen. Even if we have to leave KTRG, there is more prospect of sponsorship now than ever before. KTRG feels they may get sponsorship of this program there. Sponsorship is not a dead issue. Dr. Burden noted that funds were allocated for "Ask Your Doctor." This was confirmed.

**ACTION:**

**It was voted that the Secretary send letters of thanks to everyone who contributed financially to the Dr. Annis program.**

**HAWAII COUNTY ANNUAL REPORT**

At the request of the House of Delegates, the Hawaii County Annual Report was circulated to the Council.

**ACTION:**

**It was voted to accept the Hawaii County Annual Report.**

**GROUP MALPRACTICE INSURANCE**

A letter from the Insurance Department of Theo H. Davis & Co., Ltd., was noted. It was pointed out that no firm quotations can be made until the underwriter has further knowledge of the number of participants. It was agreed that group malpractice insurance would be received favorably.

**ACTION:**

**It was voted to discuss the insurance company's proposal further with them and make the information available to the membership.**

**SUBSCRIPTION**

It was noted that the HMA has not supported Dr. Shearon's enterprising efforts in Washingon.

**ACTION:**

**It was voted to subscribe to *Challenge to Socialism* for the Hawaii Medical Library.**

**AMA DELEGATE'S REPORT**

Dr. Moore advised that his report is in the current issue of the Journal. He said the AMA House of Delegates was the most democratic organization he had ever been in contact with. This was emphasized by their actions in changing the make-up and tenure of their Board of Trustees. The Board of Trustees was not particularly favorably disposed towards the proposed changes which were subsequently adopted. Another example was the election of Dr. Annis. In the past this office has always been offered to someone who has had service in the hierarchy of the AMA and there was some dissent because Dr. Annis had not even been a president of his state association. Some of the members felt that it was a time when medicine needed someone who could speak for the physicians and this is something Dr. Annis does very well. Dr. Moore said he attended some of the California Medical Association caucuses. They don't vote by the unit rule. Most of them felt that it would be a great mistake if Dr. Annis were not elected, although some of the California delegates were in favor of the opposing nominee.

The King-Anderson and Kerr-Mills bills came up for a lot of discussion. The House reaffirmed its position very strongly. It also declined to approve of a Board of Abdominal Surgeons because there was no clear need. They felt it was wrong to limit a specialty to any one anatomic location. Generally it was a rather quiet meeting. Dr. Burden asked if any action were taken to stimulate further implementation of the Kerr-Mills Law and was told there were resolutions on this.

**NEW DR. ANNIS FILM**

Mr. Lytle was asked to comment on the new Dr. Annis film. One copy of the film is here as well as 20 copies of the script. Additional copies of the film are due to arrive within the next few days. One copy will be sent to each island. The others will be used here. He hoped to show it here just before the general election on the HMA TV program and at the same time pay to have it shown on the other TV stations.

**DIABETES DETECTION WEEK**

Dr. Giles called attention to Diabetes Detection week scheduled for November. He asked that the neighbor island councilors keep their eyes on the minutes of the Diabetes Committee and hoped, if possible, they could implement this program on the other islands.

**HAPAC**

Dr. Giles asked the Councilors when they returned home to help with the implementation of their local Political Action Committees. He felt this would be more effective if each of the counties could develop its local project. We could become much more politically effective from the standpoint of electing individuals to the Legislature, both national and local. We have become more effective in our testimony before the Legislature and seeing that legislation is introduced that is more favorable. As practicing physicians each of us should try to improve these programs as much as we can. It should be started now to reach a most effective development by the next election two years from now.

**HALL OF HEALTH**

A letter was read from the Secretary of the Hall of Health asking the HMA to support this organization by

*continued page 148*

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## *Hawaii Medical Association* *continued from 146*

becoming a member at $10 a year. It was noted that the Honolulu Junior Chamber of Commerce contributed $1,000. The Bishop Museum has underwritten $2,500 of the expenses. There is an unpaid balance of $8,000. Mr. Lytle said there was an ad hoc committee on this. He felt some sort of recommendation that doctors be encouraged to join was in order.

ACTION:

**It was voted to accept membership in the Hall of Health at $10 a year, and that we encourage individual members to join.**

### AMA CLINICAL MEETING

Dr. Moore said that he had in personal discussions with some of the leaders of the AMA spoken about the possibility that the AMA hold a clinical meeting in Honolulu sometime after the completion of the convention hall. This is held either in late November or early December and attracts between four to five thousand doctors. It was noted that an invitation had previously been extended during Dr. Bergin's term of office.

The meeting adjourned at 9:30 p.m.

Samuel D. Allison, M.D.
*Secretary*

---

## *Book Reviews* *continued from 124*

on the possible diagnoses to be considered, given one or two signs or symptoms. It can also be a source of "browsing fun," if you enjoy games, such as seeing many diagnostic possibilities are involved with any given symptom. For instance, under hypertension are listed over 30 diagnoses under five general headings; in addition, there is a short discussion of normal variations in blood pressure and different techniques of measurement.

This second edition starts with a discussion of the ways and means of obtaining a good pediatric history. On to a chapter on physical examination by organs and systems, and one listing signs and symptoms, and finally, health supervision, all in rather complete outline form.

W. A. Myers, M.D.

## Also Received

### Psychoanalysis of Behavior, Vol. II

*By Sandor Rado, M.D., D.Pol.Sc., 196 pp., $6.50, Grune & Stratton, Inc., 1962.*

For psychiatrists.

### Medical State Board Questions and Answers, 10th Ed.

*By Harrison F. Flippin, M.D., 507 pp., $9.50, W. B. Saunders Company, 1962.*

Tenth edition in 55 years, and first since 1957. Suitable light reading for nervous candidates for licensure.

### Ciba Foundation Symposium on Tumour Viruses of Murine Origin

*G. E. W. Wolstenholme, O.B.E., M.A., M.D., M.R.C.P., and Maeve O'Connor, B.A., Editors, 441 pp., $10.75, Little, Brown and Company, 1962.*

For researchers.

*continued page 152*

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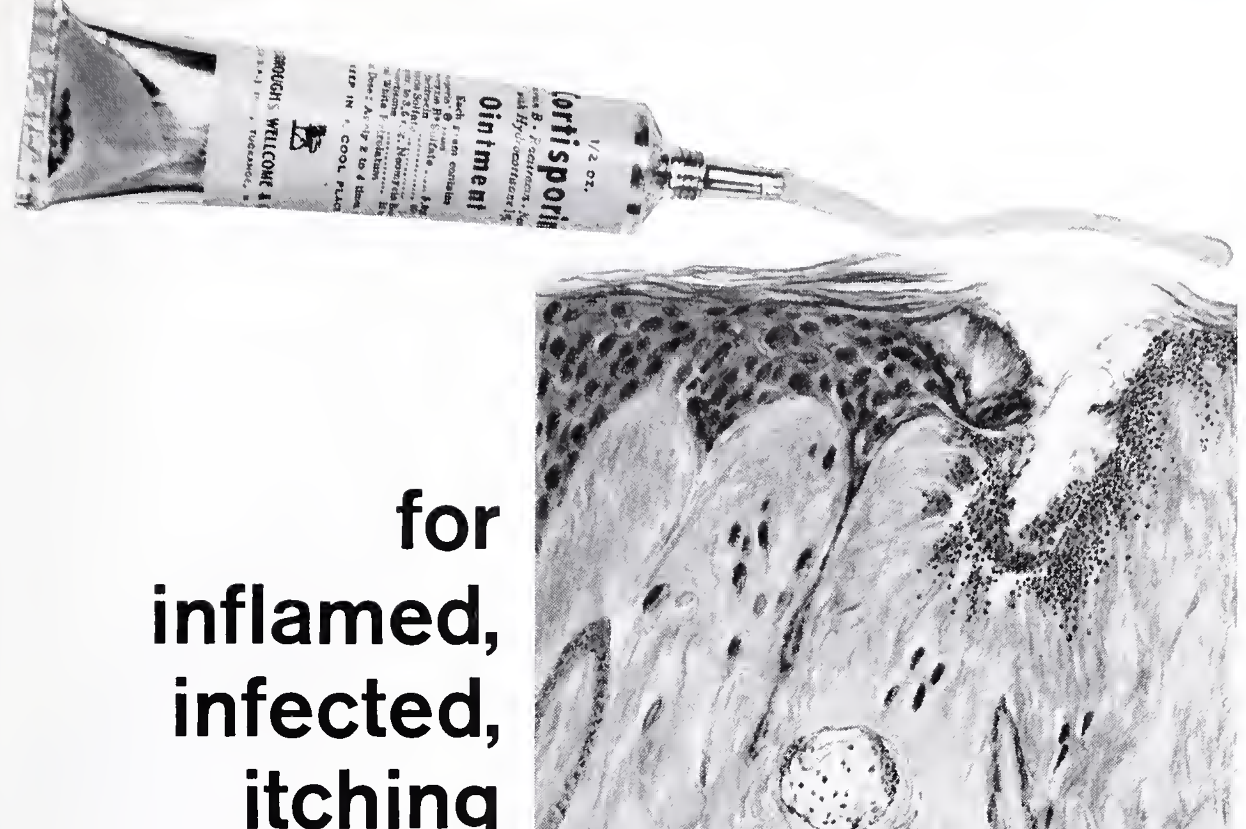

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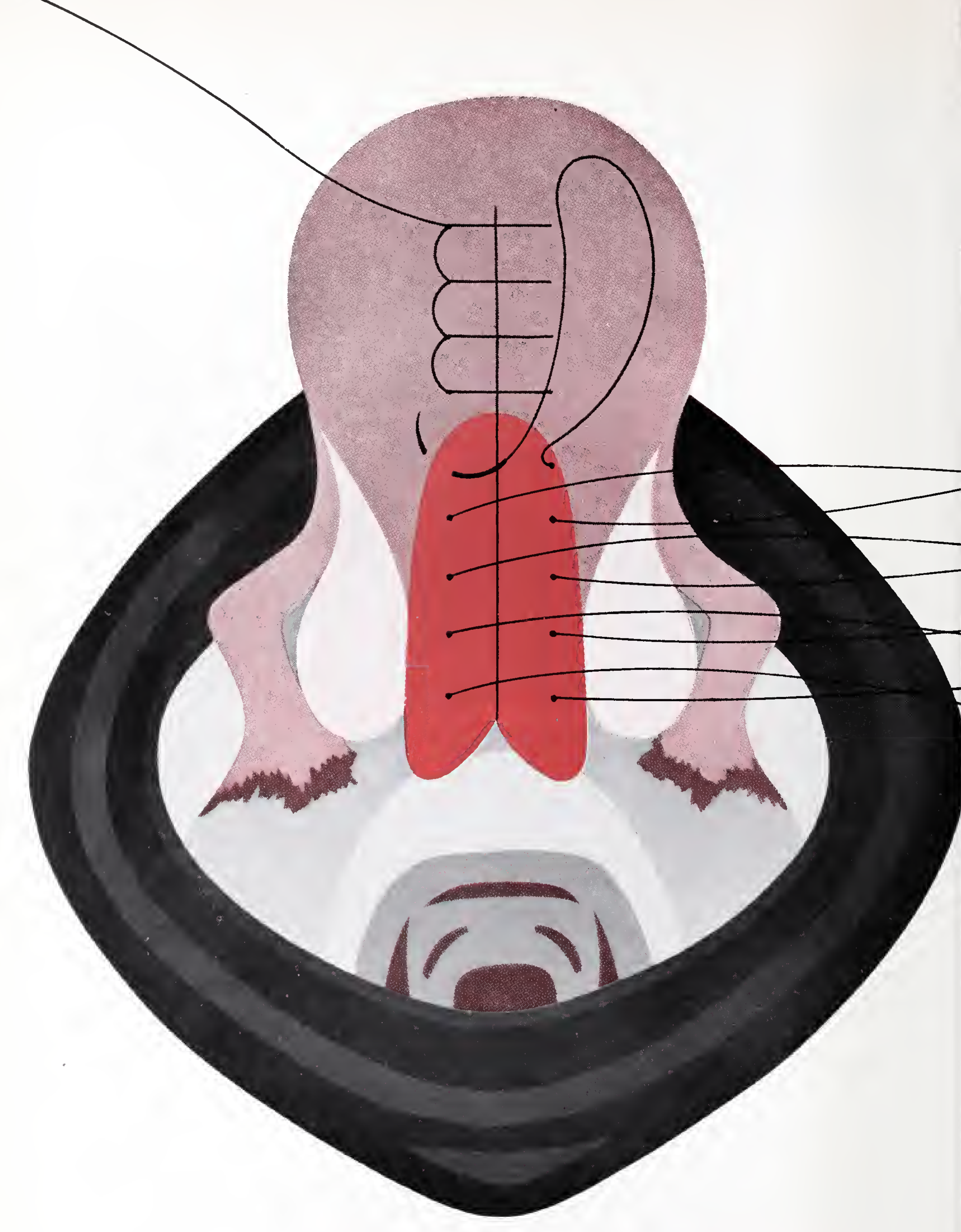


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## Book Reviews *continued from 148*

### Psychoanalysis in Groups

*By Alexander Wolf and Emanuel K. Schwartz, 326 pp., $8.00, Grune & Stratton, 1962.*

FOR psychiatrists.

### Thannhauser's Textbook of Metabolism and Metabolic Disorders, Vol. 1

*Edited by Nepomuk Zöllner. American edition translated and edited by Solomon Estren, M.D., F.A.C.P., 462 pp., $17.50, Grune & Stratton, 1962.*

INTERNATIONAL authorship. Translation from the German makes for occasionally awkward style. Beautifully printed and highly authoritative.

### Pediatric Clinics of North America, Vol. 9, No. 3

*Carl H. Smith, M.D., Editor, pp. 521-876, W. B. Saunders Company, August, 1962.*

SYMPOSIUM of pediatric hematology with 31 contributors.

### The Surgical Clinics of North America, Vol. 42, No. 4

*C. Frederic Fluhmann, M.D., Guest Editor, pp. 833-1075, W. B. Saunders Company, August, 1962.*

SYMPOSIUM of progress in gynecology and obstetrics by 26 contributors.

### The Sciences, Vol. 1, No. 13

*Published twice each month by the New York Academy of Sciences, 12 pp., December, 1961.*

"VETERAN SPACE TRAVELERS," "More Shark Lore," "Speech and Personality," "Organic Regeneration," and "Living Breakwaters" are articles appearing in this issue.

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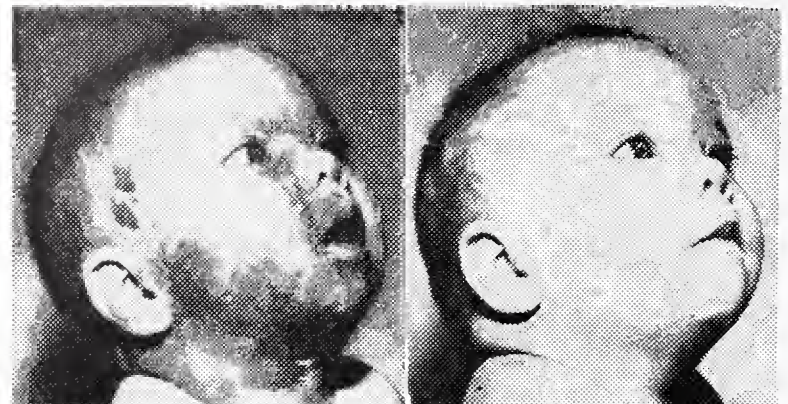

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## *Book Reviews* *continued from 152*

**Suicide and Mass Suicide**
*By Joost A. M. Meerloo, M.D., Ph.D., 153 pp., $3.75, Grune & Stratton, 1962.*
THE URGE for death—for self or others—is grimly explored.

**The Human Adrenal Cortex**
*Edited by Alastair R. Currie, B.Sc., M.D., F.R.C.P. Ed., F.R.F.P.S., T. Symington, B.Sc., M.D., F.R.F.P.S., F.R.I.C., F.R.S.E., and J. S. Grant, B.Sc., Ph.D., F.R.I.C., 644 pp., $11.00, The Williams and Wilkins Company, 1962.*
PROCEEDINGS of a conference held at the University of Glasgow, July 11-14, 1960. Two years old, but an invaluable reference. Very deep.

**Developments in Psychoanalysis**
*By Leon Salzman, M.D., 302 pp., $7.75, Grune & Stratton, 1962.*
JUST for psychiatrists.

**★Day Hospital**
*By Bernard M. Kramer, Ph.D., 103 pp., $2.75, Grune & Stratton, 1962.*
A STUDY of partial hospitalization in psychiatry. A "must" for psychiatrists. Many mentally ill patients should not spend their nights in the hospital.

**The Pancreas in Human and Experimental Diabetes**
*By Sydney S. Lazarus, M.D., M.Sc. (Med.), and Bruno W. Volk, M.D., 279 pp., $10.00, Grune & Stratton, 1962.*
FOR diabetologists.

**★Lower Digestive Tract, Part II of Volume 3, Digestive System, The Ciba Collection of Medical Illustrations**
*Prepared by Frank H. Netter, M.D., edited by Ernst Oppenheimer, M.D., 243 pp., $15.00, Ciba, 1962.*
ANOTHER Ciba service to physicians. A beautiful production!

**★The Story of X-rays from Röntgen to Isotopes**
*By Alan Ralph Bleich, B.A., M.D., 186 pp., $1.35, Dover Publications, Inc., 1962.*
FOR PATIENTS, wives, or children of radiologists—or for any layman with intelligence enough to be interested.

**Virgin Wives**
*By Leonard J. Friedman, M.D., 161 pp., $4.50, Charles C. Thomas, 1962.*
GYNECOLOGISTS and generalists would find this little manual valuable in improving their insight into marital problems.

**The Medical Clinics of North America, Vol. 46, No. 5**
*William Dameshek, M.D., Guest Editor, pp. 1135-1417, October, 1962.*
SYMPOSIUM on specific methods of treatment by 25 contributors.

**The Sciences, Vol. 1, No. 15**
*Published twice each month by the New York Academy of Sciences, 12 pp., January, 1962.*
"HEART DISEASE," "The Seas—Man's Cupboard?," "The Consistency of Perception," "The Packaging of People," "Greek Fire—Fiction and Friction," and "Regulated Aging," are articles appearing in this issue. ■

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1. Dupler, D.A., Greenwood, R.J., and Connell, J.T.: J.A.M.A. 174:123 (Sept. 10) 1960.
2. Hobbs, L.F.: To be published. 2/3026MB

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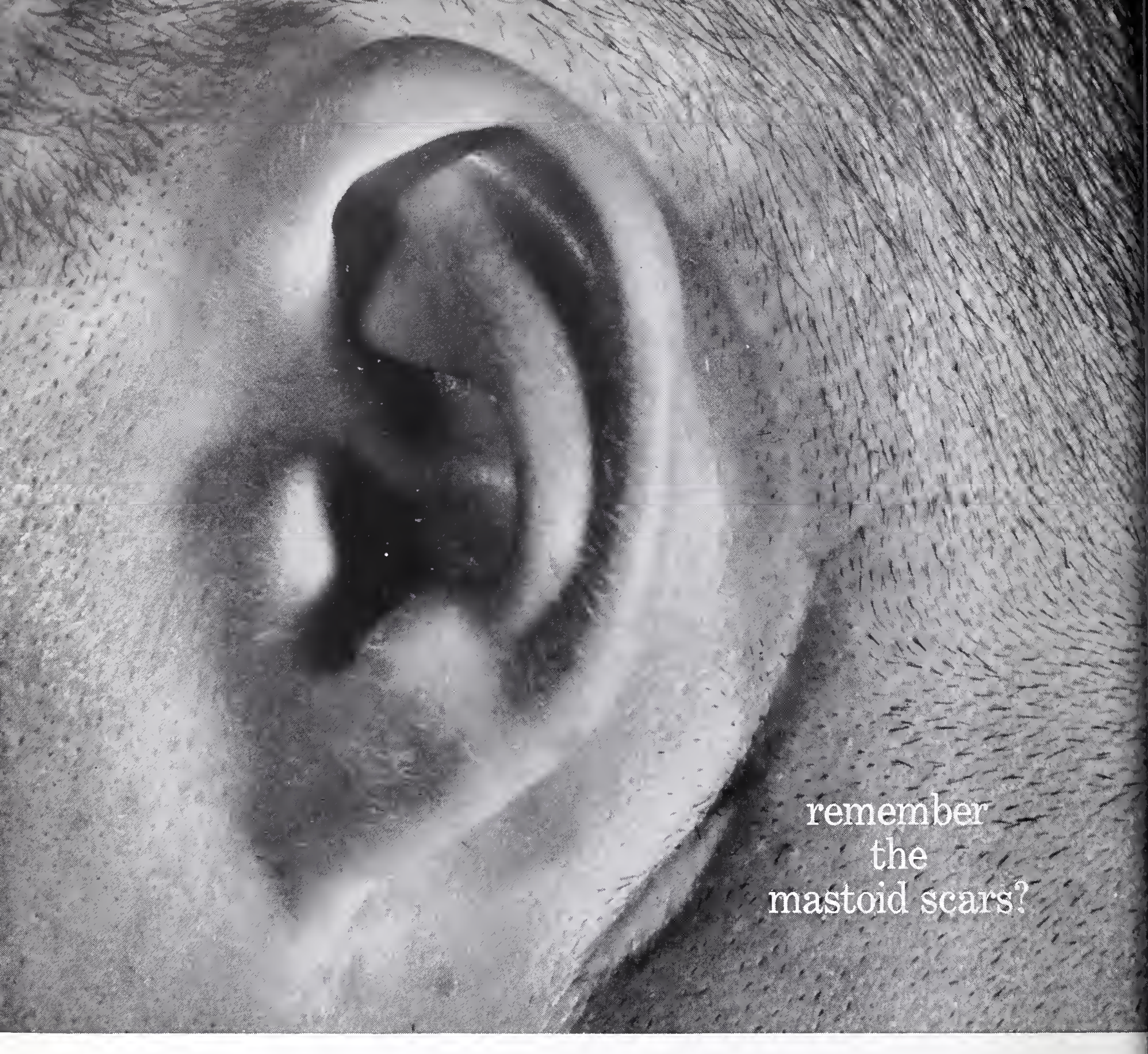


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*Asherson, N., "Acute Otitis and Mastoiditis in General Practice," H. K. Lewis & Co., Ltd., London, 1934.

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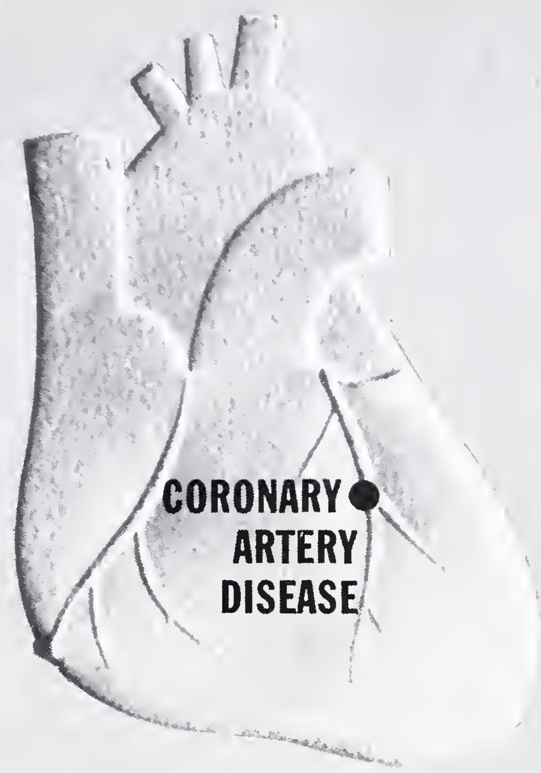


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*References:* (1) Root, H. F., and Bradley, R. F., in Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 10, Philadelphia, Lea & Febiger, 1959, pp. 411, 437. (2) Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: *ibid.*, pp. 188-189. (3) Marks, H. H., *et al.*: Diabetes 9:500, 1960. (4) Marble, A., in Summary of Conference on Diabetic Retinopathy, Survey Ophth. (Part 2) 6:611-612, 1961.

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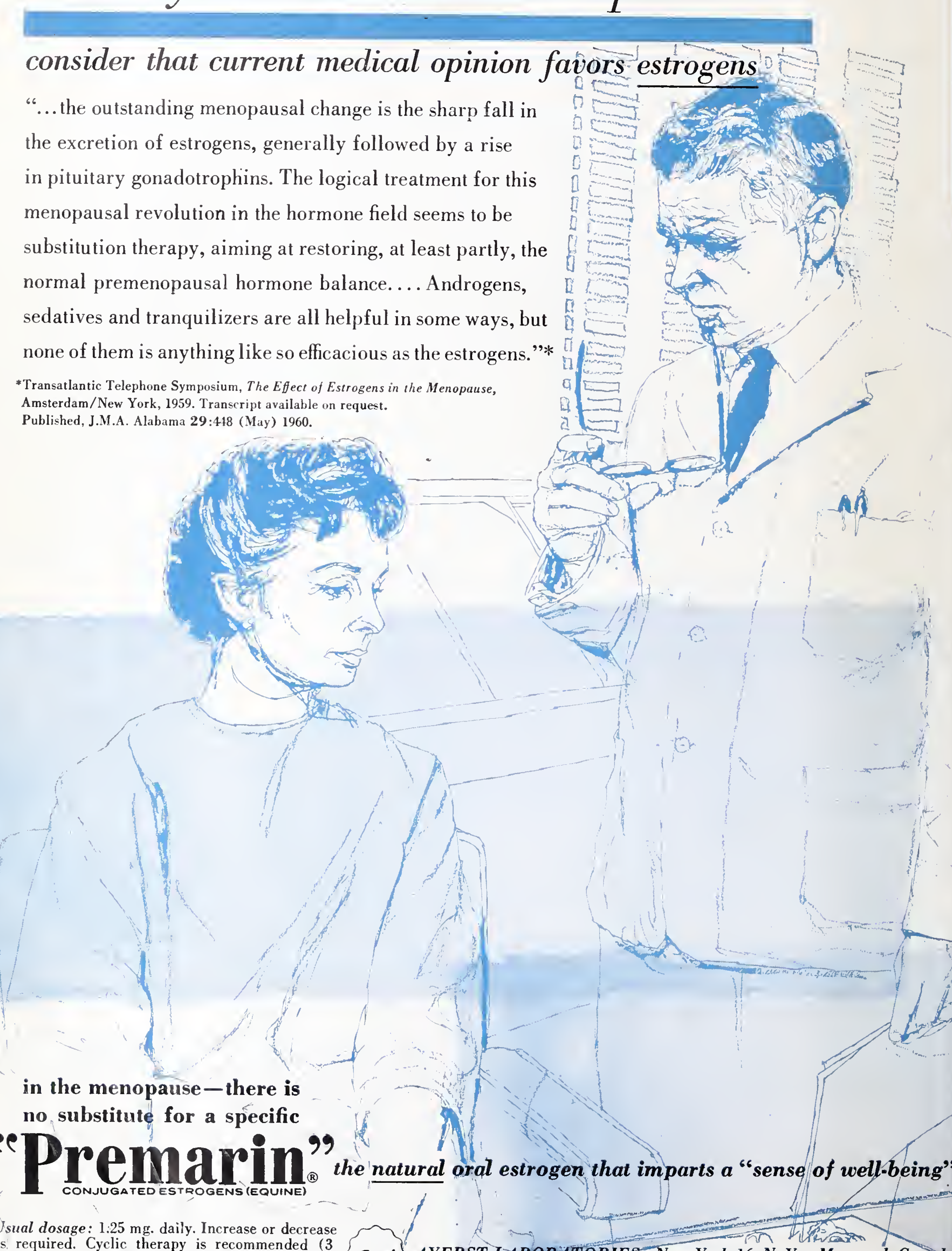

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Volume 22 • Number 3

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## In Staphylococcal Pneumonia[1-8,13]

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**References:** (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

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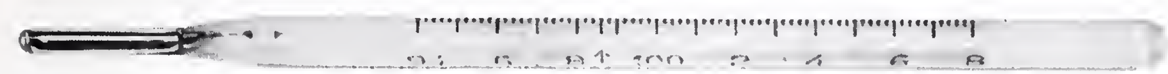

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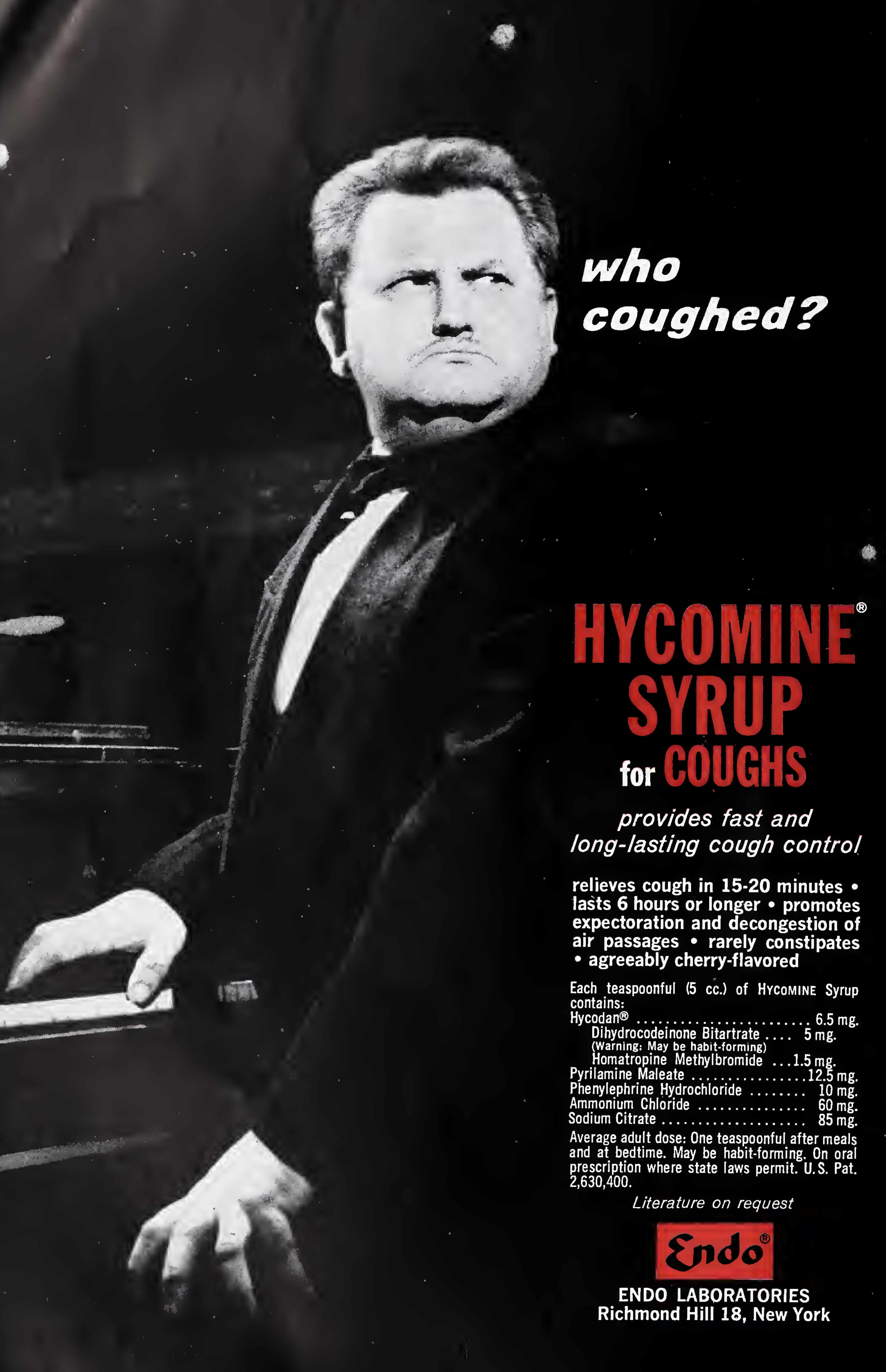
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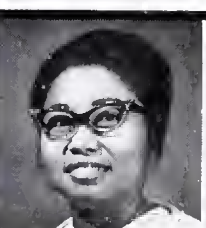
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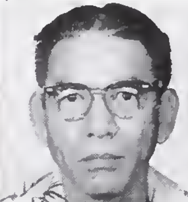
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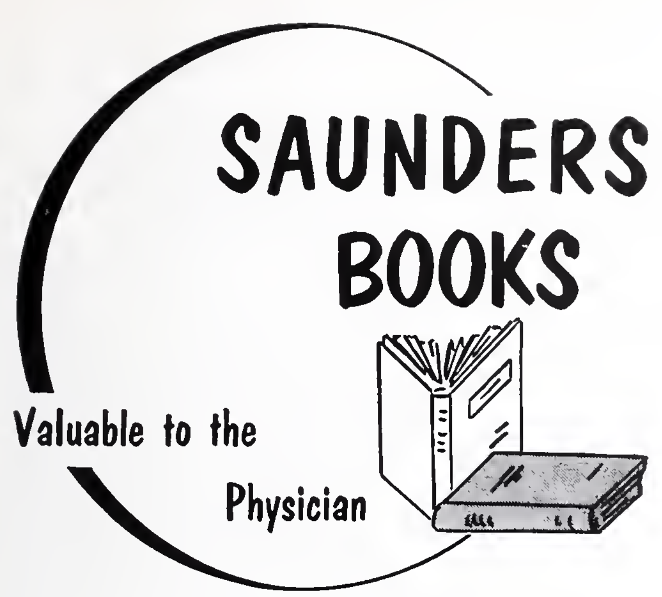


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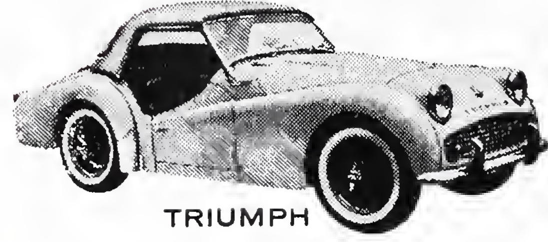

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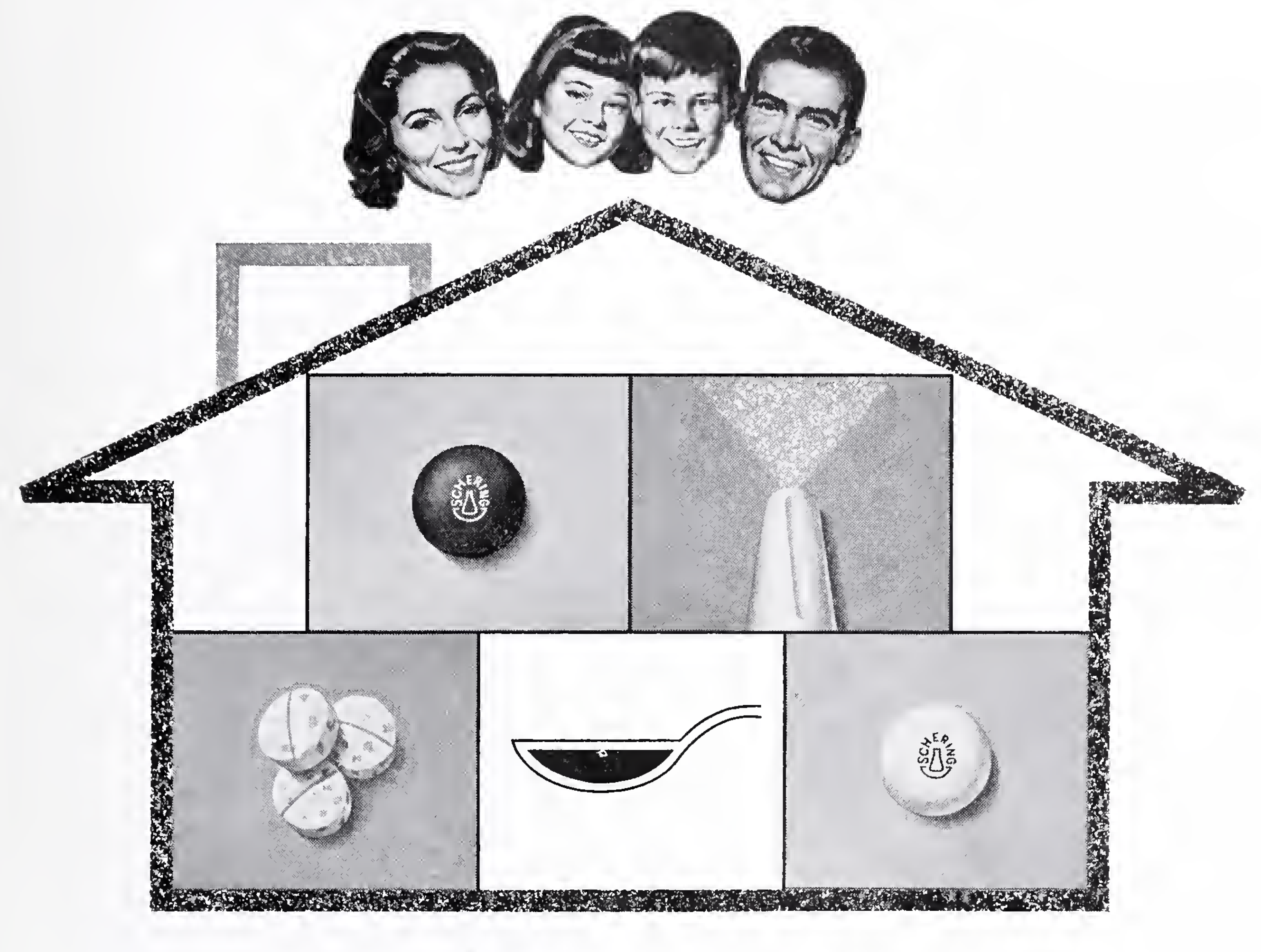


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# Medical Education in Honolulu

## Survey Report to the Continuing Education Committee of the Honolulu County Medical Society

MAX MICHAEL, JR., M.D.,* *Jacksonville, Florida*
HENRY S. M. UHL, M.D.,† *Albany, New York*

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*Executive Director of Jacksonville Hospital's Educational Programs, Inc., and Clinical Professor of Medicine, University of Florida Medical School.
† Assistant Professor of Postgraduate Medicine, Assistant Director of the Albany Regional Hospital Program, Albany Medical College of Union University.

# Preface

IT IS MOST appropriate that we extend our sincere thanks to all concerned with the survey. To those whom we interviewed—hospital officials, board members, officials of the Honolulu County Medical Society, the many practicing physicians, State Department of Health, and the personnel and officials of the University of Hawaii and of the Tripler General Hospital—goes our gratitude for the cooperative way in which they frankly discussed all questions and problems we posed. Their candor in presenting financial data, present hopes and frustrations, and future plans was reassuring and helpful. To the farseeing members of the Public Health Committee of the Honolulu Chamber of Commerce and to the various trusts that have made the survey financially possible, we extend our appreciation. We acknowledge a debt of gratitude to the chairman and to the members of the Continuing Education Committee of the Honolulu County Medical Society, whose perseverance and planning for this study made our work much smoother than it otherwise would have been.

In our report we have first reviewed our findings of the strengths and weaknesses of the hospitals surveyed, and of the present relationships between these hospitals and several community and state organizations. The section closes with a listing of the important deficiencies found that affect the quality of medical education in Honolulu.

In the final section, we have discussed in detail our recommendations for the correction of the observed defects. Our specific advice to the Continuing Education Committee is that an integrated program of graduate and postgraduate medical education be established in Honolulu. We believe that such a project is practical and essential. It is practical because the necessary resources are at hand: the community leadership, the qualified members of the medical profession, the physical facilities. It is essential because of the rapid pace of the progress of medicine, the absence of a university medical center in the islands, and the geographic isolation of Hawaii from the mainstream of medical knowledge and research.

We have chosen not to make specific recommendations concerning physical integration of the Children's Hospital and Kapiolani Hospital with The Queen's Hospital. It may be true that if one could now start from the beginning, it would be best to build an integrated medical center. But this ideal does not represent the situation in Honolulu. Physical integration will not accomplish one of its primary goals unless there is also a union, in spirit and in fact, of all those involved—trustees, administrators, physicians and surgeons, and nurses. We believe that this question can only be answered by the people of Honolulu.

It will be apparent that some of our recommen-

dations can be implemented immediately. Others will require careful planning and deliberate negotiation. The fact that the medical community of Honolulu has been restive with its present programs of medical education and has thought in terms of a major project for improvement is most significant. The accomplishment of so complex a task will require men of energy, imagination, and dedication. We are confident that such men will step forward and take up the challenge.

To you who have infected us with the persisting virus that evokes the true spirit of Hawaii—Aloha.

This survey was undertaken to determine the feasibility of a coordinated program of medical education in Hawaii. Several points from the charge given by the Continuing Education Committee of the Honolulu County Medical Society deserve special comment:

> . . . a coordinated program to bring all these facilities together will be of immense value. The hospitals, the practicing physicians, our Pacific territories and surrounding countries, the trainees themselves, and most of all the people of Hawaii, will benefit directly as Hawaii fills its role as the medical center of the Pacific under such a program.
>
> This committee feels that a program tailored to local needs is of the greatest importance.
>
> The committee wishes to emphasize that the objective is not the establishment of a medical school for undergraduate training; instead, the program recommended is one which will coordinate and augment existing facilities in this community.

We were thus charged with determining the feasibility of a coordinated educational program, of proposing the technique of undertaking such a project, and of recommending the organizational structure and practical methods of its financing. Finally, the relationship of this program to the possible development of a two- or four-year medical school at the University of Hawaii was to be considered.

### TECHNIQUE OF THE SURVEY

The following hospitals were surveyed—Children's, Hale Mohalu, Kapiolani, Kuakini, Leahi, Maluhia, Maunalani, Queen's, St. Francis, Shriner's, State Hospital, Tripler Army Hospital. We also visited the University of Hawaii, certain departments in the State Department of Health, and the Rehabilitation Unit. Discussions were held with board members, staff physicians, administrators, section chiefs and—very importantly—with interns and residents of the various hospitals. We also had the opportunity to discuss the program with two of the visiting professors who were in the community at that time.

This report will present, first, our findings as we have interpreted them, followed by a section on recommendations. Some of these can be undertaken immediately; others will require long-range planning. We have frequently compared our findings in Honolulu with similar situations in other communities. From such comparisons we have been able to draw realistic conclusions.

### MEDICAL EDUCATION IN COMMUNITY HOSPITALS

Nonuniversity community hospitals have only recently played a significant role in graduate medical education throughout the United States. This development has taken place during the past 15 years. To provide an understanding of the present position of the community hospital in the training of interns and residents, we shall review briefly the history of American medical education.

Before World War II there were about 65 approved medical schools, and almost all graduate training took place in university-affiliated hospitals. A relative handful of community hospitals offered a rotating internship of one to two years' duration, and occasionally there was a chief residency position, in medicine or surgery, of an unofficial nature.

However, even then it was clear that specialization was growing rapidly, and that in the near future there would be an expansion of hospital training programs to prepare recent medical graduates for the practice of the various medical and surgical specialties. The Advisory Board of Medical Specialties sponsored a nationwide study of graduate medical education by a special commission, whose report was published in 1940.[1] This study forecast the impending changes in medical education and pointed out that there was urgent need for skilled professional direction of programs in the nonuniversity community teaching hospital. The entire report is one of the fundamental contributions to medical education in the United States and has become a standard source of reference and information.

The recommendations of this report and their usefulness to medical educators were lost with the onset of World War II, when the whole structure of graduate medical education was disrupted and curtailed programs were initiated in order to prepare large numbers of physicians for service in the Armed Forces. After the war, thousands of discharged medical officers wished to take postgraduate refresher courses or further specialty training, since the advantages of specialization had become obvious during their wartime experience.

In order to meet this demand, many new programs were established by university and nonuniversity hospitals, under the approval of the Council on Medical Education and Hospitals and the various specialty boards. There are now approximately 12,500 approved internships and nearly 33,000 ap-

proved residency positions. Half or more of these are located in nonuniversity community hospitals.

During this rapid growth and expansion of graduate medical education to meet the postwar needs for the training of specialists, the structure of programs changed to the extent that the one-year rotating internship replaced the two-year rotating internship, largely because of the continuing needs of the Armed Forces for medical officers. The number of recognized specialty boards increased to over 20. The most common program of the American medical graduate today is a one-year internship, followed by two or more years of residency training.

In addition to American graduates, during the past ten years thousands of graduates of medical schools outside the United States and Canada have come to this country, and the vast majority have trained in the nonuniversity community hospital rather than in the university medical center.

Therefore, it is clear that the community hospital with an approved program of graduate medical education has become one of the most important parts of the structure of medical education in this country. Both general physicians and specialists are trained by the thousands in these hospitals; and there are thousands of graduates from overseas who receive all of their advanced hospital experience in these same hospitals before returning to their home countries.

The responsibility of the community hospital in medical education has become so important that poorly conducted programs can no longer be tolerated by the medical profession or the public as represented through governing boards. Each hospital with approved internships and residencies must make a maximum effort at reform and development.

The quality of medical education in the community hospital is usually far below that of the university hospital. This is largely due to a serious lack of skillful, experienced physicians to organize and direct the program. The Council on Medical Education and Hospitals of the American Medical Association and the specialty boards are aware of this difficult situation, and in recent years have gradually raised standards for the maintenance of an approved program.

At the present time, a nationwide survey is being carried out by a special committee under the sponsorship of the Council on Medical Education and Hospitals, with the approval of the Board of Trustees and House of Delegates of the American Medical Association. This study is being compared with the historically famous Flexner Report of 1910, through which undergraduate medical education in the United States was virtually revolutionized,[2] with a reduction of the number of medical schools from 150 to approximately 60 over a period of ten years.

Many community hospitals realized the deficiencies in their programs in the late 1940's and early 1950's, and established a position for a part-time or full-time Director of Medical Education. Although in 1952 there was a handful of these individuals throughout the country, a decade later the Council on Medical Education and Hospitals reported that there were 357 full-time and 493 part-time educational directors listed by the approved hospitals.[3] However, this field of work in medical education remains so new, and there are so few physicians with adequate experience and background, that the majority of the positions are filled by individuals who are forced to "learn on the job."[3,4] The American Medical Association published a guide[3] prepared by the Association of Hospital Directors of Medical Education in September of 1961, and this was followed by a detailed discussion of the position in the community hospital.

Therefore, the conclusion is inescapable that only those hospitals which vigorously organize and develop their programs to meet changing needs and standards will survive as teaching institutions in the decade ahead. It is certain that the competition among community hospitals in particular will become more difficult, and the successful recruitment of interns and residents of high quality will depend upon the skill, efficiency, and consistency with which the community hospital carries on its educational program.[5]

The important deficiencies in the community teaching hospital are seldom inadequate physical facilities, inadequate funds for the support of education, or unqualified physicians. Rather, they are the lack of experienced and skilled direction of their programs, the lack of a "faculty" with a primary interest in teaching, the lack of chiefs of clinical services with the knowledge and motivation to direct an educational program in their departments with a staff of voluntary physicians, and the lack of personnel and special laboratories for the basic sciences and research.

The country's need for programs in community hospitals will continue, although the time approaches when inadequate ones will be eliminated. Graduate medical education is equal in importance to undergraduate medical education in determining the way the individual physician will practice medicine throughout his career. The Council on Medical Education and Hospitals and all others concerned with medical education cannot tolerate indefinitely a double standard of hospital training programs, especially in view of the long and costly struggle through which double standards in our medical schools and undergraduate medical education were eliminated.

# Findings

### HOSPITALS

**Kuakini Hospital.** The physical plant of Kuakini Hospital is in the midst of extensive renovation and new construction. Despite the unavoidable confusion and occasional disruption, the hospital as a whole was clean and orderly. With the completion of the new wing, there will be both additional beds and space for special facilities, such as an intensive care unit and a recovery room. New operating room facilities are planned. The administrative offices will be integrated physically with the hospital.

The professional medical staff is self-governing, according to its constitution and bylaws, in keeping with standard hospital practices throughout the country. The chiefs of the clinical and laboratory departments are specialists certified by the appropriate American Board. There is a department of general practice, and general practitioners admit patients to all clinical departments according to their individual interests and ability. The Director of Medical Education was appointed two years ago by the administration on a part-time basis. At this hospital her role is largely administrative in nature since she does not take a direct part in clinical teaching activities.

The medical library is located in an attractive and roomy building separate from the hospital. In this building is the educational director's office. The secretary to the educational director acts as the medical librarian and secretary to the attending medical staff.

The clinical and anatomical pathology laboratories are under the direction of the chief of pathology and, although they are operating in cramped quarters, additional space will soon be available. The quality of work is excellent and the pathologist takes an active part in all teaching activities at the hospital.

There is a one-year rotating internship with a quota of 14. At the present time there are seven interns in training. In 1962, for the first time, these interns are not exclusively graduates of schools in Japan. Two are from the U. S. mainland, two are German, and others are from other parts of Asia and the Middle East. There is general agreement that the present group of interns, who are more competent to handle their responsibilities than were the Japanese graduates, have provided an excellent stimulus to the attending staff and have revived their interest in their program.

The two residents in surgery rotate through the integrated tri-hospital surgical residency program. The hospital does not operate an outpatient department, but takes care of ambulatory patients through the emergency room. The interns obtain experience in outpatient department clinics in medicine by rotating to The Queen's Hospital.

The educational program at Kuakini Hospital has made considerable progress in recent years. We believe that the basic strengths of the teaching activities are:

1. A strong department of pathology with an active interest in educational activities.
2. A strong department of radiology with an active weekly teaching program.
3. A strong department of surgery with a residency affiliation with Queen's and St. Francis Hospitals.
4. An adequate department of medicine with qualified internists participating in teaching.
5. Excellent clinical material in surgery and medicine.
6. The presence of a director of medical education.

The deficiencies of the present program at the Kuakini Hospital would appear to be:

1. Insufficient clinical material and insufficient participation by the attending staff in teaching activities in obstetrics and pediatrics.
2. An inadequate number of clinical journals received by subscription in the medical library and a textbook collection that is largely out of date.
3. The duties of the Director of Medical Education are primarily administrative: she does not take an active part in clinical teaching or in the development of planned, organized educational activities in the clinical departments, especially in obstetrics and pediatrics.
4. The large number of general practitioners who do not or who are not in a position to take an active part in educational activities for the house staff.
5. The interns are not given responsibility in the care and management of patients in pediatrics, obstetrics, and medicine, and often not in surgery.
6. We were unable to review the results of the tissue committee reports because they have not been kept for the past two years. This deficiency could well jeopardize the hospital's part in the surgical residency program.

**Kauikeolani Children's Hospital.** Our survey of this hospital revealed that the plant was adequate in patient care areas, in the emergency ward, and in the outpatient department. The clinical laboratory and the department of pathology are short of space but are expanding into an unused patient floor area. The operating room suite is relatively unused. There is a recovery room. Space in the department of radiology is adequate and includes a room that is used for cardiac catheter studies two days a week. The space for the medical library is satisfactory.

On the grounds of the hospital are included the Poison Control Center, and in a separate building the Rehabilitation Center of Hawaii, which serves the entire state. The physical plant is relatively

new and showed evidence of efficient and orderly administration.

A year ago, the position of Director of Medical Education was offered to a former resident and staff member who had returned to Hawaii after two years of advanced research training and experience in Seattle. The arrangements for his appointment were worked out between him and the chairman of the education committee. Upon assuming his duties about July 1, the new Director was faced with a new chairman of the education committee. Furthermore, this committee continued to function in a supervisory role rather than in the advisory capacity recommended by all authorities in this field of medical education. It is not surprising that a conflict has arisen.

The residency program, now staffed with a full complement of residents, has suffered a decline in the past year or two from lack of experienced direction. The decline in the percentage of staff cases admitted to the hospital, combined with the over-all decrease in admissions, has seriously affected the attractiveness and the value of the educational program. No detailed plan for the use of private patients in graduate teaching has been developed to meet this deficiency in staff cases. At the present time, the residents work up all patients but are permitted little responsibility for the writing of orders and the management of these patients. Frequently, patients are admitted with orders, or orders are telephoned into the nursing station. This same deficiency occurs on the emergency ward.

The outpatient department general clinic census is rather low, with 10 to 12 patients per session; about three-quarters of these are return visits. There is no attending staff coverage at the general pediatric clinic, but there is coverage at some of the specialty clinics such as pediatric cardiology.

A program of pro tem visiting professors is a vital part of the educational program, and as far as the residents are concerned, is absolutely essential. However, it is our impression that members of the attending staff who could benefit from the educational activities under these distinguished visitors do not take part. Almost all of the teaching is centered on the house staff; many members of the visiting staff seize this as an opportunity to devote more time to their patients in the other hospitals and in their offices.

The medical library, while adequate in space, is not administered by any one responsible individual. Journals are not kept in order, books are easily lost; there is neither a systematic lending procedure nor a method of obtaining new books; and there is no budget.

Two of the strongest aspects of the education program are the excellent clinical laboratory and the department of pathology, with its new chief, and the program of pro tem visiting professors. The rotation of the residents to Kapiolani Hospital for experience in the management of newborn infants and to Shriner's Hospital for experience and knowledge in the field of crippled children has worked out very well. However, a big gap in their clinical training is in the lack of any organized program of child psychiatry and psychology, and in the lack of opportunity to gain some basic knowledge about the child guidance clinics.

On the whole, the physical plant is adequate. The active attending staff includes virtually all the qualified pediatricians in Honolulu. But the deficiencies are striking. The inpatient census has fallen below a 50 per cent occupancy rate. There is a very low percentage of staff patients to be assigned to the residents. Very little pediatric surgery, other than routine tonsillectomies and minor procedures such as herniorrhaphy, is done. At the present time the relationship between the director of medical education and the education committee of the attending staff is unsettled, and is a source of serious conflict. Finally, a practical plan for the use of private patients in the educational program has not been worked out in detail, either for inpatients or for the emergency ward.

**Kaiser Hospital.** This 180-bed general hospital, operated by the Kaiser Foundation Health Plan, is staffed largely by the plan's physicians. It has no interns or residents, and was not inspected. It does furnish a source of clinical material and might ultimately be incorporated in the program.

**U. S. Army Tripler General Hospital.** The physical plant of this institution is beyond reproach. Its library, of first-rate caliber, is staffed by a full-time librarian. An ample full-time staff of board certified physicians, an active rotating internship, and approved residency training in medicine, surgery, pediatrics, obstetrics and gynecology, orthopedics, and pathology are available.

This hospital has one advantage over most other military installations because it serves as the veterans' hospital for the State of Hawaii, providing the house staff with an opportunity for seeing not only the younger person but the older individual with chronic diseases. Teaching rounds are held regularly, and excellent instruction is available for the residents and staff.

Interviews with interns and residents indicated that they are quite satisfied with their training. Their only objection was the excessive number of conferences that frequently cut into their ward work.

Contact between the Tripler staff and the physicians in Honolulu up to the present time has been rather poor. The consulting staff consists of physi-

cians from Honolulu, a few of whom are regular in their attendance; but the majority do not meet their teaching responsibilities. Reappointment has been automatic and, for the most part, meaningless in relation to education or service. The dermatologic groups in Honolulu and at Tripler work quite well together, with combined monthly conferences. The assistant chief of medicine now plans to begin making rounds one afternoon a week at The Queen's Hospital and certain conferences are to be alternated between Queen's and Tripler. Visiting professors who come to Honolulu rarely visit Tripler, and by the same token visiting professors at Tripler rarely go into the city. There are a number of conferences and special clinics at Tripler that would serve admirably to supplement residency training in the Honolulu hospitals. Among these are neurology, medicine, surgery, and pediatric conferences and clinics. The attendance of residents in Honolulu at the various exercises at Tripler have, with few exceptions (e.g. pediatrics), been rather spotty.

**Kapiolani Maternity and Gynecological Hospital.** The physical plant contains new and modern facilities in the obstetrical suite, delivery room, labor room, and patient rooms. The older part of the hospital, particularly the gynecologic operating rooms and ward area, is out of date and inadequate. There has been much discussion as to whether new construction should be undertaken on the present grounds or whether the hospital should abandon the present site and construct a maternity hospital, still under its present jurisdiction, but located on the grounds of The Queen's Hospital. This idea has been opposed vigorously by the obstetricians and gynecologists of the community, and by the Board of Trustees of Kapiolani.

The feeling of both groups is that such a move would make Kapiolani lose its character, its feeling of warmth, its specialized nursing service, and its special attention to maternity problems. Apparently, many women in the community prefer a maternity hospital. Taking all factors into consideration, the Board of Trustees at Kapiolani has decided against such a move and plans to expand Kapiolani in the near future. Preliminary drawings are currently being prepared by architects. The plans include revamping the gynecology operative suite, more patient beds, and furnishing adequate outpatient facilities, which are now housed in an ancient wooden structure adjacent to the main hospital building. Additional nursery and premature beds are needed now and for the future.

It is apparent to us that most of the specialists in obstetrics and gynecology prefer to bring their patients to Kapiolani, and that the general practitioners, on the other hand, do most of the obstetrics and gynecology in the three general private hospitals.

The medical staff is organized along traditional lines, the three major officers of the staff being the chief of staff, chief of the obstetrics-gynecology service, and chief of the pediatric service.

The library at Kapiolani is grossly inadequate and is in cramped quarters, used primarily by the medical records department. It is woefully lacking in material, poorly organized, and not conducive to study or contemplation.

The laboratories have limited facilities, but appear to be adequate for the general run of normal obstetrical patients. If complicated problems exist, satisfactory arrangements with one of the general hospital laboratories provide for the needed services.

The residents run their own pre- and postnatal clinics, which are held in an inadequate frame building with only two examining tables, with paper-thin partitions between them. Little or no supervision is given by the attending staff.

Better organization and supervision of the clinics with better utilization of ancillary services such as social service and dietetics could have a salutary effect.

A psychological research laboratory for investigation of reactions and learning in the newborn, operated by scientists from the University of Hawaii, is supported by a five-year grant from the NIH. There is no resident participation.

The training program at Kapiolani Hospital will be detailed in greater length in the section on integrated residencies. This program has served as a model of the value of integrated programs. Now that it is fully approved and off the ground, it must be constantly reappraised and improved. It needs better organization and planning, and residents interviewed felt the actual teaching was weak, with the exception of the visiting professor program.

We were frequently confronted with the problem of the distribution of obstetrical and gynecologic patients in the general hospitals. The obstetrical service at Kuakini is undergoing intensive study at the moment to decide whether it should close completely, since its census continues to fall and the attending obstetricians and gynecologists prefer to take their patients to Kapiolani. In the other general hospitals, the majority of the obstetrical patients are admitted by general practitioners. By the same token there is very little staff gynecology done at Kapiolani.

**Maluhia Hospital.** This is a city-county chronic disease hospital under the direction of part-time physicians. It is crowded with elderly, debilitated,

and, for the most part, bedridden patients. There is little attempt at rehabilitation. There is an inadequate physiotherapy unit. The three social workers are essentially financial investigators.

A 92 per cent occupancy rate is the usual pattern. When there is a further demand for beds, some of the patients are transferred to nursing homes that are admittedly inadequate. Any complications, medical or surgical, are handled by transferring the patient to one of the general hospitals. Only simple medications are administered. Medical care seems inadequate and although this is called a chronic disease hospital, it is in essence a nursing home type of institution. Formerly, house officers in various training programs in the city spent some time in rotation at Maluhia. Under the present establishment and with its limited facilities, it would seem inadvisable to include this hospital in any residency training program.

**Maunalani Hospital.** This is a beautifully-situated, well-equipped, and efficiently-run institution. Although it contains a moderate number of patients with chronic diseases, there are many in convalescence. Its rather inconvenient location away from the general hospitals probably explains in part why it is not used more frequently by physicians for convalescent care of their recently discharged patients. Although the nursing care is excellent, the convalescent patients still have need for the frequent attendance of their physicians.

The difficulty of getting in touch with the physicians of acutely ill patients in the hospital was pointed out. Officials at the hospital would like to have a resident spend some time at Maunalani, feeling it would be instructive for him to learn of the problems of convalescent care. During such an assignment the hospital would be willing to bear the cost of his salary and food; there are quarters where he could be lodged.

The service seems active enough to give a resident a good cross section of the problems of convalescent care. Although short assignments are undesirable, it is our suggestion that a rotation of no more than two weeks to a month would be indicated.

Perhaps this assignment could be combined with other ancillary services, such as the Alcoholism Clinic and the chronic disease unit at Leahi. If residents were to be rotated through Maunalani, it should not be for the purpose of substituting for visits by the attending staff.

**Leahi Hospital.** Leahi is the State hospital for tuberculosis, and receives its financial support from the State. It is operated, however, as a private institution with its own board of directors. The hospital's main building, constructed in 1950, is well planned, with ample space and grounds, and excellent modern features. As is the case in all hospitals for tuberculosis, its census is dropping steadily and its outpatient load increasing steadily. Within the past year, 80 patients with chronic illnesses have been transferred from Maluhia into one of the older buildings on the grounds.

There are six full-time physicians on the staff. There are well-equipped laboratories and a competent biochemist who is not only undertaking his own investigative problems, but is doing routine and special work for other hospitals and groups in the city. Research is being carried out in cardiopulmonary physiology. The pulmonary function laboratories are quite well equipped. The library has an outstanding collection of materials pertaining to diseases of the chest.

The hospital is approved for training in medical chest diseases and in thoracic surgery. A second-year resident in medicine from Queen's now rotates to Leahi.

We were informed that conversion of Leahi to (a) a general hospital, or (b) the University Hospital, when and if there is a four-year medical school, has been discussed in recent months. It is certainly true that the demand for beds for patients with tuberculosis is decreasing; however, it would be foolhardy to predict whether this could become a university hospital. The physical plant is so good that many other uses for it could be found. A well-staffed chronic disease hospital, with facilities for rehabilitation, would be ideal at Leahi. Also, with the steady growth in population of the State, one can anticipate the ultimate need for another psychiatric institution. Certainly there should be no thought of abandoning Leahi as a hospital, but careful planning must be undertaken so its ultimate role can be intelligently formulated. As far as training programs are concerned, residents in medicine can profitably continue to spend time at this hospital.

**The Queen's Hospital.** The physical facilities of this hospital are adequate in all respects. It includes a unique and efficient layout for the outpatient department, a research floor in the new wing, an outstanding clinical laboratory and pathology area, an excellent radiology department and radioactive-isotope unit, a psychiatric inpatient unit, and a psychiatric clinic. In addition, there is a modern auditorium and a new medical library.

The organization of the medical staff at Queen's is along traditional lines. Of importance to the educational program is the selection of the chiefs of the clinical departments and the position of the director of medical education in the hospital organization. The chiefs are elected by active staff members in the individual departments and their recommendations are submitted to the Board of Trustees. This may not be binding upon the board,

since that body is authorized to reject an individual recommendation if the candidate is not properly qualified. The appointment of a chief is for a maximum of three years, after which time he must be renominated and reconsidered by the Board.

The Director of Medical Education was appointed on a half-time basis and began his duties as of July 1, 1962. His relation to the attending medical staff has not been clarified and it is our impression that he is now acting as quasi head of the residency program in internal medicine. Interviews with interns and residents indicated that the appointment of the educational director has had considerable impact upon the program. In the short space of less than two months there has been marked improvement in the organization, planning, and direction of teaching conferences, of schedules, and of the development of relations with other hospitals and institutions in the area, such as the Tripler General Hospital and the University of Hawaii. Unfortunately, because of his commitments to his research activities and because of the many problems in the hospital, the Director of Medical Education has already become involved in too many activities, and this may interfere with the effectiveness of his work in the near future.

In the outpatient clinics, the space is adequate and the organization of the physical facilities is outstanding. The medical clinics are staffed by the educational director, who runs the screening clinic, and by two salaried physicians who attend the general medical clinic in the morning. However, while the house staff does most of the work, the attending staff in medicine is seriously deficient in their failure to take part in these clinics and provide supervision and teaching of the interns and residents.

The newly-established medical library is a significant contribution to the program. Even though the Hawaii Medical Library is on the same grounds, it is located in a separate building and is not readily available at night and on weekends.

The internship has its chief source of strength in the excellent clinical material that is admitted to this hospital in all fields of medicine and surgery. However, there are striking deficiencies. Too little teaching supervision is provided on the pediatric floor. In surgery, the intern has virtually no educational activities, even though he does "see an enormous amount of surgery." His experience in medicine is good on the two services with staff patients, but it is rather weak on the private services. There is a good volume of patients in obstetrics and gynecology, the majority of whom are available to the house staff for teaching, and for their own clinical experience.

The medical residency program has been seriously deficient in organization and direction by the chief of medicine and the active staff members. The program has been especially weak at the second-year level, which has been little more than a repetition of the first year. The organization of teaching conferences and schedules is left entirely in the hands of the senior or chief resident. We have already mentioned the poor coverage of teaching responsibilities in the outpatient department.

However, again, in the relatively brief period of time the educational director has been active, this program has been greatly strengthened, at least from the standpoint of organization. Conferences are scheduled accurately and are conducted properly with adequate preparation. Ward teaching has been improved. Advantage is being taken of other medical facilities in Honolulu, such as Leahi Hospital. Qualified experts from Tripler General Hospital and the University of Hawaii are taking part in individual teaching activities.

Still, there is need to develop specialties for the second-year residents. Their experience in pathology, which has now been established in the second year, is worthwhile. The biggest single deficiency remains the lack of effective participation in teaching activities by qualified members of the attending medical staff, and the correlated failures to develop sound systems of teaching and learning experiences on the private services.

**St. Francis Hospital.** The physical plant is good and is being improved by a program of renovation and rebuilding. The new laboratory and clinics are well planned and are admirably arranged for teaching programs. The conference room is bright and airy, more like a solarium than a meeting area.

The staff at St. Francis is an active and a vigorous one, organized into all of the traditional departments, including a department of general practice. The majority of patients admitted are under the care of specialists.

A surgeon is the Director of Medical Education. This position was created at St. Francis in 1958. He works on a part-time basis, and his duties are principally administrative. He spends all morning in the hospital and does some teaching in the surgical field.

Situated in a new structure on the grounds adjacent to the main building, the medical library is combined with the nursing library under the care of a full-time librarian. The facilities are adequate and pleasant for reading and contemplation. We recommend the acquisition of more recent text books and a more extensive journal collection.

At present a rotating internship is offered. All positions are currently filled by graduates of American medical schools, an improvement, since

formerly the majority were foreign graduates. Residents are in training in the field of medicine, in surgery and in obstetrics-gynecology as part of the combined programs. There are no pediatric residents.

Clinics are under the direction of a part-time physician. General practitioners are assigned in the outpatient department as preceptors, but they are not too faithful in meeting their responsibilities. A screening clinic in the outpatient department is run by a medical resident, who sees new patients, those previously seen in a specialty clinic, and those who have new medical complaints. It is planned to admit only new patients to this clinic, which averages from three to ten a day. There is a medication refill clinic, also handled by the screening physician.

The interns are the only ones assigned to the general medical clinic, each intern working one morning a week throughout the year. Although this clinic is in the province of the general practice department, it is not being administered by this group. Half of the attending men are internists and half are general practitioners. Attendance by the internists has been spotty because of time scheduling.

Medical residents work in the specialty clinics in addition to the screening clinics.

An outpatient advisory committee, composed of one member of each of the major clinical departments, the Director of Medical Education, and the director of the outpatient department, is apparently only mildly effective. Problems in the outpatient department are taken up with the particular representative from the specific group.

The obstetrics and gynecology beds are about 50 per cent occupied, and the majority of the work is done by general practitioners. Again, the specialists in obstetrics and gynecology prefer to do their work at Kapiolani. Two years ago, a threatened split of the St. Francis-Kapiolani residency affiliation failed to materialize. The visiting professor at Kapiolani also teaches at St. Francis during his tour of duty.

The surgical residency program has been integrated with that at Queen's and Kuakini, resulting in the present four-year plan, and the visiting professor in surgery also spends time at St. Francis. The chief of surgery is satisfied and would like to see a similar integrated program in other services. Those residents interviewed who had spent time on the surgical service at St. Francis were generous in their praise of the teaching and responsibility they had, even though most of the work was on private patients. This fact emphasizes that residents in surgery can be given adequate responsibility for the care of private patients.

In the pediatric department, the majority of the patients are admitted by general practitioners; most of the pediatricians on the staff send their patients to Children's Hospital. Three years ago there was an agreement between Children's and St. Francis Hospitals, whereby Children's residents rotated through St. Francis. It seemed to be satisfactory and did furnish a good program for the residents; however, this arrangement was discontinued. Formerly, the "premature" center for the island was located at St. Francis.

The current chief of pediatrics at St. Francis stated the reason he takes his patients to Children's rather than to St. Francis is that they get more specialized nursing care and there is resident coverage. Were there pediatric residents at St. Francis, he feels he would admit his patients there. Conversely, surgeons prefer to do pediatric surgery at The Queen's Hospital or one of the other general hospitals because of the presence of surgical residents, and they do not feel that there is enough material at Children's Hospital to warrant a full-time resident in surgery there.

In the department of internal medicine at St. Francis, there is insufficient teaching by internists in the community, because their efforts are diluted among three hospitals. They have had preliminary discussions about coordinating their efforts, but have made no concrete plans. There is overlapping of conferences and of service assignments. Records of interns and residents are not countersigned. Even so, a core of internists is very active and devoted to clinical teaching.

Interns said the medical service is best, because this is the only service where they feel they are responsible for the management of patients. They work up all patients on medicine, whether they are those of an internist or a general practitioner. It is standard practice, however, for a patient to arrive at the hospital with orders already written. Rounds in medicine are of good quality.

In surgery, on the other hand, the interns feel that they spend most of their time doing physicals and that they get little teaching. Their assistance in the operating room is dictated by the needs of the surgeons, and they do not necessarily assist with patients that they have worked up.

In obstetrics and gynecology, most of the training is geared for the residents. Interns and residents felt that the conferences in general were of poor quality and showed lack of preparation, and that most of them were statistical surveys. Private patients were not usually discussed at the formal conferences.

Interns felt that there were too many conferences that took them away from their work. X-ray conferences were good, but CPC's were spotty, depending upon the preparation that had been given.

The interns like the clinics, particularly the general medical clinics. Because of the limited number of staff patients, they feel more private patients should be used for teaching. When a man is on service he spends all of his time on two or three staff patients, and not enough time on other patients in the house.

The resident on medicine was interviewed; she feels that teaching is a matter of the initiative of the house officer. When she can pin down one of the visiting men, she does get good teaching. The work load and the type of patients is satisfactory, but the inaccessibility of the private physician is a major complaint.

St. Francis operates a home-care program, under a grant from the U. S. Public Health Service. This is a demonstration project that furnishes nursing care, occupational therapy, medical and social service, laboratory work, and medication to the patient in bed at home; patients may be full-pay, indigent, or part-pay. At present this is used entirely by private patients. It is anticipated that in the future the house staff will follow up their staff patients in the home.

An ad hoc committee on medical education, composed of members from all of the services, has been active for one year. Its charge is to find out how to interest the attending staff in teaching, to evaluate critically the teaching program, and to evaluate the role of the Director of Medical Education in the hospital. However, the integration of programs with other services in the community has not been explored at present. The committee has been gathering ideas and facts. Ultimately its report will go to the executive board.

The intensive self-evaluation of this committee is most commendable, and the complete cooperation of the hospital administrator is indeed noteworthy. This report might well be applied to all hospitals in Honolulu; it should be studied by all. Their preliminary recommendations and evaluation follow:

1. Patients should not be admitted with pre-written or telephoned orders.
2. Many of the interns are mediocre, and most of them come for the climate. The need for more teaching and more drive in the intern program is evident: poor coordination and poor supervision are the major faults. Although some on the committee felt that the rotation among the hospitals is the answer for interns, the majority feel that this is not the case. The general basic problem is the curriculum. The fact that residents are not first-rate means that interns lose an important aspect of training. Some of the committee feel that instead of one director of medical education there ought to be part-time instructors to create a faculty within the hospital.

There is a ferment in the field of medical education at St. Francis Hospital, and the whole group is receptive to changes. Obviously, not all staff members are interested in teaching, but the leaders in this hospital are the ones who are sympathetic with and aware of the needs of a good training program. The cost of training programs is well understood and is appreciated by the administrator, who makes every effort to find funds for all phases of the educational programs.

**Shriners' Hospital for Crippled Children.** This hospital for children with orthopedic problems is housed in a reconverted estate, pleasantly constructed, with open lanais, and has ample facilities for chronic and convalescent care. The hospital is full and at present there is a waiting list of 75 patients. The major problems seen are congenital deformities. An increasing number of patients come from the Far East, Guam, Samoa, Tonga, and Okinawa. Consequently many patients are hospitalized for procedures such as casting for club feet, ordinarily done on an outpatient basis.

There are two orthopedic residents, one coming from the Northwestern program and one, for a six-month period, from Tripler General Hospital. The second-year pediatric resident at Kapiolani manages the pediatric problems at Shriners' and has weekly rounds with the chief of pediatrics. The visiting professor in pediatrics usually goes to Shriners' Hospital. The outpatient clinic meets weekly and handles from 50 to 75 patients. Residents attend the weekly fracture conference and general orthopedic conference at Tripler. Attending physicians are paid a fee for their services.

Construction will probably begin within the coming year to expand the hospital to 60 beds. It was suggested to us, while at Kapiolani, that perhaps certain facilities used by both Shriners' and Kapiolani could be combined when both the new building programs were commenced. This would include laundry, nurses' quarters, laboratory, x-ray, steam plant, and the like. We investigated this possibility while at Shriners' and learned that according to the charter of all Shriners' hospitals, this cannot be done; they are not permitted to share any facilities with other institutions.

**Hawaii State Hospital.** The State Hospital for psychiatric patients, situated at Kaneohe, across the island from Honolulu, is in an expansion phase and its physical plant seems quite adequate. The majority of the staff are full-time. This is the hub of the training program in psychiatry.

There is a well-equipped operating suite, and a surgical resident from the integrated program holds a weekly clinic. Those patients requiring surgery are operated upon there by the resident. We were impressed by the administration of the institution and by the sincere interest in teaching displayed by all of the staff physicians. The hospital has a good psychiatric library and the laboratories are adequate for the patients cared for.

All of the newer techniques in psychiatry have

been adopted by this hospital. For example, there are rooms with one-way viewing glass so that residents can observe techniques in history-taking. The newer wards are bright and cheery and do not have the depressing atmosphere of older state psychiatric hospitals. The psychiatric training program, approved for three years, is well-rounded and offers good training in the general field of psychiatry.

### NONHOSPITAL PROGRAMS

**University of Hawaii.** Interviews were conducted with Drs. Richard K. C. Lee, Ira Hiscock, Willard Wilson, and Robert Hiatt. The educational activities of this institution relating to medicine and public health may be enumerated as follows. There are graduate programs leading to the master's degree and, in some instances, to the Ph.D. in medical genetics, social service work, psychology, microbiology, physiology, biochemistry, parasitology, entomology, marine biology, nutrition, biophysics, and health statistics. A Department of Public Health of the graduate school was created on July 1, 1962, and it is proposed that this will eventually develop into a School of Public Health.

Many of these activities will move into the Life Sciences Institute, which, financed to a large extent by the National Institutes of Health, is nearing completion. Thus, there is already a fine nucleus of professional talent that can be utilized in existing and in projected teaching programs among the community hospitals of Honolulu.

In considering a medical school for Hawaii, the fact is that at the present time little more than a score of citizens from the islands enter medical school on the mainland each year. This indicates that there is not enough demand now to warrant a full four- year medical school in Hawaii; however, the practicability of developing a two-year school in the basic sciences is being studied. It is anticipated that an application for a feasibility grant will be made early in 1963, the study to begin shortly thereafter. Perhaps an integrated program based in the Life Sciences Institute could form the nucleus for the two-year medical school.

The University officials visualize that the existing basic science program and a two-year medical school may serve as a faculty resource for limited or special support to the existing residency training programs in the city. There could be a sharing of talent in conferences and research, but the officials maintain that the community must solve its own problems of medical education and residency training, with a medical school serving as a catalyst and a strengthening agent. All officials of the University of Hawaii are enthusiastic about the projected coordinated programs of residency training, and will cooperate in the sharing of talent and the utilization of facilities. They point to the success of the existing nurses' training program between the University of Hawaii and the hospitals in the community.

Mr. Herbert Cornuelle, chairman of the Board of Regents of the University of Hawaii, has emphasized the need for careful planning for a medical school. He confirmed the cooperation of the University officials as outlined in the preceding paragraphs, but he emphasized that at this time the University cannot predict its ultimate role in medical education.

**The Rehabilitation Center.** The Rehabilitation Center on the grounds of Children's Hospital is attractively constructed, well equipped, and staffed under the capable direction of Dr. Fred Shepard. It is filling a basic need in the community, although it only reaches a small segment of those requiring its services. However, this important facet of the practice of medicine is being neglected because it is not utilized in any of the community's intern or residency programs. This does not stem from a lack of desire to cooperate on the part of the mmbers of the unit.

**The Hawaii Department of Health.** The State Department of Health, under the directorship of Dr. Leo Bernstein, has many facilities and activities which could become integral parts of all medical training programs in the community. Their utilization has been freely offered and expansion of appropriate programs could undoubtedly be undertaken. Those activities which appear particularly appropriate and useful to your consultants are:

1. The Independent Living Project is designed to furnish just that amount of rehabilitation which will permit the otherwise bedridden patient to attend to his basic physiologic needs and thus free a wage-earner from the home. Its activities are centered at The Queen's Hospital. The team approach is utilized. The Federal funds for this project will end in 1963, and thus far there has been no house staff participation.

2. The alcoholism program, designed to cope to some extent with the problem of alcoholism in the community, furnishes a splendid opportunity for residents to become acquainted not only with some of the community sources available but with some of the techniques of handling alcoholism. Participation by residents in medicine, in psychiatry, and in the clinic at Leahi would seem warranted, although this has not taken place to date.

3. The well-staffed State laboratory, with refined and sophisticated techniques, particularly in the field of infectious diseases, is being utilized by the hospitals purely as a service function. Residents do not participate, do not visit the laboratory, and have not familiarized themselves with the various

procedures, the techniques of collecting samples, or the limitations and interpretations of the tests performed.

4. The psychiatric residency program will be detailed under the residency training in psychiatry and in the discussion of the State Hospital. Under the WICHE program, the State has sponsored seminars in psychiatry for general practitioners, financed by a three-year grant from the NIH. Ten two-hour seminar sessions are held twice a year. The program is quite successful. The Waimano Home for mentally retarded could be utilized for clinical residency training, particularly in pediatrics.

5. In the three cardiac clinics (one each at Queen's, St. Francis, and Children's), the state subsidizes the physician, the social worker, the laboratory work, and the electrocardiograms, as well as the penicillin for prophylaxis, and pays the fees for service to the hospital. Three separate clinics of the same type in a community this size and under the same sponsorship are wasteful.

6. Two maternity clinics have been sponsored by the State. Complicated maternity problems are seen in the clinic at St. Francis. The demonstration clinic at Kapiolani did not work out well and was closed, which is regrettable, for here the house staff had an opportunity to observe the team approach; the clinic personnel included social workers, nutritionists, and other paramedical workers. The physicians at Kapiolani did not accept responsibility for the clinic, but left the administrative load up to the Department of Health. The head of the residency training program was cooperative, but since the physician in this position changed from year to year, no continuity was possible.

7. There are three state clinics and child health conferences, but participation by residents is negligible.

8. For the Hansen's disease program, a separate outpatient clinic at St. Francis Hospital furnishes an opportunity to observe the many manifestations of leprosy and the methods of ambulatory management. At present, the medical resident from Queen's assigned to Leahi has an opportunity to study these patients in the clinic. Formerly, when Queen's had a smaller patient load, an elective was offered where the man could spend time at Hale Mohalu. This was partially satisfactory. Although this disease is rapidly diminishing, it still poses a public health problem. Participation in the clinic at St. Francis would seem to be highly desirable, but it is questionable whether a regularly assigned tour of duty at Hale Mohalu would be profitable.

### EXISTING COORDINATED PROGRAMS

**Obstetrics and Gynecology.** This combined program was begun in 1956, between Kapiolani Hospital and St. Francis Hospital. Dr. Edward Leveroos visited Honolulu while Associate Secretary of the Council on Medical Education and Hospital of the AMA. He recommended that three hospitals (these two and The Queen's Hospital) form a coordinated program in order to provide a larger volume of patient material and to involve the various practicing specialists in the city more effectively in teaching. At that time St. Francis Hospital had a one-year residency, and Kapiolani and The Queen's Hospitals both had two-year residencies. About three years ago, the American Board of Obstetrics and Gynecology established a policy that only full three-year programs would be approved for training. At this time, The Queen's Hospital joined the other two hospitals. The program was reevaluated in the spring of 1962, and in July of 1962 approval of the three-year program for the next two years was granted. It was noted by the surveyor that efforts should be made to develop more surgery for the resident in gynecology in his third year, and a program of graded responsibility for the residents at the three levels.

The program is under the supervision of a committee of representatives of the three hospitals, and the chairman of this committee is primarily active at Kapiolani Hospital. Residency applications are received at Kapiolani Hospital and are acted upon by the committee. At the present time, residents are rotated to this program from the University of Oregon and the University of Colorado.

The present strengths of this program include the augmented clinical material available to individual residents on their rotation to the three hospitals. This exposes the residents to an increased number of experienced specialists with a genuine interest in teaching. Arrangements have been made for the chief resident to visit the State psychiatric hospital and Leahi Hospital each week to screen the relatively large number of elderly female patients for possible gynecologic medical and surgical problems.

Kapiolani Hospital provides a strong program in the care of the newborn in its nursery and in the care of premature infants through its affiliation with the pediatric residency program of Children's Hospital. In this area, St. Francis Hospital and The Queen's Hospital are not so strong. On the other hand, St. Francis Hospital provides excellent clinical experience in obstetrics, with a corps of attending staff specialists who are devoted to teaching and provide excellent supervision. Many of the patients of the general practitioners are freely used in the teaching program. The conferences at this hospital are adequately prepared and well presented.

At The Queen's Hospital, gynecology staff cases

are superior in volume and variety to those at the other two hospitals, and there is excellent teaching. However, throughout the program, instruction in office gynecology is weak and there is some deficiency in the teaching of gynecologic endocrinology. The program of pro tem visiting professors is helpful in filling in some of these important lacks.

At Kapiolani Hospital the medical library has been seriously neglected—or at least not properly developed. It should be relocated in an area not used for other activities. Some member of the administrative staff of the hospital should be put in charge of the operation of the library, and a system for its use and for its continued supervision and development must be worked out.

The department of obstetrics at Kuakini Hospital is not part of this coordinated program. It is the opinion of the majority of the obstetrical specialists in Honolulu who are concerned with the program that this service should be closed and its patients admitted to the three hospitals where there is an active teaching program. Although this point will be discussed in detail subsequently, it is mentioned now primarily to note that there is no indication that this department should be added to the combined program.

**Surgery.** Because of the decreasing number of staff patients—a universal phenomenon—and because of the desire to achieve the highest level of surgical training in a four-year program, the present integrated residency was organized to include The Queen's, Kuakini, and St. Francis hospitals. The committee for the integrated program meets regularly and concerns itself with many of the problems of training. While a good deal of progress has been made, this must not lead to a sense of complacency. This program is new, and it is possible that the present scheme of rotations will be altered as experience is acquired and properly evaluated.

Efforts to increase the amount of staff material, such as having the third-year resident hold clinics at the State Hospital, are commendable. The visiting professor program in surgery has been successful. As in other programs, these men should represent a variety of interests. The advantages of the program, in addition to providing more staff patients, are: (1) there is less friction between services and the chiefs evidence more enthusiasm for teaching; (2) the conferences have improved; (3) the relationships between the house staff and attending staff have improved.

There are certain deficiencies:

1. There is a very steep pyramidal system that creates problems, not only in attracting residents, but in maintaining a true esprit de corps among them.

2. The residents receive very little responsibility for private patients, with few exceptions. They, as well as interns, are often asked to scrub for operations on patients they have not worked up or managed. In other words, the residents are being utilized for service rather than for education.

3. The residents do not have enough of the "minor" surgical experience, including such procedures as herniorrhaphies, appendectomies, and biopsies.

4. There is a conflict between certain conferences, for instance the Saturday morning grand rounds at Queen's Hospital, and the surgical conferences at St. Francis Hospital.

5. The residents sense a lack of discipline, engendered, no doubt, by the lack of a feeling of unity and a lack of unified program direction.

6. The training program is not arranged to give the residents increasing responsibility or proper utilization of time.

### VISITING PROFESSOR PROGRAM

Historically, this program began with the appointment of Dr. Irvine McQuarrie as Director of Medical Education at Children's Hospital in 1956. The geographic isolation of Honolulu, combined with the exponential growth of medical knowledge, has made this program mandatory in order to keep the medical community informed and to reinforce the intern and residency educational training.

The program has since been extended to include surgery, obstetrics-gynecology, and medicine. There are two visiting professors in pediatrics annually, each incumbent spending three months in Hawaii. The total cost is $3,500.00 per visit. In medicine, surgery, and obstetrics-gynecology, the customary visit is one month. The majority of the teaching in pediatrics is done at Children's and this institution bears the full cost. The other visiting professors divide their time among the hospitals with residency training; these hospitals share the cost.

The selection of men, scheduling of time, and financial arrangement can easily be improved.

We have contacted former visiting professors who are, in general, enthusiastic about the program. Our major concern has been that the attending staffs have permitted the visiting professors to "take over completely" the teaching; some have felt this to be the case, others have not.

The cooperation of administration and of governing boards to provide funds is wholesome. As we shall detail later, this program is essential and, with a few changes, could be made even more profitable.

### GENERAL OBSERVATIONS

Before closing this section on our findings, we wish to make a few general statements that we believe are important in their relation to the quality of medical education being conducted in the various hospitals, and that will have an im-

portant bearing on the development of an integrated program in the future.

According to the information we obtained, relatively few interns are remaining in Honolulu for residency training. Most of those who graduate from schools on the mainland come to Honolulu for the internship, and then leave. This suggests two possibilities: first, that they come to Honolulu primarily for the experience of seeing this State and its islands; and second, that those who might consider staying have been disappointed in what they learned about educational experiences and specialty training in these hospitals and so seek an appointment elsewhere. This is contrary to the usual experience in community hospitals with internship and residency programs, which draw the majority of their residents from their own intern staffs.

Another difficult problem for the community hospital is that the number and the quality of interns and residents may fluctuate widely. This has occurred in individual programs in different hospitals. Fortunately, it is not a universal factor throughout the structure of medical education in Honolulu, but again if stability is to be achieved in the future it will require the very highest quality of medical education in all fields.

One of the most serious general problems is the inadequate clinical material on some services in different hospitals. For example, clinical material in pediatrics and obstetrics at Kuakini Hospital is grossly deficient. Clinical material at Children's Hospital, both staff and private patients, has declined considerably in recent years. This may well be part of a national trend, but, even so, does affect the quality of the learning experience and, therefore, the attractiveness of the program to superior candidates.

The opening of the new hospital on the windward side of the island may well lower the admission rate in obstetrics at St. Francis Hospital. Kapiolani Hospital has a relatively inactive prenatal and postpartum clinic for staff patients in obstetrics and gynecology. Pediatric surgical cases of the variety and volume important in training a pediatric resident are deficient at the Children's Hospital.

### SUMMARY OF DEFICIENCIES

Our intensive surveys of the individual hospitals involved in medical education in Honolulu, as well as of facilities or programs related to medical education activities, have provided us with a comprehensive knowledge of the important deficiencies that must be recognized and understood by trustees, administrators, and physicians concerned with the future development of graduate and postgraduate medical education in Hawaii. These 18 deficiencies will be itemized and discussed briefly in the following paragraphs.

1. There is a serious lack of participation in clinical teaching by the attending staffs in all hospitals surveyed. Although this condition was variable from one hospital to another and among different services in an individual hospital, most of the teaching is being done by a small minority of physicians and surgeons. Furthermore, frequently the same individuals are carrying this burden of teaching at two or more hospitals.

2. In all hospitals, there has been a notable lack of organization and planning for the present and future of the educational programs. However, in recent years with the development of the combined residency programs in surgery, and in obstetrics-gynecology, a serious effort at better educational administration has been undertaken. Nevertheless, there is still evidence to indicate that these combined programs represent largely an increase in the number of patients available to the residents, rather than an improvement in basic educational planning.

3. Too often the chiefs of the clinical services have been deficient in directing, in participating in, and in planning and developing educational programs for which they are responsible. This is a most serious deficiency, for it is one that cannot be compensated for by a director of medical education. The quality of an approved residency program will accurately reflect the interest and ability of the chief of the service who is supposed to conduct it.

4. The most striking deficiency in the participation of the members of the attending staff in clinical teaching is found in the outpatient department clinics. The care and management of patients in the clinics is being left largely in the hands of the interns and residents at various levels of training and experience. In two cases, physicians have been hired specifically for the purpose of working in the clinics and supervising the house staff. At best, this can be only a partial solution, since the house staff is clearly missing the opportunity to benefit from the guidance of many physicians and surgeons with differing professional experience and background.

5. The interns and residents have been permitted far too little responsibility for the care and management of private patients. This deficiency is noted especially at the resident level in pediatrics and in medicine.

6. In some of the hospitals there is inadequate clinical material for educational purposes. It was striking to note that the percentage of staff or service cases had diminished markedly in the past

five years and that little effort had been made by the individual hospitals to develop an effective plan for the use of private patients in clinical teaching to replace this loss of service patients.

7. There has been a failure to define educational goals and to develop progressive responsibility for the individual resident. For example, in surgery the third-year resident may do little more than repeat the experience of his first and second years. The same can be said about residency training in pediatrics and in medicine.

8. There has been a notable lack of planning and preparation of formal teaching conferences in the various hospitals. This deficiency has been relieved in part by the visits to Hawaii of distinguished visiting professors from medical schools on the mainland. Although these experienced medical teachers have brought to Honolulu a very high quality of teaching, there has been insufficient planning by the hospitals to utilize these individuals to the benefit of the attending staffs.

9. With one exception, the hospital medical libraries were found to be grossly deficient in several ways. First, the journals regularly received by subscription and the textbook collections were inadequate for the needs of graduate and postgraduate medical education. In more than one case, a library was located in an unsuitable room; there was no one in charge of the organization and operation of the library; there was no systematic means of keeping track of journals and books borrowed; and there did not seem to be any systematic means of keeping a textbook collection up to date. Often, there was no established budget for the library. Reactions of interns and residents in the various hospitals to this deplorable state of affairs was unanimously unfavorable. Ideally, the medical library should be located in the main hospital building within easy access of the patient care area constantly used by the house staff and attending staff.

10. In general, the selection of clinical department chiefs is based on departmental voting procedures, with one- or two-year tenure. There must be continuity and the selection should be for educational purposes, not to accommodate medical staff politics. The governing board has a very grave and essential responsibility in this matter.

11. As in most community hospitals, there is a lack of basic science teaching on a planned basis. This deficiency can be overcome in part by the systematic use of various qualified individuals in the departments of pathology and laboratories in the several hospitals, and those in the basic science departments of the University of Hawaii.

12. There is a notable tendency for the local attending staff members to turn over educational tasks to the visiting professors, who, in fact, provide a golden opportunity for each physician to enhance his own self-education.

13. Too few interns remain in Honolulu for their residency training programs. In general, in successful community hospitals the members of the intern staff usually provide the majority of the candidates for filling the residency programs. Furthermore, in the past year it was noted that in some programs residents had left after the first year of training to go to hospitals on the mainland.

14. There has been a lack of utilization of many potentially valuable community health facilities. Through thoughtful planning, these should be integrated with the training programs for the residents and the continuing educational activities of the attending staffs.

15. There has been a notable lack of effective liaison with Tripler General Hospital, where graduate and continuing medical education of high quality is being carried on in a number of different fields.

16. There is a dispersion of clinical facilities and functions throughout a number of hospitals, to the detriment of medical education and medical care. It would seem that this deficiency is unnecessary: different clinical activities could be concentrated in individual hospitals, thereby strengthening both education and service to the public.

17. There have been fluctuating, and at times inadequate, numbers of interns and residents in some hospitals and in some programs. This deficiency, common to many community hospitals, can be corrected only by the development of first-rate educational programs. In the future, a full quota of house staff members is likely to be attracted to Honolulu only if there is an improving quality in the individual training programs in these hospitals.

18. There is unnecessary duplication and conflict in scheduling of teaching conferences, ward teaching assignments, and clinical assignments among the various hospitals. This deficiency has a serious effect on the morale of those physicians and surgeons who are especially interested in teaching activities and who are devoting a great deal of time and effort to working with the interns and residents.

In conclusion, this summary of the deficiencies uncovered in our survey indicates that clinical and laboratory facilities adequate for a high quality of medical education are available in Honolulu, but that only in isolated instances are they effectively utilized. These many deficiencies are related largely to the fact that the various education programs lack administration by experienced and skillful medical educators.

# Recommendations

EXISTING INTEGRATED PROGRAMS

Integrated programs in surgery and in obstetrics-gynecology were established through the necessity of having an adequate number of staff patients for the residents' training. This is an admirable beginning, but the details of the individual resident's training have been neglected. The programs should be carefully planned and organized so that: (a) the resident has increasing responsibility over the years; (b) his service in a particular hospital strengthens his program (for example, one hospital will have interests more highly developed than another, and this is what should be featured in his training at each institution); (c) his clinic work is organized so that he sees the variety of material which he must study in order to become an accomplished physician in his particular sphere of interest.

**Organization.** Firmer organization of integrated programs is needed. A committee composed of the chiefs of the particular specialties in each hospital where residents will train should be responsible for the over-all planning and operation of the program. Presiding over this group should be the program director. The qualifications for this position may be simply stated. He must be a physician who is keenly aware of the problems of graduate medical education, who is willing to give the time to the teaching program, and who is a leader who can inspire his peers to work. This position is not one that should be rotated frequently; it should carry with it a tenure of at least five years. The incumbent chosen by the committee may or may not be a chief of service. The advantage of having such a director who is not a chief of service, is that he has no particular "hospital ax to grind" and can be fairly objective.

**Planning of the Program.** Much better organization is needed for the existing coordinated programs in surgery and obstetrics-gynecology. The training each year must be integrated with that of the preceding and the subsequent years. It must be planned so that the resident has increasing responsibilities, so that he is exposed to all the fields pertaining to his specialty, and so that he has adequate clinic assignments and is able to follow his patients in an orderly fashion. If one hospital has a special skill or interest in one phase of the resident's specialty, it is essential that the resident have service in this hospital at some time in his training. For example, if there is a special interest in gynecologic pathology in a hospital, then each resident in the obstetric-gynecologic program should receive some training in this institution.

**Operation of the Program.** The committee of chiefs is the executive committee of the clinical services operating the training program. There should be regularly scheduled meetings at which a planned agenda is followed. These are the suggested areas of major activities:

1. Screening of applicants and appointment of residents.
2. Recruitment of residents through (a) intimate contact with interns in the community, and (b) personal contact with acquaintances in positions of responsibility in other leading hospitals.
3. Periodic critical review of the training program in each institution.
4. Recommendation of visiting professors to the appropriate committee, and close liaison with this group to aid in planning apportionment of the visitor's time.
5. Recommendation of new faculty members.
6. Stimulation of combined research programs such as drug trials and analysis of clinical data. Coordination of the vast amount of clinical data in the various hospitals for such studies would be most fruitful.
7. Coordination of assignments of attending staffs to avoid conflicts of multiple duties at a given time.
8. Coordination of conferences among the hospitals. Several hospital conferences can profitably be abandoned and the conferences rotated among the group. Adequate planning of topics and preparation of material is essential.

SPECIFIC PROGRAM RECOMMENDATIONS

**Obstetrics and Gynecology.** 1. Staff obstetrical patients should be concentrated at Kapiolani.

2. Pre- and postnatal clinics at Kapiolani must have better supervision. Their scope should be enlarged by cooperation with the maternal health program of the State Department of Health.

3. Staff gynecologic patients should be concentrated at Queen's and St. Francis Hospitals.

4. Training deficits in endocrinology must be overcome by establishment of a clinic staffed and supervised jointly by gynecologists and internists. A properly run sterility clinic would be an excellent addition.

5. The programs should be restructured so that:
   a. The first year would concentrate at Kapiolani with the major emphasis on obstetrics.
   b. Increased responsibility for operative gynecology would be given in the third year.
   c. The programs would be arranged so that in addition to attending staff supervision, the residents in the first two years would have more supervision by the senior residents.

6. Closer attention to and supervision of the program of assignments of patients to the State Hospital and to Leahi Hospital is essential to provide additional staff gynecologic material.

7. Establishment of a combined conference with internists to discuss medical problems of obstetrical and gynecologic significance. Similarly, other conferences with psychiatrists will fill in a large gap in the present training.

**Surgery.** All staff patients in the three hospitals should be assigned to the residents in the training program.

2. The program director should establish specific guidelines for the surgical procedures the residents at each level of training may be allowed to do. This plan would prevent residents from undertaking operations beyond their competence, but would also make it difficult for the chief resident to assign all major operations to himself.

3. To eliminate the pyramidal system, we suggest the adoption of the Hartford Hospital plan: a fixed total number of residents for the first two years, within which the number at the first and second year may vary (e.g. total 8—first year 5, second year 3, or 4 in each year), and one third-year and one chief resident. No resident should be dropped after the second year.

4. Training experience with private patients must be strengthened by assigning each resident to two to four surgeons who will demonstrate their active interest in teaching by: (a) conducting daily bedside rounds pre- and postoperatively; (b) requiring the resident to obtain and record a complete history and make and record a physical examination and differential diagnosis; (c) requiring the resident's continuous study and review of surgical pathology and surgical physiology; (d) permitting the resident to participate as the operating surgeon whenever feasible, provided he has carried out the educational activities outlined above.

5. Rotation to the surgical specialties should be included only if the resident will actively assist in all procedures.

6. Establish and maintain an effective reading program in all aspects of surgery. Continuously evaluate the resident's knowledge and his progress.

7. Involve the visiting professors more deeply in the teaching program of the residents at all levels.

8. All three hospitals should agree upon common standards for appointment and promotion of attending staff surgeons in the program. All three hospitals should agree to conduct monthly tissue committee reports and to act upon the findings.

9. The development of experimental surgery would greatly strengthen the basic training features of the program.

10. The educational experience of the rotating intern on surgery will require separate plans if it is to be effective and worthwhile.

### PROJECTED INTEGRATED PROGRAMS

Your consultants recommend that three additional integrated programs be developed, in pathology, pediatrics, and internal medciine. We believe such programs will strengthen present educational activities and will provide a stronger base for the future growth and development of these three fields of medicine in Hawaii.

**Pathology.** In recommending a combined program in pathology, we are under the impression that this matter has already been discussed in some detail among the pathologists at the various hospitals. In the long run it will benefit all hospitals, if they do not compete with one another in the recruitment of candidates. There is a nationwide shortage of qualified individuals entering the fields of anatomic and clinical pathology. By establishing a combined program that would make available to the teaching and training of residents all of the special facilities and resources of the hospitals in Honolulu, it would be possible to attract many candidates who otherwise would not be interested.

It is likely that within the not too distant future there will be great advances in the use of instruments in clinical laboratory medicine in the community hospital, for example, automatic analytic instruments to perform blood and tissue chemistries; electron microscopy; and other highly sophisticated and costly instruments and procedures. It would be wasteful and extravagant for each hospital to invest in such facilities. With an integrated or combined program of residency training it would be natural for each department head to look to the future and to assign to an individual hospital the responsibility for devoloping an individual

and special technique to be shared by the other hospitals.

We were greatly impressed by the quality and the dynamic nature of the pathologists at the hospitals we surveyed. We believe it would be of great value to the individual resident to rotate among these hospitals and to be exposed to these different men.

For these reasons, therefore, we recommend that an integrated program in pathology be developed among the interested hospitals—Children's, Kuakini, Queen's, St. Francis, and perhaps others.

**Pediatrics.** In the field of pediatrics, we believe that all residency training should be under the aegis of the Children's Hospital. Indeed, this point of view has already been stated by the American Board of Pediatrics. However, at the present time the admission of patients to Children's Hospital remains far below capacity. In our survey we came to the conclusion that there could be no justification for continuing educational activities in the department of pediatrics at Kuakini Hospital, since the volume of patient material is minimal, consisting largely of minor respiratory illnesses and minor surgery, and since clinical teaching is almost nonexistent. We believe that the interns at Kuakini Hospital must be rotated to Children's Hospital for their pediatric experience.

On the other hand, at The Queen's Hospital the pediatric department is busy and a good deal of pediatric surgery is performed. Our suggestion here is that residents in pediatrics should rotate to the service at The Queen's Hospital if this hospital will provide the proper instructional supervision that is now lacking. The pediatric department at St. Francis Hospital could also support rotation of a resident if the pediatricians who are actively involved in teaching will provide appropriate instructional supervision.

The remainder of pediatric activities in the educational program should be carried on at the Children's Hospital, with the exception of care of the newborn in the nursery at Kapiolani Maternity Hospital and experience with crippled children at the Shriner's Hospital. The nature of pediatrics in the hospital has changed greatly in the last 15 years as a result of the development of medical means to control infections and surgical means to correct heretofore untreatable congenital and acquired physical disabilities. It is our suggestion that the Children's Hospital should make every effort to develop as a center of care for children with complicated and difficult medical problems and to strengthen subspecialty activities, such as pediatric neurology, cardiology, endocrinology, problems in growth and development, pediatric psychiatry, and psychology.

Finally, the strengthening of pediatric surgery at Children's Hospital would be a significant contribution to the educational program for the resident. The American Board of Pediatrics has stated that it considers preoperative care and postoperative management of pediatric patients a significant and essential part of the training experience of the pediatric resident. If such surgery cannot be developed at the Children's Hospital, when the resident rotates to the Queen's Hospital, he should devote the major portion of his time to working with pediatric patients undergoing surgery at that hospital.

In summary, we believe that pediatric residency training should remain under the aegis of the Children's Hospital, and that this hospital should become the center for the diagnosis and management of special pediatric medical and surgical problems and as a center for the management of problems in growth and development, in child behavior, and in special problems of the retarded child.

**Internal Medicine.** An integrated program in internal medicine should include Kuakini, Queen's, and St. Francis Hospitals in order to take full advantage of the limited number of staff patients available in any one of these hospitals and to expose the residents to the attending staff members in these three institutions who have the special qualifications and the interest and motivation to conduct effective clinical teaching. The rotation of interns from Kuakini Hospital to Queen's Hospital for experience in outpatient department medicine will have to continue for the foreseeable future. It is our opinion that at the present time St. Francis Hospital is conducting the highest quality of educational experience in internal medicine in Honolulu, thanks largely to its group of qualified internists who have a primary interest in teaching. Whether or not The Queen's Hospital continues to make progress in overcoming the serious problem of its medical residency program described on page 184 will depend in large part upon the quality of leadership shown in its department of medicine in the years immediately ahead.

At the present time the most vigorous direction of a combined residency program in internal medicine could be provided at St. Francis Hospital. Of course, a committee representing all hospitals should establish over-all policies for such a program as described for obstetrics-gynecology and for general surgery on page 185. In this integrated program the resident would rotate through the teaching services of the department of medicine of the three hospitals, as well as to Leahi Hosptial and perhaps in the future to other facilities that may offer special educational opportunity. In this proposed integration it would be important to

strengthen the sub-specialties of medicine and to provide opportunities for individual residents to devote part of their second year to concentration in a particular field.

**Conclusion.** The advantages to the various hospitals in integrating residency programs in pathology, pediatrics, and internal medicine in addition to the two programs already under way, may be listed as follows: (1) It will bring to an end competition in recruitment for qualified residents. (2) It will bring to an end the duplication and overlap in teaching assignments and scheduling of the various members of the attending staffs in these individual hospitals. (3) It will provide each resident with an increase in the variety of his clinical and pathologic training experience and will provide him with a greater depth of knowledge in his field. (4) It will expose him to an increased number of qualified and interested teachers among the members of the attending staffs of the various hospitals. (5) It will result in a strong and attractive program that should enhance all efforts to recruit candidates from medical schools on the mainland. (6) It will save the hospitals money. (7) It will provide a strong, broad base for the future growth and development of training in clinical and anatomic pathology in Honolulu and prepare the groundwork for participation in an academic program of a medical school should such an institution be established as a division of the University of Hawaii.

### LIBRARIES

Several times, above, we noted serious deficiencies in the development of medical libraries in the various hospitals. The library will always be the heart of a graduate and postgraduate medical education program. It has been our experience that if a medical library is located in attractive and convenient surroundings, if it is competently administered, and if its shelves are stocked with current textbooks and clinical journals of immediate usefulness, covering all the major fields of medicine and surgery, use of such a library by both the attending staff and the house staff quickly increases and does not plateau. For as its use rises, it too undergoes growth and development and offers additional services.

In Honolulu, physicians have available an unusually broad and detailed reference list of journals and textbooks in the Hawaii Medical Library. At the present time, this library is housed in crowded quarters that make it difficult for efficient display of current journals and filing of past issues of journals and textbooks. In addition, there is little space for reading and studying in conditions conducive to such independent effort. Your consultants were shown the plans for the new library building now under construction. There can be no doubt that this structure will provide sufficient space for the present and future needs of the library for some time to come. This library therefore will continue to be an extraordinarily complete source of reference for study and research in all fields of medicine. Its development and administration should be supported in every possible way by the physicians and administrative officials of all the hospitals in Honolulu.

It is our impression that, despite its excellent resources, this library is not being used by practicing physicians and house officers to the extent that one might expect. How much this deficiency has to do with the difficulties encountered in the present cramped quarters, and how much it has to do with the present level of medical education and research in Hawaii, we cannot define accurately on the basis of our information.

In the integrated program of medical education that we are proposing in this report, medical education will be greatly strengthened in Honolulu by the creation of a joint library committee with representatives from each of the hospitals participating in the coordinated program. This committee might well consist of the chairman of the library committee at each of the five major hospitals and additional representatives-at-large from other hospitals and medical organizations. The executive director of the over-all program should be an ex officio member of this committee.

The functions of this joint committee should be to establish policies for the development of individual hospital libraries, for the uniform rules and regulations for the administration of hospital libraries, and for the privileges extended to the interns and residents and to the practicing physicians in the city. By the strength of joint agreement among all hospitals such policies and regulations could have enduring force. The value of doing this will be found at least in two major areas: first, interns and residents in this important training period will learn how to use a library, not only for their own benefit, but in order to protect and to strengthen this valuable resource that they will be using throughout their professional careers; second, it will bring to an end the loss of valuable textbooks and journals that will inevitably occur when regulations are not established and when the library is not properly administered. Many community hospitals have solved these problems to the benefit of the majority and without inconveniencing any physician who wanted to use the library for a serious purpose.

We believe that each hospital should have its own library carefully developed for its own specific

purposes. The house officers should not be required to rely upn the Hawaii Medical Library for their frequent daily, practical needs. The Hawaii Medical Library should remain as a basic source of reference material offering depth and great variety. This is especially important because of the geographic isolation of Hawaii from the centers of medical education and research on the mainland.

Another important point to the advantage of each hospital in having its own adequate and well-run library is that it will also be available always to the house officer when he is on duty at night, weekends, or holidays. No one can predict when a patient will be admitted or a complication will occur that will require immediate use of the library. In the care of such patients, neither the practicing physician nor house officer can be expected to travel relatively long distances to the Hawaii Medical Library for the needed information.

Finally, since the growth of the specialization and subspecialization of medicine is continuing at a rapid pace, and since there are outstanding but expensive textbooks published in all of these various fields, the joint committee should establish a policy whereby certain hospitals would hold such reference works in individual libraries and make them available on an interhopsital loan arrangement. It would not seem necessary for each hospital to stock its own library completely with seldom used but important textbooks.

### JOINT CONFERENCE COMMITTEE WITH THE DIRECTOR OF MEDICAL EDUCATION

In an integrated program of medical education for Honolulu, each of the five major hospitals directly involved will eventually employ a salaried director of medical education. We have pointed out above that this position has not been established in the various hospitals according to presently accepted standards. Each hospital should review this matter, and determine the necessary changes in the relationships of the educational director to the hospital administration and to the medical staff. In particular, his authority and responsibility in relation to the chiefs of the clinical and laboratory departments should be clearly defined.

If a properly qualified candidate is appointed, one would assume that he would be the single member of the hospital organization who was thoroughly informed in the field of graduate and postgraduate medical education. Therefore, he would be the source of expert knowledge and useful information to the administration and to the trustees as well as to the medical staff. It is our opinion that the Director of Medical Education should take part in all meetings of the joint conference committee when problems dealing with medical education and research are discussed. In fact, this relationship would be strengthened if a member of the Board of Trustees were delegated by the officers of the board to work continuously in collaboration with the educational director, so that he too could become a source of expert information for the Board of Trustees.

### UNIFORM PAY SCALE FOR THE HOUSE OFFICERS

It is our recommendation that the five major hospitals taking part in the integrated program should establish a uniform scale of salaries for interns and residents. Such a policy should include not only salaries, but the customary benefits, such as housing allowance or facilities, board, laundry, uniforms, hospitalization, and vacations. Furthermore, it would be wise to reach common agreement on a policy for reimbursement of travel costs of interns and residents from the mainland to Hawaii.

Surveys and studies by the Association of American Medical Colleges and the Council on Medical Education and Hospitals provide abundant proof that an effort to recruit interns and residents of quality on the basis of salaries and benefits is seldom successful and may actually harm a hospital's reputation. The present recommendation of these two national organizations is that the house officer should be paid a salary that will adequately meet necessary living expenses; if he is married and has children, the hospital may consider providing an additional allowance or its own apartments, on a rent-free or minimal rental basis. It is customary for the intern to be paid the lowest salary and for the residents at various levels to be paid at an increasing scale for each additional year of residency training. However, the chief resident of any service, regardless of the number of years of previous training, should be paid the same salary at each hospital. He is not being paid for years of accumulated training, but for the assumption of an important responsibility providing services to the hospital, to the attending staff, and to the other house officers.

We hesitate to recommend a specific salary scale but would note that, in general, in nonuniversity community teaching hospitals, monthly salaries for interns are in the range of $250 to $300 plus room, board, and other benefits. A joint committee of the American Medical Association and the American Hospital Association has been studying this difficult problem for the past year

and a half. It is antieipated that this joint eommittee will have prepared and made specific recommendations to the two parent organizations within the next six months. Their reeommendations may become a convenient yardstiek for all hospitals to use in establishing their own policies.

We suggest that the best philosophy that hospitals can adopt as a guide in this matter should be that these individuals are being paid for the extensive serviees they provide to the hospital and its patients. Therefore, their salary should be based on their individual living needs as professional men and women, whose dignity and self-respeet should not suffer beeause of inadequate ineome. The salary seale should not be related to recruitment, as it has in reeent deeades. Because an individual hospital has had sueeess in obtaining interns and residents does not mean that it ean by any scale of human values justify paying a graduate physieian less than his worth to the institution.

A FACULTY OF MEDICINE

Although the word "doctor" means teacher, it does not necessarily follow that all physicians ean partieipate in a teaehing program or indeed should be expeeted to. In a medieal program sueh as is projected for Honolulu, it is essential that a loeal faculty be ereated. This would (1) aecomplish better utilization of the physician's time; (2) give the physician status in the eommunity; and (3) serve to reward him in some fashion for his time spent away from his private practice.

**Selection of the Faculty.** Those physieians who have shown a willingness to teaeh, or those who will eome into the eommunity later and similarly evince sueh a willingness, should be appointed to the faeulty. Tenure will be based upon attendanee at teaehing eonferenees, participation in teaching programs, aeeeptanee of assignments in elinics and on ward rounds, partieipation in the deliberation on edueational policies, and general interest in the total program.

The ereation of a faeulty will cause some hurt feelings. To organize the faculty, the program direetors for eaeh of the elinieal serviees, after consultation with the respective committee of ehiefs, should propose members in their particular department suitable for faeulty status. Consideration must not be related solely to seniority, to friendships, or to "politieal connections." The selection must be on the basis of qualifieations and willingness to teaeh. It would be wisest at first to give no rank and to call everyone an Instruetor. As time goes on, various levels of rank might be instituted.

**Utilization of the Time of the Faculty.** The assignments of faculty members to teaehing rounds should be eoordinated through the eommittee of ehiefs. The number of assignments needed in the particular department throughout all hospitals for the year must be determined, and time alloeated evenly among all of those partieipating. Thus, a man eould visit at more than one hospital, but at no one time should his assignment be in more than one institution. Similarly, the short tour of duty must be avoided: an appointment of two to three months, visiting time is essential.

**Reward for the Faculty.** 1. Certifieates should be presented to the faculty members at the hospitals' annual meetings.

2. An attending man who is on the faeulty should have the benefit of his patients' being worked up by interns and residents in eaeh hospital in the program. It cannot be emphasized too strongly that the interns and residents should work up *only* the patients of the faculty members, for it is this group that has signified its willingness to teaeh, and it is this group that will keep the house officer from being exploited by being on duty merely to do paper work to satisfy aeerediting ageneies.

3. In order to create teaehing beds, patients of the faeulty members, be they staff or private, should be eoneentrated in one single area of the hospital. Moreover, when an attending man is assigned to the ward or the elinics, he should have one or two beds available for his patient in an emergency. Obviously if he eoneentrates his patients in the hospitals in which he is doing his teaehing, his time will be more efficiently utilized. This point eannot be emphasized too strongly. It will require priority in alloeation of beds, but preferenee would be assigned to the one who is giving of his time for the training program. The administrators can be shown promptly that the total number of patients will not ehange and that there will be no problem of empty beds.

LABORATORIES

The inereasing eomplexity of laboratory studies, the ever-burgeoning list of proeedures needed for the thorough study of patients, and the need for expensive equipment and for highly-skilled technical personnel for supervision of these tests, dietate eareful consideration of eonsolidation of eertain laboratory proeedures and for the establishment of eentral facilities. This is essential (a) to provide the eommunity with the more sophistieated teehniques; (b) to provide teehniques for the physieian trained in the newer proeedures; (e) to support teaehing programs in all speeialties.

The hospital pathologists have proposed the development of a central laboratory.

Your consultants recommend that a central laboratory be formed. On the mainland, such laboratories are a part of all university medical centers. Their services are available to community hospitals. It is safe to predict that in the next few years there will be a tremendous demand for new chemical studies, such as tests for trace metals and an extension of the already existing array of steroid analyses. In the not too distant future, electron microscopy will be an integral part of first-rate patient care; since this equipment is costly, these tests could be best done in a central laboratory.

By pooling the physical resources and the technical ability already available in the community, such a laboratory would have much to offer. Eventually we envision a full-time director of such a laboratory. In no sense would this compete with hospital laboratories nor with the private laboratories that various physicians now operate in the community.

A committee of all pathologists of the hospitals would be charged with the operation of the laboratory. The individual hospitals would be billed for services on a fee basis. Similarly, patients who are studied in a physician's office would be billed for work in the laboratory. As this laboratory would be an integral part of the teaching programs, some of its funds could be contributed to the educational program. One should realize, however, that because of the complexity of procedures contemplated, because of the limited demand for many of the determinations, and because of the cost of equipment, this will not be a significant source of revenue.

The location of such a laboratory poses many problems. Ideally it should be in a single structure, but in our survey no such facilities were noted. It could perhaps be put in the now unoccupied wing at the Children's Hospital.

### OUTPATIENT DEPARTMENTS

Supervised teaching in outpatient department clinics is required by the Council on Medical Education and Hospitals for all approved internships and by all of the specialty boards for approved residency training programs. Nevertheless, medical education in outpatient departments is seldom carried out effectively and conscientiously. This is the case in the hospitals in Honolulu.

The greatest activity in the community hospital is usually found in the medical clinic, particularly the general medical clinic. Here a large volume of patients with multiple complaints, but usually without any challenging specific disease entity, are referred from subspecialty clinics and from surgical clinics. These are the patients who have no personal or family physician and must depend on the clinic for proper medical care. Such patients are usually assigned to the new intern or the young resident and, indeed, often are neglected by the more experienced or senior residents; however, these are the patients who are most in need of expert and knowledgeable management, if their symptoms are to be correctly diagnosed and adequately managed. These types of medical problems make up the bulk of the practice of medicine for the internists and the general physician and, therefore, are most important for the house staff to study and treat.

At Queen's and St. Francis Hospital, physicians have been hired on a part-time basis to supervise outpatient clinics and to provide continuity in care. Through such a solution, the hospital does partly meet its obligation to the patients; however, this procedure is not consistent with sound educational policies. Here is the golden opportunity for the experienced and seasoned clinician to indoctrinate the young physician with the best techniques of history taking, physical diagnosis, use of the laboratory, and use of the modern pharmacopeia. It is to the discredit of medical education in the United States that this responsibility is often neglected. One of the reasons is that the senior physician, and in particular the chief of medicine, in most hospitals, will not take the time to participate in outpatient department teaching activities. These individuals seem to think that their elevated station in the hospital staff organization relieves them of this most important educational responsibility, and thereby they miss the opportunity to demonstrate the highest standards of patient care to the interns and residents in their own programs.

In the integration of medical education throughout Honolulu, it should be possible to eliminate duplications in various clinics and to consolidate the teaching schedules for the practicing physician. This would not only improve the efficiency of educational activities, but should relieve many physicians of an unnecessary burden created by repetitive assignments. For example, at the present time there are three different cardiac clinics supported by the State Department of Health. Apparently after one clinic was established in one hospital, other hospitals felt that they must also have such a clinic. Therefore, all clinics are carrying relatively small numbers of patients and demands upon qualified physicians to attend such clinics are tripled. The consolidation of these into one major clinic would provide an excellent source of valuable teaching material for the residency programs and should greatly strengthen the opportunities for teaching among the practicing physicians in the community. It would also be more efficient

and economical from the standpoint of administration.

In addition to consolidation of various clinics, teaching in the outpatient department should be integrated with all other educational activities according to a carefully constructed plan that will use to the maximum efficiency the physicians in Honolulu who are qualified to carry out such instruction, and to utilize most effectively the time available to the interns and residents. Such integration will require a coordinated plan developed by the executive director of the over-all program and the individual educational directors in each hospital. Consolidation and integration should improve and strengthen clinical teaching in the subspecialties of medicine and in pediatrics, in obstetrics and gynecology, and to a lesser extent in some of the subspecialties in surgery.

### STAFF PATIENTS

The present system of reimbursement of hospitals for staff patients by the State is indeed a happy one. It does not involve a loss of hospital funds for the handling of the hospitalized indigent. There are frustrations over admission of indigent patients and the controls imposed by the Department of Social Services. A realistic solution should be sought by conferences between the Department of Social Services officials and members of the medical group concerned.

The following recommendations are presented in order to strengthen the obstetrics-gynecology and pediatrics training programs and to furnish more staff patients for the senior residents, who should have total responsibility for these patients.

1. The staff obstetrical patients at Kuakini should be referred to Kapiolani.
2. The staff obstetrical patients at Queen's should be referred to Kapiolani.
3. The staff gynecology patients at Kapiolani should be referred to Queen's.
4. All staff pediatric patients should be sent to Children's Hospital.

It is recognized that these recommendations cannot now be carried out to their fullest, and that there are certain patients who for one reason or another would insist upon a specific hospital. But such a policy would strengthen existing residencies. If an existing service is closed, then interns can be assigned for a time to a hospital furnishing a particular special type of case.

### A GENERAL COUNTY HOSPITAL

It is our feeling that the present situation of taking care of indigent patients in private hospitals on a fee basis with compensation to the hospital for outpatient service is a most admirable one. The trend all over the United States is for a decreasing number of staff (service) patients. As insurance plans increase, this type of admission will further decrease. This means, of course, that more reliance than ever must be placed on the private patient for teaching. It would seem to us sheer folly, at this stage of development, to contemplate a general county hospital for the indigent patients, and that the present arrangement should be continued.

### VISITING PROFESSOR PROGRAM

The geographical isolation of the State of Hawaii makes it essential that the visiting professor program be continued, and perhaps enlarged. Many physicians in the State have not been to a medical meeting on the mainland for over five years. Several of the residents were brutally frank in stating that this program was the only strong teaching feature.

The visiting professor program can serve five major functions: (1) to teach interns and residents; (2) to teach and stimulate the attending staff, and especially to refresh them with newer ideas and newer techniques; (3) to demonstrate some of the techniques and methods of teaching to the attending staff; (4) to acquaint visiting professors with the teaching programs in the hope that they might "steer" interns and residents from their respective institutions to Hawaii for further training; (5) to obtain objective constructive criticism of the teaching program from the visitors. For items 2 and 3 to be fulfilled it is essential that the attending staff participate actively in the visiting professor program. This cannot be emphasized too strongly. Frequently, in his teaching, the practicing physician is content with didactic aphorisms, loses the objectivity he learned in his training, and is content to rely on the dangerous phrase "in my experience."

**Selection of Visiting Professors.** This must not be on a haphazard basis. There should be a planning committee consisting of an internist, a a surgeon, a pediatrician, an obstetrician and gynecologist, a pathologist, and a general practitioner. An ex officio member should be invited from Tripler Army Hospital, one from the State Department of Health, and one from the University of Hawaii. This committee must be charged with (a) obtaining suitable visiting professors; (b) scheduling their time while in Honolulu; and (c) obtaining guest speakers for the hospitals from the group of consultants frequently visiting for brief periods of time at Tripler, the State Department of Health, and the University of Hawaii. Those coming to

these latter three installations should be contacted prior to their departure from the mainland, so that hospital activties can fit into their schedule. A small honorarium should be provided them.

Younger men in the teaching fields of medicine must be included in the roster of visiting professors. They may not necessarily be the famous names associated with the visiting professor category, but they are frequently the most energetic and enthusiastic in their teaching. Financial adjustment will need to be made for this group. The selection of visiting professors should also take into account the different skills and different interests that might be offered. There should be an attempt to cover all fields in a particlular specialty. For example, there should be someone in pediatrics interested in the problems of emotionally disturbed children, at least every three or four years. Men whose skills interest several of the specialties should also be obtained, such as someone in internal medicine whose special interest is infectious diseases.

**Utilization of Time of the Visiting Professor.** Although in general this has been fairly satisfactory, we wish to offer certain suggestions. Some time should be spent in the outpatient department clinics. The general tendency is to present the rare and exotic patient and to request lectures on equally esoteric subjects. The more mundane types of patients and topics must also be covered.

The difference in time between the pediatrics visiting professor, who stays three months, and the others who stay one month, is of interest. Previous visiting professors in pediatrics feel very strongly that three months is a satisfactory time. Scheduling men on a one-month basis, however, might make it much easier to obtain visiting professors. A three-month absence from one's university is often hard to arrange, unless it be in the summer.

The visiting professors must be well acquainted with what is expected of them before they arrive. If there are to be formal talks, they should be told the number and suggested topics that would interest the local group. The schedule should include presentations by the visiting professors in all participating hospitals, including Tripler.

**Relationships with the Visiting Staff.** The visiting professor must not preempt the teaching time of the local attending physicians. He should supplement their activities. It is essential that the local visiting staff participate in the visiting professor program, attending not only lectures but rounds and informal exercises as well. This will acquaint them with the newer ideas that are being presented as well as permit them to watch the subtle techniques in teaching.

When a visiting professor finishes his tenure he should be asked to write a critique of the teaching program as he sees it, and in particular of the visiting professor program. Some will do this more easily than others, and an occasional visitor will be reluctant to submit an evaluation.

It would also be worthwhile to contact former visiting professors for suggested names of future candidates. Careful watch must be kept for medical meetings being held in Honolulu, and if particularly noteworthy visitors will be present they should be asked to come a day or so before the meeting or stay a day or so after to participate in the teaching program with the house staff.

**Financing.** Details of suggested methods are discussed in the recommendation for over-all financing. The stipend of $1,500.00 a month offered a visiting professor is not realistic for some individuals. (Some of the previous guests, and undoubtedly some who will visit in the future, are financially solvent through their own resources and can utilize this as a pleasant way to provide a working vacation with the family.) Particularly the younger men, whom it is important to attract, will not be able to afford the trip. Even though their salary is continued, the added cost of living in Hawaii may pose quite a problem. Negotiations should be undertaken with potential visiting professors for a realistic financial settlement. Certainly their transportation should be provided. If they plan to bring their family, and if housing is available, as it happily seems to be in many circumstances, the cost would be much less. All efforts must be made to find such housing to ease the financial burden.

### UNIFORM STANDARDS FOR ATTENDING STAFF APPOINTMENTS

If true integration among the various hospitals is developed, and if the major residency programs are to be conducted on a combined basis, then it will be necessary to establish uniform standards for the appointment and promotion of practicing physicians and surgeons to the active staffs of the different hospitals. At all times, those officials in each hospital responsible for individual education programs must keep in mind the serious and challenging responsibility they have accepted. They are involved in preparing recent medical graduates for a lifetime career in the practice of medicine in Hawaii, on the mainland, and in nations throughout the world. Graduate medical education of high quality cannot be conducted, unless it is organized and administered by highly motivated department chiefs, and unless the teaching is carried out on a daily basis by properly qualified instructors. The

attending staffs of the community hospitals are the "medical faculty" of the program.

Effective education with consistently high standards cannot be conducted if, in one hospital, members of the attending staff do not meet the standards of appointment or promotion that they do at another hospital. For example, in the conduct of a specialty residency program, those involved in teaching and administration should all either be certified by the corresponding specialty board or be qualified for certification by reason of their previous training, experience, and competence in their field as recognized by those in charge of the program.

Nevertheless, it should be noted that not all those who have completed an approved program of training qualifying for board certification, and not even all those who are board certified, necessarily meet the standards of teaching performance required for graduate medical education.

### SELECTION OF CHIEFS OF DEPARTMENTS

The Council on Medical Education and Hospitals and the specialty boards have made it unequivocally clear that the chief of a clinical or laboratory department is the individual finally responsible for the quality and the conduct of the educational programs in his department. Therefore, these physicians, key individuals in graduate and postgraduate medical education, must be selected for their obvious competence for the job and not because of seniority or as a compromise solution in the face of medical politics. The only other physician in the hospital organization whose appointment is equal in importance to these is that of the Director of Medical Education.

Fortunately for the purposes of our report, the Joint Commission on Accreditation of Hospitals published, in August, 1962, a special bulletin (No. 30) stating specifically the procedures and standards that hospitals should follow in the selection and appointment of chiefs of departments or chiefs of services. We quote selected statements from this bulletin and include the reference in our bibliography[6] as an important source of information to all hospitals involved in this proposed integrated program of medical education for Honolulu and Hawaii:

> The proper selection of a good chief of a department or service of the medical staff organization in our modern day hospitals is one of the gravest responsibilities of a Board of Trustees. This should be accomplished only in close cooperation with and advice from the medical staff. It in turn must show integrity and live up to its own responsibilities in helping make the selections. A chief who is a dictator can ruin a department. A poor administrative chief can produce organized chaos.
>
> In the selection of a chief, both his professional competence and his administrative adequacy must be evaluated. He must have quality—and quality means, besides the two requirements mentioned above, the many intangibles that go into its structure, such as compassion, skill, efficiency, economy, understanding, sympathy, integrity, and character. The chief of a department or service should be a specialist in the service for which he is responsibile.

This bulletin lists several basic principles that should be followed in the selection and appointment of the chiefs, discusses the manner of selection, the tenure of office, and outlines in some detail the duties and responsibilities of the chief. We wish to quote a few statements from this latter section:

> He is responsible for the proper management and quality of service in his department.
>
> He is responsible for the arranging and expediting in his department, embracing organization, education, supervision, and evaluation of the clinical work.
>
> He should check the medical records in his department to determine whether they are promptly written and acceptable in content and quality.
>
> He is responsible for the teaching and educational programs of his department unless this function is specifically assigned elsewhere. Even then, he should be cooperative and helpful in promoting medical education in all its facets.
>
> In surgery the chief should exercise general supervision over the operating suites and provide consultation service in all matters of administrative and clinical nature. Especially he must see to it that committees which have special problems pertaining to surgery carry out their functions; i.e., the tissue and infection committees.

Your consultants are in complete agreement with these statements by the Joint Commission on Accreditation of Hospitals. Until community hospitals accept their responsibility in the appointment of properly qualified and competent chiefs of clinical services for the conduct of an educational program, they will continue to fail to meet the full measure of the challenge that has been accepted. In effect, they are downgrading their own medical education program and are directly and indirectly responsible for lowering the future standards of medical education and medical care in their own community and elsewhere in the country.

### CONSOLIDATION OF FACILITIES

**Laboratories.** The general program outlined on page 198 for the laboratories should be a primary goal. Until such time as a specialized laboratory for the community is in existence the following temporizing measures might be instituted. Certain special procedures could be concentrated in a single hospital laboratory. For example, endocrine assays should be performed in one laboratory which would admirably serve the entire community. Another hospital should develop the rapidly

expanding field of chromatography. The isotope laboratory at The Queen's Hospital is an exceedingly well-staffed and well-equipped one, and there would seem to be little indication for other hospitals to try to equal or to compete with it. Patients requiring isotopic procedures, whether they be outpatients or hospitalized in another hospital, could be sent over to the Queen's laboratory for such determinations.

**Special Activities.** It is fashionable nowadays for every hospital to strive for open heart surgery and cardiac catheterization. These are costly operations, and inefficient if done only infrequently. We make two recommendations: (1) Cardiac catheterizations should be concentrated in a single hospital. (2) Open heart surgery should be concentrated in a single hospital. A "team" should be devised for each group. This should consist of those individuals who are adept in the procedures, either in cardiac physiology or in cardiac surgery. The teams must be flexible, for new physicians will enter the community and bring with them new skills and techniques. They must not be denied membership on such teams merely because they do not have seniority. It will be found that, in the long run, this plan is more economical, less time consuming and more efficient. There should be a weekly conference for those interested in cardiac physiology and surgery, at which all patients could be presented for discussion. This would be useful as a teaching aid, since the medical residents must participate.

### UTILIZATION OF COMMUNITY FACILITIES IN TEACHING

**U. S. Army Tripler General Hospital.** 1. The educational committee of each combined clinical service, for example medicine or pediatrics, should include a member from the corresponding service at Tripler in its deliberations in planning programs and conferences. This device will afford an opportunity for exchange of information and for an exchange of planning.

2. Those physicians in Honolulu who hold the position of consultant at Tripler should either become active in this role or resign and make way for some more energetic and enthusiastic physician. The pattern set by the dermatologists is one well worth emulating.

3. Not only residents but physicians in the community should avail themselves of the many excellent programs at Tripler.

**Department of Health.** All residents in pathology should spend a day or two in the State laboratories to learn about the various techniques and facilities available. Similarly, residents in medicine and in pediatrics would benefit by one session with the Director of the Laboratory, in which they would learn of the newer techniques, facilities, and more importantly, the limitations of the various procedures.

**Alcoholism Clinic.** This growing problem, not only for Hawaii but for the entire United States, needs further attention. It is suggested that the program for the medical residents, preferably in their second year, include two three-hour sessions in the Alcoholism Clinic. During this time they would become aware of the facilities and learn the general principles of handling alcoholism. Of importance is the opportunity to lose some of their fear of handling alcoholics.

**Waimano Home.** The pediatric residents should spend one month at Waimano Training School & Hospital county clinic.

**Mental Hygiene Clinic.** The residents in medicine lack planned training in psychiatry, and a regular assignment to follow their own patients in this clinic would be most profitable.

**University of Hawaii.** At the present time, there are strong departments at the University of Hawaii, whose members could participate effectively in the various teaching programs. This would be particularly pertinent in the fields of microbiology, biochemistry, and genetics. It is suggested that Dr. Richard K. C. Lee or his designate serve as an ex officio member of the educational committee of the proposed organization. We hope that the various faculty members at the University of Hawaii with special competence in certain fields will be asked to participate in the hospital teaching conferences.

### ROLE OF GENERAL PRACTITIONERS

The medical profession and the public are well aware that the composition of American medicine has been changing. In the past 30 years the total number of physicians in this country has increased by about 50 per cent, but the number of physicians in private practice has increased only by about 20 per cent. At the same time the number of physicians in general or part-time specialty practice declined 25 per cent, and physicians in full-time specialty practice increased 254 per cent.

These figures tell the story of one of the most difficult and complex problems faced by the community teaching hospital. The general practitioner today has little place in the teaching activities of

specialty residency training programs. There are only occasional generalists who have developed and maintained a special interest and competence in some field of medicine or surgery that would qualify them to participate in teaching. As the complexity of hospital medicine and medical education has increased, and as the competition for recruitment of interns and residents has become more widespread, the community hospital has been faced with the dilemma of limiting the coverage of patients by house officers to those physicians who are directly involved in teaching. Yet often a large segment of the medical staff admitting patients to the hospital is made up of general practitioners. There is no easy solution to this problem at this time.

Your consultants wish to make a few comments, however, in the hope that solutions can be developed in the future. First, it should be recognized by everyone concerned that one of the purposes of medical education in a community hospital is to provide an opportunity for continuing learning by each practicing physician. Therefore, it would be a serious mistake to eliminate the general practitioner from an active role in the hospital.

Second, we believe that individual general practioners who do possess demonstrated competence in specialty fields should be integrated into clinical teaching activity both in the hospital and in the outpatient department.

Third, if individual general practitioners do not have the time or the interest and inclination to take part in educational activities according to a planned schedule, and if they expect house staff coverage of their patients, they should provide something of benefit to the program and the hospital in return. For example, they should make their patients available to a private teaching service to which such patients would be admitted without orders and without a differential diagnosis, in order that the intern and resident can undertake a complete work-up of the patient before reviewing their findings with the responsible physician; or these physicians should contribute significantly to a voluntary fund for the support of the medical library or medical research in the individual hospital.

Fourth, they should faithfully attend the regularly-scheduled teaching conferences at the individual hospital in the broad general fields of medicine, surgery, pediatrics, and obstetrics-gynecology.

In our own experience we have found that although the general practitioner believes that he is being gradually forced out of active participation in community hospitals, in actual fact the majority of these men have little interest in teaching and are much too busy with the demands of general practice to take part. Clinical teaching at the graduate level requires a minimum of one to two hours per day when a physician is responsible for a ward service or an outpatient department clinic. Few general practitioners are willing to give up this much time. Furthermore, the majority of these physicians are deficient in maintaining their own self-educational activities and frequently simply do not have the current information to conduct effective bedside teaching. These men for the most part practice symptomatic medicine and apply symptomatic therapy, turning over their complicated problems to specialist and subspecialist colleagues who manage such patients in the various hospitals.

Therefore, if the general practitioner of the present and the future wishes to contribute to his hospital's educational activities and to play an effective role in the medical staff organization of his hospital, he will have to demonstrate the sincerity and meaningfulness of his intentions by making positive contributions such as those suggested above. Otherwise, his place in the growing and complex community hospital involved in medical education will be an ever diminishing one.

### RELATIONSHIP OF MEDICAL EDUCATION IN HONOLULU TO THE UNIVERSITY OF HAWAII

We have previously indicated (page 203) how at present the talent at the University of Hawaii can be used in the various hospital teaching conferences. One must now project to the future and think in terms of the formation of a two-year medical school. How will this affect the contemplated residency program?

A two-year medical school will bring in additional men who will be able to participate more actively in the various teaching programs. Physicians in the community could also take part in the medical school, since second-year students will require clinical instruction, particularly in physical diagnosis. At the moment it seems that this teaching should take place in the existing hospitals in Honolulu. Before this participation could be undertaken, it would be necessary to fulfill these requirements:

1. Well organized clinics and instruction in existing hospitals.
2. Staff physicians dedicated to teaching, reliable and faithful in meeting their assignments.
3. Adequate clinical material for the medical students. This is currently available.

A two-year medical school at the University of Hawaii thus could serve as a stimulus to strengthen residency training in the Honolulu hospitals. However, the problem of running the program will rest upon the shoulders of those charged with this direct responsibility, and they must not anticipate

that the officials and the faculty of the University of Hawaii can or should assume this role.

If a four-year school is established, and it seems reasonable to expect this future development, the problem arises as to where a university hospital might be located or whether existing hospitals will be utilized for all clinical training. One can anticipate that the pattern being set by other institutions throughout the country will be followed. If so, a university hospital will be built, in close conjunction with the medical school buildings. Past experience indicates that the development of a medical school may strengthen training programs in the community hospital, but the work of running these programs, of staffing them, of securing interns and residents, will rest on the community. To assume that the medical school will take responsibility for the training programs in the community hospitals is unwarranted.

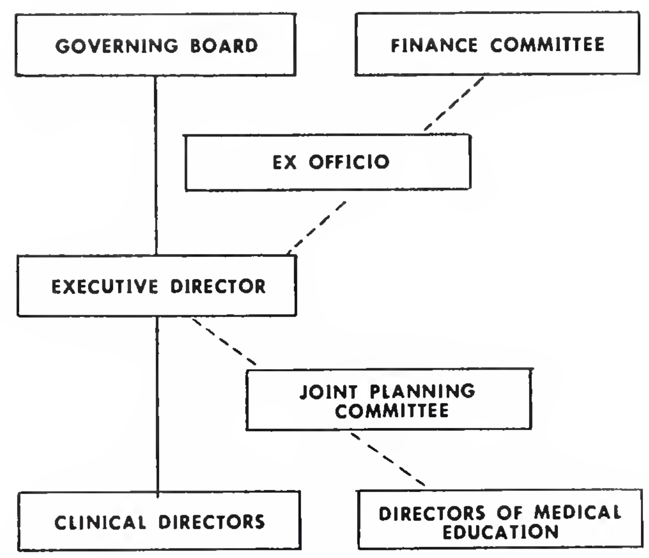
A word of caution is indicated. Many physicians, in the communities where medical schools are planned, express considerable anxiety that this will interfere with their practice and that there will be competition for patients. Such has not proved to be the case, and initial fears and qualms have been dissipated once the medical school and its hospital have become operational.

### ORGANIZATIONAL STRUCTURE OF THE INTEGRATED PROGRAM

The establishment of an incorporated and properly organized integrated program of medical education for Honolulu and the State of Hawaii will require a specific organizational structure administered by an experienced and skillful medical educator. We wish to propose the structure as schematically represented in the accompanying diagram. The three main levels of administration would be: (1) a governing board; (2) an executive director; (3) educational directors in each of the five principal hospitals.

**The Governing Board.** The governing board of the integrated program should consist of 19 members, three from each of the five major hospitals involved, three at large, and a chairman. Each hospital should be represented by its administrator, by a physician from the executive committee of the attending staff, and by a trustee who is either an officer of the board or a member delegated the specific responsibility of overseeing the education program in his hospital.

The at-large members should include a representative of the County Medical Society, perhaps the Chairman of the Continuing Education Committee, and two ex officio members representing




the University of Hawaii and the State Department of Health.

We specifically do *not* recommend an executive committee of the board. We do recommend that the chairman be selected from among community civic leaders and that he have no direct association with any of the five hospitals. We also recommend the formation of a finance committee, consisting of administrators and trustees and the executive director ex officio. Its membership should be limited to a total of seven, a chairman plus six committeemen.

The governing board will immediately be faced with several important tasks: first, the development of a sound financial structure for the integrated program; second, the establishment of the bylaws and constitution of the incorporated project; third, incorporation; fourth, the selection of an appropriate title for this incorporated education and research project; fifth, the appointment of the executive director (to be an ex officio member of the finance committee); sixth, the development of effective public relations and communications with the nonmedical and medical population of the county.

**Executive Director.** The proposed executive director of the integrated program will be presented with extraordinarily complex problems. His qualifications should include: (1) Several years of experience in medical education and administration. (2) Personal knowledge about the special problems of the nonuniversity community teaching hospital. (3) A medical degree. (4) Certification as a specialist. (5) Age at least in the middle decades of maturity, although it would be a mis-

take to set an arbitrary minimum or maximum age limit. (6) A reputation, based on previous experience in medicine and education, of the stature to command the respect of his professional colleagues in Hawaii, and carrying with it the sense of authority and command that will be necessary to acomplish these goals. Such an individual obviously will require an excellent salary and the best possible organizational set-up of the proposed program that can be devised by the governing board.

**Educational Directors.** Each of the five major hospitals directly involved in the various educational programs for interns and residents will have to establish or to appoint at least a half-time director of medical education. We wish to refer again to the guide prepared by the Association of Hospital Directors of Medical Education and published by the Council on Medical Education and Hospitals in the *JAMA* in the annual Internship and Residency issue of September 2, 1961. This guide is an authoritative statement of the relationships that must be developed between the educational director on the one hand, and the administration, the trustees, and the medical staff on the other, in establishing this key position. This guide, prepared by a group of experienced and knowledgeable education directors, represents a concise statement of what they have learned from their years of work in community hospitals. Also we wish to refer again to the article by one of us which appeared in the *New England Journal of Medicine,* entitled "The Director of Medical Education in the Non-University Community Teaching Hospital."[4] This paper analyzes the many serious, complex, and difficult special problems of community hospitals involved in graduate and postgraduate medical education.

Once the position of educational director has been established in accordance with the principles expressed in these two references, each hospital must keep in mind the fundamental qualities that are essential in this man:

1. This individual should be a physician who has been trained in a clinical or laboratory field and who is thoroughly familiar with the present standard system and procedures of residency programs.

2. He should be a specialist, preferably certified by the appropriate board.

3. He should either have had experience in medical education and administration, or have knowledge in some field of medical research.

4. His qualifications should be such that he will have the respect of the physicians on the attending staff of his hospital.

5. His personality ought to combine intellectual and professional imagination and drive with tactfulness, diplomacy, and a proper sense of timing.

The nature of this work prohibits quick solutions and immediate success, and therefore requires some persistence and staying power. We believe that within the relatively near future The Queen's Hospital and St. Francis will require a full-time educational director, while the Children's Hospital, the Kapiolani Maternity Hospital, and the Kuakini Hospital would not require more than a half-time director of medical education. We are aware, of course, that Children's Hospital has already appointed a full-time director, who, however, will devote a good deal of his time to clinical research.

We have also recommended that a special group of part-time or full-time individuals be appointed to this integrated program as clinical instructors. We suggest that these individuals should be certified specialists with outstanding qualifications and with experience in clinical research. Such men could well be appointed in some of the subspecialties in medicine or surgery. They would fill the special role of salaried faculty members within this integrated program. It is our conception that these individuals would work under a separate schedule of activity prepared by the educational directors and the executive director of the project, and would carry out specific teaching activities in the various hospitals at different times of the year. There are individual physicians now practicing in Honolulu who could fill this role, and undoubtedly other such individuals could be attracted from the mainland. These physicians would not only take part in special teaching conferences and seminars, but would carry on bedside teaching and instruction in the outpatient department clinics. Other details of the organizational structure of this project would be worked out in the individual hospital, institution, or health agency.

## METHODS OF FINANCING

Medical education is costly and it can be anticipated that the costs will continue to increase. The salaries of house staffs and the costs of ancillary services will continue to rise; if a community goes wholeheartedly into a teaching program, it must realize this. The one who ultimately pays and benefits the most from such a program, namely the patient, must also appreciate its value.

A realistic budget can be worked out only when a director of the proposed program is chosen. The items that will need financing, exclusive of salaries for interns and residents, would include:

a. Salaries, for the Executive Director and his secretary.

b. Office equipment, including supplies and postage.

c. Developmental program, to include cost of printing, of preparation and mailing of brochures, of sending out a newsletter and a roster of current events.

d. Travel funds for the Executive Director to attend appropriate meetings on the mainland.

After a final budget has been prepared, we suggest that the following means of financing be considered.

1. Hospital contributions. Each participating hospital would pay a base assessment each year. There would then be a sliding scale of assessment per patient admitted for the preceding year. This method is to be preferred over patient days, because it works hardships on smaller hospitals that have patients who stay longer, and to the advantage of the hospital with a rapid turnover. This suggested method seems to be the most equitable.

2. Physicians' contributions. The physicians of the community contribute financially to the educational program at present, in that (a) those who teach give their time, which involves a financial sacrifice, and (b) they all contribute by means of their County Society dues to the operation of the Hawaii Medical Library. If additional assessments are asked of the practicing physician, the logical contribution would be towards support of the visiting professors.

3. Visiting professor fund. It is through this technique that the community can become most intimately involved with the teaching program. For example, a central fund should be created for the visiting professors and be administered by the director of the proposed program. Individuals in the community should be approached for their suggestions for supporting this phase of the program. One could establish, for example, "The Jones Visiting Professorship in Medicine." This would, in effect, create endowed chairs to be named for the public spirited citizens who have created them. This plan would relieve the hospitals of this particular cost and permit their funds to be diverted towards the over-all educational program.

4. Other Support

a. Voluntary agencies

From local voluntary health agencies limited funds could be obtained towards equipping laboratories, establishing research fellowships and sponsoring certain lecturers.

b. The following foundations should be approached for contributions to this experimental program:

(1) The Kellogg Foundation of Battle Creek, Michigan.

(2) The John A. Hartford Foundation of New York City.

(3) Local foundations and trusts, which have displayed interest and concern over the health and well being of the citziens of the state.

(4) The Public Health Committee of the Chamber of Commerce might reasonably be approached for a continuing grant, since this program is concerned with health measures for the entire population of the island.

c. Federal Funds

The United States Public Health Service is allocating funds for various aspects of teaching programs. One can anticipate that this amount will increase. Funds might be obtained towards salaries of instructors, for individual research projects and for the development of specialized laboratories. It is questionable whether direct operational funds could be obtained from this source.

### RELATIONSHIPS WITH THE NONMEDICAL COMMUNITY

An organizational structure that will include members of the administrative board of the various participating hospitals, will of course include many leading nonmedical citizens in the community. It is essential that this representation be broadened to include representatives of the Chamber of Commerce, of various trusts, and of various civic groups. We suggest that an advisory committee of the nonmedical, "nonhospital associated" groups be set up. These individuals could advise as to the general tenor of the public attitude towards medical education. They could spearhead any fund raising in the community.

Medical education is costly and the patient is the one who ultimately pays for it, hence a steady program of public relations to the community at large is necessary to emphasize the value of medical education in the community hospitals, and specifically in Honolulu. We do not suggest a public relations counsel necessarily be obtained for this project, because it is probable that within the existing framework of all hospitals such talent is available.

Above all, it is essential that any arrangement or agreements that are made between hospitals or between one hospital and a particular medical group must be open to the medical and lay public alike. There must be no secret arrangements. The entire community must be apprised of what is going on in the field of medical education. An uninformed public, medical or nonmedical, will become a hostile one.

# Conclusion

The medical profession in Honolulu is presented with an opportunity to develop an integrated and coordinated project in graduate and postgraduate medical education. There is no more urgent task facing our profession than the need for involving all physicians in a continuing effort to maintain current knowledge about scientific medicine and to insure its effective application in the care of patients and in the prevention of unnecessary illness and injury.

This goal cannot be accomplished without the skillful implementation of a planned program of education that will fit into the daily activities of the profession. Continuing medical education for the physician will be successful only when it has become a habit of time and place. In the present and future pattern of medical practice, this can best be accomplished in the hospitals where physicians take care of their patients. The recommendations in this report are designed to accomplish this goal. ■

## Acknowledgments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- Honolulu County Medical Society

Continuing Education Committee
- Drs. James W. Cherry, David I. Katsuki, Isaac Kawasaki, Satoru Nishijima, and H. M. Sexton (Chairman)


## Bibliography


1. Graduate medical education, Report of the Commission on Graduate Medical Education, 273 pp., Chicago: University of Chicago Press, 1940.
2. McKittrick, L. S.: Interns, residents, and John Q. Public, JAMA 181:435-436 (Aug. 4) 1962.
3. Nunemaker, J. C., Thompson, W. V., Adams, R. E., and Tracy, R.: Graduate medical education in the United States, JAMA 177:620-633 (Sept. 2) 1961.
4. Uhl, H. S. M.: The director of medical education in the non-university community teaching hospital, New Eng. J. Med. 266: 647-652 (Mar. 29) 1962.
5. Uhl, H. S. M., Nelson, W. P., and Woolsey, F. M.: The Albany regional hospital program—a preliminary report, New Eng. J. Med. 267:599-603 (Sept. 20) 1962.
6. "Special Bulletin No. 30," Joint Commission on Accreditation of Hospitals, (August), 1962.

# *The President's Page*

As long as we, as physicians, remember that the alleviation and prevention of illness, to the best of our knowledge and ability, is first and foremost, no criticism will sway us from maintaining our high standards. We can always count on having an image in the minds of the major part of the American public that will continue to help the medical profession attain even higher standards of medical care. The majority of these people who are behind us are not as vociferous as those few who criticize us. This majority still hold their physician in the highest esteem. Those criticisms which are developed, we must use to our advantage, building upon them to create a still stronger organization. We must be forceful and energetic in our replies to these criticisms so that the record may be kept straight, and we must continue with our eyes on the goal which we hope to attain in the years to come, the best medical care possible for every person who inhabits this world of ours.

Each of us in our own communities should at this moment resolve that for the new year we will direct our energies toward correcting situations which have led to injury and illness among the peoples of our communities in the past. We should lend our energies toward correcting such horrendous demonstrations as the New Year's fireworks display where so many injuries occurred which resulted in maiming of eyesight and limbs for life. Such an annual occurrence as this should not be allowed to continue. Let us get behind every effort which will result in the banning of fireworks for public sale.

Let us make every effort possible to see that seat belts are a part of the equipment of every automobile. A large percentage of the deaths in the City and County of Honolulu would not have occurred in 1962 had seat belts been used in the automobiles of those involved in the accidents.

Our beaches are becoming increasingly crowded and dangerous. Let us work with all our energy for adequate safety measures and equipment and let us see that this equipment is available and in use at those public beaches where it is required so that the fatalities from water accidents will be cut to a minimum.

Let us also develop an education program so that every youngster will learn to swim and know the dangers as well as the delights of water sports.

Handsome is, as handsome does. In such a positive, constructive program as the above, we may all unite in an effort that cannot fail to win friends for us all.

*Th. Giles MD*

# *Editorials*

## Graduate Medical Education: a Challenge!

An opportunity for greatness lies before the doctors of Hawaii; the blueprint for achieving it is in this issue of the JOURNAL, and every doctor is urged to read it with care and ask himself what part he can play in building the structure it describes.

We have never been faced with a more vitally important challenge. It should be the principal concern of every one of us, second only to the conduct of our own practice, to meet it. If this report by Dr. Michaels and Dr. Uhl is merely used to repair the deficiencies in our existing program, it will have failed to achieve its purpose.

These deficiencies are numerous, and are spelled out frankly and in detail in the report. "Insufficient clinical material and insufficient participation by members of the attending staff" . . . "residents . . . are permitted little responsibility for the writing of orders" . . . "medical education in outpatient departments is seldom carried out effectively and conscientiously" . . . "consultant[s] at Tripler should either become active in this role or resign" . . .

But it is with the positive recommendations that we should be concerned, and these are exciting, if a little frightening. These men are practicing experts in the field of intern and residency training. They are confident that we can, given a little money and a lot of work, create an integrated training program in Honolulu which would make proper use of our unusually fine facilities and our many unusually competent physicians.

The remoteness of such a training program from the "ivory tower" setting, and its intimate connection with private practice, are points of practical value which—except for residency training in a few specialties—go far to outweigh the disadvantage of having no medical school and no university hospital in the program. Added to Hawaii's natural attractiveness, they should enable us to obtain a full complement of first-rate interns and to keep—as we are *not* now doing—a fair proportion of them for residency training afterward.

So vitally important is this program to Hawaii, and to the medical profession here in particular, that we cannot afford to give it less than total support. We cannot conceive of a better public relations program, of anything better calculated to win friends and admirers for the medical profession, than an all-out drive to put it into being. We could well afford to divert all the time, money, and personnel now concerned with our public relations effort into promotion of this integrated training program.

Please read it with care; read it twice; be prepared to discuss it, to criticize it constructively if you see cause for criticism, (Letters to the Editor are invited!) and to devote a fair share of your time to helping to get it under way. It won't be easy, and it won't be done in a day or a month or a year. But it can be done—and the Hawaii Medical Association and the Honolulu County Medical Society may never have an opportunity to do anything of more basic and lasting value.

# Financial Help for Students

A far-reaching new medical education loan guarantee program is now under way in American medicine. The goal of this program is to help eliminate the financial barrier to medicine for all who are qualified and accepted by approved training institutions. It is designed to provide a means of financing a substantial portion of the cost of a medical education.

The loan program for medical students, interns, and residents is the result of a cooperative effort by American medicine and private enterprise.

The program is administered by the American Medical Association's Education and Research Foundation. The ERF has established a loan guarantee fund. On the basis of this fund, the bank will lend up to $1,500 each year to students. The ERF in effect acts as co-signer. For each $1.00 on deposit in the ERF's loan guarantee fund, the bank will lend $12.50.

More than 3,300 students, interns, and residents have borrowed more than $6,000,000 through this fund since it was started last February. Physicians and others have contributed almost $700,000 to the loan guarantee fund, which makes possible these loans.

Hawaii's medical students (usually 15 or 20 at any one time) are presumably spending about the national average of $2,911 a year for their medical education. Nationally, over 43 per cent of the students are from families with incomes over $10,000, but 14 per cent are from families making less than $5,000. Loans secured by the AMA-ERF fund in Hawaii last year totalled $3,000, all to finance postgraduate medical training.

The guarantee fund is almost depleted and more money is needed immediately to keep up the loan program. Eventually it will become self-sustaining as loans are repaid, but right now substantial financial help is needed. Your check to the AMA-ERF, 535 North Dearborn St., Chicago, will help to keep this important program viable. Contributions to the Foundation are tax deductible.

# Cigarette Smoking

The committee on Cancer of the American College of Chest Physicians has been studying the effect of cigarette smoking on the pulmonary and cardiovascular systems. The members of the Board of Regents of the College are convinced that sufficient evidence has been accumulated to warrant issuing an official statement with regard to cigarette smoking and health. Accordingly, a resolution connecting cigarette smoking with various pulmonary and cardiovascular conditions was approved by the Board and issued by the College.

The resolution stated that cigarette smoking and the inhalation of other atmospheric pollutants have a relationship which strongly suggests a causal connection with chronic bronchitis, pulmonary emphysema, cor pulmonale, cardiovascular diseases, and cancer of the lung.

The College in its official statement urged its members and the medical profession in general to intensify their educational campaign directed toward the public, and the youth in particular, relative to the hazards of smoking.

The College urges that efforts to control atmospheric pollution be encouraged and that support be given to endeavors in the field of research for additional scientific information concerning other etiologic agents.

The resolution was introduced by Dr. J. Winthrop Peabody, Jr., Washington, D. C., to the House of Delegates of the American Medical Association and was referred to their Council on Drugs, which is conducting a study on the relationship between tobacco and disease. A preliminary report is to be presented by the Council within 12 to 18 months. Surgeon General Luther L. Terry of the U. S. Public Health Service has announced plans for an advisory committee to make recommendations on the health aspects of smoking. The College resolution will be referred to this committee. ■

HAWAII MEDICAL JOURNAL

# In Memoriam—Doctors of Hawaii

This is the forty-second installment of In Memoriam—Doctors of Hawaii.

## Arthur Flournoy Jackson

Arthur Flournoy Jackson was born at West Point, Troup County, Georgia, on October 28, 1878. He was the son of Arthur Ophelius and Alice (Zachry) Jackson. His grandfather was Major Wyche Sanford Jackson of Civil War fame.

DR. JACKSON

He was educated at West Point public school and high school, receiving his B.S. from Alabama Polytechnic Institute in 1901. From 1905 to 1907 he attended the University of North Carolina as a medical student. He then entered the University of Pennsylvania, from which he received his M.D. in 1909. Dr. Jackson interned at Philadelphia General Hospital from October, 1909, to April, 1911. The following year he was granted a certificate in tropical medicine and hygiene from the University of Pennsylvania.

Coming to Honolulu, Dr. Jackson served as resident physician at The Queen's Hospital from July, 1912, to January, 1914. On the completion of his residency, he entered private practice in Honolulu. He was on the staff at The Queen's Hospital as visiting physician and surgeon and served as physician to Palama Settlement, Mid-Pacific Institute, Castle Home, and Lanakila Hale.

On November 20, 1914, Dr. Jackson married Margaret Christy Tupper in Honolulu. Three daughters were born to the Jacksons, Alice Rebecca (Mrs. Louis B. Wagner), Margaret Christy (Mrs. William R. Scott), and Nancy Lee (Mrs. Clark F. Spencer).

Dr. Jackson began his service in World War I as medical examiner of draftees, and, after sending many men into active service, he felt that he should volunteer and that, being a doctor, the logical place for him to serve would be in the Red Cross. Commissioned as captain, the doctor went to Siberia with the Hawaiian Red Cross unit which left Honolulu in November, 1918.

Arriving in Vladivostok, he was sent to Nikolak to inspect a typhus hospital. While he was there the infamous "Death Train" filled with Bolsheviks arrived from Samara. Hundreds of people had been crowded into box cars from which they were not allowed to leave, half-fed and with no sanitary precautions; sickness and death were rife. The train was unloaded, the well put into new cars and the 550 sick taken to the Russian Military Hospital, which had a 250 to 300 bed capacity.

The doctor's next assignment was to a hospital for tubercular Czech patients in Buchedu, Manchuria. These patients had been driven out of Czechoslovakia by the Bolsheviks and when the hospital closed they were returned to their homeland via San Francisco, completing their circle of the globe.

While at Buchedu, Dr. Jackson was asked to be medical director of the anti-typhus train which the Red Cross operated all over Siberia.

Following this, Dr. Jackson received orders to become superintendent of the Red Cross hospital at Umsk, which was the largest and finest in Siberia. Along with this assignment, he was made medical director of Western Siberia. In the winter of 1919-1920, failing health compelled Dr. Jackson to return to Hawaii. In recognition of his services to the Russian people, the Russian government decorated him with the order of St. Anne, third degree.

In January, 1921, Dr. Jackson joined Dr. George F. Straub and Dr. Guy C. Milnor as the third partner and first internist in The Clinic, now the Straub Clinic.

On October 5, 1921, Dr. Jackson died of leukemia in a Philadelphia hospital. He was within a few days of his 43rd birthday.

He was a member of the American Medical Association, the Medical Society of Hawaii (President in 1920), Honolulu Medical Society, American Association for the Advancement of Science, Honolulu Chamber of Commerce, Ad Club, Public Questions Club, a director of the Y.M.C.A., director of the Pan Pacific Union, and a Mason.

An editorial in the *Star-Bulletin* had this to say of Dr. Jackson: "Much of his professional life was given over to unremunerative work among obscure, impoverished people. When he received a

*continued page 236*

# *This Is What's New!*

• **Automatic analysis of electrocardiograms** by high speed digital computers has been found superior to analysis by "conventional means." **IBM 7090 computers** race through coded electrocardiograms at the rate of 700 to 800 records per hour with an accuracy that is superior to careful study of the records by trained electrocardiographers. (*Ann. Int. Med.* [Nov.] 1962.)

• **Waldenstrom's macroglobulinemia** is a rare disease, diagnosed in Hawaii on only two occasions. Since 1960, a small group of patients have been treated by plasmaphoresis—the **removal of the patient's plasma** containing the abnormal protein and transfusing the red cells back into the patient. Although never curative, this procedure may relieve some of the signs and symptoms. (*Brit. Med. J.* [Nov. 17] 1962.)

• The **infertile couple** (defined by lack of conception after a year of adequate exposure) may be so because of multiple factors within either the man and the woman, or both. With a systematic and optimistic approach, the Professor of Obstetrics at the University of Michigan achieves an over-all **success of 35 per cent.** (*Postgrad. Med.* [Nov.] 1962.)

• The **anemia** that commonly accompanies **multiple myeloma** results chiefly from patient's inability to make enough red blood cells. Iron deficiency, hemolysis, and hemorrhage contribute to the anemia, but usually in a minor way. Recommended treatment: **androgenic steroids.** (*Am. J Med.* [Oct.] 1962.)

• Teenage **glue sniffers** run the risk of liver, kidney, brain and bone marrow damage. The youngsters get hooked on the volatile solvents in model airplane and similar glues. An acute alcoholic-like intoxication results. The craze is apparently widespread and may have much more serious consequences than previous teen pastimes, such as goldfish swallowing and telephone booth cramming. (*J.A.M.A.* [July 28] 1962.)

• **Freezing an inoperable rectal carcinoma** with a cryogenic cannula inserted into it in three locations through a sigmoidoscope, at –150° C. for three minutes, reduced it in ten days to a shriveled, grayish, necrotic mass in which **no neoplasm** could be found on biopsy. (*J. Am. Geriatrics Soc.* [Oct.] 1962.)

• A **Honolulu physician** has related certain instances of **drug-induced hepatitis** to minor changes in **molecular structure** of the offending drug. This finding may open a small crack in the problem of drug hypersensitivity with hepatitis. (*J.A.M.A.* [Dec. 8] 1962.)

• Blood investigators in Boston have found **Döhle bodies** associated with the **May-Hegglin anomaly.** This familial [if unfamiliar—Ed.] condition is of course not to be confused with the superficially similar **Chediák-Higashi anomaly.** (*Blood* [Dec.] 1962.)

• Patients with **cystic fibrosis** are able to smell, and to taste salt, sweet, sour, and bitter substances, in more dilute concentrations than normal persons can. The only other patients whose senses of smell and taste are more acute than normal are those with adrenal insufficiency. If these results are confirmed, the simplest screening test for cystic fibrosis would be to have the patient **taste dilute salt water.** (*Science* [Dec. 7] 1962.)

• The **United Nations** through its **Atomic Energy Agency** is attempting to train doctors throughout the world in the pratical use of **radioisotopes.** One such physician trainee spent two years at an American university doing $C^{14}$ studies on the isolated rat heart, with predictable results, when he returned to his own country as an expert in nuclear medicine. A committee in Austria hopes to correct this by emphasizing the practical application of radioisotopes. (*J. Nuc. Med.* [Nov.] 1962.)

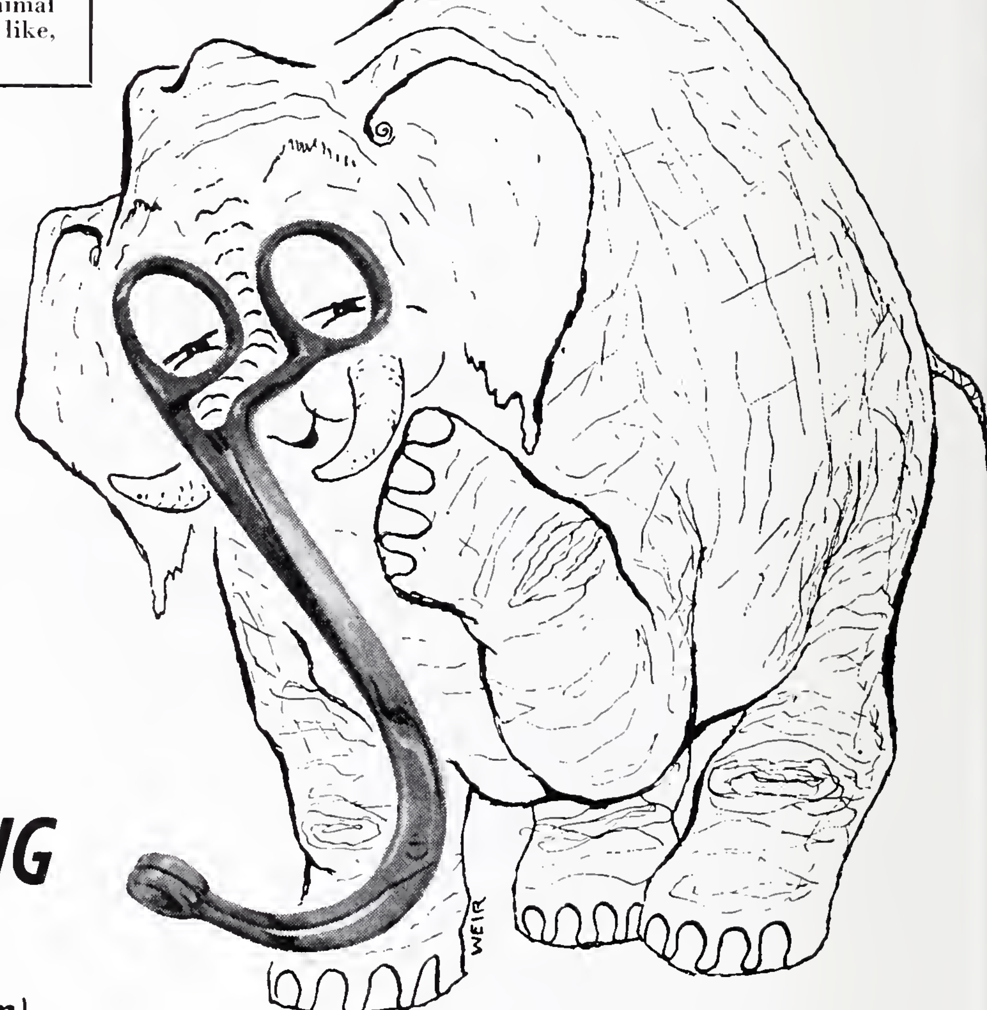
• Reports solicited from chest clinics in England, Scotland, and Wales indicate that **corticosteroid treatment** made **no significant contribution** to either the incidence of new **tuberculosis,** or the relapse rate of old cases, during 1959 and 1960. The proportion of sputum-positive cases occurring in corticosteroid-treated persons was on the high side, but there was no striking evidence of either especially acute or especially insidious disease. The authors conclude that the risk of tuberculosis as a complication of corticosteroid therapy is trivial from the epidemiologic standpoint, but warrants both **preliminary and periodic chest** x-rays for the protection of patients who will probably be taking corticosteroids for more than a month or so. (*Tubercle* [March] 1962). ■

Fred I. Gilbert, Jr., M.D.

Introducing

**The ZOOID ZOO Series**

zo'oid (*zō'oid*), *n.* An entity which resembles but is not wholly the same as a separate individual animal; a more or less independent animal produced by fission, proliferation, or the like, and not by direct sexual methods.

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# *Hawaii Academy of General Practice*

The hospital is the doctor's workshop.

One of my overseas WW II tentmates is a general practitioner in the suburbs of a large Eastern city. Once he sends an ill patient to the nearest hospital, 15-20 minutes away by car, he sees no more of him. Probably in direct relationship to this, my colleague also does not have a scalpel in his office. He is very busy, overworked as usual, and he spends many evenings doing life insurance physicals in clients' homes.

This is not uncommon on the Mainland; it is the rule in England under the National Health Service system. We who live in Hawaii look upon this with horror and disbelief.

Many local physicians have rather elaborate offices in which they have direct and immediate access to laboratory and x-ray facilities. They also have minor surgeries and competent paramedical assistants. Yet they would probably resist strongly any attempt to bar them from hospitalizing and attending their own patients when the signs and symptoms indicate the necessity thereof.

It is in the hospital that a physician meets his colleagues in formal and informal discussion. Even in attending his own private patient exclusively, he does so under the eyes of his professional public. This cannot help but make for better medical care of the patient. The care of the sick and injured in hospitals should be encouraged, therefore. But it is not . . .!

### THE RESTRICTIONS OF COST

Inhospital costs are rising so rapidly and to such heights, that the point of diminishing returns is already at hand. When a local hospital charges $4.50 for the use of its emergency room and its Stryker cast-cutter, while the attending physician does all the cutting, it is time for doctors collectively to sit up and take notice. Without our participation, the hospitals are as nothing. The trend has been for the hospitals to divest themselves of all charitable efforts, other than the charity dispensed by the volunteer attending, and to make a profit. This applies not only to the entire hospital but is even expected of every department. Since nearly all health insurance carriers cover hospital charges in full or in large part, they too aid and abet this trend, at increasing premium cost, of course.

In addition to pricing themselves out of the patient's reach, and so driving both patient and doctor to increasing use of the office for both surgical and medical treatment, hospitals are increasing restrictions on the freedom of practice of the very people upon whom they depend for the admission of their paying customers.

### THE RESTRICTIONS OF POETRY

It is we doctors, however, who, in the last analysis, are doing this to ourselves and to our patients, the "we" being a non-specific pronoun. It represents only a handful of physicians who are not *our* representatives. Even though elected to office and membership in executive committees by the medical staffs, these men are actually elected by minorities, and small minorities at that. In one large general hospital in Honolulu, restrictions of attendance and participation have brought about the rather ridiculous situation in which some twenty "active" members, out of several hundred physicians who use the hospital, are the only ones allowed to vote at elections!

In this particular hospital "active" membership offers the privilege to vote in exchange for a lot of mandatory hard work and no thanks. It should be the other way around: by the Golden Rule, the favor should be offered first; the payment in kind will follow.

### LEARNING BY DOING

The American Academy of General Practice is a strong advocate, together with the AMA, and the Joint Commission on Accreditation of Hospitals, of permitting every physician who can present proper credentials of training and licensure and who can demonstrate competence, to practice in hospitals of his choice without arbitrary or unfair restriction. The Academy particularly, of course, encourages the rights of general practitioners in hospitals, not only to be allowed to do that in which they can prove competence, but also to be allowed to improve their competence and skill. It is unalterably opposed to the concept that a physician must be pigeonholed at the just-out-of-internship level and kept there.

In this, the American Academy of General Practice simply corroborates the basic tenets of hospital practice stated clearly by both the AMA and the JCAH. ■

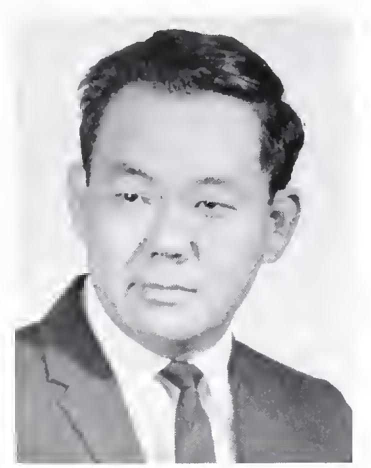
J. I. FREDERICK REPPUN, M.D.
*Secretary*

# New Members

**Francis H. Soon, M.D.**
1481 S. King, Suite 312
Honolulu 14, Hawaii
Obstetrics & Gynecology
St. Louis University Medical School, 1958
Internship—St. Elizabeth Hospital, Youngstown, Ohio
Residency—St. John Hospital, Cleveland, Ohio
Presbyterian Medical Center, San Francisco

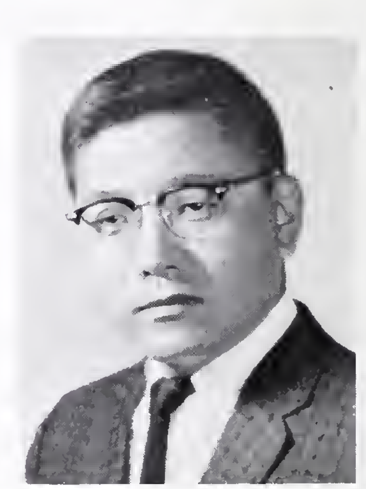
**Tom Keizo Taira, M.D.**
1441 Kapiolani Boulevard
Honolulu 14, Hawaii
Plastic Surgery
Harvard Medical School, 1956
Internship—University Hospital, Columbus, Ohio
Residency—VA Hospital, Hines, Illinois
UCLA

**Gloria Nano Natino Badua, M.D.**
1697 Ala Moana Boulevard
Honolulu 15, Hawaii
General Practice
University of Santo Tomas, 1954
Internship—Affiliated hospitals of the University of Santo Tomas
St. Francis Hospital
Residency—St. Francis Hospital



**Raymond Masatomo Tamura, M.D.**
Ewa Hospital
Ewa, Oahu
General Practice
University of Illinois Medical School, 1957
Internship—San Diego County General Hospital
Residency—Ohio State University Medical Center

**Roy I. Iritani, M.D.**
1010 South King Street
Honolulu 14, Hawaii
General Surgery
University of Colorado Medical School, 1954
Internship—The Queen's Hospital
Residency—The Queen's Hospital
Cincinnati General Hospital



**Norman Y. Nakamura, M.D.**
1133 Punchbowl Street
Honolulu 13, Hawaii
Orthopedics
Tulane Medical School, 1957
Internship—Charity Hospital, New Orleans
Residency—Charity Hospital, New Orleans

# County Society News

**Audrey Wilkins Mertz**
45-260 Waikalua Road
Kaneohe, Oahu
Psychiatry
Cornell University Medical College, 1952
Internship—St. Vincent's Hospital
Portland, Oregon
Residency—Hawaii State Hospital
The Queen's Hospital

**Frederick A. Dodge, M.D.**
94-801 Farrington Highway
Waipahu, Oahu
General Practice
Jefferson Medical College
1961
Internship—St. Francis Hospital

## Hawaii

The November 15 meeting was held at the Hilo Hotel. Guests present were Drs. Mathews and Zelko plus Dr. and Mrs. Rees B. Rees. A movie on gout was shown just prior to the business meeting. Dr. Okumoto read a letter from the HMSA advising that all medical cases will in the future be reviewed by the Federal Medical Review Committee. The Society voted to sponsor the 1963 AAPS Essay Contest. Dr. Oda was appointed to look into the possibility of establishing a closer relationship with the educational program at Queen's. Dr. Steuermann gave the Treasurer's Report and advised that there was more than $11,000 in the treasury. Dr. Wippermann gave a report on the disaster planning meeting which he had recently attended in Chicago. He again pointed out the lack of adequate facilities at the Hilo Airport to cope with an airplane disaster. Dr. Okumoto reported on Operation Swallow. The Nominating Committee submitted its report. The relationship of the doctors to the Department of Social Services was discussed. Dr. Bracher pointed out that the medical profession is the only group working for the Welfare Department that receives reduced compensations. He objected to the Department's setting fees without the consent of the doctors. It was noted that the schedule which was set forth many years ago was with the County. The Society were of the opinion that a new agreement should be made. Dr. Rees, Professor and Chairman of the Department of Dermatology of the University of California, gave an interesting talk on "Common Dermatoses and Their Management."

A special meeting was called on November 19 to hear Dr. Claude Welch, Associate Professor of Surgery at Harvard, who discussed some surgical aspects of peptic ulcers and other surgical abdominal problems.

## Honolulu

Approximately 200 members attended the October 2 meeting which was scheduled at 7:00 p.m. in order that the film "The Next Step" on polio vaccine could be shown the membership. New members introduced were Drs. Charman J. Akina, John A. Harbinson, and Robert Kim. Following these introductions, the second Dr. Annis film "Your Health, Your Choice" was shown. Members were reminded to contribute to the Community Chest Drive through the Society officers. Dr. Varian Sloan presented a report on Operation Swallow. Recommended changes in the HMSA administrative procedures as well as the master and individual contracts were presented by Dr. Chew Mung Lum. After a lengthy discussion and clarification by Dr. Lum, and several intervening motions which failed to pass, the report was approved without change. Dr. Reppun suggested that in the future committee meeting dates be posted in advance in order that interested members can attend. Dr. Pinkerton presented an up-to-date report on the present housing problems of the BME and the Society, covering the proposed expansion of the Mabel Smyth Building and the several alternatives the Society could consider. Mr. Tom Rice was called upon to explain to the membership the legal restrictions involved in the use of the building and the present status of the lease.

Dr. Rees B. Rees spoke on "Common Dermatoses and Their Management" at the November 13 meeting. The President congratulated Dr. Ando on his recent election to the School Board Advisory Council. The following new members were welcomed into the Society: Drs. Douglas B. Bell, II, Hing Hua Chun, Charlotte T. Kutsu-

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# Hawaii Medical Association

## AMA Delegate's Report

The meeting of the AMA House of Delegates Los Angeles, November 25-28, 1962, was a relatively quiet one.

One item which caused considerable discussion was the change in the Constitution and Bylaws implementing the action of the House at the June, 1962, meeting, which would increase the number of the Board of Trustees from 11 to 15 and reduce the term of office from five to three years. Apparently the Board of Trustees, or certain members of the Board, objected rather strenuously to this action. In spite of this, the House, by a vote of 130 to 48, adopted changes in the Constitution and Bylaws affirming the change. It was later learned that at least 144 affirmative votes were needed. Therefore, this action must again be voted at the June, 1963, meeting. It is interesting to speculate whether any change in the temper of the House will occur by then.

Considerable discussion in reference committee was occasioned by a report of the Judicial Council containing new opinions on the medical ethics involved in physician ownership of drug stores, drug repackaging houses and drug companies, dispensing of glasses by ophthalmologists, and advertising practices of medical laboratories. Only the lattter was acted on. The Council had apparently done little or no preparatory liaison work with others interested in these problems.

The ophthalmologists in particular were disstressed because there had been no prior consultation with them. Even in an organization with as large a staff as the AMA, it seems, matters may go awry due to poor preparation. It also illustrates the value of discussion before reference committees in helping to prevent precipitous action by the House which might later have to be rescinded.

Another example of this occurred with the intensive report by the Committee to Study the Scientific Sections which recommended major changes in the organizational structure of the sections and scientific programs. Here, again, there had not been sufficient prior consultation with the various sections. As a result an ad hoc committee of the House was appointed to study the subject and report next June.

A special report on compensation of interns and residents, published in the October 27 issue of *JAMA*, was presented to the House. This promised to stir up considerable discussion, but because of the need for further time to study the report, it was wisely deferred until June. Your delegate urges that all persons interested in this matter study the report and forward suggestions to him or to the AMA's Council on Medical Education and Hospitals or the Council on Medical Service, as soon as possible.

Several changes in the Essentials of an Approved Internship, submitted by the Council on Medical Education and Hospitals, were approved by the House.

While on the subject of medical education, it was gratifying to learn that ten per cent of all medical students in the U. S. are now benefiting from the new student loan program sponsored by the AMA. Since its inception, nine months ago, loans totaling more than nine million dollars have been granted to 3,032 medical students and 1,787 interns and residents. New applications for these loans are being received at a rate of 600 per month. In Hawaii, $3,000 has been loaned to interns and residents.

In the field of medical economics, the House reaffirmed its present policy of opposition to King-Anderson type legislation and support of the Kerr-Mills program. The following suggested amendments to the Kerr-Mills law were approved in principle: 1. Remove the requirement that both Old Age Assistance (OAA) and Medical Assistance for the Aged (MAA) programs be administered by the same agency. 2. Provide flexibility in the administration of the income limitations proposed under state law, so that a person who experiences a major illness may qualify for benefits if the expense of that illness, in effect, reduces his income below the maximum permitted. 3. Include a provision in the law which would require state administering agencies to seek expert advice from physicians or medical societies through medical advisory committees. 4. Provide for "free choice" of hospital and doctor under the state program.

A resolution, passed by the House, instructed the Board of Trustees to use every influence at their command to have the Hill-Burton Law amended in such a manner as to eliminate all categorical grants, eliminate the term "diagnostie and treatment centers" from any listing in the act, and prevent Federal funds from being awarded under existing law as a grant to closed panel medical

*continued page 230*

HAWAII MEDICAL JOURNAL

# Book Reviews

## Progress in Neurology and Psychiatry An Annual Review, Vol. 17

*Edited by E. A. Spiegel, M.D., 607 pp., $14.00, Grune & Stratton, 1962.*

ANOTHER outstanding annual review of the literature in neurology and psychiatry, in which 66 contributors have surveyed nearly 5,000 publications. For the busy practitioner in the field of neurology, neurosurgery, or psychiatry, a volume of this type is essential to any attempt to keep up with the voluminous literature of today. Unlike the *Yearbook of Neurology, Psychiatry, and Neurosurgery*, in which a short synopsis of each publication is made, the text of *Progress in Neurology and Psychiatry* is more like that of a very readable textbook in which the various publications are discussed under specific subject headings.

MICHAEL M. OKIHIRO, M.D.

## Wound Ballistics

*By Medical Department, United States Army. Editor in Chief, Colonel James Boyd Coates, Jr., MC., Editor for Wound Ballistics, Major James C. Beyer, MC., 883 pp., $7.50, U.S. Government Printing Office, 1962.*

A CONCISELY DETAILED study of offensive weapons and their products, protective mechanisms and their products, and the care and technique of handling the various casualties of battle in total war.

This is a long and detailed volume involving well over 800 pages in much finer print than the usual text. It is beautifully and realistically illustrated using actual on-the-spot pictures from the files of the U.S. Army.

Every conceivable wounding agent is described as to its action and potential. The mechanisms of wounding are in detail as are casualty surveys of the various battles of World War II.

*Wound Ballistics* is an excellent reference and one is proud to know all of this vital information has been tabulated for posterity. It is a work for one with a special interest in this field and not a work for the ordinary practicing doctor.

JAMES G. MARNIE, M.D.

## ★Synopsis of Obstetrics, 6th Ed.

*By Charles E. McLennan, M.D., 464 pp., $6.75, The C. V. Mosby Company, 1962.*

AN EXCELLENT abridgement of obstetrics. The format is well arranged and in good sequence. All subjects presented are very much abreast of current advancements in the field.

Illustrations and figures seem accurate and adequate.

It is always a pleasure to see among our huge volumes a handy, ready reference with such excellent qualities.

S. J. BUIST, M.D.

## Gynecology

*By Langdon Parsons, M.D., and Sheldon C. Sommers, M.D., 1250 pp., $20.00, W. B. Saunders Company, 1962.*

THIS BOOK is unique in that it is written by a gynecologist and a pathologist whose interests lie in gynecology. It covers every aspect of the field of gynecology in detail.

Refreshing differences from the run-of-the-mill gynecology texts are: 1) division of the subject matter into age groups rather than diseases; 2) much more information on childhood, teenage and geriatric gynecology; 3) excellent chapters on sterility, marriage counseling and sexual problems; and 4) an easy-to-read format utilizing commonly posed questions as paragraph headings, each followed by clear, concise, and complete answers. The bibliography is extensive, reflecting the amount of work done in producing this book.

This complete, up-to-date fund of information would be excellent, not only for medical students, but for all those interested in the specialty. It is practically a library in itself.

ARNO J. MUNDT, M.D.

## ★Thoracic and Cardiovascular Surgery with Related Pathology

*By Gustaf E. Lindskog, B.S., M.A., M.D., F.A.C.S., Averill A. Liebow, B.S., M.D., and William W. L. Glenn, B.S., M.D., F.A.C.S., 1024 pp., $18.00, Appleton-Century-Crofts, 1962.*

THIS IS THE FIRST revision of a book originally published in 1953 by Drs. Lindskog and Liebow, now joined by Dr. William W. L. Glenn, Chief of the Cardiovascular Surgery Section, Yale University School of Medicine. All are acquainted with the vast strides that have been made in thoracic surgery in the nine years since the original volume. This is particularly true in the field of cardiovascular surgery.

The original chapters dealing particularly with pulmonary diseases have been extensively revised, but not as completely as current accepted practice dictates, e.g., in some aspects of the surgical treatment of TBC. The 20 new chapters dealing with cardiovascular surgery are the outstanding portion of the book. The development of cardiac surgery is reviewed in relation to both methods of perfusion and operative techniques. Six chapters deal with congenital lesions of the heart and great vessels, and ten chapters with acquired heart lesions. This emphasis fairly well parallels the trend in this field, that an increasing number of acquired heart lesions are becoming amenable to surgery.

For those particularly interested in thoracic surgery, there are excellent bibliographies at the end of each chapter which facilitate the more extensive review of any given subject. This volume is an important addition to the library of those who deal in the field of pulmonary diseases and cardiac surgery.

NIALL M. SCULLY, M.D.

## Peripheral Vascular Diseases, 3rd Ed.

*By Edgar V. Allen, B.S., M.A., M.D., M.S., in Medicine, F.A.C.P., Nelson W. Barker, B.A., M.D., M.S., in Medicine, F.A.C.P., and Edgar A. Hines, Jr., B.S., M.A., M.D., M.S., in Medicine, F.A.C.P., 1,044 pp., $18.00, W. B. Saunders Company, 1962.*

STILL AN excellent text on the subject of peripheral vascular disease, this edition includes such new sections as cerebral artery diseases, blood coagulation mechanisms, anticoagulant and fibrinolytic agents, angiography, and other matters of current interest. The first three chapters (60 pages) are most interesting, covering the basic fundamentals of peripheral vascular disease.

The discussion of diseases is excellent. The weakness of this text lies in the chapters on the use of anticoagulants

*continued page 238*

★ means highly recommended.

**LAUDED** for long and honored careers at Honolulu County Medical Society's annual meeting were (standing from left to right) Drs. Kiyoshi Hosoi, Harry L. Arnold, Robert B. Faus, Joseph E. Strode, Forrest J. Pinkerton, (seated) Lyle G. Phillips, Clarence L. Carter, Nils P. Larsen, Joseph Palma, Min Hin Li, and Fred K. Lam. Also honored, but not pictured, were Drs. Eijiro Nishijima, George F. Straub, Steele F. Stewart, Mon F. Chung,† Clarence E. Fronk, and Hastings H. Walker.

† deceased

## NEWTON E. WAYSON, M.D.
## 1883-1962

Dr. Newton E. Wayson, who was in charge of the Leprosy Investigation Station at the Kalihi Receiving Hospital from 1927 to 1935, died of coronary occlusion at his home in San Francisco on December 8, 1962. He had been retired since 1947 from the U. S. Public Health Service, having reached the mandatory retirement age of 64.

Dr. Wayson will be remembered by the kamaaina physicians on Oahu for the excellent clinics and demonstrations which he conducted at the Kalihi Receiving Hospital. From 3:00 to 4:30 P.M. on the last Friday of each month he presented selected patients to demonstrate physical findings and laboratory techniques for diagnosing leprosy in its earliest recognizable stages. These clinics were generally very well attended by members of the county medical society and frequently by visiting physicians from other countries.

Dr. Wayson was born in Saint Inigoes, Maryland, to George Washington and Irene (Allen) Wayson on November 22, 1883. He received his M.D. degree from Northwestern University in 1910. Following graduation he served as bacteriologist in the laboratories of the Illinois State Board of Health. He then interned at the Cook County General Hospital, Chicago, for eighteen months, followed by a one-year residency at the Wichita( Kansas) General Hospital.

In 1914, he married Anne Christina Ewing. Born to this marriage were two sons and one daughter. The eldest son and daughter are deceased but Edward Ewing Wayson, a one-time Punahou student, is now a physician in active practice in Portland, Oregon. Also, in 1914, Dr. Wayson was commissioned an Assistant Surgeon in the U. S. Public Health Service and continued on active duty in that Service until his retirement. During most of his Public Health Service career he was engaged in leprosy and plague investigations, having made many significant contributions to our knowledge of those diseases.

Dr. Wayson is survived by his wife, Anne; son, Edward; and several grandchildren.

E. W. Norris, M.D.

## TEODORA FIDELINO AVECILLA, M.D.
## 1907-1962

Teodora Fidelino Avecilla died in Quezon City, Philippines, on June 27, 1962. She was born in Manila, on April 28, 1907. Before studying medicine, Dr. Avecilla took her degree in pharmacy in Manila and practiced pharmacy for two years.

Dr. Avecilla studied medicine at the University of the Philippines and received the degree of Doctor of Medicine in 1937. Following her graduation in medicine Dr. Avecilla had an active practice in both internal medicine and obstetrics in Manila for the ensuing eleven years.

In May, 1948, Dr. Avecilla came to the United States and, to join her husband, took an internship at the Harlem Hospital in New York City in 1950, after which she held the position of medical resident in the Harlem Hospital until 1956. During this period Dr. Avecilla suffered severe injuries in an automobile accident, which contributed to her final illness.

In 1957, Dr. Teodora Avecilla served as plantation physician at Pepeekeo, Hawaii, moving to Honolulu and becoming a member of the Honolulu County Medical Society from 1958 until her demise.

Dr. Avecilla was greatly loved by those she served, not only in the Philippines, but in New York and Hawaii as well. She is survived by her husband, Dr. Marcelino Avecilla.

L. Clagett Beck, M.D.

# Notes and News

## Names in the News

Physicians have been getting "oodles" of publicity lately—what with the election, diabetes detection drive, and Operation Swallow. The Hawaii Physicians League for Good Government (whose name has now been officially changed to the Hawaii Political Action Committee) bore the brunt of severe criticism on the decision to back certain political candidates. **Dr. Frederick L. Giles**, HMA President, clarified the issue by stating that the Committee was not a part of the HMA. Former Committee chairman, **Dr. Richard E. Ando,** at that time a candidate for a school advisory council seat, resigned "to leave no doubt anywhere" that he was nonpartisan. When Ike Sutton was abandoned in a bid to beat Tom Gill, the "crying" towel was really dripping. **Dr. F. J. Pinkerton** disagreed and urged his patients to vote straight Republican. **Dr. P. H. Liljestrand's** comment was to the point when he said "action was taken to oppose Gill." **Dr. Randal Nishijima** was blunt. Quote "The handwriting is on the wall. Sutton is not strong enough even if he goes along with our views." Of course, Sutton was bitter and disappointed, while Gill made "hay" in his inimitable way and blasted the doctors. More than 110 physicians subscribed to an ad in order to tell the public why the King-Anderson "Medicare" bill is bad. Kudos to them for standing up and being counted.

Diabetes Detection Drive week helped get **Dr. L. George Stuhler** and **Dr. Peter Kim** in the news. **Dr. Frederick L. Giles** announced the dates of the drive, while Dr. Stuhler made radio appearances. One hundred twenty-nine previously unsuspected diabetics were referred to their physicians.

Operation Swallow I and II were great successes. The HMA and all the counties which coöperated should be commended. Much time and energy were expended to make the projects so successful. To **Drs. O. D. Pinkerton,** President of Honolulu County, and **Dr. R. Varian Sloan,** chairman of Honolulu's steering committee, thanks for a job well done! **Dr. Ira Hirschy** of the Health Department also deserves great credit for Swallow's success. There were many others who helped but space does not permit naming all. Over 75% of the population in the entire state received I and II viruses. The county getting the best coverage for Swallow I was Kauai. Kauai again took the lead in Swallow II with 85.3%, followed by Hawaii (77.1%), Oahu (76.4%), and Maui (70.4%).

P.S. Apologies to other county doctors who worked so hard in their counties. We have no information of their activities so cannot mention them. Sorry. Representative F. W. C. Loo, member of the House Public Health Committee, had praise for the project and the doctors as well as others. **Drs. Leo Bernstein, F. L. Giles,** and **R. V. Sloan** have announced that Operation Swallow III will be postponed indefinitely until favorable word is received from the Surgeon General's (PHS) office in Washington, D. C.

## In the Public Eye

The past few months many physicians have been before the public on television. "Call The Doctor," formerly "Spotlight on Medicine" has been shown on KTRG-TV, Channel 13, every Tuesday at 8:30 P.M. The TV time is donated and the subjects have ranged from autopsies and teen-age narcotic problems to menopause, fertility, and politics. Those who have participated include **Drs. O. D. Pinkerton, Richard D. Moore, Raymond Yap, Katherine Edgar, Duke Cho Choy, Calvin Sia, Thomas Chang, James Marnie, Fred Gilbert, William Stevens, Edward Furukawa, Robert Spencer, George Schnack, Thomas Richert, Toru Nishigaya, Claude Caver, L. Q. Pang, John Peyton, Leo Bernstein, Doris Jasinski, Paul Tamura, Marquis Stevens, William Walsh, Colin McCorriston, Gail Li, Rodney T. West, Robert Mookini, Robert Hunter, Laurence Winter, Thomas Min, Bernard Yim, Tom Fujiwara, John Felix,** and **Fred Shepard.**

**Dr. John Holmes'** efforts to get ophthalmologists to volunteer services at the Good Counsel Catholic Hospital in Viet Nam were headlined in the local press.

**Dr. James F. Fleming** helped ferry a five-passenger

*OUTGOING HAWAII COUNTY PRESIDENT Pete T. Okumoto congratulates Robert Henderson, who was elected president for 1963. Other new officers, from left to right, are Rudolph P. Wipperman, James K. Matayoshi, and Harold Lewis.*

*O. D. PINKERTON HANDS OVER GAVEL to Honolulu's newly elected president, Theodore Tomita. Other new officers, from left to right, are John J. Lowrey, B. Allen Richardson, and Robert T. Wong.*

Beechcraft Baron plane from Oakland. He will use it in his charter flight service.

**Drs. Nils P. Larsen, Lyle G. Phillips,** and **Robert T. Wong** helped sponsor the 10th annual Eagle Scout Recognition Dinner at the Royal Hawaiian Hotel.

**Dr. Barton Eveleth** blamed news stories of fluoride as being "rat poison" as a cause of the failure in the Kohala attack on tooth decay.

Most immunizations against polio, diphtheria, whooping cough, and tetanus to begin July 1, 1963, will not be necessary on Hawaii, so stated **Dr. Leo Bernstein.** "The national campaign will give the rest of the nation the protection Hawaii has had since 1942," he continued.

**Dr. Doris R. Jasinski** favored a humane leash law so strongly that she presented a petition to the Honolulu City Council.

**Dr. F. J. Pinkerton,** chairman of the Shriners' annual Aloha Bowl game, was mighty disappointed at the apathy on the part of fans to support "the biggest game for the greatest cause."

**Dr. Richard R. Kelley** posed alternatives to "Medicare" in his letter to the editor. Comments by **Drs. H. L. Arnold, Jr.,** and **J. R. Clark,** were also apropos.

**Dr. Walter Quisenberry** was pictured chatting with crew members of the Soviet Ship "Zarja."

Ditto **Dr. and Mrs. Harold Sexton,** who were pictured admiring a snowman on a Christmas table.

UPW charges of a "freeze" on employment at the State Hospital at Kaneohe endangering care because of staff shortage were denied by **Dr. Robert Spencer.**

## Visitors

AMA President **Dr. George M. Fister** stopped briefly in Honolulu on his way to the Pacific Air Force Conference in Tokyo. His statements on the AMA Student Loan Fund were timely and apropos.

**Dr. Francis M. Forster** of Madison, Wisconsin, chairman and professor of neurology at the University of Wisconsin, addressed a statewide gathering of physicians by invitation of the Hawaii Academy of General Practice.

**Dr. F. J. L. Blasingame,** AMA chief, stopped in Honolulu for a day on his way home from the World Medical Association meeting in New Delhi, India. As expected, his statements against Social Security medicine were strongly worded.

## Congratulations to . . .

The officers and membership of the Honolulu County Medical Society who at their last annual meeting so thoughtfully and graciously honored 17 of their colleagues for long and distinguished services to the community and the profession.

**Dr. Leo Bernstein,** who was reappointed Director of the Hawaii Department of Health by our new Democratic Governor, John A. Burns.

**Dr. David K. L. Pang,** President of the Hawaii Academy of General Practice for 1963. Also to **Dr. Robert P. C. Ho,** President-elect, and **Dr. Frederick Reppun,** Secretary-Treasurer.

**Dr. A. Y. Wong,** newly elected president of the Hawaii Industrial Medical Association.

**Dr. L. Q. Pang,** new President of the Hawaii Chapter, American College of Surgeons.

**Dr. O. D. Pinkerton,** for the signal honor of being elected trustee of the National Medical Foundation for Eye Care.

**Dr. Richard E. Ando** (shades of Senator Dan Inouye) for leading the ticket in his election for the school advisory council of the 4th district.

## New Shingles

**Dr. T. K. Taira,** plastic surgeon, has joined the parade to 1441 Kapiolani Blvd. His shingle is up at Suite 707.

**Dr. Bunzo Nakagawa,** Ob-Gyn, is now associated with The Central Medical Clinic in the Professional Center Bldg. annex.

**Dr. Sherrod V. Anderson,** general practitioner, has located in Waikiki.

**Dr. Robert Kim,** dermatologist, practices at the Professional Center Bldg.

**Dr. Winfred Y. K. Chang,** internist, has chosen the windward side and is located in the Kaneohe Medical Bldg.

## Change of Scene

After many, many years in downtown Chinatown, **Dr. Hing Biu Luke** has moved to the Professional Center Bldg.

**Drs. Cora and Henry Manayan** have relocated to 72 So. Kukui St.

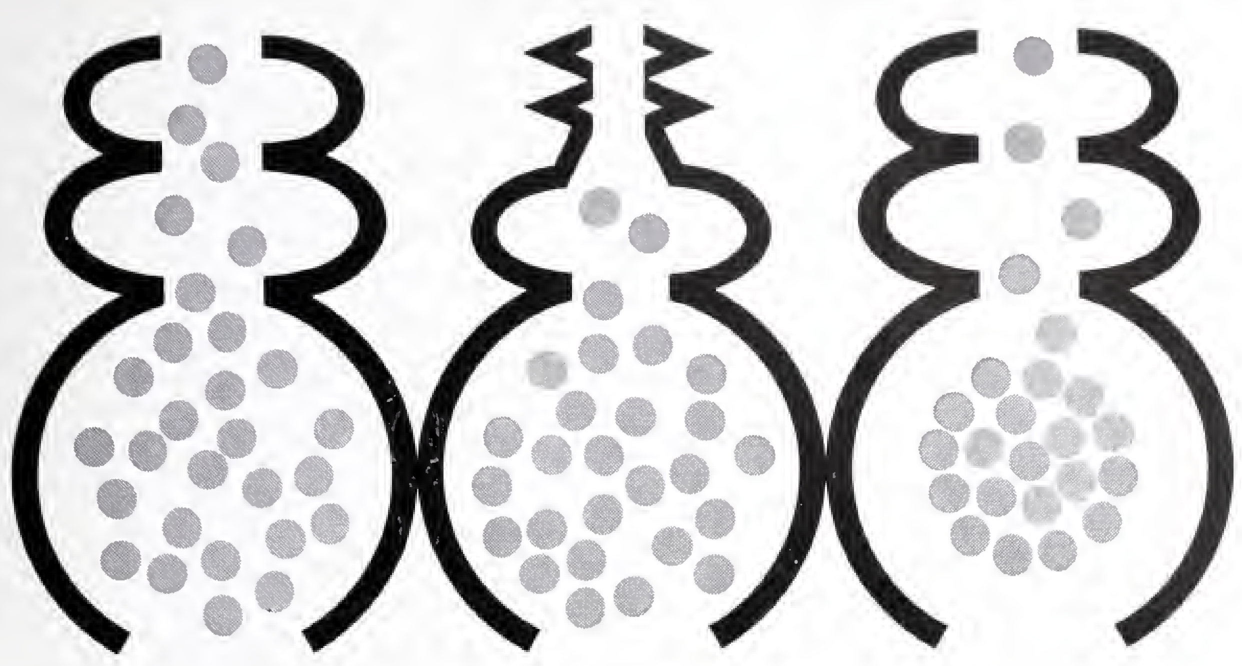
**Dr. Jeanette H. J. Chang** has also moved to the Professional Center Bldg.

**Dr. L. George Stuhler** is now at the Kaiser Medical Center.

## Traveling Doctors

Seen at the Western Conference of Prepaid Medical

*continued page 224*



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Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

*Note:* Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.


1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholino-Butyrylpyrrolidine and Related Amides. I. Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.
2. Cayer, D., and Sohmer, M. F.: Long-Term Clinical Studies with a New Constipating Drug, Diphenoxylate Hydrochloride, N. Carolina Med. J. 22:600-604 (Dec.) 1961.


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*Notes and News* *continued from 222*

Plans along with **Dr. B. Allen Richardson** were **Drs. John Frazer** and **Toru Nishigaya.**

Hobnobbing in San Francisco at the California Academy of General Practice annual meeting were **Drs. Fred Lam, Sr.,** and **Toru Nishigaya.**

Ye editor is wondering why so many local physicians attended the recent American Academy of Ophthalmology and Otolaryngology meeting in Las Vegas recently. Conspicuously present were **Drs. Harold F. Moffat, W. T. Minatoya, C. W. Trexler, P. M. Corboy, Mamoru Tofukuji, O. D.** and **F. J. Pinkerton, Albert Ho, Robert T. Wong, L. Q. Pang,** and **Wayne Wong.**

**Drs. K. Miyamoto, L. Q. Pang,** and **Richard K. C. Chang,** three of seven national consultants to **Brigadier General O. K. Niess,** U. S. Air Force Surgeon-General, accompanied AMA President **Dr. George M. Fister** to Tokyo for the Pacific Air Force Medical Conference.

## Hawaii Doctors in Print

*JAMA's* December 8, 1962, issue carried **Dr. Fred I. Gilbert's** article on "Cholestatic Hepatitis Caused by Esters of Erythromycin and Oleandomycin."

**Dr. Joseph C. Finney's** paper on "Prolegomena to Epidemiology in Mental Health!" appeared in the *Journal of Nervous and Mental Diseases,* August, 1962.

"Bacteriophage Type 80/81 Staphylococcal Infection in Human Beings in Association with Mastitis in Dairy Cattle" was the subject of **Dr. Walter B. Quisenberry's** article which appeared in the August, 1962, issue of the *American Journal of Public Health.*

**Drs. Robert A. Nordyke, Robert G. Rigler,** and **Walter S. Strode** wrote on "Radioisotope Renography" in the August, 1962, issue of the *American Journal of Roentgenology, Radium Therapy and Nuclear Medicine.* ■


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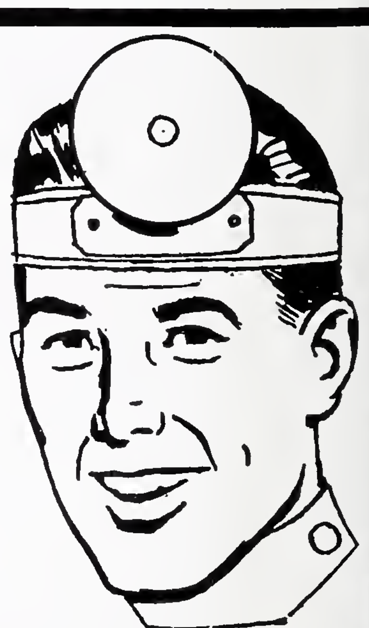

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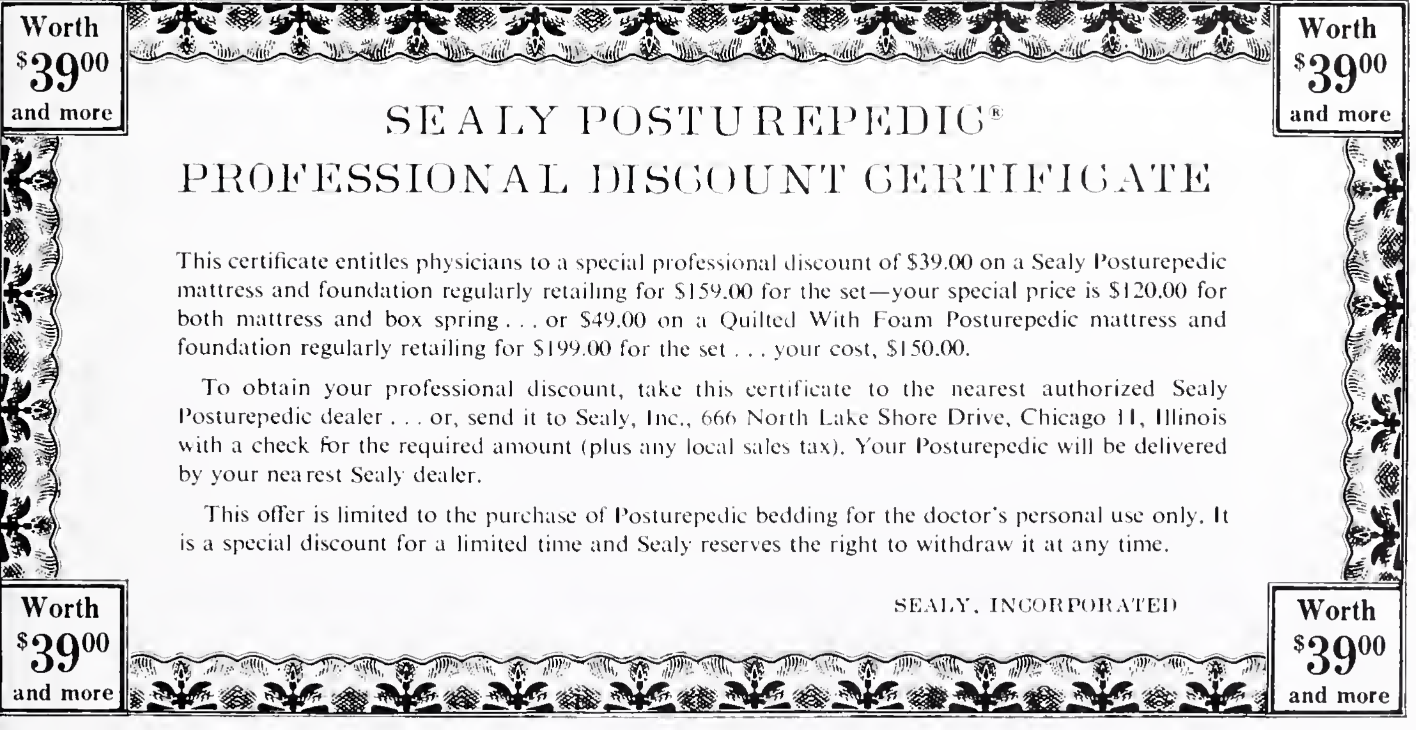

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# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

*Editor:* NELLIE CHEREVAS, St. Francis Hospital Laboratory

## *Local Lab News*

Rachel M. West, MT (ASCP) is the new member of the HSMT Board of Directors, replacing Amy E. Nakamura, who sent in her resignation—other precious commitments, you know!

Gertrude Ching, our finance chairman, made the plans for our fund-raising project this year. Because See's candy went over so big last year, arrangements were made to secure this item before the Christmas rush. Last year the boxes were sold out in three days—magnifique!

Kaiser Hospital regrets the loss of Miss Phyllis Prince, former technologist from British Columbia, Canada. She was fatally injured in a car accident in November.

## *Book Reviews*

• A new book, *Protozoan Parasites of Domestic Animals and of Man,* written by Norman D. Levine, Professor of Parasitology, College of Veterinary Medicine, University of Illinois, published by Burgess Publishing Co., Minneapolis, Minnesota, 1961. Cost $6.50. Given an excellent rating by Dr. Louis S. Diamond of the National Institutes of Health in the July, '62, issue of the *American Journal of Tropical Medicine & Hygiene.* This same professor happens to be the son of our long-time friend, Dr. Max Levine.

• As the slide rule is to the mathematician, so should *Medical Technology* (a review for licensure examinations) be for the student and graduate technologist. The handbook presents all phases of lab work, i.e., chem, bacti, tissue, etc., in concise, up-to-date methods. Chemical analyses are so methodically represented that there remains no doubt in the mind about the exact reaction in each test. For example, it enumerates the various anticoagulants, their use with each test, advantages, disadvantages, and preparation. This handbook is highly recommended. Cost is $5.00. It can be ordered from Biotechnical Publishing Co., Berkeley, Calif.

## *Hawaii Calls for Scientific Writing*

The deadline for submitting the scientific papers for the various awards is not too far off, and each of us thinks to herself or himself, "I'm not smart enough to write a paper, anyway," and we settle back in our little nook in the lab, which is really bristling with curiosities of rare diseases here in Hawaii. Students are eligible for the $100.00 award by ASMT, and when they are prodded to only *think* about writing a paper, they inevitably show great surprise and say, "Who . . . me?" Yes, you, and every graduate, not excluding the ones in far corners of the pineapple and sugar fields on the Big Island. It takes a little curiosity, a little experimenting, a great deal of reading and above all, unswerving faith in your ability.

Walk into the Hawaii Medical Library any day and there may be only a handful of people, yet this very place holds great vaults of scientific knowledge. Take advantage of *Abstracts of World Medicine* which gives a listing of the most up-to-date, significant papers from the various world's medical journals. It summarizes the essence of the original paper, but enables you to judge its value and decide whether you should read it in full. The librarians are most helpful. There have been 19 cases of hemoglobin "H" disease reported in Honolulu, and, this being a rather new hemoglobinopathy, there is much to investigate. You can do it right where you are—in your own laboratory. Take interest in things around you and perhaps start with a case study.

Kaiser Hospital has recently taken avid interest in holding monthly meetings of their technologists to discuss interesting and unusual cases, each thereby benefiting from this knowledge. They have unravelled a rare case of thrombasthenia.

The following will assist you in preparing a scientific article for the '62-'63 Award-O-Gram:

**I. The Thesis.** The thesis of the article should either add something new or furnish a fresh approach to that which is known. There should be a clearly defined objective; a point to be made, a condition to be described, an experience to be documented. A single goal is preferable. Repetitious papers are a dead weight.

**II. The Title.** The title should state, in as few words as possible, the subject and objective. It should be a fair label for what the author has attempted to say.

**III. The Form.** Remember that the attention span of most readers is quite short; thus paragraphs should be short, complete units. All articles should follow an orderly outline and should include the following:

1. The INTRODUCTION, which states the objective.
2. The BODY, which develops the thesis and covers material, methods, and results. It tells only what the *author* did and what *he* found. The only references here are to technical methods.
3. The COMMENT or DISCUSSION, which develops the author's deductions from the results and brings

in references to the work of others. If the findings are contradictory or are inconsistent with the work of others, a statement of comparative validity is desirable.

4. The CONCLUSION, which sets forth the author's conclusions and can appear either at the end of COMMENT or DISCUSSION or, if extensive, in a separate section preceding the SUMMARY.

5. The SUMMARY, a brief review which refines with clarity the basic facts presented in the BODY, COMMENT, and CONCLUSION; it should be based only on material that has been presented in these sections. The SUMMARY is considered by many to be the most important part of the paper. It should be written as if it were to be used as an abstract. In fact, many readers turn to the SUMMARY first to see if the article may be of interest to them.

There is a trend in medical publishing today toward placing this part or a condensation of it at the head of the article.

**IV. Types of Articles.** Scientific articles fall generally into six types:

1. The CLINICAL REPORT OF OBSERVATION is the commonest type of article and, using the above outline, should be developed as follows:

(a) *Introduction*—Brief history of condition and reason for report, such as opportunity, timeliness, rarity. Statement of author's series of cases.

(b) *Body*—Describes condition under consideration. In the report of cases give only the pertinent facts. Report controls wherever possible; include analysis of results.

(c) *Comment or Discussion*—Summarizes briefly work done in the field by others, comments as to whether author's result corroborates or refutes this.

(d) *Conclusion*—Sets forth author's conclusions, may appear as part of COMMENT.

(e) *Summary*—Extremely concise digest of the foregoing with author's final conclusion from facts presented.

2. The article which REPORTS ON EXPERIMENTATION and especially therapeutic trials requires meticulous attention to detail.

3. The REVIEW ARTICLE may be one of two types: the complete review which attempts to cover the whole subject and is practically a monograph, or the review which is a critical assessment and which attempts to make a true evaluation and synthesis of work in a given field.

4. The DESCRIPTION OF A NEW INSTRUMENT OR TECHNIC should be as good as the descriptions in the Sears-Roebuck catalog. It should be concise and clear and leave the reader with a desire to try it. It should state what the new instrument or technic offers over other methods, such as speed, accuracy, operation by less skilled personnel, or saving in cost. It should be accompanied by a photograph or diagram good enough for reproduction.

5. The CASE REPORT is a very useful means of medical communication; it is something within every reader's ken and will be read where the more profound article may not. Emphasize what you consider to be important. Was it the symptoms, the difficulty in diagnosis, the therapy, or the pathologic findings? Write the case report around this for interest, without distorting the facts.

Do not use hospital or personal abbreviations. Dates are helpful, particularly in conjunction with time intervals given in days, weeks, months, years. For example: "On Dec. 16, 1959, six weeks following operation." Use metric measurements for the size of lesions.

Write the history in narrative form using the patient's expressions wherever possible. Delete everything extraneous. The physical examination, work-up, treatment, and progress reports should follow in logical sequence. If there are pathologic findings to report, quote the pathologist's own terms.

Use only the essential lab reports; negative results important in the differential diagnosis may be included.

If the case report points a moral or raises an issue, this should be discussed following the case report. All known facts should be brought to bear. Speculation is generally not useful.

In the summary and conclusion the point of the case may be emphasized once more.

6. The MONOGRAPH is a comprehensive review in depth. It requires wide historical background and up-to-the-minute knowledge of developments in the subject.

**V. Aids to the Writer and Reader.** Break up the monotony of the printed page with tables, graphs, drawings, and illustrations. Illustrations should point up important findings; they should be used sparingly; they should sparkle like jewels. Tables and graphs should bring together facts in logical sequence. Like an appetizer they can be an aid to mental digestion, but if overdone or poorly done they are a deterrent. Keep them as simple as possible, use them sparingly, space them widely, make them uncluttered and pleasing to the eye. The bar graph stands out well and is perhaps the easiest to follow.

Statistical methods of sampling, choosing of controls, and evaluation of results are of high value. Valid conclusions are directly proportional not only to quantity but to quality of sampling as well. Failure to follow accepted statistical technics leads to serious pitfalls for the unwary.

References are of twofold importance—first, to meticulously give credit where credit is due, and, second, to give the reader the opportunity to consult the sources.

Note: The Hawaii Medical Library has several books on medical writing and is at your disposal. Only one caution: allow the librarian at least 20 minutes to locate them, dust and fumigate them and release them to you with a great sigh of accomplishment, comparable to that of an archaeologist in finding the long lost tomb of an Egyptian pharaoh. ■

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## *County Society Reports* *continued from 217*

nai, Richard K. S. Pang, Michael Schiff, Francis H. Soon. Tom K. Taira, and Ronald G. Latimer. Dr. Nishimoto reported that only 170 doctors had contributed to the Community Chest and urged those who had not already done so, to send in their checks. Dr. Varian Sloan gave a brief run down on the first Swallow operation and announced another training session for Swallow II.

The Nominating Committee's report was accepted and the following nominations were made from the floor: For the Board of Governors, Drs. T. Nishigaya and Herbert Chinn; for the alternate Board of Governors, Dr. Joseph Nishimoto; and for delegate to HMA, Dr. O. D. Pinkerton.

Dr. Bowles' letter questioning the use of the "loyalty statement" in the Society's membership application form was brought up for discussion and it was voted that the membership instruct the officers of the Society to delete the above requirement from the application for membership. A resolution honoring Dr. Rogers Lee Hill was read by the President and Dr. Hill acknowledged the honor bestowed upon him with a brief message to the membership. The Public Relations Commitee was asked to report to the Board of Governors with suggestions for helping Guam.

### Kauai

A dinner meeting was held at the Prince Kuhio on September 4. Dr. Kim reported on the oral vaccine program. Kauai's budget will be $5,000. He also reminded the members of the annual diabetic campaign and of the recommendations relating to flu vaccine. A motion was passed that the Society recommend that a political action committee of the Hawaii Medical Association study Senator Hiram Fong's proposal for medical care of the aged.

The October 2 meeting followed a dinner held at the Kauai Surf. There were committee reports on HMSA overusage, status of members who have reached 70 years of age, and fee schedule conversion factors. The Society received a tape recorder from the Kauai Cancer Society. An allotment of $200 to buy books was divided equally between the Kauai Veterans Memorial Hospital and the G. B. Wilcox Memorial Hospital. It was voted to accept the Cancer Society's offer of a dressing program for cancer patients.

The November 5 meeting was presided over by Dr. Goodhue at the Wilcox Hospital Library. There were no guests present. Dr. Kim gave a report on Operation Swallow. He advised that after the expenses are deducted from the total income, the surplus will be used to repeat Swallow I next March. The Society approved a Glaucoma Survey for January 26 and 27 as presented in a letter from Dr. O. D. Pinkerton. The nominating committee presented its report.

### Maui

The October 25 meeting followed a showing of the new Dr. Annis film "Your Health, Your Choice." Dr. Moran appointed Drs. Burden and Rockett to head up a Maui County Political Action Committee. Dr. McArthur reported on Swallow I and advised that the strongest districts were Hana and Molokai. All monies collected will be turned over to the local chapter of the National Foundation. It was suggested that future funds might be donated to other charitable organizations. A letter from the HMSA advised that the name of the Federal Review Committee had been changed to the Review Committee. Dr. Fleming was placed in charge of the AAPS Essay Contest for 1963. Dr. Burden proposed that a letter be written to Workmen's Compensation asking that the charge for the initial visit be changed to $10. The balance of the meeting was devoted to a discussion of fees. ■

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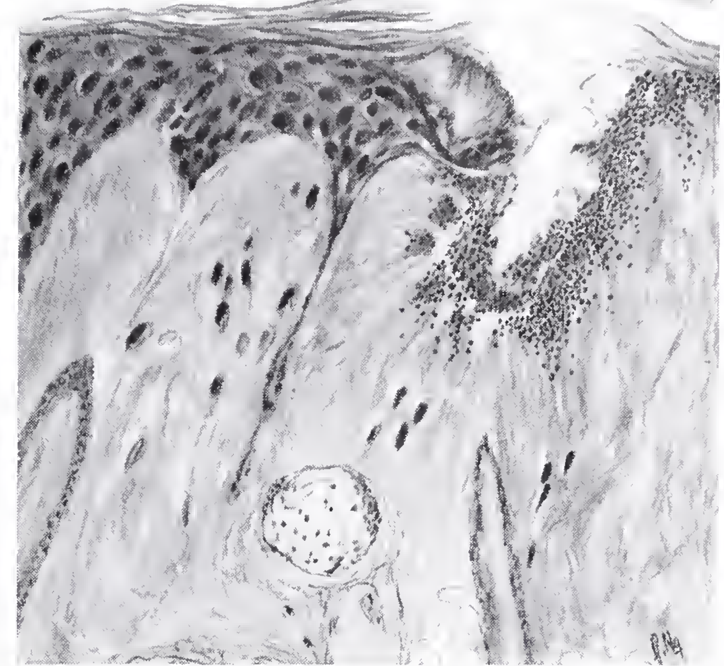

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*AMA Delegate's Report* *continued from 218*

corporations to build diagnostic and treatment centers.

Our Association through your delegates was honored by appointment to a reference committee. It was an interesting experience to be on the other side of the fence, so to speak, to hear the testimony given, and to assist in the preparation of the report of the committee.

Again, considerable interest was expressed by several delegates in having a clinical meeting of the AMA in Hawaii. I believe that serious thought should be given to this matter. With the completion of our municipal auditorium and convention hall we might be able to put on such a meeting. Since these clinical meetings are voted upon years ahead, the 1966 clinical meeting is scheduled for Las Vegas, and it is not too early to submit a bid for this meeting if such is desired and our facilities are found to be adequate.

In various miscellaneous actions, the House:

**Approved** *Essentials* of Acceptable Schools for Inhalation Therapy Technicians, Cytotechnology and Medical Technology and of Approved Residencies in Pediatric Cardiology.

**Recommended** that a Board report and two resolutions dealing with the *"Liberty Amendment"*

*continued page 234*

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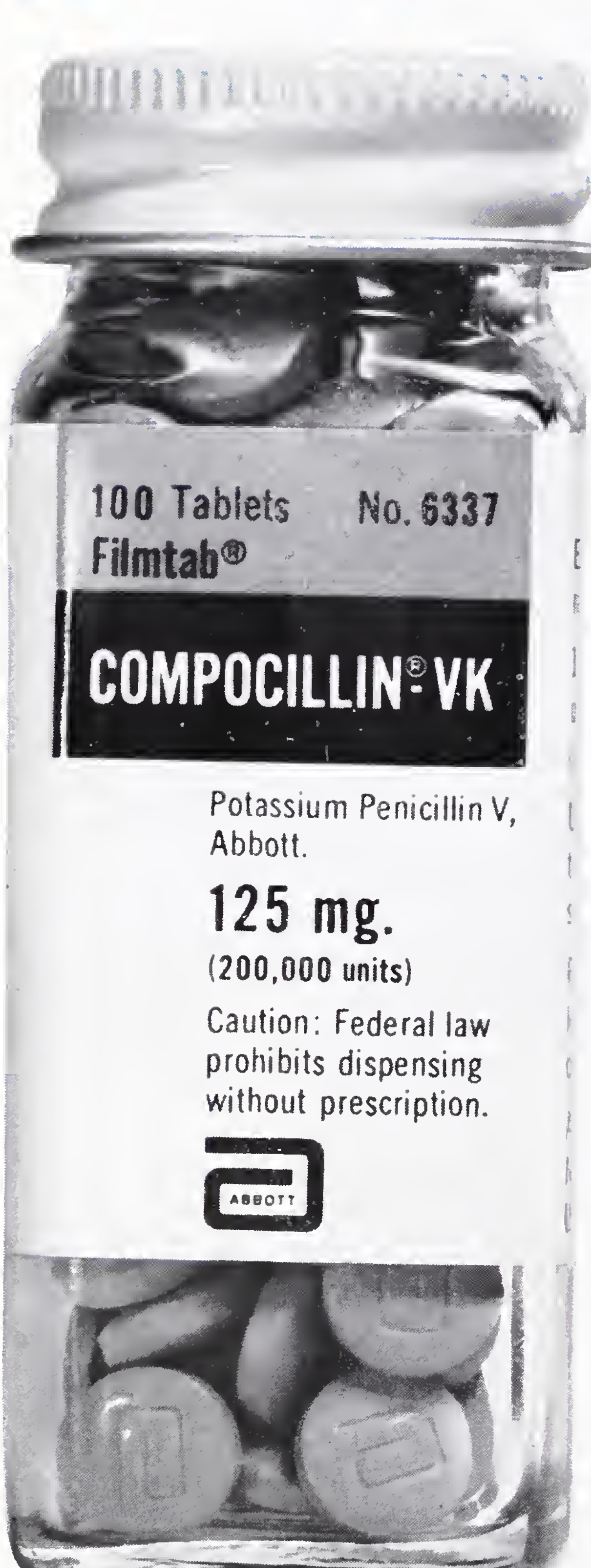


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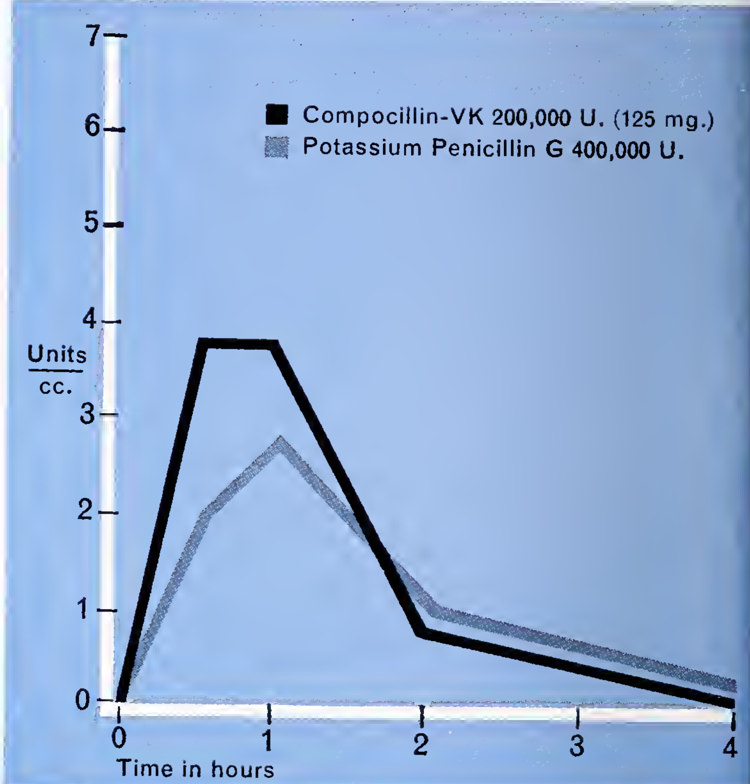


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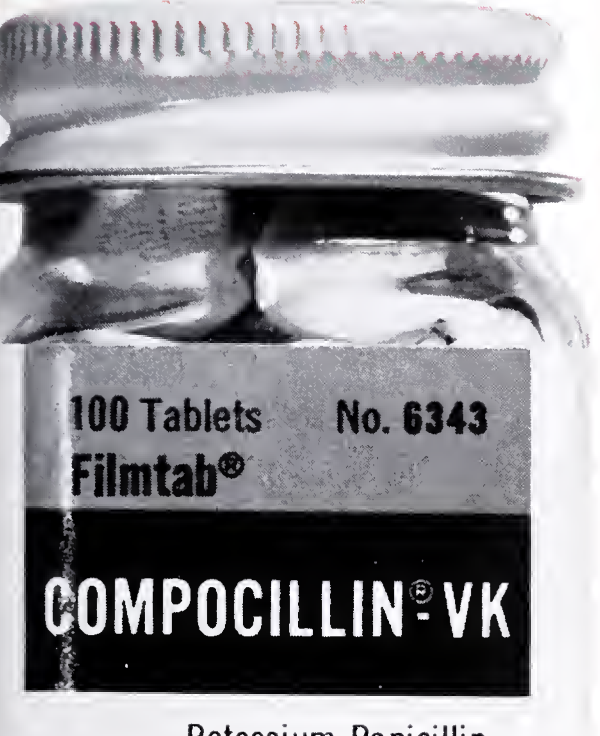
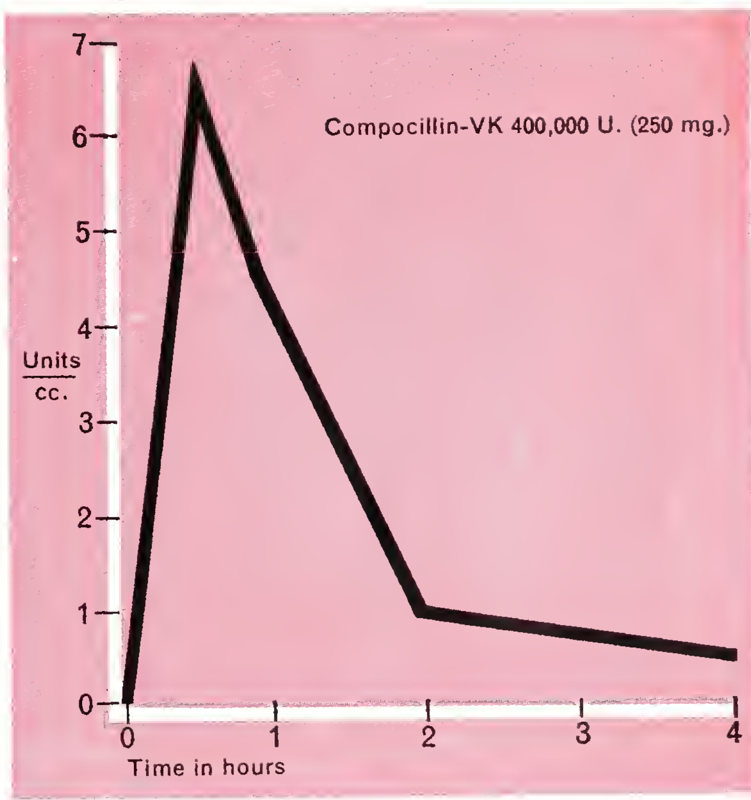



Potassium Penicillin V, Abbott.

**250 mg.**
**(400,000 units)**

Caution: Federal law prohibits dispensing without prescription.

Single Oral Doses to Fasting Subjects*




## Then, for severe infections...

. . . where your primary concern is high peak serum concentrations, you can prescribe Compocillin-VK at *full therapeutic dosage* and get the maximum antibacterial activity possible with an oral penicillin. The chart above shows the rapid peak blood levels obtained with 400,000 units (250 mg.) of Compocillin-VK. Actually, these peaks occur faster—and are higher—than those obtained with intramuscular penicillin G. Indeed, Compocillin-VK has been used in cases previously reserved for parenteral treatment. The safety advantage (oral vs. injectable) goes without saying.

*Chart data from two separate studies completed by the Microbiologic and Medical Departments of Abbott Laboratories.

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— *or* —
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*AMA Delegate's Report* *continued from 230*

be re-referred to the Council on Legislative Activities for further study.

**Warned against** the dangerously low level of immunization for *smallpox* and urged physicians and their patients to maintain the needed protection.

**Pointed out** that the state and county medical societies should collaborate with departments of *public health* in the interest of community health, always keeping in mind the need for a proper balance between local public health programs and the private practice of medicine.

**Authorized** the Board of Trustees to investigate the feasibility of establishing a *physicians' pension plan* and to present a pian for the implementation of such a program to the House in June.

**Instructed** the Board of Trustees to study the feasibility of *regional clinical sessions,* taking into consideration the already established regional meetings of medical specialty groups and the Academy of General Practice.

**Commended** the Council on National Security and its Committee on *Disaster Medical Care* for initiating a visitation program with committees on emergency medical service of state medical societies.

*continued page 236*


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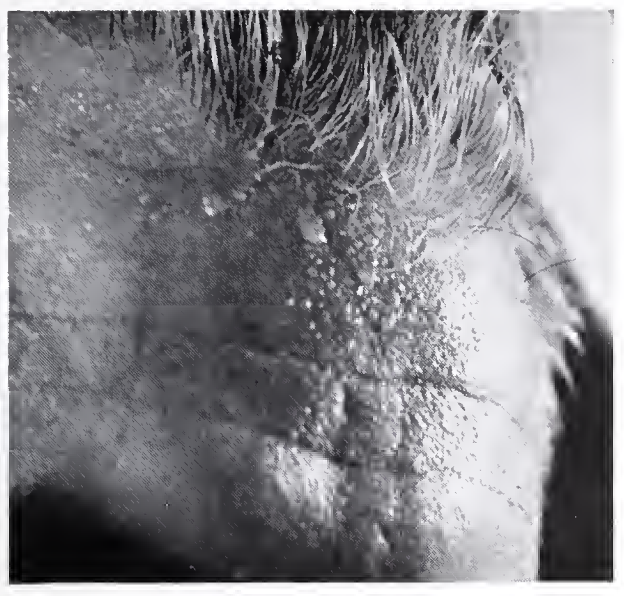

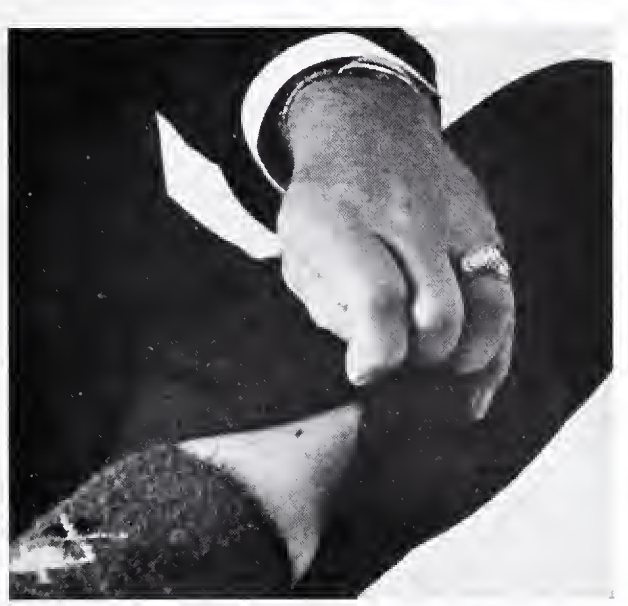
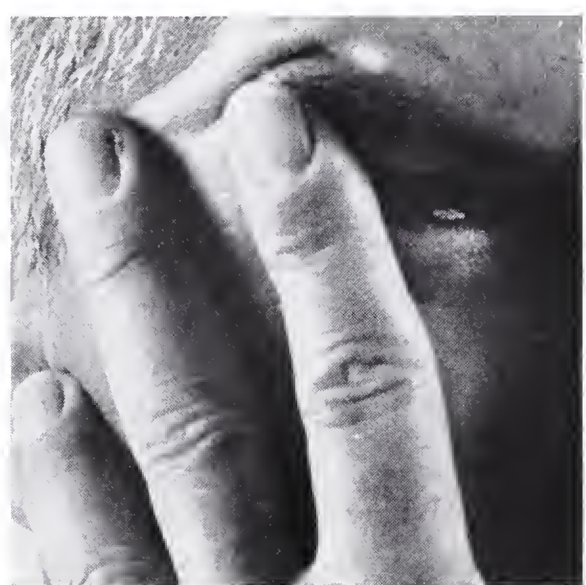

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In mild to moderate hypertension, Serpasil is a basic therapy. In more severe hypertension, Serpasil is valuable as a primer and background agent; by allowing lower dosage of more potent antihypertensives, Serpasil reduces the incidence and severity of side effects.

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*AMA Delegate's Report* *continued from 234*

**Urged** state and county medical societies to continue promoting the aggressive, consistent development of *Blue Shield* senior citizen programs.

**Encouraged** medical societies and physicians to provide cooperation and leadership in the formulation and operation of regional *hospital planning* bodies.

**Expressed appreciation** and thanks to the *Woman's Auxiliary* for its impressive accomplishments in behalf of our free society. ■

RICHARD D. MOORE, M.D.

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*In Memoriam* *continued from 212*

call to go into Red Cross work in Siberia, he answered it at a serious financial loss to himself, and those who were associated with him there testify to his fidelity to duty and to the unselfish and humane spirit in which he carried on his arduous activities. He served his country well, and his death is a loss to his profession in Hawaii and to the people of Hawaii." Dr. Straub remembers Dr. Jackson as the most Christ-like man he ever knew, and the late Dr. Fennel, who also knew him intimately, used to say that Dr. Jackson was the greatest practicing Christian that he had ever known. ■

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| Powdered opium U.S.P. (equivalent to paregoric 6 ml.) | 24.0 mg. |
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| Pectin | 142.8 mg. |
| Natural belladonna alkaloids | |
| hyoscyamine sulfate | 0.1037 mg. |
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| hyoscine hydrobromide | 0.0065 mg. |
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SUPPLIED: Pleasant-tasting banana flavored suspension in bottles of 6 fl. oz.

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## *Book Reviews* *continued from 219*

and the purpuras. For example, the use of heparin has been recommended for brief periods of a few days only (because of the expense) and the coumarin derivatives and others if longer anticoagulation is required. The authors agree that heparin is superior to the coumarin derivatives. The reader should refer to other articles regarding the use of heparin versus coumarin derivatives in thrombophlebitis.

The references given after each chapter are quite complete.

N. OISHI, M.D.

### Surgery in World War II
### Activities of Surgical Consultants, Vol. I.

*Editor in Chief Colonel John Boyd Coates, Jr., MC, Editor for Activities of Surgical Consultants, B. Noland Carter, M.D., 621 pp., $6.50, U.S. Government Printing Office. 1962.*

A HISTORICAL register of the activities of the surgical consultants in World War II. Its presentation is detailed and in the 600 pages there is a tremendous amount of factual material. The various specialties of surgery and the individual Service and Army Commands are authored by different surgeons, each having personal acquaintance with the activity.

This book will serve primarily as a reference chronicle, and a valuable one, and it will take its place with similar books for use by the individual with a particular interest in the subject. It is regrettable that the indexing is not more extensive, as this would greatly facilitate its use.

ROBERT A. ROSE, M.D.

## Also Received

### College Students in a Mental Hospital

*By Carter C. Umbarger, James S. Dalsimer, Andrew P. Morrison, and Peter R. Breggin, 168 pp., $5.75, Grune & Stratton, 1962.*

INSTITUTIONAL psychiatrists should read this.

### ★Ciba Foundation Symposium on Enzymes and Drug Action

*J. L. Mongar, Ph.D., and A. V. S. de Reuck, M.Sc., D.I.C., 556 pp., $12.50, Little, Brown and Company, 1962.*

UP to Ciba's high standard. For the research-minded.

### ★Tumors of Bone and Cartilage

*By Lauren V. Ackerman, M.D., and Harlan J. Spjut, M.D., 347 pp., $3.00, Armed Forces Institute of Pathology, 1962.*

NO pathologist could afford not to own this invaluable looseleaf atlas.

### Textbook of Ophthalmology, 7th Ed.

*By Francis Heed Adler, M.D., 560 pp., $9.00, W. B. Saunders Company, 1962.*

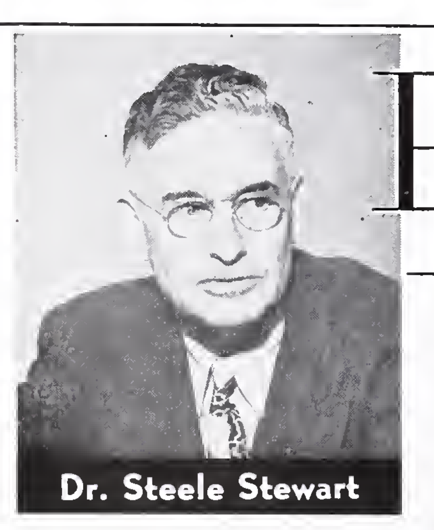
A TEXTBOOK—for students or ophthalmologists, primarily.

### ★Textbook of Pathology with Clinical Application, 2d Ed.

*By Stanley L. Robbins, M.D., 1190 pp., $19.00, W. B. Saunders Company, 1962.*

FOUR rewritten chapters (on the nervous system, the oral cavity, the liver, and the skin) and two new ones (on

*continued page 244*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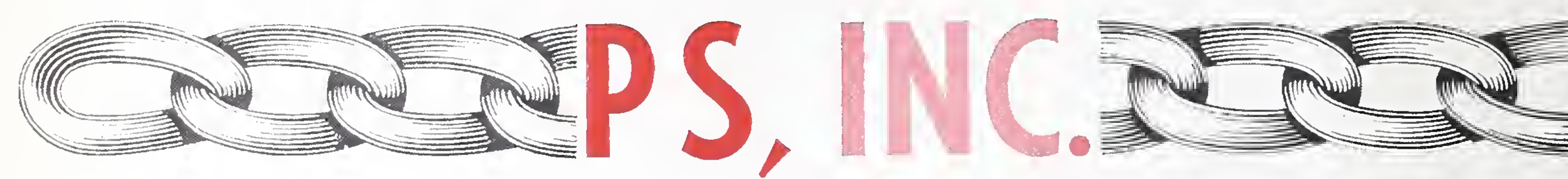


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Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

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†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

For full information, see your Squibb Product Reference or Product Brief.

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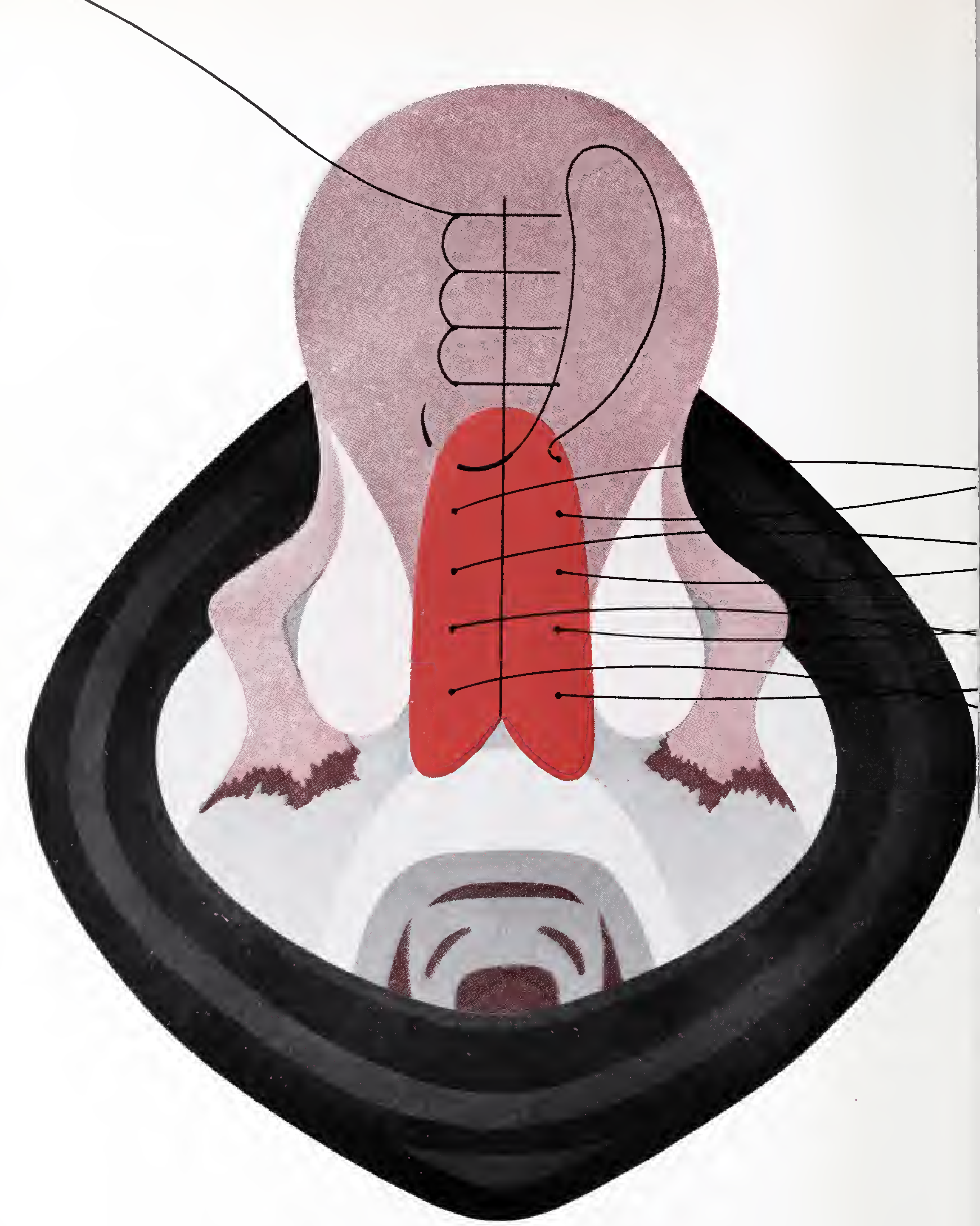


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## *Book Reviews* *continued from 238*

inflammation and the adrenal) add luster to this beautifully printed second edition of a standard textbook.

**The Gynecologic Patient**

*By Somers H. Sturgis with Doris Menzer-Benaron, 243 pp., $7.75, Grune & Stratton, Inc. 1962.*

PSYCHIATRIC and endocrine factors in gynecology. Many case reports.

**Age-Grouping Methods in Diptera of Medical Importance**

*By T. S. Detinova, 216 pp., $5.25, World Health Organization, 1962.*

STRICTLY for preventive medicine men, preferably entomologists.

**Current Psychiatric Therapies, Vol. 2**

*Edited by Jules H. Masserman, M.D., 289 pp., $8.75, Grune & Stratton, Inc., 1962.*

ONLY for psychiatrists.

**The Consumers Union Report on Family Planning**

*By Editors of Consumer Reports and Alan F. Guttmacher, M.D., 146 pp., $1.75, Consumers Union, 1962.*

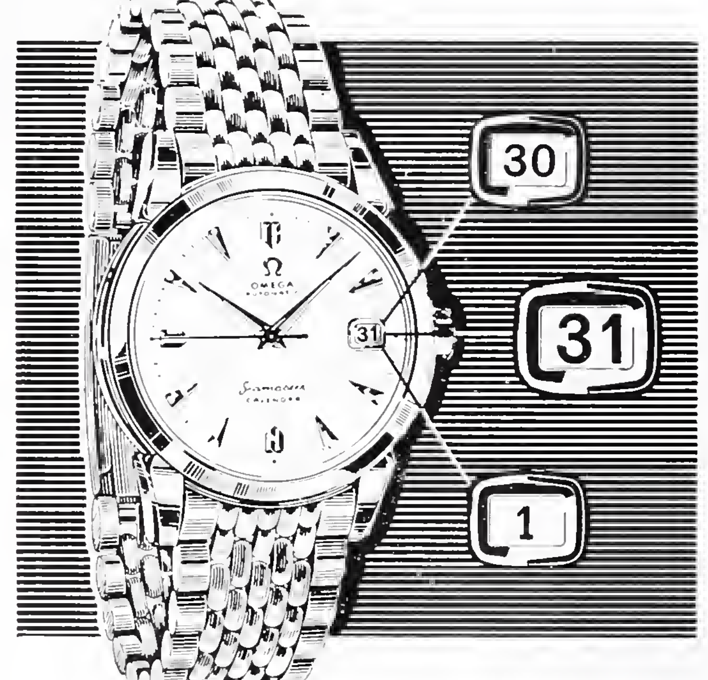
A GOOD BOOK for your newly married patients, if they have no religious prejudice against contraception.

**Body Fluid Disturbances**

*Edited by W. D. Snively, Jr., M.D., 122 pp., $4.75, Grune & Stratton, Inc., 1962.*

A SYMPOSIUM, with diagrams and illustrations, presented at the AMA meeting in 1961.

*continued page 250*

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1. Lease payments are entirely deductible as ordinary business expense.
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**NOTE:** You may purchase the equipment at the end of the lease term for a nominal price if desired from U. M & M Leasing Corp.

The leasing period may run from 1 year through 6 years. At the end of the lease period you may renew the lease on a year to year basis at a rate of 2% of the original cost per annum.

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Equipment—total cost .......................... $3,000.00
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# 'METHEDRINE'®

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HAWAII MEDICAL JOURNAL

# Reports & Snorts

The new ICRU Handbook says that the roentgen is no longer to be referred to as a unit of radiation dose, but only as a unit of radiation *exposure,* and it is to be written as R instead of r. The unit of radiation dose is the rad: the amount of absorbed radiation that imparts 97 ergs of energy per gram of tissue. For conventional therapeutic x-rays, 1R = 1 rad.

• • •

**If you have been doing some significant medical laboratory research and would like a year off in which to write it up as a monograph or a series of articles, write to Dr. Robert F. Loeb, W. B. Saunders Co., West Washington Square, Philadelphia, between January 1 and May 1, 1963. Saunders Publishing Company might award you $15,000 for this purpose!**

• • •

*Neither radium nor radon gives off any radiation whatever except alpha particles (helium nuclei). All the radiation that comes from a radium plaque or needle is given off by two products of radioactive decay: lead* ($^{82}Pb^{214}$) *and bismuth* ($^{83}Bi^{214}$).

• • •

Five physician members of Congress ran for re-election, and three made it, together with one new one. Re-elected were Representatives Durward Hall and Thomas Morgan, and Senator Ernest Gruening; newly elected was Representative James D. Weaver.

• • •

**At least 25% of mothers of phocomelic babies are believed not to have taken thalidomide during their pregnancy, a Cincinnati professor of pharmacology reports after visiting 14 medical centers in Germany.**

**A couple of hundred years ago an English Nominalist philosopher, William of Occam, formulated a famous principle—*pluritas non est ponenda sine necessitate* (several [ideas or causes] ought not to be supposed unless it is necessary). The principle became known as the Novaculum Nominalium, or the Razor of the Nominalists, and subsequently just as "Occam's Razor." It is the same as the familiar law of economy of diagnosis: a single diagnosis, if it explains all the findings, is more apt to be right than two diagnoses. But why was such a rule ever called a razor?**

• • •

*Hawaii had 239 general practitioners and 542 specialists in 1962; 151 of the GP's and 433 of the specialists were in in private practice, and the others in government or administrative work.*

• • •

The NIH, whose research and training grants enrich hundreds of American universities and research centers, complains that it is in danger of losing many or most of its top-level scientists and administrators to those same universities—where they can be offered larger salaries and opportunities for teaching.

• • •

**Dulles International Airport, 25 miles west of Washington, costing $106,000,000, will have 20 mobile lounges to move passengers up to three miles from the terminal building to their aircraft. "I'm terribly sorry, sir; the agent must have thought you said 'Dallas.' "**

• • •

Eye and ENT men take note: if enough of you are interested, Audio-Digest (619 Westlake Ave., Los Angeles 57) will issue one tape a month on eye and one on ear, nose and throat. ■


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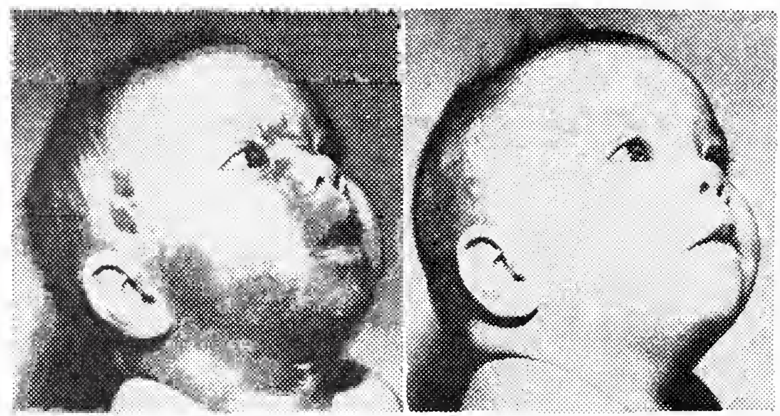

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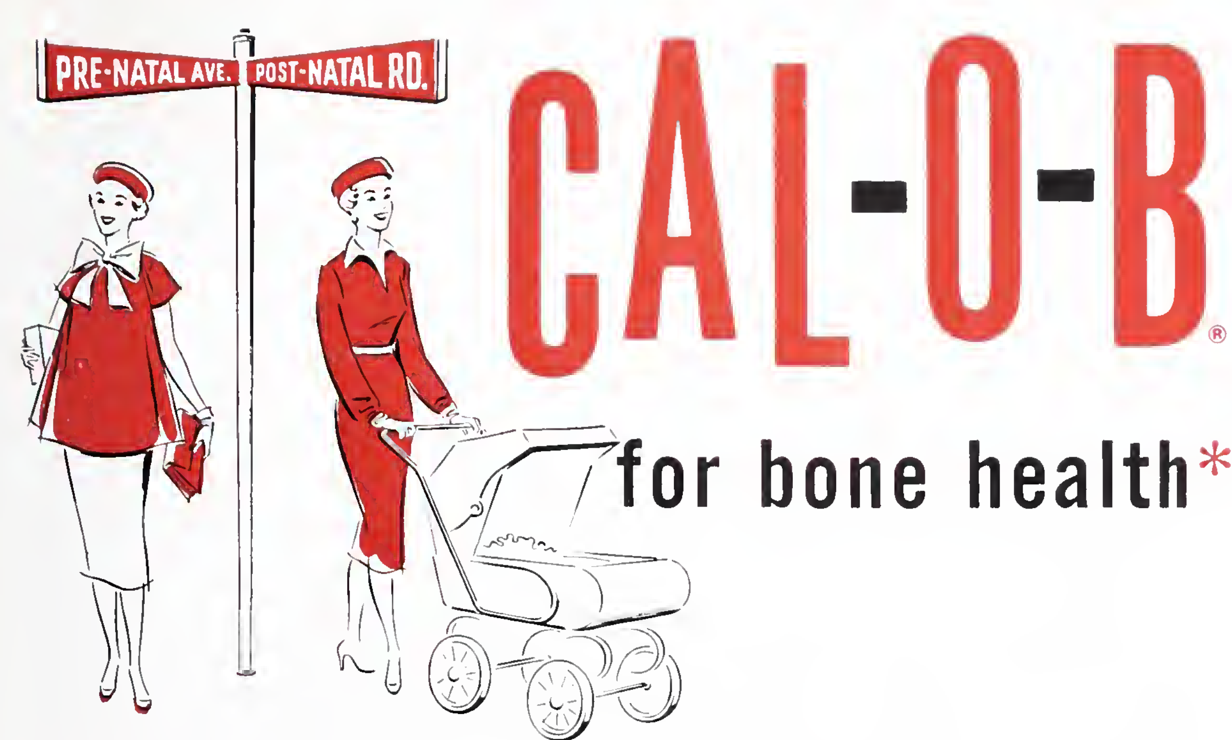


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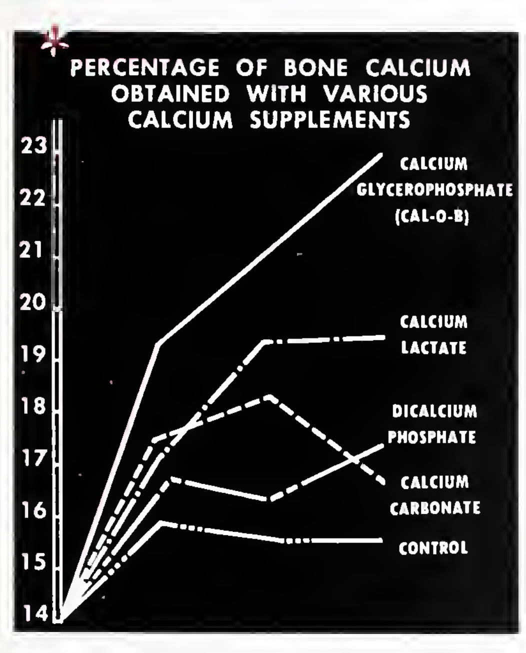


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*Book Reviews* *continued from 244*

**Typhoid Fever and Other Salmonella Infections**

*By R. L. Huckstep, M.A., M.D., 334 pp., $8.75, The Williams and Wilkins Company, 1962.*

This excellent, orderly, well-illustrated, pocket-size volume is, happily, of largely historical interest to physicians in Hawaii.

**Diagnosis and Management of Pain Syndromes**

*By Bernard E. Finneson, M.D., 261 pp., $8.50, W. B. Saunders Company, 1962.*

Brief, lucid, practical expositions with diagrams.

**Correlative Neuroanatomy and Functional Neurology, 11th Ed.**

*By Joseph G. Chusid, M.D., and Joseph J. McDonald, M.D., 385 pp., $5.50, Lange Medical Publications, 1962.*

A compendium, primarily for beginning students of neurology. A lot for your money!

**Humors, Hormones and Neurosecretions**

*By Chandler McC. Brooks, Jerome L. Gilbert, Harold A. Levey, and David R. Curtis, 313 pp., $7.50, State University of New York, 1962.*

Endocrinology and neurology in historical perspective.

**Aids to Embryology, 6th Ed.**

*By M. B. L. Craigmyle, M.D., 200 pp., $3.00, The Williams & Wilkins Company, 1962.*

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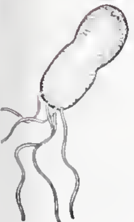

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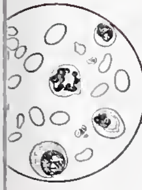

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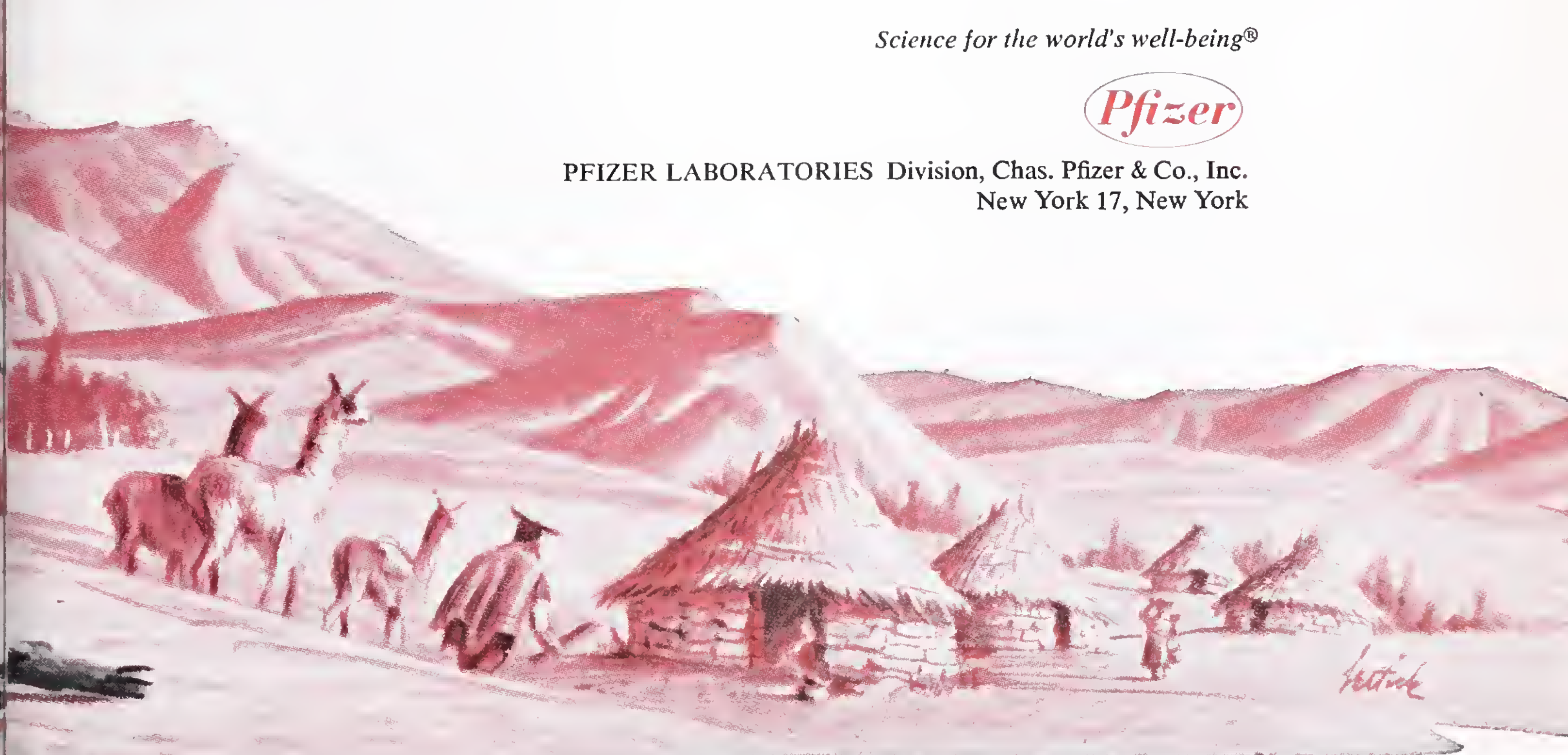

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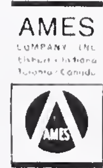

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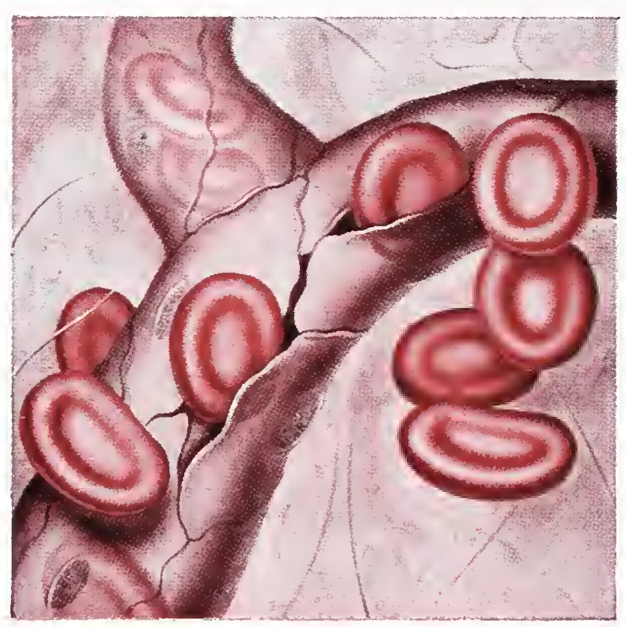
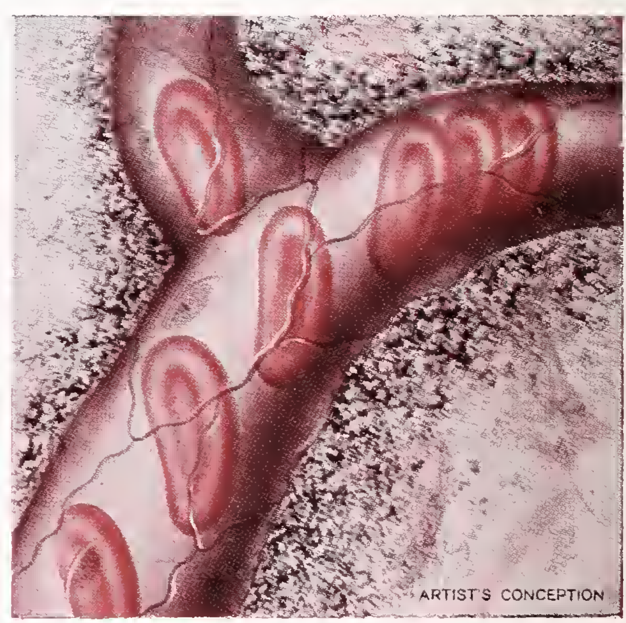

Capillary oozing following surgery



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* Schiff, M., and Burn, H. F.: A.M.A. Arch. Otolaryng. 73:43 (Jan.) 1961.

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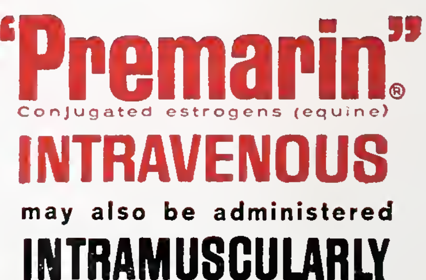

March-April, 1963

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Census Statistics

Arthritis in Hawaii

Tuberculin Testing

Inactive Tuberculosis

Leptospiral Myocarditis


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in severe respiratory infections refractory to other measures

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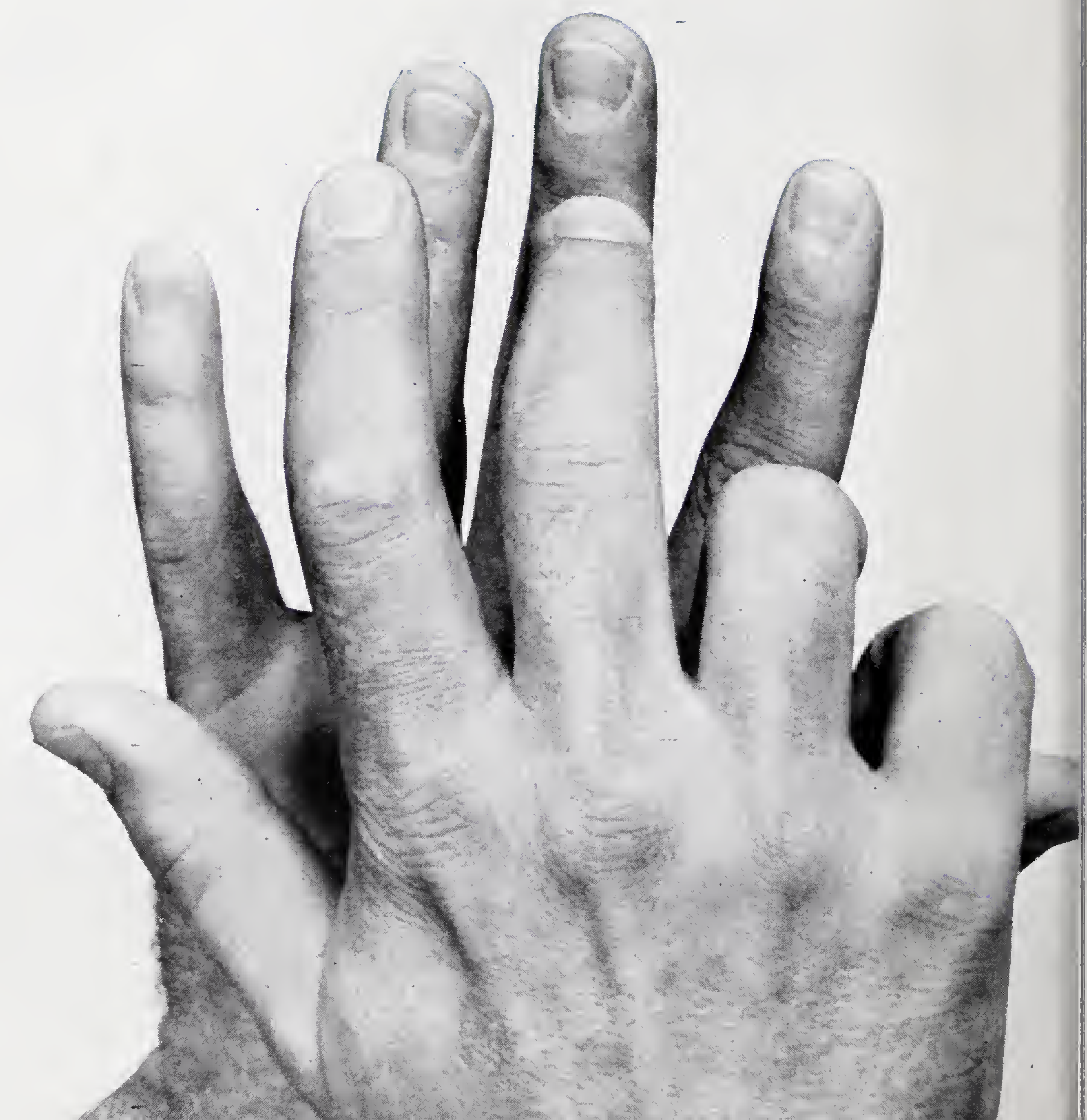
for established clinical efficacy against susceptible organisms



### In Friedlander's Pneumonia[3,13]

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### In *Hemophilus Influenzae* Pneumonia[3,4,13,14]

Because the invading organism is usually sensitive to CHLOROMYCETIN, this agent is generally effective in pneumonias caused by *H. influenzae*.

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**Precautions:** It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

**References:** (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

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# Correspondence

## Somebody Up There Likes Us

To the Editor:

I wish to express my deep personal appreciation to you and to your staff for the splendid job in the editing and publication of our survey report on medical education in Honolulu. The format is most pleasing and contributes much to the ease with which one can follow the contents of the report.

I would like to obtain reprints if any are to be prepared. If not, I would like to obtain additional copies of this issue of the Journal. Reprint needs total no more than nine. And of course, if you can only provide me with additional copies of this issue I shall be happy to pay the costs.

The editorial "Graduate Medical Education: A Challenge" added an extra dividend of pleasure for me and I hope that the response you seek from your colleagues in Hawaii will be forthcoming. ■

February 15, 1963

Henry S. M. Uhl, M.D.

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**EXAMPLE OF LEASE:**

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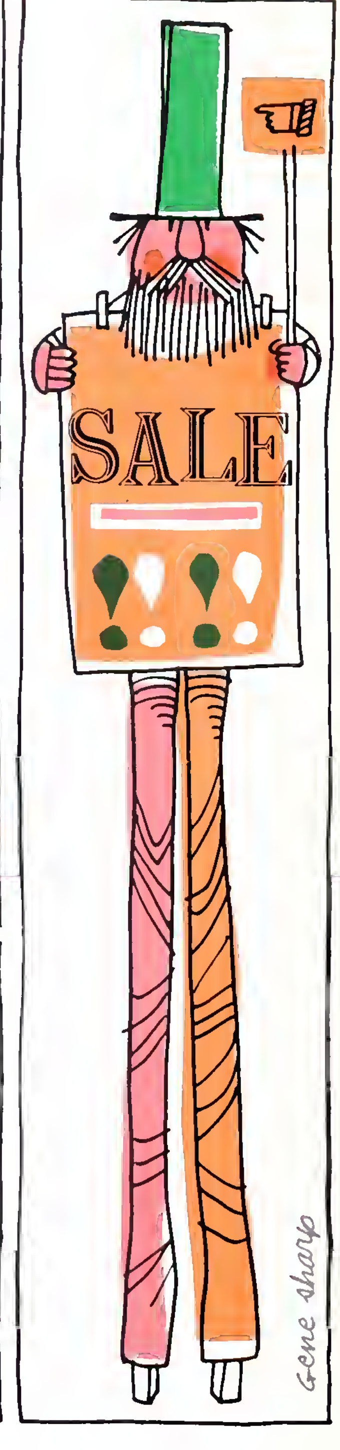


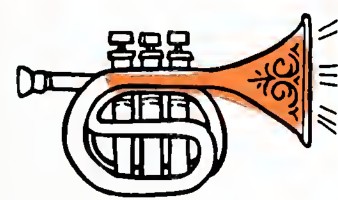

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Accustomed as we are to talking about purity, potency, stability, things like that, we thought you might like to know that mothers can make a nice saving on Vi-Daylin Chewables for the next few weeks. Nothing complicated. She buys a bottle of 100 at the regular price. She gets a bottle of 30 free. Big deal? Well, not a bad one. It means she's getting her Vi-Daylin for less than 3¢ per daily dose per child. You might find some vitamins somewhere that would cost even less. But will the youngsters take them?

Vi-Daylin—Vitamins A, D, $B_1$, $B_2$, $B_6$, $B_{12}$, C, and Nicotinamide, Abbott

ABBOTT 75TH ANNIVERSARY

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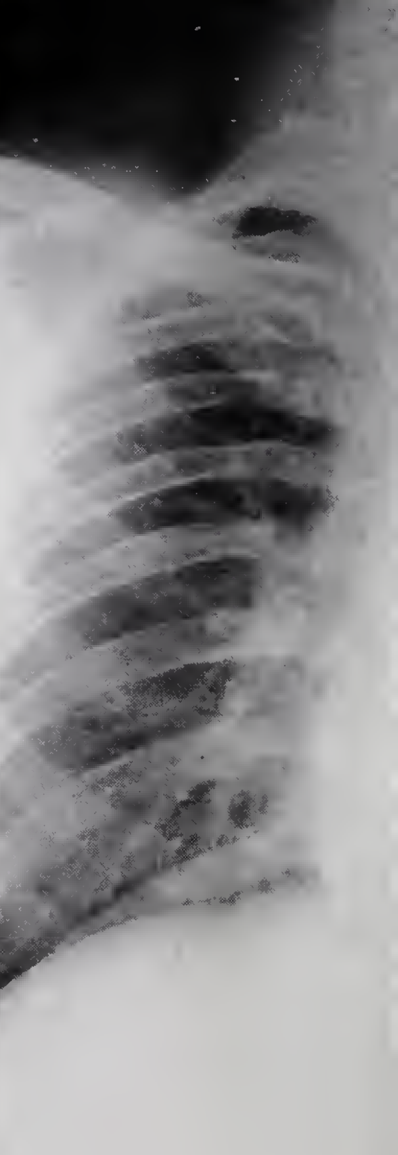

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***in bronchitis***—Considering the pattern of mixed bacteria, localized or diffuse involvement, potential underlying disease, and the need to allay symptoms and ease respiratory/cardiac function...physicians often include DECLOMYCIN demethylchlortetracycline in the course of therapy.

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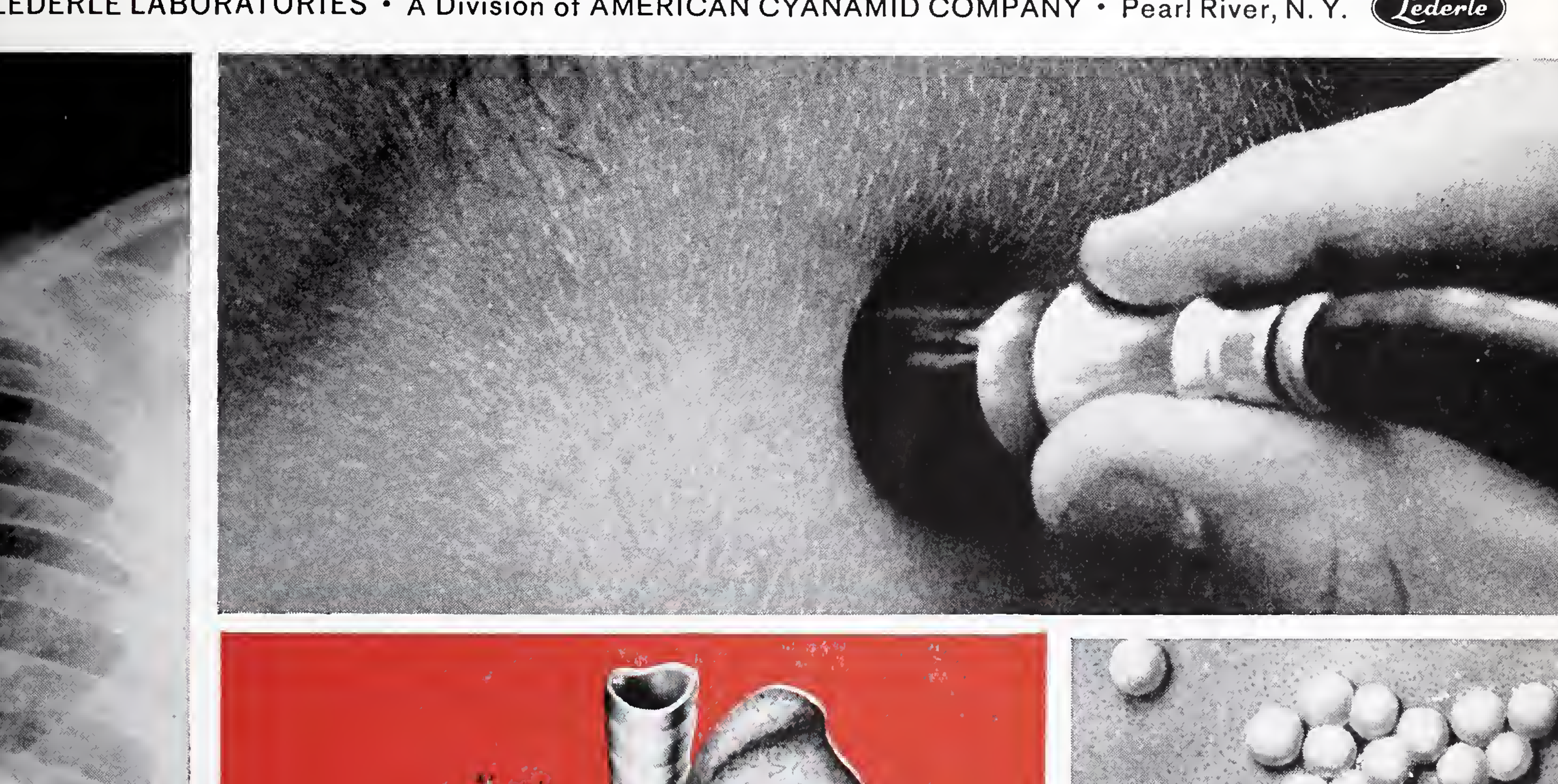

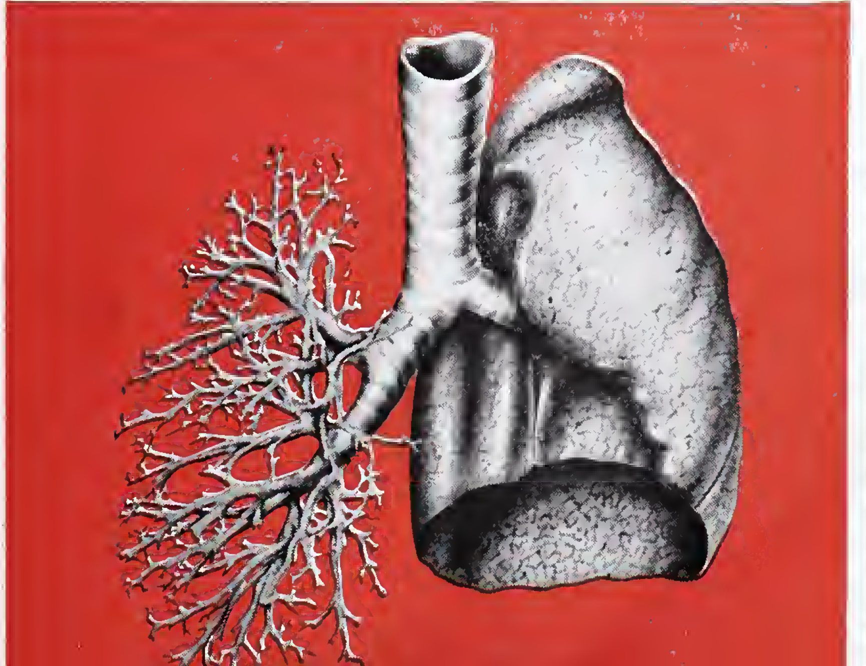

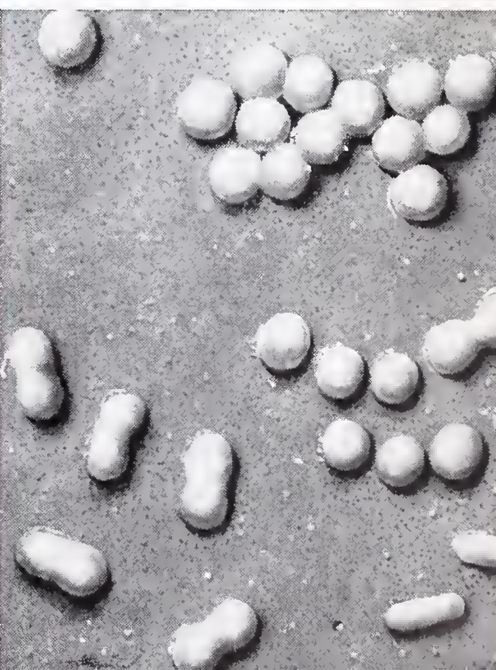

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nor **tension**
stays this patient
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*For dosage and contraindications, see PDR, product package, or literature available on request.*

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**New (2nd) Edition!** The first volume of this highly respected 3-volume work has been completely revised. The entire set of books will cover every known disease and condition of the gastrointestinal tract and associated organs. The author emphasizes a sound clinical approach to each problem, and carefully explains the causes and mechanisms responsible for each complaint. *Volume I* incorporates all important advances in therapy for diseases of the *esophagus and stomach.* New chapters are included on topics such as: *Oral Manifestations of Internal Disease; Tests Employed in the Study of Esophageal Function and Disease.* More than 150 pages are devoted to modern methods of diagnosis and management of peptic ulcer, with special emphasis on complications. A particularly significant new section shows endoscopic views of the esophagus and stomach, in magnificent color.

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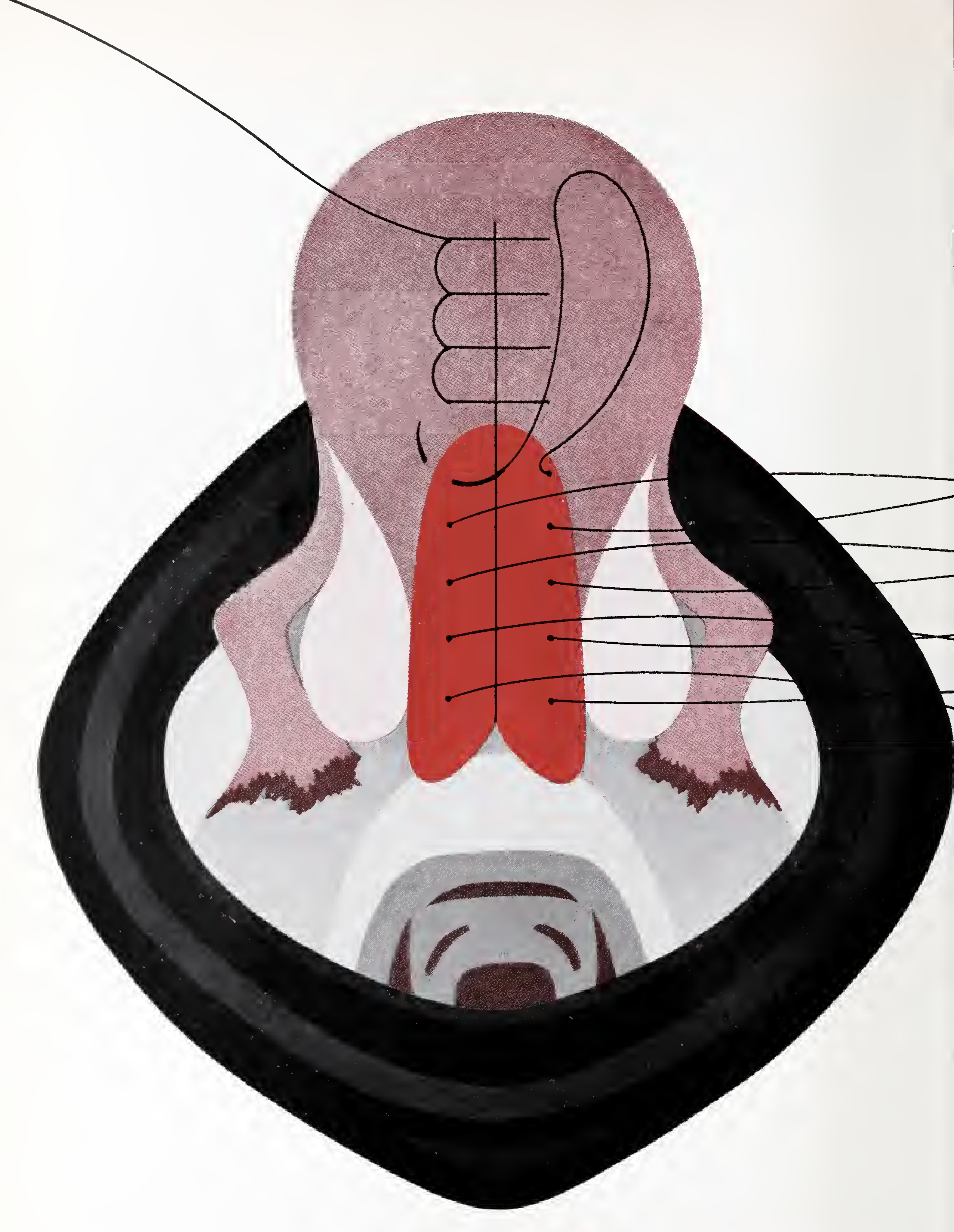


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HAWAII MEDICAL JOURNAL

# Reports & Snorts

**Illegibly scribbled hospital orders added an estimated $12,000 to the annual operating costs of the Methodist Hospital in Gary, Indiana, last year—the cost of the 6,400 extra hours required to decipher and interpret them. The computation was made by the hospital's research director, Herman Feldman, Ph.D.**

• • •

Micro Systems offers a pressure sensitive microminiature solid state transducer 2.3 mm in diameter that fits into the tip of a No. 7 F catheter, or can be implanted into the heart.

• • •

*ITT Federal Laboratories has developed an encoder which permits a three-dimensional display of a vcg (vectorelectrocardiogram) on a cathode ray screen. The original model was made for Lankenau Hospital in Philadelphia.*

• • •

A new Institute of the NIH—the National Institute of Child Health and Human Development—was established in February, with Dr. Robert A. Aldrich, Professor of Pediatrics at the University of Washington, as its Director.

• • •

**Pellon Corporation has designed a nonwoven face mask which permits free breathing but traps 98.4% of airborne bacteria at an air flow rate of 15 liters per minute. Write to Apasco Corp., Wolfeboro, New Hampshire.**

• • •

*Mead Johnson has a 14-page pamphlet on football injuries which is free, on request, for team physicians. Write to them at Evansville 21, Indiana.*

• • •

Write to J. T. Posey Co. at 2727 East Foothill Blvd., Pasadena, for their heel protectors and elbow protectors, with disposable cotton liners, for bed patients. Only $3.75, and the liners are $4.80 a dozen. Luxurious!

• • •

**Metronidazole (Flagyl, Searle) orally or vaginally is reported to cure 96% of cases of trichomoniasis—twice as many as were cured by five other trichomonacides—with no harmful side effects even in 14 pregnant women.**

• • •

"The patient was first examined in 1952, and was found to have a slight amount of excessive intra-oscular pressure."

—*The Citation* (A.M.A.) 6:25(Nov.30) 1962

Fun, though!

Undiagnosed kidney disease is estimated to be present in 100,000 U. S. children and 500,000 adults, according to *Patterns of Disease.*

• • •

*Chelocardin (Abbott) intramuscularly kills Escherichia coli, Proteus vulgaris, and Salmonella enteritidis. It was obtained from Nocardia sulfurea isolated from a flowerbed in Springfield, Mass.*

• • •

Reynolds Metals has produced a water-soluble transparent plastic laundry bag that dissolves promptly after being dumped, without being emptied, into the washing machine.

• • •

**A man troubled by a bird that persistently nestled in the mane of his horse was advised by a Chinese scholar to sprinkle the mane with powdered yeast. The bird left and didn't come back—because, as the scholar explained, "Yeast is yeast, and nest is nest, and never the mane shall tweet."**

• • •

"It is established by experience that softness and indulgence toward yourself and hardness toward others is one and the same vice."—La Bruycre. Charles P. Curtis (*A Commonplace Book,* Simon Schuster, 1957) asks whether hardness toward yourself and indugence toward others is, similarly, one and the same virtue. Of course it *might* be one and the same vice.

• • •

*If we all obeyed our schoolteachers and used only comparatives, not superlatives, when speaking of two alternatives, we would have to say "Put your better foot forward"; "May the better man win"; or "Which car got the worse of it?" Idiom wins, every time.*

• • •

**"Wag" originated in "waghalter"—one destined to die by hanging, i.e., wagging a halter. As a term of mock-abusive endearment, applied to mischievous boys, according to Bergen Evans (*Comfortable Words,* Random House, 1959), it gradually came to mean an impudently merry person.**

• • •

A Chinese scholar was giving a lecture, and the lights went out. "Will everyone please raise his hands in the air?" he asked. And the lights went on. "This indicates the truth of the old Chinese proverb," he said, "to the effect that many hands make light work."

• • •

*The AMA grant to nurses was doubled this year (to $20,000) to help in their recruitment program.* ■

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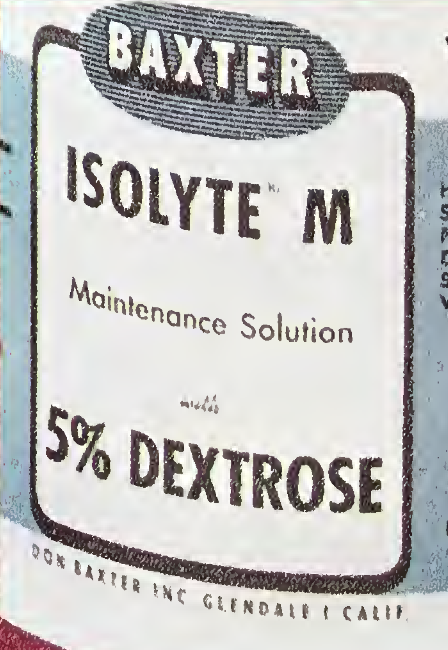


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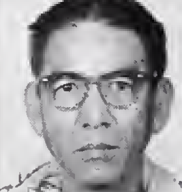
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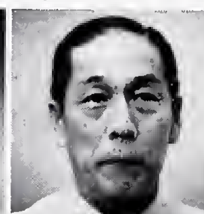
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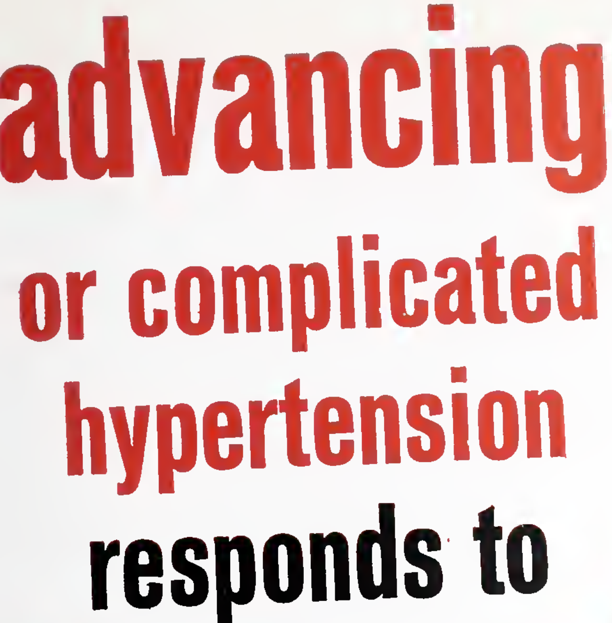

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**References:** (1) Ernst, E. M.: Current Therap. Res. **3**:167, 1961. (2) Starling, R. J.: J.M.A. Georgia **50**:442, 1961. (3) Sprogis, G. R.: Current Therap. Res. **3**:393, 1961. (4) Coffee, H. L.: Clin. Med. **69**:1561, 1962. (5) Mattey, W. E.: Indust. Med. **31**:33, 1962.

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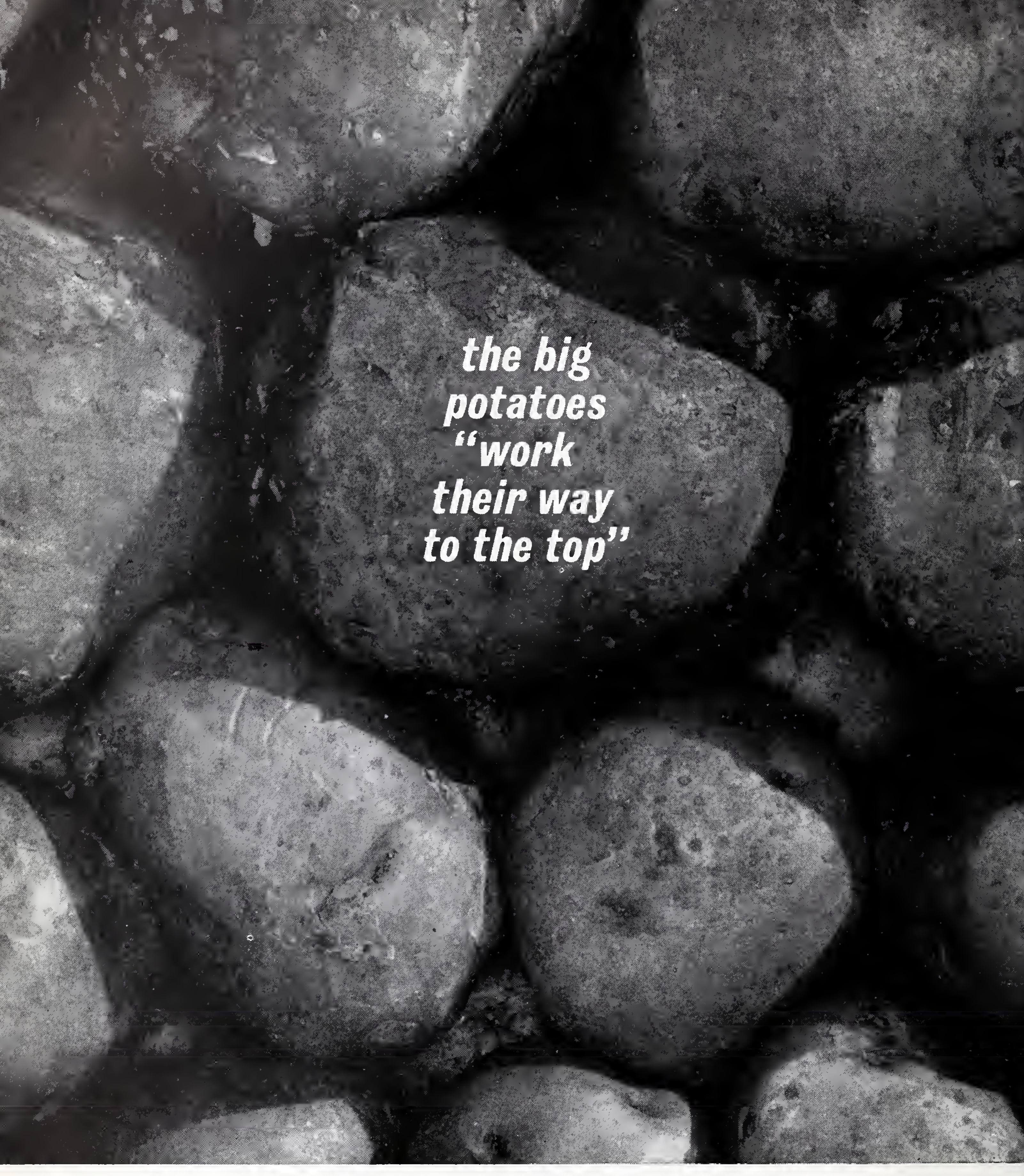


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*The prevalence of rheumatoid arthritis in Hawaii is about what it is elsewhere. Gouty arthritis is commoner, at least in Filipino patients.*

# Some Aspects of Arthritis in Hawaii

## Evaluation of a Slide Latex Test as a Screening Method

HIROSHI NAGAYA, M.D.,* *Durham, N. C.*

AMONG 888 patients seen at the General Medical Clinic of St. Francis Hospital, the incidence of definite, classical rheumatoid arthritis was 1.1 per cent and that of probable or possible disease was 0.9 per cent.

The incidence of gouty arthritis was 2.5 per cent. Among 22 patients with gouty arthritis, 16 were Filipino men, suggesting a high incidence of gouty arthritis in Filipino men in Hawaii.

The results of a slide latex (RA) test and the standard latex fixation test in cases with rheumatoid arthritis were comparable to those of most investigators, but a high incidence of a false positive RA test was noted in gouty patients, especially in those who had tophi.

It is an old belief that the incidence of rheumatoid arthritis is high in areas with a cold and damp climate. Certainly it is a frequent complaint of patients with rheumatoid arthritis that cold and damp weather is bothersome. Therefore a role of common environmental factors cannot be ignored in its epidemiology, especially when an epidemiologic survey is carried out by mass interviews. I have tried to estimate the prevalence of rheumatoid arthritis in this ever-warm State of Hawaii by diagnoses made in the outpatient department of St. Francis Hospital.

Among many serologic tests available for rheumatoid arthritis, the value of a slide latex (RA) test[1] as a simple screening method has been well recognized. Since it has been found in Hawaii that there are many Filipino people who have hyperuricemia, with or without joint involvement,[2,3] it is possible that a diagnosis of gouty arthritis can be made erroneously because of hyperuricemia. A second purpose of this paper is to evaluate the RA test as a screening method for rheumatoid arthritis and as an aid for differential diagnosis of arthritides in comparison with the original latex fixation test.

### MATERIALS AND METHODS

All the patients studied came to the General Medical Clinic of St. Francis Hospital, December, 1961, through April, 1962, primarily because of joint discomfort, and were seen by me, either there or on the ward when they were hospitalized. Altogether, 888 patients made 2,511 visits to the General Medical Clinic during this period. They were all 15 or more years of age, and came to the Clinic for complaints varying from a minor cold to a serious illness.

Although there were no data available for racial extraction, sex or age, rather few people of Japanese, Chinese, and Caucasian extraction came to

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This work was done at St. Francis Hospital, Honolulu, Hawaii.

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the Clinic. Except for the older Filipino patients, most of the patients were born and raised in Hawaii. Even those Filipino patients who were born in the Philippine Islands came to Hawaii at a young age, so that in the majority of the cases their arthritis developed after they had moved to Hawaii.

Any diagnostic problems were referred to an arthritis clinic where the patients were seen and followed by a rheumatologist. The diagnosis of rheumatoid arthritis was based on the American Rheumatism Association's criteria,[4] without the agglutination test. The criteria for the diagnosis of gouty arthritis included hyperuricemia, attacks of acute arthritis lasting not more than a few days followed by more or less complete remission, a good response of joint symptoms to colchicine, involvement of the first metatarso-phalangeal joints, and presence of tophi. Those with rheumatic fever included here had acute joint manifestations.

The serum samples were separated and stored at —20° C. Except for a few serum samples on which the latex fixation test was not run, the RA test and the latex fixation test were performed on all the sera simultaneously. The sera were not inactivated before the test.

The latex fixation test (hereinafter abbreviated as F II LP) was done following the original method described by Singer and Plotz[5] using glycine-saline buffer solution at a pH of 8.2. The first tube had a serum dilution of 1:20 and serial two-fold dilutions were made to a total of five tubes. An agglutination titer of 1:20 or greater was considered positive. The RA test was performed according to the accompanying directions.

For the interpretation of the result of the RA test, the following criteria were set in order to determine a response in a more informative way.

| RESPONSE | APPEARANCE OF AGGLUTINATION | FORMATION OF GOOD AGGREGATES |
|---|---|---|
| 4+ | Within 15 seconds | Within 30 seconds |
| 3+ | Within 30 seconds | Within 60 seconds with moderate to large aggregates |
| 2+ | Within 30 seconds | Within 60 seconds with small aggregates |
| 1+ | Within 60 seconds | Within 90 seconds with very small aggregates |

## RESULTS

Age, sex, and racial extraction of the patients and a response to the RA test and F II LP are summarized in Table 1.

Out of 56 cases of arthritis, ten patients had classical or definite rheumatoid arthritis and eight patients had probable or possible rheumatoid arthritis. Thus the incidence of classical or definite rheumatoid arthritis was 1.1 per cent, and that of probable or possible disease was 0.9 per cent. There seemed to be no particular racial predilection.

A total of 22 patients, of which 16 were Filipino males, had gouty arthritis. The incidence of gouty arthritis was 2.5 per cent.

F II LP was positive in six out of ten patients with classical or definite rheumatoid arthritis and two out of eight patients with probable or possible rheumatoid arthritis, whereas the RA test was positive in seven of the ten in the former group and four of the eight in the latter group.

All the 22 patients with gouty arthritis had a negative result with F II LP, but nine of them had a positive result with the RA test. However, most of the reactions were 1+ (six out of nine). Six of the 22 patients with gouty arthritis had obvious tophi and five of these six patients had a positive RA test, the reaction of one being 3+ (Table 1).

One patient who was thought to have either lupus erythematosus or rheumatoid arthritis clinically had a positive result with both F II LP and the RA test, but on autopsy he was found to have subacute bacterial endocarditis. Another patient, who had traumatic hemarthrosis of the right knee, had a positive F II LP and RA test. He had a history of alcoholism and had a slight liver dysfunction. One patient with osteoarthritis also had a positive F II LP and RA test. She had jaundice about 30 years ago and her liver was enlarged one finger breadth below the right costal margin, although she was asymptomatic and her liver function was within normal limits. One of the five patients with rheumatic fever had a positive RA test with a negative F II LP.

## COMMENTS

The wide range of estimates of the prevalence of rheumatoid arthritis can be attributed as much to diagnostic criteria, population selection, and survey methods as to true epidemiological variations in prevalence.

Lawrence[6] studied the prevalence of rheumatoid arthritis based on a 1 in 30 random sample of persons aged 15 and over and an area sample in England, using the American Rheumatism Association criteria. He found that the minimal prevalence of definite disease was 0.4 per cent in males, and 1.4 per cent in females, and that of probable disease was 1.7 per cent in males and 3.8 per cent in females.

In the present study, as we took a passive rather than active attitude in finding cases with rheumatoid arthritis, by selecting only those patients who actively complained of joint discomfort, it is pos-

TABLE 1.—*Data and test results in 56 cases.*

| AGE | SEX | RACE | F II LP | RA TEST | REMARKS |
|---|---|---|---|---|---|
| *Gouty arthritis* | | | | | |
| 57 | M | Filipino | — | 1+ | Tophi, confirmed histologically |
| 62 | M | Filipino | — | 1+ | |
| 44 | M | Filipino | — | 1+ | |
| 60 | M | Haw-Chin | — | — | |
| 50 | M | Filipino | — | — | |
| 60 | M | Filipino | — | — | |
| 63 | M | Caucasian | — | 1+ | Tophi, confirmed histologically |
| 71 | M | Filipino | — | — | |
| 62 | M | Filipino | — | — | |
| 68 | M | Filipino | — | 2+ | Tophi |
| 45 | M | Filipino | — | 2+ | Liver disease |
| 47 | M | P. R. | — | — | Tophi |
| 55 | M | Filipino | — | — | |
| 64 | M | Filipino | — | — | |
| 60 | M | Filipino | — | — | |
| 64 | M | Filipino | — | — | |
| 68 | M | Filipino | — | — | |
| 61 | M | Samoan | — | 1+ | Tophi, confirmed histologically |
| 50 | F | Haw-Cauc | — | 1+ | |
| 56 | M | Haw-Cauc | — | 3+ | Tophi |
| 71 | M | Filipino | * | — | |
| 64 | M | Filipino | — | — | |
| *Ankylosing spondylitis* | | | | | |
| 53 | M | P. R. | — | — | |
| *Psoriatic arthritis* | | | | | |
| 36 | F | Filipino | — | — | |
| *Osteoarthritis* | | | | | |
| 53 | F | Port. | — | — | |
| 54 | F | Japanese | * | — | Kidney disease |
| 52 | F | Caucasian | + | 1+ | Liver disease |
| 55 | F | Hawaiian | * | — | |
| 47 | M | Filipino | * | — | |
| 66 | M | Filipino | — | — | |
| *Classical or definite rheumatoid arthritis* | | | | | |
| 37 | F | Filipino | — | 1+ | |
| 54 | M | Filipino | + | 3+ | |
| 55 | F | P. R. | + | 2+ | |
| 68 | F | Port. | — | — | Kidney disease |
| 47 | F | Filipino | — | — | |
| 62 | M | Port. | + | 4+ | |
| 51 | F | P. R. | — | — | |
| 54 | F | P. R. | + | 4+ | |
| 51 | F | P. R. | + | 1+ | |
| 64 | F | P. R. | + | 4+ | |
| *Probable or possible rheumatoid arthritis* | | | | | |
| 68 | F | Filipino | + | 2+ | |
| 40 | F | Eng-Haw | — | — | |
| 27 | F | Port. | + | 1+ | |
| 31 | F | P. R.-Fil | — | 1+ | |
| 26 | F | Haw-Chin | — | — | |
| 55 | F | Hawaiian | — | — | |
| 20 | F | Haw-Sp-Iri | — | — | |
| 69 | F | Port. | — | 1+ | |
| *Rheumatic fever* | | | | | |
| 40 | M | P. R. | — | — | |
| 25 | F | Haw-Chin | — | — | |
| 29 | F | Haw-Fil | * | — | |
| 16 | F | Samoan | — | 1+ | |
| 16 | F | Haw-Cauc | — | — | |
| *Traumatic arthritis* | | | | | |
| 55 | M | Port. | + | 2+ | Liver disease |
| *Subacute bacterial endocarditis* | | | | | |
| 55 | M | Filipino | + | 3+ | |
| *Undiagnosed* | | | | | |
| 37 | F | Hawaiian | — | — | |

Note: P. R. = Puerto Rican, Port. = Portuguese, Eng = English, Sp = Spanish, Iri = Irish, Haw = Hawaiian, Chin = Chinese, Cauc = Caucasian, Fil = Filipino, * = test was not done.

sible that some arthritics escaped detection. On the other hand, as can be seen from the total number of visits of the patients to the Clinic, on the average each patient was seen about three times during this period. This must have increased the chance for arthritics to be detected. Although the survey method was not the same, but using the same diagnostic criteria, the incidence of 1.1 per cent for classical or definite rheumatoid arthritis is comparable to the prevalance in Lawrence's study.

In spite of this similarity in the incidence of classical or definite rheumatoid arthritis, there is a striking difference in the incidence of probable or possible disease. In Lawrence's study it can be estimated as high as 10.7 per cent mostly because of the high incidence of possible disease, whereas in the present study it was only 0.9 per cent. The most likely explanation for this disparity would be a difference in survey methods, although there might be a true difference in epidemiology as well.

As mentioned earlier, it is a frequent observation that arthritics complain more in cold weather than in warm. Even in Honolulu, where the lowest recorded temperature was 55° F,[7] patients with rheumatoid arthritis seem to complain more in the so-called winter months than in the rest of the year. Therefore, another possible cause for this

disparity may be that, as the diagnosis of possible rheumatoid arthritis can depend on "morning stiffness" and "tenderness or pain on motion with history of recurrence or persistence for three weeks," it is conceivable that difference in temperature alone can cause variation in severity or even presence or absence of these symptoms. Hence, in a colder climate the incidence of probable or possible disease would be higher, whereas the climate would have little influence on the incidence of definite disease.

Despite earlier reports[8-11] on low incidence of gout in Filipinos in the United States and the Philippine Islands, Fisher[2] found hyperuricemia in 50 and gouty arthritis in 32 of 100 consecutive Filipino men aged 40 or more in The Queen's Hospital outpatient department in Honolulu during 1957. Decker and Lane[12] found the incidence of gouty arthritis in men admitted to a large city hospital to be 2.5 per cent in Filipinos and 0.13 per cent in non-Filipinos. Steuermann and Farias[3] studied 428 Filipinos on a sugar plantation in Hawaii and found a higher level of serum uric acid in them than in the rest of the population living in the same district. Decker, Lane, and Reynolds[13] also found that the mean serum uric acid of healthy Filipino men was greater than that of Caucasian men. Our finding that 16 of the 22 gouty patients were Filipino men suggests a high incidence of gout among Filipino men. I am not aware of any accurate information regarding the prevalence or incidence of gout in the general population. Rook[14] reported in 1959 that, in an extensive orthopedic practice, the prevalence of gout among 13,589 patients seen over a five-year period was 0.6 per cent. The incidence of gouty arthritis in the present study was 2.5 per cent. This is more than four times higher than that of Rook's study. We don't know how many of 888 patients seen at the General Medical Clinic were Filipino, but even if we assume that all were, the incidence of gouty arthritis in Filipinos in Hawaii would be at least 1.8 per cent and a true incidence would be much higher than this value.

F II LP was positive in six of the ten patients with classical or definite rheumatoid arthritis. This is comparable to the results of most investigators.[15] One case with classical or definite rheumatoid arthritis and two cases with probable or possible rheumatoid arthritis had a positive result with the RA test, whereas F II LP was negative. In no case was F II LP positive with a negative RA test.

The higher incidence of positive results with the RA test has been encountered elsewhere. Lane and Decker[16] in their comparative study of latex particle slide tests found that 19 patients with negative reaction to F II LP had a positive reaction to either eosin slide test or the RA test or both. Six of the 19 patients had classical or definite rheumatoid arthritis, suggesting that simple slide tests were more sensitive. However, the remaining 13 patients fell into the nonrheumatoid category and were considered false positive reactors. They thought this was an unacceptable increase in terms of diagnostic error. Furthermore, studying 30 patients with hyperglobulinemia who had negative F II LP, they found that only two of the 30 patients had positive reactions to the slide test. Thus, although hyperglobulinemia appeared to enhance the number of positive results with F II LP, little further increase was found with the more sensitive slide test. They felt that the greater sensitivity of slide tests than F II LP could not be ascribed to the effects of nonspecific hyperglobulinemia, and the RA test may be more sensitive, but less specific, than F II LP.

The most remarkable finding in the present study was that nine of the 22 gouty patients had a positive RA test. Lane and Decker[16] stated that a positive RA test in patients with gouty arthritis who had a negative F II LP was an unusual finding. As they stated, the differential diagnosis between gouty and rheumatoid arthritis can often be difficult. This was demonstrated by Goldthwait, Butler, and Stillman[17] who showed that hyperuricemia was associated with rheumatoid arthritis predominantly in males (22 out of 32).

However, as in the present study all the nine positive reactors to the RA test had a negative result with F II LP, including those who had a 2+ or 3+ RA test, it is difficult to ascribe these positive RA tests to the presence of rheumatoid factor which F II LP failed to demonstrate. Especially as five out of six patients with obvious tophi reacted to the RA test, there might be some unknown mechanism involved in the serum of gouty patients or of high uric acid level which might give a false positive reaction to the RA test.

Although a remote possibility of coexistence of rheumatoid arthritis and gouty arthritis in these patients cannot be ruled out completely, presence of tophi excludes a diagnosis of rheumatoid arthritis, according to the American Rheumatism Association's criteria. The unusually high incidence of a false positive RA test among gouty patients in this study may be related to a high incidence of tophaceous gout in this group. In the study of RA test by Mayne and Mathieson[18] it was also noted that there was one positive reactor among 12 gouty patients, and he had tophaceous gout, although F II LP was not done on their patient.

Aside from patients with rheumatoid arthritis, there were three cases who had a positive F II LP. Two of them had liver disease and the third had subacute bacterial endocarditis. Both liver disease and subacute bacterial endocarditis have been

shown to give a higher incidence of positive F II LP than is found in normal controls.[19] The present observation on the result of the RA test in gouty patients suggests that a positive result with the RA test in a case with hyperuricemia or gouty arthritis should be confirmed by F II LP. Since the most of the false positive results with the RA test were 1+, any weak or 1+ slide test agglutination should be checked by the tube method as stated by Singer.[15] However, if we regard only 3+ or 4+ response of the RA test as positive according to the criteria proposed previously, incidence of a false positive reaction can be reduced considerably.

The RA test seems to be a highly effective screening method and utilization of this simple test will enhance detection of cases with rheumatoid arthritis if one keeps in mind the false positive reactors. Possible presence of a mechanism which accounts for a false positive RA test in gouty patients should be investigated further.

ACKNOWLEDGMENT

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REFERENCES

1. Hyland Laboratories, Los Angeles, California.
2. Fisher, H. W.: Diseases of Filipino men, Hawaii M. J. 18:252 (Jan.-Feb.) 1959.
3. Steuermann, N. S., and Farias, A. H.: Hyperuricemia in Filipinos, Hawaii M. J. 20:151 (Nov.-Dec.) 1960.
4. Ropes, M. W., Bennett, G. A., Cobb, S., Jacox, R., and Jessar, R. A.: 1958 revision of diagnostic criteria for rheumatoid arthritis, Bull. Rheum. Dis. 9:175 (Dec.) 1958.
5. Singer, J. M., Plotz, C. M.: The latex fixation test, I. Application to the serologic diagnosis of rheumatoid arthritis, Amer. J. Med. 21:888 (Dec.) 1956.
6. Lawrence, J. S.: Prevalence of rheumatoid arthritis, Ann. Rheum. Dis. 20:11 (Mar.) 1961.
7. Climatology Department, Weather Bureau, Honolulu, Hawaii: Personal communication as of July, 1962.
8. Berk, M. E.: Gout, report of an unusual case in a young man, Amer. J. Med. Sci. 215:290 (Mar.) 1948.
9. Mackler, H.: Gout in Filipinos, with report of 3 cases, J. Amer. Med. Wom. Ass. 8:15 (Jan.) 1953.
10. Manahan, L.: Is gout found in the Philippines?, Acta Med. Philipp. 10:477 (Jan.-Mar.) 1954.
11. Castillo, G., Campos, P. C., Maramba, T.: Gouty nephropathy, J. Philipp. Med. Ass. 34:289 (May) 1958.
12. Decker, J. L., and Lane, J. J.: Gouty arthritis in Filipinos, New Engl. J. Med. 261:805 (Oct. 15) 1959.
13. Decker, J. L., Lane, J. J., and Reynolds, W. E.: Hyperuricemia in a male Filipino population, Arth. & Rheum. 5:144 (April) 1962.
14. Rook, F. W.: Gout in orthopedic practice, Southern Med. J. 52:1111 (Sept.) 1959.
15. Singer, J. M.: The latex fixation test in rheumatic disease, Amer. J. Med. 31:766 (Nov.) 1961.
16. Lane, J. J., and Decker, J. L.: Latex particle slide tests in rheumatoid arthritis, JAMA 173:982 (July 2) 1960.
17. Goldthwait, J. C., Butler, C. F., and Stillman, J. S.: The diagnosis of gout, significance of an elevated serum uric acid value, New Engl. J. Med. 259:1095 (Dec. 4) 1958.
18. Mayne, J. G., Mathieson, D. R.: An evaluation of a polystyrene-globulin particle flocculation test for serum rheumatoid factor, Proc. Mayo Clin. 36:365 (July 19) 1961.
19. Bartfeld, H.: Incidence and significance of seropositive tests for rheumatoid factor in non-rheumatoid diseases, Ann. Int. Med. 52:1059 (May) 1960.

# Criticism of Drug Advertisements

If . . . the doctor, when he comes across an ad he doesn't like, would take the time to write, to the drug house responsible, a letter or even a postal card indicating his objections, the results would surprise him. As far as the physician is concerned, the pharmaceutical industry is much like Sweet Alice in the poem "Ben Bolt." As you remember, she "wept with delight when you gave her a smile and trembled with fear at your frown." At SK&F, when we get a critical letter from a doctor, we really turn the place upside down.—Francis Boyer, Chairman of the Board, Smith Kline & French Laboratories, in New York Academy of Medicine *Bulletin,* March, 1962.

*The Heaf tuberculin test seems more sensitive than the standard Mantoux, and has other advantages.*

# Comparative Tuberculin Testing Study in a Honolulu Private School

NATHAN SHKLOV, M.D.,* *Honolulu*

• *In the second year of its use, the Heaf tuberculin test was positive and the standard Mantoux negative in four times as many students as the number in which the reverse relationship prevailed. Only 6.5% of Kamehameha School students were positive to both tests, and only 5.7% were positive to either (and not to the other). Nearly 88% were negative to both.*

DUAL TUBERCULIN testing has been conducted at The Kamehameha Schools in Honolulu for two successive years. Both years the Heaf technique, using a concentration of 2 mg tuberculin PPD in 1 ml of solution, and the Mantoux technique, using 10 TU strength, were employed.

The Kamehameha Schools are private schools maintained by the Bernice Pauahi Bishop Estate for children of Hawaiian descent. The preparatory school ranges from kindergarten through the eighth grade and the boys' and girls' schools are ninth through twelfth grade.

The first year Mantoux tests were administered and read by a public health nurse provided by the Oahu Tuberculosis and Health Association. Heaf tests were administered and read by a school nurse from the Kamehameha staff.

The second year the Mantoux tests were administered and read by the Kamehameha staff nurse, and the Heaf tests by a public health nurse from the State Department of Health, Tuberculosis Branch, Chest Clinic.

Participation in the school tuberculin testing program at The Kamehameha Schools has always been high. Consent slips are sent to the parents with school enrollment papers at the beginning of each school year. The first year of the dual testing program 98.4 per cent of the preparatory school and 92.7 per cent of the high school students participated. The second year of testing 90.4 per cent of the preparatory students and 86.6 per cent of the high school students participated. Thirty per cent of the nonparticipating students the second year (3.6 per cent of the total enrollment) are known positive reactors who received chest x-rays only.

Criterion for positive reaction to the Mantoux test was induration (a papule) 8 mm or more in diameter. This criterion is used for all survey tuberculin testing in the Honolulu schools, public and private.

The first testing, done in April, 1961, showed very poor correlation between the two tests. Upon

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careful study of the test results and consideration of all variables, it was decided to retest all students who had been positive to either test and negative to the other. Several changes were also made in procedures for the retested group. The original tests had been read after three days and it was decided to read the retests after five days. Test personnel was changed: Heaf tests were given and read by the nurse from the Department of Health Chest Clinic, and Mantoux given and read by the Kamehameha staff nurse. No change was made in strength of PPD solution for either test. There were 242 individuals in the retested group. Retesting was done four weeks after the first testing.

Table 1 compares the original test results to the adjusted test results for the first year. In the retest procedure to obtain adjusted results, the 242 original test reactions to both tests were deleted and retest results substituted for both tests. Upon statistical examination of the results for the first year, it was decided to use the five-day reading interval and the retest testing teams for the second year of testing.

TABLE 1.—*Comparison of original test results to adjusted test results (first year).*

| | APRIL 1961 ORIGINAL TEST RESULTS | | MAY 1961 ADJUSTED TEST RESULTS | |
|---|---|---|---|---|
| | *No.* | *%* | *No.* | *%* |
| Positive to Both Tests | 132 | 7.4 | 144 | 8.0 |
| Positive to Mantoux Only | 213 | 11.9 | 16 | 0.9 |
| Positive to Heaf Only | 29 | 1.6 | 7 | 0.4 |
| Negative to Both Tests | 1418 | 79.1 | 1625 | 90.7 |
| Total Readings | 1792 | 100.0 | 1792 | 100.0 |

Second year testing results correlated well with the adjusted first year results. The same testing teams were used and a five-day reading interval was used for both Heaf and Mantoux. There was a nine month period between first and second year testing. The month of December was chosen for the second year as this seemed to be the best time for minimum interruption of the normal school routine. With one exception, conditions were unchanged from the retest conditions. The exception was that the use of the plus-or-minus reading for Heaf testing was discontinued. This resulted in a tendency to place questionable reactions in the one-plus group, accounting for an increase of about four per cent of individuals who were positive to the Heaf test only the second year.

Table 2 compares the first year adjusted test results to the second year test results. It was not deemed necessary to retest any students the second year as all individuals with a positive reaction to either test were x-rayed.

TABLE 2.—*Comparison of first year adjusted results to second year test results.*

| | FIRST YEAR ADJUSTED TEST RESULTS | | SECOND YEAR TEST RESULTS | |
|---|---|---|---|---|
| | *No.* | *%* | *No.* | *%* |
| Positive to Both Tests | 144 | 8.0 | 114 | 6.5 |
| Positive to Mantoux Only | 16 | 0.9 | 20 | 1.1 |
| Positive to Heaf Only | 7 | 0.4 | 80 | 4.6 |
| Negative to Both Tests | 1418 | 90.7 | 1542 | 87.8 |
| Total Readings | 1792 | 100.0 | 1756 | 100.0 |

As expected, the high school groups showed a larger percentage of students positive to both tests and positive to the Heaf test only. Table 3 shows the differences between reactions of the preparatory school students and the high school students.

TABLE 3.—*Comparison of second year test results for preparatory school and high schools.*

| | PREPARATORY SCHOOL | | HIGH SCHOOLS | |
|---|---|---|---|---|
| | *No.* | *%* | *No.* | *%* |
| Positive to Both Tests | 38 | 5.4 | 76 | 7.3 |
| Positive to Mantoux Only | 8 | 1.1 | 12 | 1.1 |
| Positive to Heaf Only | 21 | 3.0 | 59 | 5.6 |
| Negative to Both Tests | 641 | 90.5 | 901 | 86.0 |
| Total Readings | 708 | 100.0 | 1048 | 100.0 |

It is the opinion of the tuberculin testing committee that results of the dual testing justify using the Heaf technique alone for annual tuberculin testing in The Kamehameha Schools.

The committee is at present studying the feasibility of a dual testing project this coming school year using the standard Heaf PPD solution and Battey antigen for the second solution. It is anticipated that the Heaf gun will be used to administer both tests, as the students greatly prefer the use of the gun to the syringe and needle.

All students who were positive to either test had chest x-rays taken by the State Department of Health's mobile x-ray unit, and no cases of tuberculosis found. The first year, 432 students were x-rayed, resulting in nine suspicious films, although upon further examination the nine students with suspicious miniature films were found to be negative for TB. The second year, 358 students were x-rayed by the mobile unit, resulting in two suspicious films which later were diagnosed TB negative. Both years the students receiving x-ray included those individuals not consenting to the skin tests; thus the student body was surveyed 100 per cent.

Figures 1 and 2 show graphic comparisons of percentage positive and negative reactions to each test. As the "plus" or "minus" reaction, which

FIG. 1.—*Comparison of Percentage of Negative and Positive Reaction for Each Test— First Year (Adjusted)*

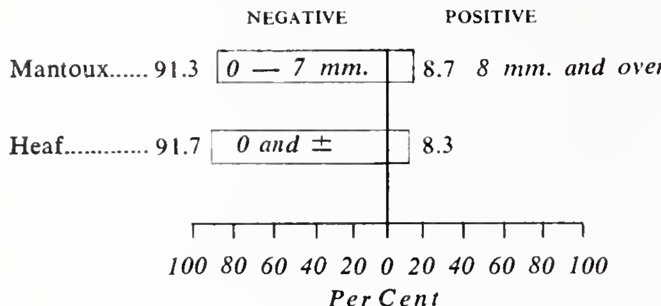
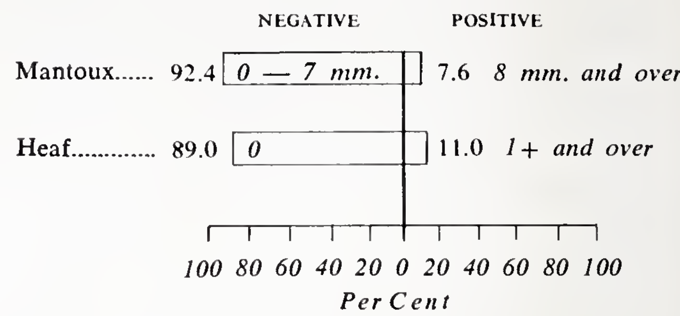



FIG. 2.—*Comparison of Percentage of Negative and Positive Reactions for Each Test—Second Year*




more closely resembles the 4 to 7 mm Mantoux reaction, is considered borderline, it has been placed in the negative group.


SUMMARY

The Heaf technique of tuberculin testing was evaluated at The Kamehameha Schools.

Results:

1. Heaf test is believed to be more sensitive than Mantoux test.
2. Less painful.
3. More acceptable to the student body.
4. Speedier test and takes less school time.

Partly on the basis of this study the public schools are switching to the Heaf test.



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and also to the Nursing Staff at Hale Ola, Kamehameha Schools, and to Doris R. Morishige, PHN, Tuberculosis Branch, State Department of Health. ■


REFERENCE


1. A single tuberculin test for epidemiological use: a comparison of the Mantoux and Heaf tests (a report to the research committee of the British TB Association by their Tuberculin Sub-Committee), Tubercle 40:317 (Oct.) 1959.
2. De Hamel, F. A.: A trial of Heaf and Mantoux tuberculin tests, New Zealand Med. J. 56:316 (Dec.) 1957.
3. Anderson, S. R.: Dual testing—Heaf and Mantoux: Bellevue Hospital Clinic, A.M.A. J. Dis. Child. 99:764 (June) 1960.
4. Hsu, Katharine H. K.: Further studies on Heaf testing, American Rev. Tuberc. 84:1 (July) 1961.
5. Stott, H.: Heaf's multiple-puncture test compared with the Mantoux test (0.1 mg OT), Tubercle 36:119 (Apr.) 1955.
6. Low, E.: Mantoux and Heaf multiple-puncture tuberculin tests: comparison in BCG vaccinated and unvaccinated subjects, Tubercle 37:102 (Apr.) 1956.



# Give Generously to the AMA-ERF Student Loan Fund.

*Reactivation of pulmonary tuberculosis seems to happen most often in Filipino patients, and between 10 and 15 years after arrest is achieved.*

# A Study of Inactive Tuberculosis Cases Removed from the Register

ROBERT H. MARKS, M.D.,* and
BETTY G. MacLEAN, M.S.,† *Honolulu*

• *One-fifth of the inactive case register records were drawn and an effort made to locate these 1,000 patients to determine the reactivation rate, which groups were apt to reactivate, and whether lifetime follow-up would be feasible.*

*It was possible to obtain current diagnostic information for 563 of these individuals. Of this group 2.4 percent had reactivated, with the largest number of Filipino extraction. Slightly over 40 per cent had been diagnosed as inactive for over ten years. Two-thirds of the patients reactivating were participating in voluntary supervision.*

*Lifetime follow-up would detect reactivation at an early period, benefiting the patient and preventing undue exposure of others.*

THE OAHU Tuberculosis and Health Association, in cooperation with the Tuberculosis Branch, State Department of Health, conducted a review of the present status of a sample of persons in Honolulu County who had been removed from the Tuberculosis Case Register. The primary purposes of this study were to detect reactivation and to determine the feasibility of lifetime follow-up.

This study was conducted because of a strong indication that many persons relapse into active disease even after long periods of inactivity. These individuals who relapse represent 25 per cent of the TB cases placed on the current case register each year. A study of when and where reactivation occurs should help determine the type and extent of follow-up that would be practical and productive.

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#### METHOD

The State Department of Health maintains a case register which is an alphabetical file. Records that have been declared inactive by reason of the patient's leaving the state, unlocated or lost to follow-up, duplicate, primary inactive, nonpulmonary inactive, diagnosis not confirmed, and inactive over five years, are flagged so that the individual is not on follow-up. These records are then termed inactive and the patient is considered as being "removed from the register."

It was decided that a 20 per cent sample of these inactive records would yield about 1,000 cases to both satisfy the statistical requirements and be sufficiently representative of the total inactive records. The sampling procedure followed was to select every fifth card. This yielded 969 individuals who, when removed from the register, did not have active tuberculosis.

The distribution of the sample with regard to age, sex, race, and diagnosis corresponds to information regarding new cases obtained from other sources such as the new case reports in the Department of Health's annual reports, suggesting that the selected group is a valid sample of the inactive register records.

#### RECORDS

A record card was prepared for each case included in the sample. The following information was recorded:

Name, age, sex, race
Occupation and place of employment
Date registered
Diagnosis upon registration
Agent reporting case

Table 1.—*Response and reactivations by reason of removal from register.*

| REASON FOR REMOVAL | NUMBER OF CASES REMOVED | NUMBER EXAMINED | PER CENT EXAMINED | NUMBER OF REACTIVATIONS | PER CENT REACTIVATIONS |
|---|---|---|---|---|---|
| Left the State | 151 | 15 | 9.9 | 2 | 13.3 |
| Unlocated or Lost to Follow-up | 62 | 20 | 32.3 | 1 | 5.0 |
| Duplicate | 10 | 1 | 10.0 | .... | .... |
| Diagnosis Rescinded | 65 | 12 | 18.5 | .... | .... |
| Primary Inactive | 49 | 35 | 71.4 | .... | .... |
| Nonpulmonary Inactive | 8 | 3 | 37.5 | .... | .... |
| Diagnosis Not Confirmed | 30 | 4 | 13.3 | .... | .... |
| Apparently Cured* | 192 | 122 | 63.5 | 4 | 3.3 |
| Inactive over 5 Years | 402 | 291 | 72.4 | 5 | 1.7 |
| TOTAL | 969 | 503 | 51.9 | 12 | 2.4 |

* "Apparently cured" was a valid diagnosis and reason for removal according to Diagnostic Standards until 1950.

Table 2.—*Response to study and reactivations by racial groups.*

| | NUMBER OF RECORDS DRAWN | NUMBER OF EXAMINATIONS | PER CENT EXAMINED | NUMBER OF REACTIVATIONS | PER CENT REACTIVATIONS |
|---|---|---|---|---|---|
| Hawaiian and part-Hawaiian | 137 | 71 | 51.8 | 2 | 2.8 |
| Caucasian | 119 | 28 | 23.5 | 0 | 0 |
| Chinese | 96 | 60 | 62.5 | 2 | 3.3 |
| Japanese | 382 | 227 | 59.4 | 2 | 0.9 |
| Filipino | 186 | 102 | 54.8 | 4 | 3.9 |
| All Others | 49 | 15 | 30.6 | 2 | 13.3 |
| TOTAL | 969 | 503 | 51.9 | 12 | 2.4 |

Reason for initial examination
Terms of hospitalization
Date removed from active register
Reason for removal from active register
Diagnosis at removal from active register
Medical supervision, removal to present time
Present clinical status

A search of chest clinic records and inquiries to hospitals and other agencies was made to establish how many of these cases had continued voluntarily under medical supervision and their current clinical status. Special attention was given to the residual group of persons who apparently had not kept up with some form of medical supervision. They were requested to report to their physician or the TB Branch for an examination which included a chest x-ray and such laboratory procedures as the Medical Director recommended. A nurse was employed for home visits, patient interviews and interpretation of records. A clerk was employed for record maintenance and tabulations.

Upon completion of the investigation and examination phases, all pertinent information was coded and transferred to Unisort Analysis Cards, Form Y9.

## RESULTS

Of the 969 records drawn in the sample, it was possible to obtain current diagnostic information for 563 cases. Table 1 shows the reason for removal from the active register, response to project, and number of reactivations for each group. Upon investigation of the original 969 records drawn for the sample, it was found that 60 of the cases had died of other causes than tuberculosis during the interim of removal from the active register to the time of the study, thus leaving 503 cases yielding current information.

Table 2 presents a comparison of number of cases and reactivations by racial groups. It must be considered when observing the number of cases and reactivations that the ethnic groups of the general population of Hawaii for 1960 are composed as follows: Hawaiian and part-Hawaiian, 16.1%, Caucasian, 32.0%, Chinese, 6.0%, Japanese, 32.2%, Filipino, 10.9%, and all other racial groups, 2.8%. For instance, it should be noted that the number of cases for the Filipino group represents almost 20 per cent of the total while they are only 11 per cent of the general population.

Figure 1 relates the response to the study for each ethnic group to the total number of records drawn for the sample. It will be noted that response was highest for the Japanese and lowest for the Caucasians. Upon examination of the records, it

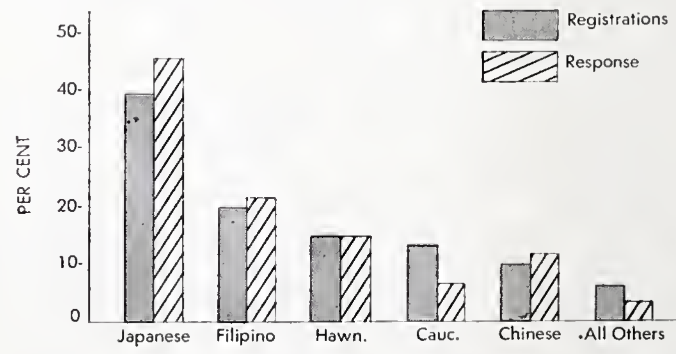


Fig. 1.—*Graphic Representation of Cases Removed from the Register and Response to the Study by Ethnic Groups*

TABLE 3.—*Length of time various agents supervised patients discharged from register in their care.*

| SUPERVISING AGENT | TOTAL | YEARS 1-2 | 3-4 | 5-6 | 7-8 | 9-10 | 11-12 | 13-14 |
|---|---|---|---|---|---|---|---|---|
| Survey* | 51 | 14 | 18 | 12 | 7 | .... | .... | .... |
| Chest Clinic | 388 | 75 | 86 | 59 | 42 | 40 | 84 | 2 |
| Private Physician | 51 | 17 | 20 | 6 | 6 | 1 | 1 | .... |
| Veterans Administration | 24 | 7 | 11 | 2 | 3 | 1 | .... | .... |
| Leahi OPD | 91 | 30 | 42 | 8 | 6 | 5 | .... | .... |
| Other OPD | 5 | 3 | 1 | 1 | .... | .... | .... | .... |
| No Information | 359 | .... | .... | .... | .... | .... | .... | .... |
| TOTAL | 969 | 146 | 178 | 88 | 64 | 47 | 85 | 2 |

* Not a supervising agent: this was voluntary activity by the patient.

appears that more mobility in the Caucasian population contributes to the lack of response to the project as proportionately related to the fact that Caucasians had the highest number of persons re-removed from the active register by reason of leaving the State.

The ratio of reactivations was the same (16.7 per cent) for Japanese, Hawaiian, and part-Hawaiian, Chinese, and all others while the Filipinos had twice as many reactivations. Only 5.1 per cent of the original group of 119 Caucasians were located for examination and none of these 28 individuals had reactivated. Figure 2 clearly demonstrates these comparisons between the number examined and the number of reactivations.

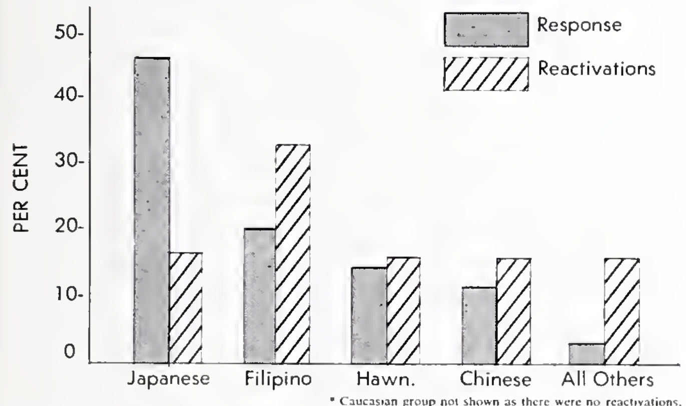


FIG. 2.—*Graphic Representation of Response and Reactivations by Ethnic Groups**

The length of time these patients were supervised by various agencies after being discharged from the register varied from no supervision to 14 years' supervision, as shown by Table 3. Of the 969 records studied, no information was available regarding supervision of 359 individuals. Most of these individuals were from the four groups: left the state, unlocated or lost to follow-up, duplicate, and diagnosis rescinded. It must be presumed that of this 37 per cent receiving no supervision according to the records, some received supervision from other agencies outside of the State.

It is evident from Figure 3 that the longer patients have been removed from the active register the more the possibility there is that they are not receiving some type of follow-up.

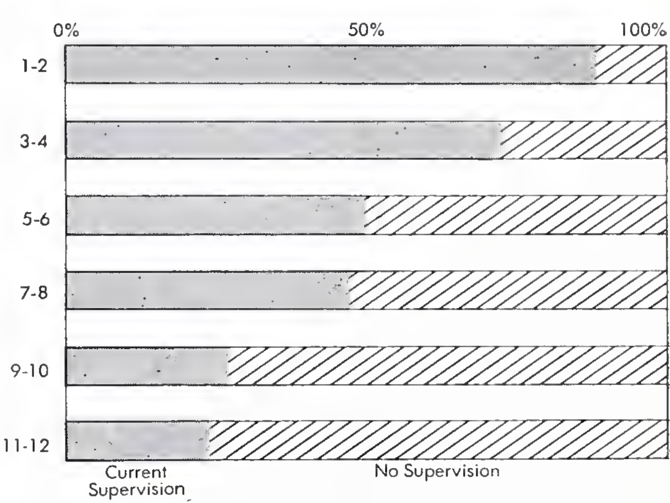


FIG. 3.—*Patients under Current Supervision by Years Since Removal from Register*

Current recommendations made by the examining agent for the 503 individuals located for the project are shown in Table 4. Of the 12 cases reinstated to the register, nine were hospitalized, two received care from private physicians, and one was hospitalized and discharged against medical advice to the care of a private physician.

TABLE 4.—*Current recommendations made by examining agency.*

| EXAMINING AGENT | TOTAL | FOLLOW UP RECOMMENDATION: *No Follow-up Recommended* | *X-Ray in One Year* | *X-Ray Every 6 Months* | *X-Ray & Bact* | *Reinstate to Register* |
|---|---|---|---|---|---|---|
| Survey | 12 | 11 | .... | .... | .... | 1 |
| Chest Clinic | 326 | 30 | 103 | 93 | 95 | 5 |
| PMD | 58 | 29 | 23 | 5 | .... | 1 |
| Leahi OPD | 88 | 14 | 5 | 62 | 5 | 2 |
| Other OPD | 13 | 3 | 3 | .... | 6 | 1 |
| TOTAL | 503 | 89 | 135 | 161 | 106 | 12 |

Table 5.—*Detailed information for twelve reactivated cases.*

| CASE NO. | LENGTH OF TIME ON REGISTER | TIME SINCE REMOVAL FROM REGISTER | LENGTH OF TIME FOLLOWED | DIAGNOSIS AT REGISTRATION | DIAGNOSIS AT REMOVAL FROM REGISTER | CURRENT DIAGNOSIS | REASON FOR REMOVAL |
|---|---|---|---|---|---|---|---|
| 129 | 4 years | 11 years | 2 yrs. prior to reactivation | I, Quiescent | II, Arrested | II, Active | Left State |
| 152 | 8 years | 1 year | 1 year | II, Undetermined | II, Arrested | II, Active | Inactive 5 yrs. + |
| 162 | 9 years | 7 years | 7 years | II, Active | II, Inactive | II, Active | Inactive 5 yrs. + |
| 344 | 9 years | 2 years | 2 years | II, Active | II, Inactive | II, Active | Inactive 5 yrs. + |
| 354 | 5 years | 8 years | None | I, Questionable | I, Inactive | II, Active | Lost to follow-up |
| 359 | 7 years | 10 years | 10 years | II, Active | I, Inactive | I, Active | App. cured |
| 393 | 11 years | 1 year | 1 year | II, Prob. Active | III, Inactive | III, Active | Inactive 5 yrs. + |
| 477 | 4 years | 9 years | 9 years | II, Unstable | II, Inactive | I, Active | Moved–Military |
| 499 | 11 years | 3 years | 3 years | II, Active | II, Inactive | III, Active | Inactive 5 yrs. + |
| 536 | 11 years | 10 years | None | Tbc., Pleurisy | I, App. cured | II, Active | App. cured |
| 789 | 9 years | 11 years | none for first 10 yrs., 1 yr. | I, Quiescent | II, Inactive | II, Active | App. cured |
| 818 | 12 years | 11 years | 1 yr., none last 10 yrs. | I, Arrested | I, App. cured | II, Active | App. cured |

Detailed information regarding the 12 reactivations is presented in Table 5. Three of these patients had no follow-up from the time they were discharged to the time they were examined for the study. In each of the three cases the stage of disease had progressed from the diagnosis at the time of removal from the active register. The other nine reactivated cases had all been x-rayed and showed no change from previous x-rays taken sometime during the year preceding the study. All 12 cases had been diagnosed as inactive for at least five years regardless of the reason for removal from the active register. Only two of the nine individuals receiving regular follow-up showed change in the stage of their disease, one had improved, and one had changed from minimal to moderately advanced.

As there are approximately 5,000 records in the Hawaii Case Register that have been placed on an inactive status, the results of this study show that at least 100 readmissions to the active register come from this source each year. Due to the fact that 268 or 53.3 per cent of the individuals located for the study have had at least an annual x-ray since removal from the register, it can be interpreted that almost one-fourth of these 5,000 individuals participate in some form of follow-up activity.

The critical time for reactivation to occur seems to be after at least five years of inactive disease reaching a maximum between 10 and 15 years. Therefore, it is evident that removal from the register for the reason of "inactive over five years" does not provide a sufficient amount of supervision for those individuals who do not voluntarily continue follow-up.

Seven of the reactivated cases were diagnosed as moderately advanced on removal from the register, four were minimal cases, and one far advanced. As there is an inverse relationship between the reactivation rate of each classification and the number of each group removed from the register, there is five times more chance of the far advanced case reactivating and four times more probability of the moderately advanced case reactivating than the minimal case.

The group of patients who are in the moderately and far advanced classifications have been inactive over five years, and have not received at least minimum chemotherapy for their disease, would be the individuals most likely to reactivate and should receive priority in a plan for lifetime follow-up.

The degree to which patients would participate in renewed follow-up after having been previously removed from the active register is indicated by the fact that at the present time over 50 per cent of the 503 examined are now voluntarily under supervision. It is to be noted, however, that many of these patients are supervised by the Chest Clinic or TB Hospital outpatient departments and receive appointment notifications for their checkup. It required considerable time and effort to locate and examine the balance of individuals in the project. As the effort made to locate and obtain current information regarding each patient in the study sample resulted in 51.9 per cent participation, it could be anticipated that approximately 2,500 individuals would participate in follow-up. About 1,200 of these patients are receiving supervision at the present time. There would still be a group of individuals living in Hawaii who would refuse to participate in regular follow-up. It would seem profitable from the standpoint of TB control to provide lifetime supervision for at least the high risk groups that produce the most reactivations.

Concurrently with the study results, the Tuberculosis Branch of the Hawaii Department of Health has discontinued placing any records on an inactive status except those who are diagnosed non-TB, deceased, or have left the State. This will provide continuing follow-up for all diagnosed cases remaining in the State.

The study now being conducted by the Tuberculosis Branch of prophylaxis for inactive cases of tuberculosis to prevent reactivation is also expected to produce results that will be directly related to this problem. ■

*The 1960 census won't be replaced until 1970.*
*Here is some expert advice on using its results.*

# Census Statistics for Medical Workers

ROBERT C. SCHMITT, M.A.,* *Honolulu*

• *The 1960 U.S. Census, and supplemental reports cited in this review, lend themselves to a variety of uses by medical workers. Data on age, race, sex, and military status, for example, are essential for computing morbidity and mortality rates, life tables, or admission rates to civilian hospitals. Group health insurance plans have to take account of employment patterns, data on marital status, and fertility ratios. Physicians seeking an office location might well consider population redistribution trends, density patterns, and family income differentials. Such statistics, available in many cases on a census tract or even block basis, are invaluable for research, both basic and applied.*

THE RELEASE of 1960 decennial census statistics for Hawaii, now underway, is providing physicians, public health officials, actuarial statisticians, hospital administrators, and many other workers in the healing arts with a major research resource.

The 1960 census of Hawaii is the latest, and possibly most comprehensive, of a series of enumerations extending back some five or six centuries. King Umi, lengendary ruler of the Big Island at that time, is reputed to have conducted a census near Hualalai, on the "Plain of Numbering," in which each person deposited a stone on a pile representing the district in which he resided. These districts, or *moku,* exist today as "census county divisions," the basic statistical area in modern census enumerations. Umi's census was the last until the missionary tallies of 1831-1832 and 1835-1836. Passage of special legislation in 1846 led to the first complete governmental censuses in 1849, 1850, and 1853. From 1860 to 1896, the Department of Public Instruction conducted censuses at six-year intervals. Annexation shifted this responsibility to the United States Bureau of the Census, which thereafter included Hawaii in its regular decennial counts, beginning in 1900.[1]

Totals from these two missionary and seventeen official census counts graphically portray both the depopulation (chiefly a result of high mortality) which characterized the first three-fourths of the nineteenth century, and the rapid growth (a product of in-migration, declining death rates, and high fertility) which followed:[2]

| YEAR | POPULATION | ANNUAL PER CENT INCREASE | YEAR | POPULATION | ANNUAL PER CENT INCREASE |
|---|---|---|---|---|---|
| 1831-32 | 124,449 | .... | 1890 | 89,990 | 1.8 |
| 1835-36 | 107,954 | −3.5 | 1896 | 109,020 | 3.3 |
| 1850 | 84,165 | −1.8 | 1900 | 154,001 | 9.3 |
| 1853 | 73,138 | −3.5 | 1910 | 191,874 | 2.2 |
| 1860 | 69,800 | −0.7 | 1920 | 255,881 | 2.9 |
| 1866 | 62,959 | −1.7 | 1930 | 368,300 | 3.5 |
| 1872 | 56,897 | −1.7 | 1940 | 422,770 | 1.4 |
| 1878 | 57,985 | 0.3 | 1950 | 499,794 | 1.7 |
| 1884 | 80,578 | 5.4 | 1960 | 632,772 | 2.3 |

The 1960 enumeration revealed that Hawaii's population had become highly urbanized, with 483,961 (or 76.5 per cent) of the 632,772 residents of the State living in its 19 cities and towns with populations of 2,500 or more. Honolulu—the 83.9 square mile area extending from Red Hill and the ewa side of International Airport to Makapuu Point, and including nine tiny islets terminating almost 1,400 statute miles distant at Kure—alone accounted for 294,194, or 46.5 per cent of the total. The City and County of Honolulu, con-

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[1] For a more extensive review of early Hawaii censuses, see Robert C. Schmitt, "A Census Comparison of Hawaii's Citizens," *Paradise of the Pacific,* vol. 65, no. 6, June 1953, pp. 28-29, and the Hawaii Department of Planning and Research, *The Censuses of Hawaii, 1500-1960* (Research Report 25, July 11, 1962).

[2] From official census reports cited in the Hawaii Department of Planning and Research, *op. cit.* The 1831-1832 and 1835-1836 figures incorporate Adams's adjustments. For detailed discussions of long-term trends, see Andrew W. Lind, *Hawaii's People* (Honolulu: University of Hawaii Press, 1955); Robert C. Schmitt, *Population Trends in Hawaii and French Polynesia* (University of Hawaii, Romanzo Adams Social Research Laboratory, Report No. 29, March, 1961); and the Hawaii Department of Planning and Research, *Population Trends in Hawaii, 1778-1960* (Research Report 3, April 11, 1961).

sisting of the Island of Oahu and the aforementioned islets, numbered 500,409 inhabitants, yet had less than one-tenth of the State's area. Only 132,363 persons lived in the other four counties of the State. Growth on Oahu (41.8 per cent between 1950 and 1960) has been accompanied by declines, both absolute and relative, on the neighbor islands.[3]

Not surprisingly, densities varied greatly from island to island. Niihau reported only 3.5 persons per square mile, and Lanai had only 15.0. Oahu, in contrast, had a 1960 density of 836.8. Oahu densities ranged from 24 persons per square mile in census tract 100 (between Haleiwa and Waimea, makai of Wahiawa and Whitmore) to 46,000 in tract 53 (bounded by King St., Liliha St., School St., and College Walk) and 84,000 in tract 54 (Mayor Wright Homes).[4]

Males still outnumbered females, although by a smaller margin than in earlier years. The 1960 Census reported that the Statewide sex ratio (males per 100 females) was 114.8, compared with 121.2 in 1950 and 223.3 in 1900. The abundance of men stemmed from both the inclusion of 47,267 military personnel (all but 629 of them males) in the count and the presence of many plantation workers who came as single men in the first part of the century.

The population was relatively young. Almost two-fifths were under 18 years of age, only 4.6 per cent were 65 or over, and the median age was 24.3 years. The 1950 median was 24.9 years, well above the 1930 low of 22.0 but less than the 26.9-year median recorded in 1900.

About one-third of the population was Caucasian, another third was Japanese, and the remaining third consisted of Chinese, Filipinos, Hawaiians, part-Hawaiians, and other smaller groups. Although all groups have reported gains in absolute numbers in recent decades, the most dramatic relative increases were those found for Caucasians, who accounted for only 21.8 per cent of all residents as recently as 1930 and 23.0 per cent in 1950, but rose to 32.0 per cent by 1960. By individual ethnic group, the 1960 distribution was as follows:

| ETHNIC GROUP | NUMBER | PER CENT |
|---|---|---|
| Japanese | 203,455 | 32.2 |
| Caucasian | 202,230 | 32.0 |
| Filipino | 69,070 | 10.9 |
| Chinese | 38,197 | 6.0 |
| Negro | 4,943 | 0.8 |
| American Indian | 472 | 0.1 |
| Hawaiian, part-Hawaiian, and other | 114,405 | 18.1 |

[3] The census reports from which these data were taken are cited in the bibliography at the end of this article.

[4] Census tract densities, not given in any census report, are taken from the Hawaii Department of Planning and Research, *Land Areas and Population Densities in Hawaii, 1960* (Research Report 13, October 24, 1961).

The statistics on race must be used with considerable caution, chiefly because of the growing number of persons of mixed background arbitrarily assigned to one group or another. Any person with some Hawaiian blood, no matter how fractional, is classified as a part-Hawaiian. (Hawaiians and part-Hawaiians, grouped with Samoans, Koreans, and other miscellaneous ethnic groups in the regular census reports for 1960, will be shown separately in special tabulations now in progress.) Any part-Caucasian is included in statistics for his nonwhite parent. Other mixtures, such as Chinese-Japanese or Filipino-Korean, are classified by race of father. Puerto Ricans, listed as a separate ethnic stock from 1910 to 1950, have been absorbed into the Caucasian and Negro classes. Persons of Portuguese or Spanish ancestry, shown as Caucasian subgroups as late as 1930, were combined with "other Caucasians" in the 1940 and succeeding enumerations.

Nativity, parentage, and country of origin also appear in 1960 census data. The statewide total included 563,872 persons born in the United States (421,168 of them in Hawaii, 128,992 in another State, and the remainder in outlying possessions, at sea, or in unreported places) and 68,900 born in foreign countries. Out of 242,584 persons of "foreign stock," that is, foreign born or with at least one foreign born parent, 198,993 reported China, Japan, Korea, the Philippines, or another Asiatic nation as their country of origin.

*Kamaainas* outnumbered *malihinis*. Out of 551,781 persons five years of age or more in 1960, 240,895 were still occupying the same house as in 1955, 175,971 had moved from a different house in the same county, 15,281 had moved from a different county in Hawaii, 94,768 had moved from a different State, and 19,402 were living abroad in 1955. (The remaining 5,464 were movers not reporting their 1955 residence.) Perhaps half of the in-migrants were military personnel.

Data on marital status revealed that 57.7 per cent of the males and 66.4 per cent of the females 14 years of age or older were married as of the census date.

There were 153,064 households, and average household size was 3.87. The population in institutions, barracks, and other group quarters numbered 39,965. Families (a different concept than that of households) numbered 130,871; unrelated individuals, 67,996. There were 120,192 married couples in the State.

School enrollment totaled 179,532. Enrollment in grades 1 to 8 was 110,436, of whom 15.8 per cent were in private schools. Enrollment ratios dropped from 98.6 per cent of the population 7 to 13 years old to 15.7 per cent of those 20 or 21 and even lower for older groups. Among all per-

sons 25 and over, the median number of school years completed was 11.3; on Oahu, it ranged from 1.1 years (in census tract 79, consisting of Waimano Home) through 8.2 years (tract 104, State Hospital) to 14.3 years (tract 5, Waialae-Kahala).

The labor force included 231,707 males and 194,788 females, including the 47,267 members of the armed forces stationed in Hawaii (some aboard ships at Pearl Harbor) and 9,070 unemployed persons seeking work. All occupations and industrial categories were represented. The great majority worked in the county they lived in, but a surprising 1,510 were employed in other counties or overseas. Most workers (156,992) went to work by private automobile or car pool, but 22,214 walked, 20,039 took the bus, 23 went by "railroad, subway, or elevated," and 32,843 worked at home.

The median family income was $6,366 for the State and $6,792 for Oahu. Local variations were considerable, ranging on Oahu from $3,157 (for tract 71, NHA-3) to $15,013 (tract 5, Waialae-Kahala).

The "fertility ratio" (children under 5 per 1,000 women 15 to 49) was 546, and ranged from 440 in Wailuku to 904 in Lualualei-Maili. Children ever born to women ever married, 35 to 44 years old, averaged 3.01.

The 1960 Census includes statistics on housing as well as on population. Subjects covered in the final reports describe tenure and occupancy of housing, units per structure and rooms per unit, condition and plumbing, year built, persons per room, value or rent, and many other items. Statistics are available for counties, urban places, census tracts, and (for Honolulu, Hilo, Wailuku, and Lahaina) city blocks.

With the passage of time, these statistics will become progressively more out of date. The eighteenth decennial census was taken as of April 1, 1960. Unless legislation mandating a mid-decade census, now under consideration by the Congress, is passed, the next complete enumeration will not take place until April 1, 1970.

It thus becomes necessary to turn to postcensal estimates and surveys published by various public agencies. Among the more useful postcensal studies are the Current Population Survey, published by the U. S. Bureau of the Census; the semi-annual population estimates issued by the State of Hawaii Department of Health; the estimates and projections prepared from time to time by the State of Hawaii Department of Planning and Research; the monthly labor force estimates developed by the State Department of Labor and Industrial Relations; and the "Honolulu Household and Housing Survey," which appears annually in the Honolulu Redevelopment Agency's publication, *Redevelopment and Housing Research.* Guidance in finding little-known or unpublished statistical series can often be obtained from these agencies, particularly the Planning, Research and Statistics Office of the State Department of Health, and the Research Division of the State Department of Planning and Research.

BIBLIOGRAPHY

The following bibliography cites the 1960 Census reports likely to prove most useful to health workers in Hawaii, together with other reference works of special value.[5]


*U. S. Bureau of the Census*

*U. S. Census of Population: 1960. Number of Inhabitants, Hawaii.* Final Report PC(1)-13A. 1961. 25 cents.

*U. S. Census of Population: 1960. General Population Characteristics, Hawaii.* Final Report PC(1)-13B. 1961. 40 cents.

*U. S. Census of Population: 1960. General Social and Economic Characteristics, Hawaii.* Final Report PC(1)-13C. 1962. 55 cents.

*U. S. Census of Population: 1960. Detailed Characteristics, Hawaii.* Final Report PC(1)-13D. 1962. $1.50.

*U. S. Censuses of Population and Housing: 1960, Census Tracts, Honolulu, Hawaii.* Final Report PHC(1)-62. $1.00.

*U. S. Census of Housing: 1960. States and Small Areas, Hawaii.* Final Report HC(1)-13. 1961. 60 cents.

*U. S. Census of Housing: 1960. Vol. III, City Blocks, Honolulu.* Series HC(3), No. 126. 1961. 25 cents. Also available, at 20 cents each, for Hilo (No. 125), Lahaina (No. 127), and Wailuku (No. 128).

*Statistical Abstract of the United States: 1962.* July 1962. $3.50.

*Other sources*

State of Hawaii, Department of Health, *Annual Report,* Statistical Supplement, 1961. No charge.

State of Hawaii, Department of Planning and Research, *Statistical Abstract of Hawaii, 1962.* May 1962. $1.00.

Star-Bulletin Printing Co., Inc., *All About Hawaii: Thrum's Hawaiian Annual and Standard Guide* (85th Edition, 1961). $1.25.

Chamber of Commerce of Honolulu, *Hawaii Facts and Figures.* No date; revised periodically. No price indicated.


■

[5] Available from either the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., or the Department of Commerce Field Office, 1022 Bethel St., Room 202, Honolulu, Hawaii.

# *The President's Page*

How's your health, Doctor?

It is no coincidence these days that individual physical capacity and strength is one of the major topics of the day. We have seen marines, soldiers, and airmen walking 50 miles. We have seen some top national executives walk 50 miles, and also large troops of civilians. I have not seen any news items describing doctors walking 50 miles. I'm sure there aren't many these days physically capable of completing such a stroll. Certainly, we must recognize that our physical fitness has not kept up to the standards which are most beneficial for good health.

Those who play golf or have an exercise program are to be congratulated; however, even a couple of rounds of golf is not sufficient to maintain a muscular reserve which will prevent the deteriorating effects of fatigue at the end of a day's work.

Physical examinations performed by the American Medical Association at the annual meetings in June have shown that almost yearly more than 20 per cent of the doctors have cardiac defects of which they were unaware. Diabetes is also a frequent finding. Enough other conditions are found in these physical examinations, cursory as they are, to indicate that the standard of health among physicians is not very high. Very few physicians avail themselves of the opportunity to have a complete physical yearly. This is a must and is the first step in a good health program. With the increasing demands of our profession such as the increasing number of patients to be seen, the decreasing number of doctors to see them, the duties we have toward our community such as participating in community projects, medical association activities, and finding a small amount of time to spend with our families, it is necessary that some thought be given to developing a health care plan which will be permanent and can be participated in day by day, so that the best results are achieved.

You, Doctor, advise your patients to do this every day. Why don't you do it?

# Hawaii Medical Association

## 107th Annual Meeting

May 2
through May 5
1963

Honolulu
Hawaii

# GUEST SPEAKERS

James P. Cooney, M.D.

Edward R. Annis, M.D.

Emerson Day, M.D.

Ian Macdonald, M.D.

Maurice L. Tainter, M.D.

Robert W. Miller, M.D.

# 107th Annual Meeting

## PROGRAM

House of Delegates meetings will be held in the Mabel Smyth Building. Scientific sessions will be held at the Princess Kaiulani Hotel.

**WEDNESDAY MAY 1**

8:00 P.M. Fireside Chats—Mabel Smyth Lounge—sponsored by the Hawaii Thoracic Society and the American College of Chest Physicians, Hawaii Chapter

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**THURSDAY MAY 2**

7:00 A.M. Breakfast

7:30 A.M. Panel on *Cancer Etiology*
MODERATOR: Dr. James P. Cooney
PANELISTS: Drs. Jerome Kern, Ian Macdonald, Noboru Oishi, Maurice L. Tainter

8:30 A.M. Intermission to view exhibits

9:00 A.M. Panel on *Cancer Epidemiology*
MODERATOR: Dr. Grover Batten
PANELISTS: Drs. Emerson Day, Paul T. Bruyere, Robert W. Miller, Walter B. Quisenberry

• • •

1:00 P.M. House of Delegates Meeting

• • •

7:30 P.M. Panel on *Patterns in Cancer Pathology*
MODERATOR: Dr. Grant N. Stemmermann
PANELISTS: Drs. W. Harold Civin, Robert E. Kellenberger, Paul Y. Tamura, I. L. Tilden

8:30 P.M. Intermission to view exhibits

9:00 P.M. Panel on *Cancer Detection*
MODERATOR: Dr. Emerson Day
PANELISTS: Drs. Y. Fukushima, Philip J. W. Lee, John M. Ohtani, I. L. Tilden

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**FRIDAY MAY 3**

7:00 A.M. Breakfast

7:30 A.M. Panel on *Cancer Therapy, Part I*
MODERATOR: Dr. Ian Macdonald
PANELISTS: Drs. Emerson Day, Albert K. S. Chun, Robert A. Nordyke, Francis M. Terada

8:30 A.M. Intermission to view exhibits

9:00 A.M. Panel on *Cancer Therapy, Part II*
MODERATOR: Dr. Ian Macdonald
PANELISTS: Drs. Edward C. Wo Lum, Mor J. McCarthy, L. Q. Pang, Maurice L. Tainter

• • •

2:00 P.M. House of Delegates Meeting

• • •

7:30 P.M. Introduction of New Officers

7:35 P.M. Presentation of Awards by Governor John A. Burns

7:40 P.M. Presidential Address by Dr. Frederick L. Giles

7:45 P.M. *Fedicare Facade* by Dr. Edward R. Annis

8:30 P.M. Intermission to view exhibits

9:00 P.M. *Viruses and Cancer* by Dr. James P. Cooney

9:30 P.M. *Some Recent Research in Childhood Leukemia* by Dr. Robert W. Miller

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**SATURDAY MAY 4**

7:00 A.M. Breakfast

7:30 A.M. *Evaluation of a Program of Cancer Detection* by Dr. Emerson Day

8:00 A.M. *Selective Therapy of Head and Neck Cancer by Surgical and Radiation Therapy* by Dr. Ian Macdonald

8:30 A.M. Intermission to view exhibits

9:00 A.M. Panel on *Some Problems in Cancer*
MODERATOR: Dr. James W. Cherry
PANELISTS: Drs. James P. Cooney, Emerson Day, Ian Macdonald, Robert W. Miller, Maurice L. Tainter

• • •

6:30 P.M. Cocktails and Dinner Dance
Oahu Country Club—dinner jackets optional

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**SUNDAY MAY 5**

6:30 A.M. Breakfast at the Oahu Country Club and the Waialae Golf Club

7:00 A.M. Annual Golf Tournament

1:00 P.M. Picnic for Physicians Only at the home of Dr. H. L. Arnold, Jr., 4992 Kahala Avenue

## REGISTRATION

Registration at the Princess Kaiulani Hotel

THURSDAY, MAY 2—6:45-10:30 A.M. and 7:00-8:30 P.M.

FRIDAY, MAY 3—6:45-10:30 A.M. and 7:00-8:30 P.M.

SATURDAY, MAY 4—7:00-10:00 A.M.

Registration Fee—$15.00

↑ ↑ ↑

## SPECIAL EXHIBIT

Mobile Hospital Display

Lower Level—Princess Kaiulani Hotel Parking Area

↑ ↑ ↑

## WOMAN'S AUXILIARY ACTIVITIES

FRIDAY
MAY 3

9:00 a.m. Convention
Hawaiian Village Hotel

SUNDAY
MAY 5

Fun Day
Oahu Country Club

GRATEFUL ACKNOWLEDGMENT
TO
AMERICAN CANCER SOCIETY—HAWAII DIVISION
FOR
FINANCIAL SUPPORT IN PROVIDING SPEAKERS FOR THE PROGRAM
AND TO
ROCHE LABORATORIES
FOR
ADDITIONAL FINANCIAL SUPPORT

# Editorials

## Careers Day

Some 124 high school upperclassmen of both sexes, and nearly 70 physician volunteers, spent last Presidents' Day together from breakfast and a movie at 8:30 until a second educational movie at 3:30 p.m., surveying facilities at Honolulu's hospitals and discussing a medical career.

Authorized by the HMA House of Delegates last year, planned by the Careers Committee of the Hawaii Medical Association, and brought to fruition by days of hard work by the committee's Chairman, Dr. Sau Ki Wong, and the man in charge of assignments and exhibits, Dr. John Stephenson, the day-long program was, judging from a first-hand look at it and from the overwhelmingly enthusiastic evaluation of it by the participating students, a smashing success.

Exhibits at the participating institutions included x-ray and laboratory demonstrations at St. Francis Hospital; a demonstration and lecture at the Rehabilitation Center; x-ray, laboratory and cardiology demonstrations at Children's Hospital; x-ray and surgery exhibits at Kuakini; laboratory and environmental medicine demonstrations at the Department of Health; and laboratory and artificial kidney exhibits at The Queen's Hospital. The students breakfasted and lunched with their host-guides at one of the four hospitals, and changed to a different guide for the afternoon session. Nearly every group of four students was taken to the host physician's own office as a part of the tour.

Except at the movies, at meals, and at the Rehabilitation Center, there was no merging of the groups of four, so that questions, discussions, and comments were always easy to handle. The wisdom of this aspect of the careful planning was evident in its execution.

The few doctors whose relationship to organized medicine consists chiefly of sitting back and criticizing it would do well to read the students' comments on this day of hard work by their 70-odd confreres: They liked it, and unquestionably they all like the idea of becoming doctors a great deal better because of it. It was a highly creditable exercise in practical, down-to-earth, effective public relations. On behalf of the HMA members, we extend thanks to the working members of the committee: Drs. Mary Glover, John Stephenson, Doris Jasinski, Louis Pang, Norman Sloan, and Sau Ki Wong (Chairman): and to the doctors who gave up half (and in four instances all) of their holiday to promote the recruitment of more doctors for Hawaii.

## The Place of Research in the Future of Hawaiian Medicine

We frequently hear visiting professors express surprise at the unexpectedly high level of competence of medical practice in our Islands. Any visitor, however, is burdened with the obligation of politeness, and our Hawaiian hospitality would certainly never lessen the sense of this obligation. We should not allow ourselves the delusion that Hawaiian medicine has any valid claim to medical excellence, as compared with the famous teaching centers of the mainland. This is only attained if day-to-day medical practice nurtures a vigorous hospital teaching program and is stimulated by minds active in significant medical research. Nor should our inertia be comforted by the thought that top level medical practice can only be expected in a fairly large metropolitan center. We all know that Rochester, Minnesota, may have many attractions, but large size is not counted among them.

Postgraduate teaching and research are as firmly committed to a symbiotic existence as the algae and fungi in lichens. If one should wither, the other will not thrive. The Uhl-Michael report, if put to good use, will establish an effective postgraduate teaching system. But what of its symbiotic partner?

Top quality residents and interns will not fill this system unless they are attracted by a merited reputation for scientific achievement.

It is, perhaps, too much to ask of hospitals that they should commit themselves to the large expense of personnel, space, and equipment for a continuing program of research; or perhaps it is not. It all depends on whether the hospital is shooting at the stars with multistage rockets or at street lights with sling shots. No separately funded and managed research foundation is now in operation in any of our hospitals. If this satisfies our physicians, our hospital administrators, and our hospital directors, we should consider whether we really want a teaching program, or whether we shouldn't subside to the level of dispensary practice with detail men for visiting professors.

The picture is not entirely dark, however. Two medical research foundations have appeared on the Honolulu scene. One of these is at the University of Hawaii, and we wish it well. It is the logical place for the pursuit of research in the basic medical sciences. It does not, however, seem likely to be a promising source of medical research until the establishment of a medical school under medical control.

Meanwhile, down at Thomas Square, the Straub Clinic has set up the Straub Medical Research Institute. It has the purpose of stimulating medical research by Honolulu physicians. Ultimately to be housed separately from the Straub Clinic, it deserves the support of the medical profession and the community. It has the advantage of medical control by physicians from both in and outside of the Straub Clinic, the majority being in the latter category, plus guidance by five lay directors.

A foundation of this type will be able to concentrate its equipment purchases in those nonremunerative areas where hospital administrators (but not angels) fear to tread. How often we have all heard how wonderful it would be if we only had this or that piece of equipment to solve this or that problem! And haven't many of us complained that the sharp edge of our mental sword has been dulled from hacking away at the routine? The operation of an effective Straub Medical Research Institute, separately housed and headed by its own Medical Director, will afford us the opportunity of solving these problems.

In spite of the fact that its funds and its equipment are to be available to any local researcher with a valid project regardless of his medical affiliations, we assume that cross-town professional jealousies might well appear. It is to be hoped that these will be kept to a minimum. It should be remembered that the Institute gains its name from the surgeon whose generous personal gift got the Institute off the ground, rather than from the clinic named after him. And it should be added that the Straub Medical Research Institute claims no monopoly in this field. If other such foundations were started, the rivalry for achievement might be a source of strength. The point might be made that there can be too much of a good thing, but this is scarcely a problem at the moment.

GRANT N. STEMMERMANN, M.D.

# Investigation of New Drugs, 1963

Qualification as an expert is required, under new Federal legislation, of physicians who wish to try out new drugs still "limited by Federal law to investigational use." Five pages of biographic and bibliographic data must be filled out and submitted, including a statement of the number and characteristics of patients to be treated, the number of controls, kind of observations and tests to be made, and the duration of the study. Most companies will be kind enough to help the doctor out by supplying the FDA with copies of the report forms to be used. Most doctors, we suspect, on being handed this sheaf of forms, will just say "The hell with it" and throw the lot away.

Each patient fed the new drug, or anointed with it, must be informed that it is an experimental preparation "except where [the physicians] deem it not feasible or, in their professional judgment, contrary to the best interests [of the patient]. The fact that such a practice would almost *always* constitute a fatal obstacle to the clinical evaluation of the new drug—to say nothing of the likelihood that it would be likely to generate lawsuits galore—is ignored, unless "not feasible" can be stretched to cover this point.

Clearly these procedures will foster more careful clinical studies, more carefully reported, than the looser regulations heretofore in effect. Probably most of the physicians scared off by the new nuisance restrictions will be those whose reports in the past have been least carefully prepared. But the amount of clinical testing under the new rules is going to accumulate much more slowly and reach a smaller total than it has in the past. In effect, the new law will expand and prolong the present next-to-last phase of drug evaluation, and transform the present final phase into unsupervised clinical utilization.

Whether care can substitute for quantity in this situation remains to be seen.

HAWAII MEDICAL JOURNAL

# This Is What's New!

• A new **antihypertensive** drug, **Methyldopa,** has been used over the past year at Hammersmith Hospital in London. Methyldopa inhibits an intermediate reaction in the formation of noradrenalin. (It inhibits the decarboxylation of dopa to dopamine.) The effectiveness of this medication appears to be in the middle-range antihypertensives: that is, less potent and less toxic than the potent ganglionic blockers such as guanethidine but more potent than the milder hypotensives such as reserpine or the thiazides. (*Am. Heart J.* [Jan.] 1963.)

• Although they are still talking about it in Philadelphia and writing about it in New York, the **Masters two-step** is regarded by many as being about as **obsolete as the fox trot** in the Twist era. Those who have followed this business over the last few decades and recall such adventures as the two-step with smoking, with and without the ballistocardiograph, et cetera, will now note that the two-step exercise electrocardiogram has gone double blind. The authors are, as usual, one of the old gang and nearly half a dozen helpers. Conclusion: a double-blind study on the Masters two-step exercise cardiogram test has been carried out. (*Circ.* [Dec.] 1962.)

• **Hashimoto's disease** of the thyroid, which is relatively common in Hawaii, may be **inherited as a mendelian dominant.** At least the tendency for families to develop antithyroid antibodies appears to be inherited. In 17 out of 19 families studied, one or both parents of the 19 patients with Hashimoto's had significant antithyroid antibodies. (*Lancet* [Dec. 22] 1962.)

• **Rats** fed on a low protein, high fat diet developed cirrhosis whether the fat consists of ten per cent corn oil or ten per cent coconut oil. However, the **coconut oilers** developed a **much less severe cirrhosis** than the corn oilers. (*Arch. Path.* [Mar.] 1963.)

• A five-year cure following radical resection for **primary cancer of the duodenum** is not uncommon: eight of 19 such cases survived for this period of time. The author presents four patients treated by himself! The average physician will not see a single case of carcinoma of the duodenum in a lifetime. (*Ann. Surg.* [Feb.] 1963.)

• Not so long ago, the biggest problem in the diagnosis of **leukemia** was in determining the type of leukemia. Now the problem is the **numbers and abnormalities of chromosomes.** In several patients recently studied in France, one, a child with lymphoblastic leukemia, had **deletion** of part of the long arm of one of the medium-sized chromosomes, probably number ten. Two cases of acute myeloid leukemia exhibited a **double** granulocytic population, one population being normal, the other **haploid** for chromosome number 21 or 22. (*Rev. Franç. Etudes Clin. Biol.* 7:639-647, 1962. Quoted from *Blood* [Jan.] 1963.)

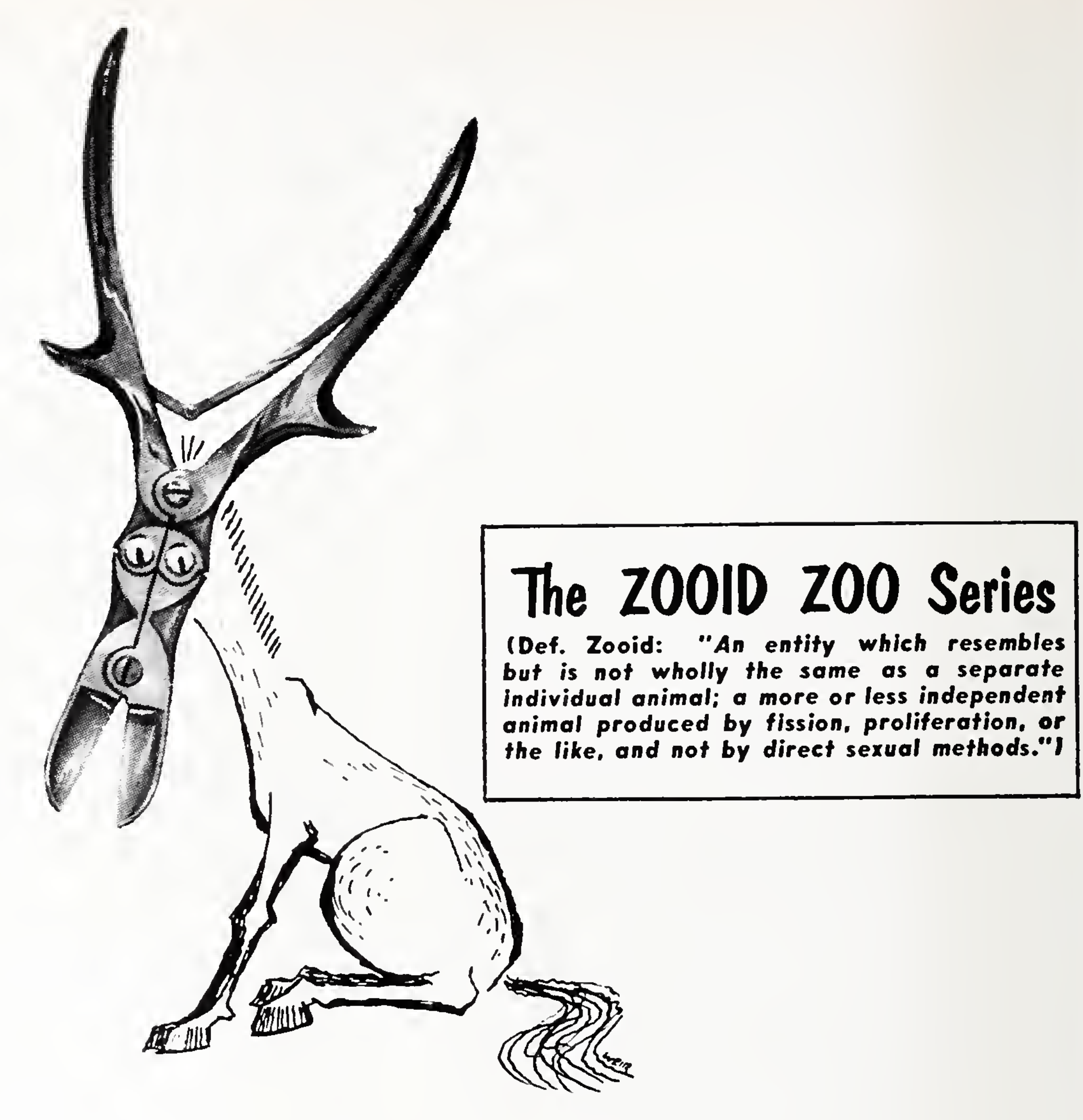
• Lilly, after much effort to communicate with dolphins, finds that the **dolphins are learning English** faster than he is learning delphinese. His dolphins have learned to repeat short phrases in English without too much difficulty. This may be viewed as an attempt to close an evolutionary gap of 30 million years over a period of a few weeks. (*Gen. Psych.* [Feb.] 1963.)

• Of 159 patients with **hereditary hemorrhagic telangiectasia** over 80 per cent had gastrointestinal or nasal **hemorrhages.** Symptomatic replacement of iron, and transfusions, were most beneficial therapeutically. Gastrointestinal surgery for bleeding was almost invariably unsuccessful: the bleeding point could not be found, nor the hemorrhage stopped. (*Gastroenterol.* [Jan.] 1963.)

• **Plastic catheters** used for prolonged I.V. therapy may occasionally **slip away and be lost** along the venous channel. This can be a very serious complication of a seemingly benign situation. In 11 patients where the catheters were not readily recovered, approximately **half died** as a result of the infected plastic tube lodging against the annulus of the tricuspid valve. (*Arch. Surg.* [Feb.] 1963.)

• Serious peripheral **neuropathy** may occur in patients who are receiving **nitrofurantoin (Furadantin)**, especially if there is significant **impairment of renal function.** This condition has recently been reported in seven patients. In three patients who are receiving **nitrofurantoin (Furaoccurred.** If the drug is withdrawn improvement gradually occurs. (*Lancet* [Dec. 1] 1962.) ■

Fred I. Gilbert, Jr., M.D.

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*(Asinus Sturdibus)*

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*BLUE SHIELD PLAN FOR HAWAII*

*Member of the Western Conference of Prepaid Medical Service Plans*

# Hawaii Academy of General Practice

The hospital is for the patient's benefit!

Those of you who have perused the Michael and Uhl Report (and you all should have!), might well agree that it could have been entitled: "How to Capture and Keep a House Staff for Your Hospitals."

Any mention of the patient as the primary beneficiary of hospital care was couched by these medical surveyors in terms both casual and indirect.

### A MEDICAL APPRENTICESHIP

There was once a time when a young man with an M.D. to his name and only "book larnin' " to back it up, was pleased to sacrifice ease and luxury; he didn't complain about menial scutwork, just so he could be at the feet of his preceptors and ready to climb the ladder of medical success at a nod from them. The apprentice was tolerated, for the most part benevolently, by the hospital and by the professionals.

But times have indeed changed. The house physician is not only a hospital employee, underpaid, and unprotected by a union, but he is also made to bow down before the god of paperwork. To get him to sign up and serve his indentureship, the intern is bought on a bid basis, sanctimoniously cloaked in a fancy promise to provide him education and training.

### MEDICAL EXPLOITATION

Michael and Uhl have said: ". . . the [house staff] are being utilized for service rather than for education;" and the first of the 18 deficiencies they listed starts: "There is a serious lack of participation in clinical teaching by the attending staffs . . ." Did it take these koleas to tell us the obvious: that the young medical graduate coming to Hawaii soon comes to feel himself exploited?

The History and Physical was once a teaching mechanism. It has now become a required piece of paper, to be filled with the permitted chicken tracks of abbreviation, to be countersigned by an Attending who neither cares to read it, nor can, and to be held over the Attending's head as a disciplinary club. It is a boring requirement for the intern or resident, who most likely will never consult the Attending about the case, and will probably never see that patient again.

### THE PATIENT ENTERS

This medical community seems to be ignoring two vital facts: (1) that it is the Attending, who brings his patient to a hospital, who does the most in the way of tangible support of that hospital, and (2) that it is this clinical material that could provide the education desired by the intern and resident.

Everyone will grant that the Teaching Staff Patient is a fast vanishing entity. It should be equally obvious that "his own" single case—the one he has worked up with a history and physical, that he discusses with that private patient's PMD, that he follows personally to discharge—is the intern's greatest learning experience.

Why then is not the house physician assigned to follow through on "his own" case? Why not let him pick the brains of a particular Attending, and learn as much from "bad" treatment as from a good brand of medical or surgical care? The house doctor's searching questions would stimulate the Attending to his best effort; the house doctor would soon become another personal physician to the patient, who would thus benefit twofold.

### POSTGRADUATE EDUCATION

If the grand rounds, the teaching conferences, and the Visiting Professor programs were geared to the convenience of the busiest of the practitioners, instead of to the house staff or to the younger, not-yet-busy preceptors, the purposes of postgraduate continuing medical education would be served, to the benefit of both patient and house doctor. The patient would be served because his private doctor would not be left out of such vital programs. The house doctor could find no better forum of mature medical discussion.

Members of the Hawaii Academy of General Practice are disappointed in the Michael and Uhl Report. It failed completely to point out our dedication to the furtherance of continuing medical education in Honolulu. The flat statement in the Report: ". . . the majority of these [General Practitioners] are deficient in maintaining their own self-educational activities . . . ," is in direct conflict with the facts, and perhaps indicates the sort of company these two kept while they were in Hawaii.

J. I. Frederick Reppun, M.D.
*Secretary-Treasurer*

# Book Reviews

## ★Malpractice Law Dissected for Quick Grasping

*By Charles L. Cusumano, Member of the New York Bar, 130 pp., $10.00, Medicine-Law Press, Inc., 1962.*

IF EVERY DOCTOR would read this book, and apply, even reasonably well, the advice given him, the life of the ambulance-chasing type of lawyer would be less happy and profitable.

It is written in a succinct, but very readable style, and avoids technical legal terms almost entirely. When these words must be used they are clearly defined. He gives no examples of consent forms, but advises the use of the AMA pamphlet on that subject. There are also chapters for dentists, nurses, hospitals, and employers of labor regarding their liability for medical malpractice suits.

There are innumerable examples of a physician's potential liability which might not otherwise be thought of: for example, their liability for the acts of others.

I shall buy a copy myself.

H. L. ARNOLD, SR., M.D.

## Essentials of Pediatric Psychiatry

*By Ruben Meyer, M.D., Morton Levitt, Ph.D., Mordecai L. Falick, M.D., and Ben O. Rubenstein, Ph.D., 208 pp., $6.00, Appleton-Century-Crofts, 1962.*

WITHIN the confines of this small book the authors have succeeded in presenting "a clear idea of what constitutes healthy development in children; what can be done to support and reinforce it; what items of behavior are to be regarded as borderline or pathological; how to evaluate these problems; and where, when, and how to refer patients." In so doing they have selected only those issues and viewpoints which represent their own preoccupations (but include the major areas of concern to pediatricians).

Although the discussions are at times too full of polysyllabic jargon to be light reading (and must be re-read to be "clear") this book should be useful for house officers dealing with children, and practitioners whose training has not included emotional and behavioral problems of childhood, but who must deal with them daily.

W. F. MOORE, JR., M.D.

## ★Todd-Sanford Clinical Diagnosis by Laboratory Methods, 13th Ed.

*Edited by Israel Davidsohn, M.D., F.A.C.P., and Benjamin B. Wells, M.D., Ph.D., F.A.C.P., 1,020 pp., $16.50, W. B. Saunders Company, 1962.*

THE LAST edition of Todd and Sanford was in 1943, after 45 years of periodic revisions through 12 editions. In this series of texts, as the editors put it, ". . . are mirrored . . . the history and development of clinical pathology in this country." The new edition reflects the rapid developments in clinical pathology not only by many new chapters but also by multiple authorship for the first time. The new material includes quality control, isotopology, water and electrolytes, microchemistry, and enzymology, to name a few. I have already used this text as a source of quick reference, and find it to be an excellent book.

PAUL Y. TAMURA, M.D.

★ means highly recommended.

## Surgery of the Chest

*Edited by John H. Gibbon, Jr., M.D., with the collaboration of 35 authorities, 902 pp., $27.00, W. B. Saunders Company, 1962.*

DESPITE a rather glowing foreword by Edward D. Churchill, M.D., who seemed impressed by the sections dealing with heart surgery, I found this compilation very similar to others in this category which have recently been appearing in surfeit, and hardly worth $27.

Much of the material and many of the illustrations have previously appeared in the periodical literature. There is a pretty generous mixture of good with bad. The section on "Roentgen Diagnosis" is good, but has no illustrations. Some of the introductory historical reviews contain inaccuracies, including a misspelled proper name. If the section on foreign bodies of the air and food passages has a rightful place in this book, it should be more complete. There is some question of authoritative origin when descriptions and illustrations indicate techniques employing continuous sutures, and particularly pericostal sutures.

PAUL W. GEBAUER, M.D.

## ★Novak's Gynecology and Obstetric Pathology With Clinical and Endocrine Relations, 5th Ed.

*By Edmund R. Novak, A.B., M.D., and J. Donald Woodruff, B.S., M.D., 713 pp., $16.00, W. B. Saunders Company, 1962.*

THIS FIFTH EDITION, coauthored by Edmund R. Novak and J. Donald Woodruff, continues the high standards traditional of the late Emil Novak in such an excellent way that I am sure that it will remain the number one book on gynecologic and obstetric pathology for student and practitioner alike. Dr. Robert E. L. Nesbitt has expanded and improved his section on obstetrical pathology, and Dr. John K. Frost has revised and brought up to date his section on cytopathology. New illustrations and photographs have been added, many in color. Some basic chapters have been revamped and bibliographies have been brought up to date. In summary: the best in print of its kind.

FUGATE CARTY, M.D.

## Advances in Rheumatic Fever 1940-1961

*By May G. Wilson, M.D., 249 pp., $10.00, Hoeber Medical Division, Harper & Row, 1962.*

DR. WILSON'S TEXT is stimulating in that she presents a different approach in her discussion of rheumatic fever. She cautions against the dogmatic interpretation of modified Jones Criteria for the diagnosis of rheumatic fever. She feels that carditis is the only sure sign of rheumatic fever and can be elicited by the presence of a murmur or murmurs and by the demonstration of cardiac dilatation. The latter is demonstrated by serial fluoroscopy (fluorogram), and obtaining permanent records with the robot camera.

She questions the value of continuous prophylaxis. In her study over a six-year period (1952-1958), 110 patients received continuous oral penicillin prophylaxis and 103 patients received penicillin therapeutically for ten days only on indication; that is, at the onset of a respiratory infection. Dr. Wilson's study revealed that the

*continued page 316*

HAWAII MEDICAL JOURNAL

# *In Memoriam – Doctors of Hawaii......*

This is the forty-third installment of In Memoriam—Doctors of Hawaii.

## George Walter McCoy

George Walter McCoy was born in Cumberland Valley, Pennsylvania, June 4, 1876.

He graduated from the University of Pennsylvania Medical School in Philadelphia in 1898.

Two years after his graduation, Dr. McCoy joined the U. S. Marine Hospital Service, now the U. S. Public Health Service. Serving first as Assistant Surgeon, he became a Surgeon in 1913 and Medical Director in 1930. He was in charge of the U. S. Plague Laboratory in San Francisco from 1908 to 1911. From 1911 to 1915 Dr. McCoy was stationed in Hawaii and was Director of the U. S. leprosarium at Kalawao, Molokai. Concurrently, he served as sanitary adviser to Governors Walter F. Frear and Lucius E. Pinkham. In 1915 he became director of the Hygienic Laboratory of the U. S. Public Health Service, now known as the National Institutes of Health.

Dr. McCoy returned to Honolulu in 1932 with a Washington delegation to investigate possible financial aid for the Hansen's disease problem in Hawaii. Although this aid was not immediately forthcoming due to the depression, it was passed by Congress later.

On the conclusion of his service with the National Institute of Health in 1937, Dr. McCoy engaged in epidemiologic studies in leprosy and in 1938 became Director of the Department of Preventive Medicine and Public Health at Louisiana State University School of Medicine at New Orleans. He served in this capacity until 1947 when he became Professor Emeritus. During 1945-1946 he was Acting Dean at the university.

Dr. McCoy's many contributions to medical literature in the fields of bacteriology and public health also reflected his special interest in plague and leprosy.

In 1931 he was awarded the Sedgwick Memorial Medal of the American Public Health Association.

Dr. McCoy died April 2, 1952, in Washington, D. C., at the age of 75.

He was a member of the American Society of Tropical Medicine, American Association of Pathologists and Bacteriologists, Association of Military Surgeons of the U. S., American Public Health Association, Philadelphia Pathological Society, California Academy of Medicine, Association of American Physicians, and the American College of Physicians. He was an honorary member of Delta Omega, and in 1935 he was President of the Washington, D. C., Academy of Science. For many years he was honorary Vice-President of the American Mission to Lepers. From 1920 until his death he served as a member of the U. S. Pharmacopeia Revision Committee. He was a member of the Council on Pharmacy and Chemistry of the American Medical Association since 1916, and for more than 20 years he served on the Association's Committee for Protection of Medical Research.

## Francis A. Lyman

Francis A. Lyman was born in Honolulu, May 7, 1863, in the Chamberlain house in the rear of Kawaiahao Church, now the oldest frame house in Hawaii. He was the son of F. S. Lyman and the grandson of the Rev. David Beldon Lyman who arrived as a missionary in 1832 and later founded the Hilo Boarding School.

DR. LYMAN

He received his early education at Hilo and at Punahou Academy, graduating in 1881. He was a student at Beloit College, Beloit, Wisconsin, and at Western Reserve University, Cleveland, Ohio, graduating from the latter in 1885. His medical education was received at Rush Medical College where he graduated with honors in 1889.

For two years Dr. Lyman practiced at Presbyterian Hospital in Chicago.

Dr. Lyman served as superintendent of the Wisconsin Insane Asylum for nine years.

At Mt. Carmel, Illinois, he married Mamie A. Aldrich, daughter of a prominent merchant of

*continued page 330*

# New Members

**Bal Raj Mehta**
c/o Kaiser Foundation Clinic
Maili, Oahu
General Practice
Medical College Amritsar (Punjab), 1950
Internship—Kuakini Hospital, Honolulu
Residency—St. John Hospital, Cleveland, Ohio
Cleveland Metropolitan General Hospital, Cleveland, Ohio
V. J. Hospital Amritsar, India

**James K. Matayoshi**
59 Hoku Street
Hilo, Hawaii
General Practice
Internship—Detroit Receiving Hospital, Detroit

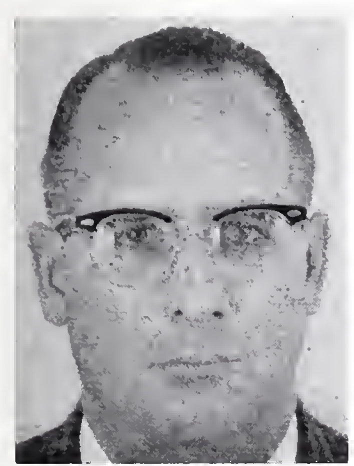
**Winfred Y. K. Chang**
45-939 Kam Hiway
Kaneohe, Oahu, Hawaii
Internal Medicine
St. Louis University Medical School, 1956
Internship—Mercy Hospital, Buffalo, N. Y.
Residency—L. A. County Harbor Hospital, Torrance, Calif.

**Tung Kuang Lin, M.D.**
1697 Ala Moana Boulevard
Honolulu 15, Hawaii
Internal Medicine (Cardiology)
Medical College, National Central University, Nanking, China, 1947
Internship—University Hospital, Nanking, China
St. Luke's Hospital, Kansas City
Residency—University Hospital, Nanking, China
St. Luke's Hospital, Kansas City

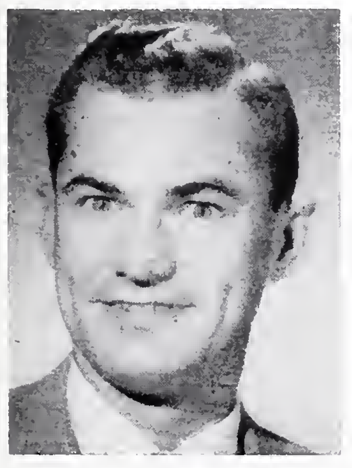
**Rodman Benson Miller**
Waialua, Oahu
General Practice
Louisiana State University, 1950
Internship—Shreveport Charity Hospital, Shreveport, La.
Residency—Colorado State Hospital, Colorado

**Bunzo Nakagawa, M.D.**
1481 South King Street
Honolulu 14, Hawaii
Obstetrics & Gynecology
University of Oregon Medical School, 1952
Internship—The Queen's Hospital Honolulu, Hawaii
Residency—Kapiolani, St. Francis, Queen's Hospitals, Honolulu
Walter Reed Army Hospital, Washington, D.C.

# County Society News



**William J. T. Cody**
1481 So. King St., Suite 343-347
Honolulu 14, Hawaii
Psychiatry
Tufts University Medical School, 1951
Internship—St. Elizabeths Hospital
Washington, D. C.
Residency—St. Elizabeths Hospital,
Washington, D. C.
Territorial Hospital, Kaneohe, Oahu
West Haven V. A. Hospital,
West Haven, Conn.



**Lowell G. McLellan**
1697 Ala Moana Blvd.
Honolulu 16, Hawaii
Obstetrics & Gynecology
Cornell Medical University, 1955
Internship—Mary Imogene Bassett
Hospital, Cooperstown, N.Y.
Residency—Mary Imogene Bassett
Hospital, Cooperstown, N.Y.
Syracuse Memorial Hospital,
New York

## Honolulu

Approximately 280 members attended the annual meeting on December 4. The following new members were introduced: Drs. Gloria Nano Natino Badua, Frederick A. Dodge, Roy I. Iritani, Richard B. Joseph, Tung Kuang Lin, Audrey W. Mertz, Norman Y. Nakamura, and Raymond M. Tamura. The President made announcements of coming meetings, congratulated Dr. Bernstein on his reappointment, presented Mr. Robert Short with a lei, asked the physician who failed to sign the check covering a campaign donation to Mr. Evensen to get in touch with Mr. de Roode, and asked for volunteers to write a column for *Medical Economics*. The rules governing the annual elections were announced and tellers appointed. The chair announced that not all the annual reports would be read and that these would stand approved as circulated unless additional comments were made. Mrs. S. R. Horio presented the annual report of the Woman's Auxiliary. The Society honored seventeen of its senior members. Dr. Pinkerton read his President's report and was presented with a lei and a plaque. The results of the election were announced and the new officers were installed.

There were 157 members present at the January 7 meeting which featured a presentation by Mr. Abel Fraga who spoke on "The Physician and the Narcotic Law." Dr. B. Allen Richardson reported on his attendance of the Western Conference of Prepaid Medical Plans held in Seattle, and Dr. John P. Frazer outlined the background development of these conferences. Dr. John F. Chalmers brought the members up to date on the status of the proposed rules and regulations being promulgated by the Board of Pharmacy and urged the physicians to attend the next hearing.

## Hawaii

The guest speaker at the January 29 meeting was Dr. George Ewing, who spoke on "Convulsive Disorders." After the treasurer's report was given, a committee was appointed to investigate the possibility of setting up a permanent endowment fund of about $10,000. Dr. Henderson spoke on the importance of electing HMA delegates who would consider their election a duty and a privilege. It was voted to pay the delegates $20 per diem as well as their transportation costs. Dr. Okumoto reported on coverage and financial aspects of Swallow I and II. Dr. Matayoshi reported that the APS Essay Contest had been dropped inasmuch as necessary information from the HMA was delayed and the Department of Education had not taken the matter under consideration. It was voted to endorse the Heart Association program that would enable heart patients to obtain drugs at cost from the druggists. Action on a letter from the Philippine Consulate in Honolulu requesting a name of a Hawaii physician to do physical examinations for visa applicants was deferred to permit the Secretary to obtain further details.

## Kauai

The annual meeting was held on December 4 at which time Dr. Frederick Giles paid his presidential visit to the Society. The following new officers were elected: William Goodhue, president; Kenneth Fujii, vice-president, and Patrick Cockett, secretary-treasurer. A motion relative to charging for cytology slides was tabled. Dr. Giles addressed the Society and explained the proposed fee schedule survey, changes in the HMA administrative department, public relations, Sabin oral polio vaccine, and the development of political action committees.

*continued page 316*

# Notes and News

## In the Public Eye

"Call The Doctor," HMA's weekly TV series on KTRG, Channel 13, has presented "Blue Babies," "Nutritional Nonsense," "Asthma," "Birth Control," "Hangovers," "Mercy Deaths," and "Are You a Neurotic?"

After 12 years as medical director at HMSA, **Dr. R. B. Faus** retired December 31. He will continue private practice from his Young Hotel Building offices and take on the added task of Commander, Diamond Head Post 13, American Legion. His successor is **Dr. Verne C. Waite.**

**Dr. Clarence I. Chang,** personal physician and great booster of Governor Burns, deservedly receives favorable publicity.

## Names in the News

**Dr. and Mrs. Harold Kushi** were hosts for Chairman (Mayor) Eddie Tam's 15th wedding anniversary celebration at the Royal Lahaina Beach Hotel.

**Dr. Harry L. Arnold, Jr.'s** recent visit to new Sheraton Maui Hotel at Kaanapali was noted for his humorous comments; e.g., "This is the only hotel in the world where you get a terrific view from the lobby."

The President of the A.A.U., Louis J. Fisher, was high in praise for **Dr. R. You's** sports activities when he was named sportsman of the year in 1962.

**Dr. Min Hin Li** was recently appointed Medical Director of the Pacific Guardian Life Insurance Co.

**Dr. O. D. Pinkerton** was to the point in demanding effective restrictions of fireworks by the city politicians.

The Continuing Education Committee of the HCMS, **Drs. Sexton, Kawasaki, Cherry, D. Katsuki,** and **S. Nishijima,** has done a great job of focussing attention on postgraduate medicine programs in Honolulu.

**Dr. Frank Tabrah,** former medical field consultant to the Unitarian Service Committee in Nigeria, cited almost total lack of tooth decay among seriously malnourished natives.

**Dr. Milton Howell** told of needs for extra funds for the new Hana Medical Center.

**Dr. Robert C. H. Chung** was described as the "happiest man" who saw the culmination of seven years of work toward a goal—a hospital for Windward Oahu (Castle Memorial).

The recent fund-raising activities of **Dr. George H. Mills,** President of the Hawaii Heart Association, received good newspaper support.

**Dr. Frank Tabrah** and **Dr. Barton Eveleth** have embarked on a survey to learn if "ancient Hawaiians really had something when they used Hawaiian plants to make medicines."

Plans for a Congenital Defect Center at Children's Hospital were announced by **Dr. Donald Char.**

Announcement of a new group drug plan offering 40 per cent discount on drugs announced **Dr. Thomas Chang** as one of its principals.

A committee on asthma chaired by **Dr. William A. Myers** announced that Hawaii's asthma–hay fever rate is twice that on the mainland.

After 28 years, **Dr. F. J. Pinkerton** retired as chairman of the Shrine Athletic Committee.

The marriage of Nichols Beck, son of **Dr. and Mrs. L. Clagett Beck,** to Pamela Wilcox received much social attention.

**Dr. Richard You's** 12-story York International Building had groundbreaking ceremonies recently.

"Hawaiian Doctors Lend a Helping Hand in Samoa" was a feature article in the morning paper.

**Dr. Clifford Moran's** Kihei, Maui, home was featured in the Sunday papers.

Feature stories on DNA brought favorable comments from **Drs. F. L. Giles** and **T. T. Tomita.**

### DR. EIJIRO NISHIJIMA
### 1874-1963

Dr. Eijiro Nishijima was born on October 4, 1874, in Fukuoka, Japan, to a family of doctors. His father was a doctor and so was his grandfather. He died on January 6, 1963, in Honolulu at the age of 89; at the time of his death, he had resided in Hawaii for 62 years.

Dr. Nishijima was graduated from Kyoto Medical College in 1900 and soon after his graduation came to Hawaii to practice medicine. When he arrived in Hawaii he went to Kapaa, Kauai, because there were many Japanese people there in those days. These were truly horse and buggy days and oftentimes it took two days to see a patient in the next village. In those days the most prevalent diseases in the plantation villages were beri-beri and typhoid fever. Leprosy was another fairly common disease, but it took tact and serious consideration before the diagnosis was made because the patient was quickly removed to Molokai and often the rest of the family became revengeful, as in the case of a certain Dr. Smith.

Dr. Nishijima practiced in Kapaa until 1907 when he temporarily returned to Japan. He married the former Moto Uyeno of Fukuoka, and a son, Satoru, was born. In 1912, Dr. Nishijima returned to Hawaii accompanied by his young wife and infant son, established himself in Honolulu as a specialist in Obstetrics and Gynecology, and practiced many years on Kukui Street.

Dr. Nishijima was one of the founders of the Japanese Benevolent Society and Hospital which is now known as the Kuakini Hospital and Home. He was also very active in the civic affairs of the Japanese community, and many times headed the now defunct Japanese Medical Society before World War II. When his son Satoru came back from Philadelphia in 1941, after finishing his graduate work in obstetrics and gynecology, the elder Dr. Nishijima gracefully stepped out to retire.

Dr. Eijiro Nishijima is survived by his widow; four sons, Drs. Satoru and Randal, a surgeon, two dentists, Drs. Theodore and Frank, all practicing in Honolulu, and eight grandchildren.

Kyuro Okazaki, M.D.

## GARDNER BLACK, M.D.
## 1896-1963

Gardner Black, recently deceased, lived a long, happy, and useful life devoted to the service of the people of Hawaii. He was born in 1896 in Pasadena, California, the only son of a practicing physician, Stanley Patterson Black, pathologist and bacteriologist, and Ella Piper Black.

There he attended school until he was admitted to the famous old Rush Medical College on the west side of Chicago, from which he graduated in 1921.

His internship was spent at The Queen's Hospital, where he arrived with three others on July 5, 1921 as part of a program to raise Hawaii's standards by importing outstanding doctors from good medical schools in the hope that they would remain in the community, as he did.

On October 5 of that year, at St. Andrew's Cathedral, he married a lovely Presbyterian Hospital nurse, Esther King, with whom he celebrated happily last year his 41st wedding anniversary at Kamuela, Hawaii.

In 1922, he practiced on Molokai for one year. He then took up private practice in Honolulu, volunteering his services to the welfare of babies in Palama Settlement. He became a member of the congregation of St. Andrew's Episcopal Church, and joined the Country Club and the Honolulu County Medical Society, where he worked long and hard. He served on the Program Committee in 1934; in 1936 he was elected Treasurer, and, in successive years, Recording Secretary and Corresponding Secretary, followed by the Vice Presidency in 1939, and the Presidency in 1940. He also served on the Resolutions Committee.

In 1938, he worked on the newly formed committee on Forms of Medical Practice, on which he served through 1946; and from 1942 to 1945, the Board of Censors.

In 1949 he left Honolulu to live and work as Parker Ranch physician in the local community of Kamuela where he was also valued and loved. Here, he and Esther built a lovely home and there he lived until his terminal illness caused him to return to his home hospital, Queen's, where he died on January 3 of this year.

Hawaii is a better place to live because he gave his life to it, and he will long be remembered and appreciated by all who knew him through the long and busy years of his valuable community-dedicated life. He leaves his wife Esther; two sons, Stanley and Robert Black, both of Honolulu; five grandsons; and two sisters, Mrs. Harrington Cochran of Pasadena and Mary R. Black of Honolulu. To them we extend our heartfelt sympathy. We are proud he was one of our Hawaii Medical Association members, and of the work he did for us all.

Marie K. Faus, M.D.

The newly formed Health Facilities Planning Council includes **Drs. George Mills** and **T. Nishigaya.**

**Dr. H. M. Johnson's** talk on infectious syphilis at the HCMS meeting evoked favorable press comments.

**Drs. F. Lam, Sr.,** and **Clarence Fronk** were prominently featured doing honors to **Dr. P. Reinert,** visiting president of St. Louis University.

## Traveling Doctors

**Dr. Leo Bernstein,** business trip to Bethesda, Maryland, for session on Hill-Burton Fund Program.

**Drs. George Schnack, Edward Colby,** and **Y. T. Wong,** and Executive Secretary Lee McCaslin, attended AMA's 9th Annual Conference of Mental Health Representatives of State Medical Associations, held in Chicago.

## Interesting News

**Dr. Jerome Glaser,** Clinical Professor of Pediatrics (University of Rochester), in association with **Dr. Ruth A. Lawrence** and **Dr. Anne Harrison,** will investigate the dietary value of poi.

## Visitors

**Drs. Walter Wiggins** (Secretary, Council on Medical Education, AMA) and **Richard Young,** Dean, Northwestern University Medical School, were consultants for the local University about development of medical science education on the Manoa campus.

**Dr. William Keattle** (Professor, University of Iowa) has recently been visiting professor of obstetrics at Kapiolani Hospital.

**Dr. J. Robert Willson** (Professor, Temple University), former visiting professor, told of new plans to nip population boom.

**Dr. Derrick B. Jelliffe** (Professor, Makererie Medical School, Uganda), visiting professor at Children's Hospital in recent months, was featured as a "safari" doctor in the local papers.

**Dr. W. H. Aufrance,** USPHS, completed two weeks' study of Hawaii's usage of Federal funds. He was high in praise of Hawaii's health programs, and its "well trained and diligent" personnel.

**Dr. Harold Hodge** (University of Rochester), a leading U. S. toxicologist, considers that water fluoridation possesses the greatest guarantee of safety of any public health measure ever introduced to the American people.

## Medical Research Advances

**Dr. Fred I. Gilbert, Jr.,** was named Acting Medical Director of the Straub Medical Research Institute. Newly named to the voting membership of the Institute were **Drs. Joseph Stokes III, John J. Lowrey,** and **L. Clagett Beck,** and Mr. Fred Klebahn, Jr. A two-year grant in the amount of $12,000 was made to the Institute by the Picker Foundation for a study of thyroid disorders by **Dr. Robert Nordyke.**

## Congratulations to . . .

**Dr. Walter B. Quisenberry,** newly appointed Deputy Health Director for the State.

**Dr. Vernon K. S. Jim,** for being elected to active membership in the American Society of Plastic and Reconstructive Surgery.

**Dr. R. Varian Sloan,** new president, Kiwanis Club of Honolulu, also for receiving an award of merit from the

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## MINUTES OF THE COUNCIL MEETING

**February 13, 1963—6:00 P.M.**
**Oahu Country Club, Honolulu**

### PRESENT

Dr. Frederick L. Giles, presiding; Drs. Allison, Andrews, Benson, Burden, Lum, Miyamoto, Nishijima, Richert, Wade, and West, plus Dr. Robert G. Hunter and Mr. Howard Pearce.

### MINUTES

The minutes of the September 26, 1962, meeting were approved as published.

### UTILIZATION COMMITTEES

The Council can recommend to each county medical society that they study and develop, within their society and the staffs of the hospitals, utilization committees, so that the full efficiency of the hospitals and hospital beds can be obtained. The purpose is to cut down on hospitalization costs to insurance companies and patients. It is going to be somewhat of a policing activity.

ACTION:

**It was voted to urge each county society to develop within its organization utilization committees in the hospitals in its jurisdiction.**

### SECRETARY'S REPORT

The recommendations contained in the Secretary's report were reviewed.

ACTION:

**It was voted to approve the Secretary's Report as circulated.**

### TREASURER'S REPORT

Dr. Richert expressed regret that the anticipated revenue was insufficient to permit inclusion of the full amounts requested by the various committees and explained where the cuts had been made. His report recommended cutting the budgets of both the Health Education Committee and the Public Relations Committee and deleting the request for funds made by the Medical Care Plans and Fees Committee. It was pointed out that the Council could not legally do anything about the proposed fee survey since this project had been mandated by the House of Delegates. Dr. Hunter spoke to this point and explained how the requested budget had been arrived at, why it was necessary to conduct the survey in the manner outlined in his report, and how the results would be handled. He said the AMA recommended that the same method be used by all states. It was pointed out that the survey would do nothing to increase physicians' fees. Dr. Richert pointed out that all our present reserve funds are committed to the Mabel Smyth Building for facility improvements.

ACTION:

**It was moved and seconded that the Hawaii Medical Association appropriate the funds to carry out the fee survey as recommended by the House of Delegates and the Medical Care Plans & Fees Committee. It was moved and seconded that the motion be amended to include the provision that the money would be appropriated provided the various county and specialty societies would agree beforehand that they will accept the findings of this survey for two years without change. The amendment failed to carry. The main motion carried without amendment.**

**It was voted to advise the House of Delegates that we need a $15.00 assessment in order to remain solvent, now that funds have been appropriated for a fee survey.**

**It was voted to commend the Medical Care Plans & Fees Committee on its fine work and to pay the bills covering meals to which labor and management representatives had been invited.**

**It was voted to approve the Treasurer's Report with the deletion of the recommendation relative to the fee survey.**

### REPORTS OF STANDING COMMITTEES

*Legislative Committee Report.* It was noted that although the Legislative Committee recommended to reduce the amount of assessment to $20.00, the chairman was not in accord with this decision. Dr. Andrews advised that Maui was willing to go along with the full assessment, but the balance of the fund to be left with the Legislative Committee.

ACTION:

**It was voted that the Legislative Assessment be $22.00.**

**It was voted that the Hawaii Medical Association send out the bills and hold the county societies responsible for those who do not pay.**

**It was voted that all members be assessed the same amount.**

**It was voted that members joining after the assessment is levied have their assessment prorated on a quarterly basis.**

**It was moved and seconded to hold unexpended funds in the Legislative Committee's account for future use. The motion failed to pass. It was voted to put unexpended funds in the general fund.**

**It was voted that all assessments will become delinquent 90 days after they are levied and that the Bylaws and Parliamentary Committee be asked to insert in the bylaws a provision setting forth the date of delinquency for assessments.**

*Mental Health Committee Report.* It was noted that the Division of Mental Health was not proposed by this committee as one of the sponsoring agencies for the proposed conference. Dr. Richert asked if the money requested by the Mental Health Committee might more properly come from the Department of Health. Dr. Giles did not feel that this would be important and emphasized the importance of the Association's assuming the responsibility for its activities.

ACTION:

**It was voted to approve the Mental Health Committee's report and to recommend to them that the Division of Mental Health be listed as one of the sponsoring members of the proposed conference.**

*Health Education Committee Report.* The budget requested was reviewed. The Council felt that the request for ads in the daily papers would have to be cut out in order to conform with funds available. The Council was advised that subsequent to the compilation of this report, the committee voted to supply posters to doctors' offices

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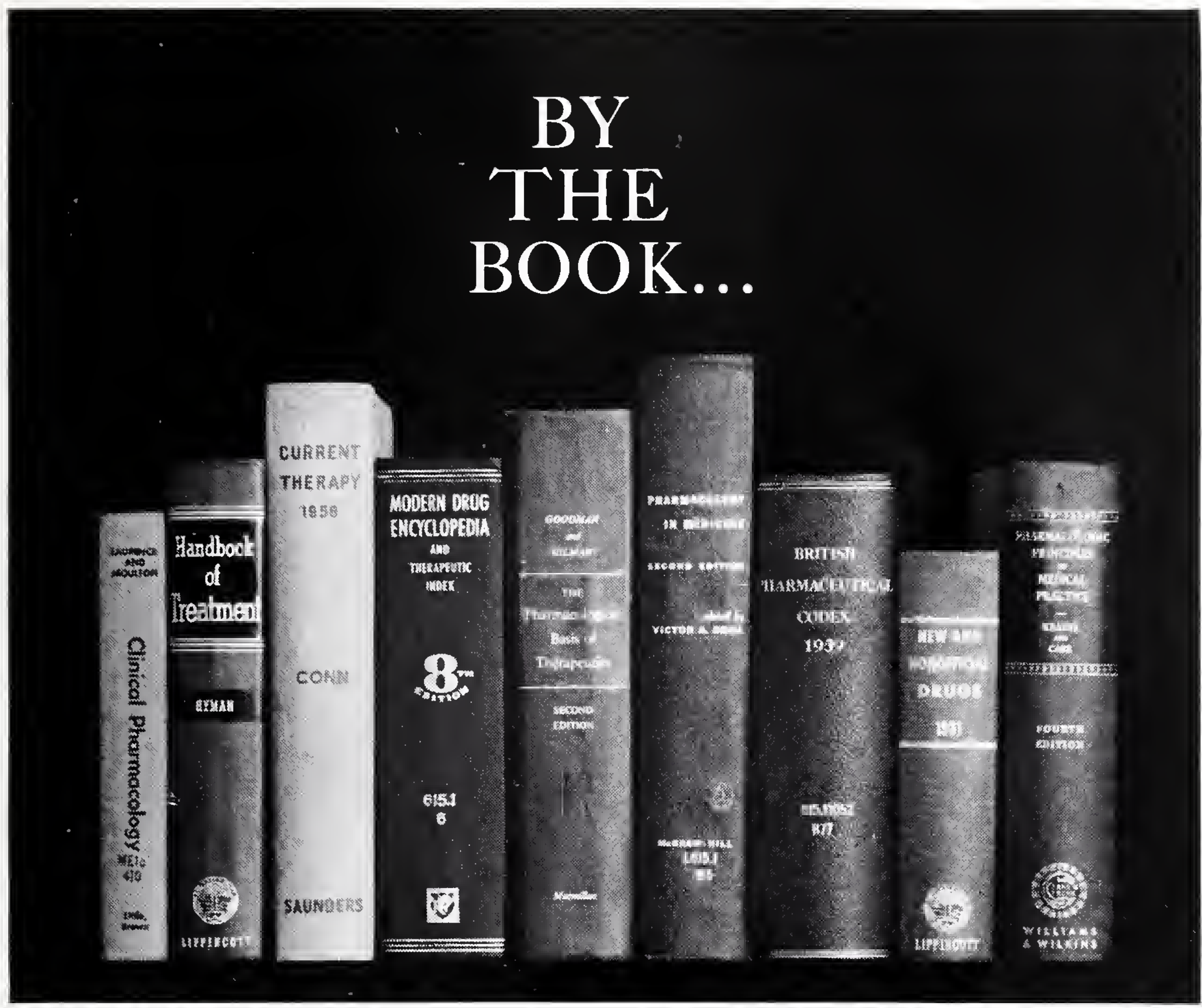



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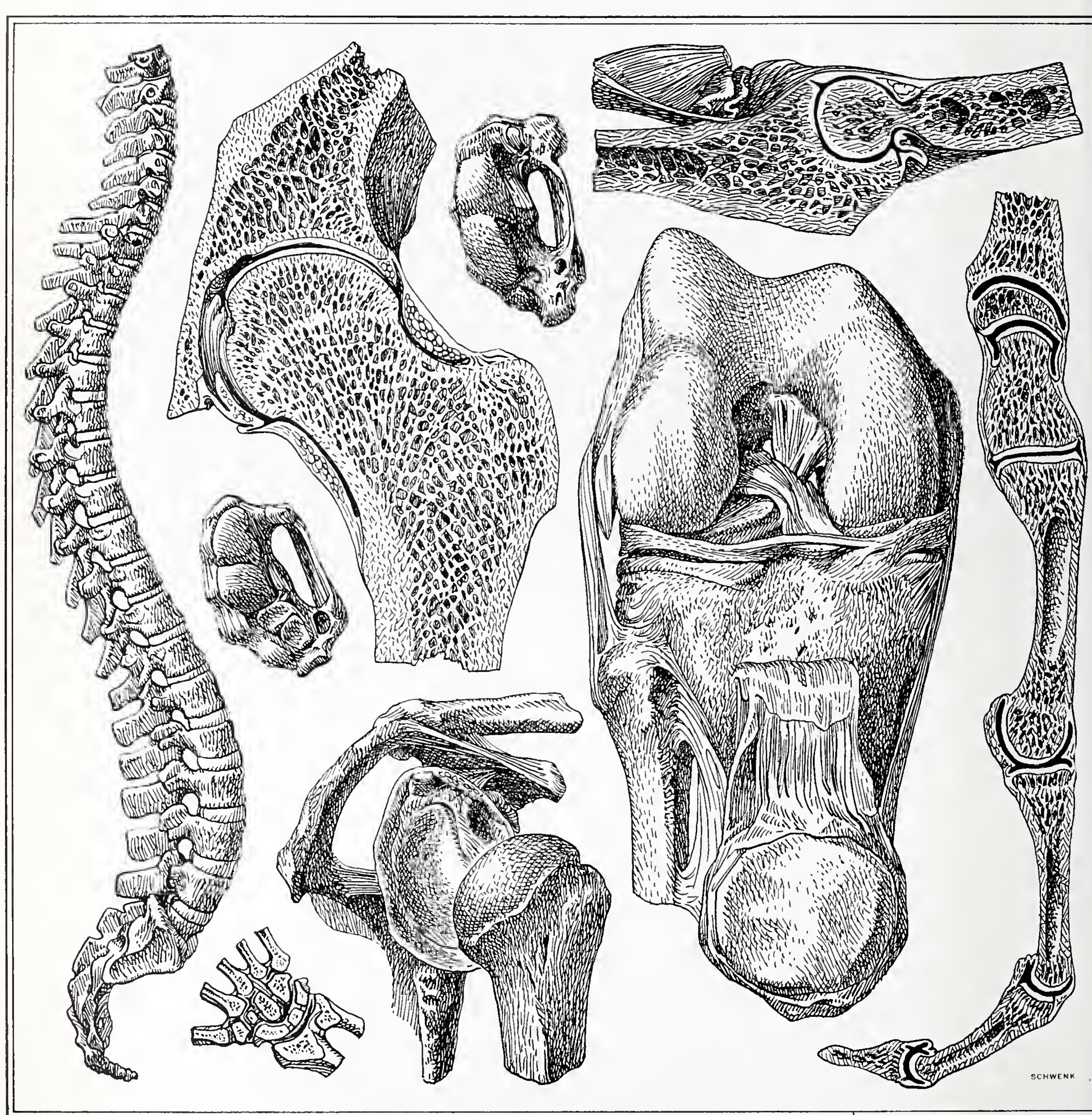
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# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

*Editor:* NELLIE CHEREVAS, St. Francis Hospital Laboratory

## *News Briefs*

The month of December was busier than usual for the Society members. The regular monthly meeting held December 17, 1962, at St. Francis Hospital was purposely different, with a little fun for the holiday season and a little serious thought for the new year and our futures. A travelogue of New Caledonia in color was presented. This was followed by an informal discussion of the stock market and investments, led by Thomas A. Jones. Armed with his chemistry major, Tommy worked for many years in industrial chemistry and developed a hydroponic tomato farm in his spare time. But the lure of the stock market became too great, and his hobby is now his work. Hampered as technologists are by salaries that have definite ceilings, the discussion on investments was appropriate. This subject is especially important for our career technologists, who may have discovered that their retirement pay doesn't meet anything more than the bare necessities of life. Moral? Plan your future —don't just let it happen haphazardly.

Our annual fund-raising drive under the able leadership of the Finance Committee chairman, Gertrude Ching, was a rousing success. See's candy was sold for the second year in a row. Because each of you is extra busy just before Christmas, it was most heartening to see the response of the members to get out and sell with just a little over a week to accomplish the task. Many thanks go to all "salesmen," to the committee, to Gertrude, and to the Blood Bank of Hawaii for its kokua.

This month also saw a new experiment by the membership committee, under the leadership and inspiration of Edith Eckstein. An invitation was sent to all technologists, members, and nonmembers to come and get acquainted with the HSMT on December 27. The affair was held in the Kam Auditorium, and refreshments were served. A good sprinkling of new faces were present to learn about our Society. The final results won't be known for some time, but an immediate result was the signing up of Frances Koiki as a new member. Welcome to the fold, Frances!

Dates to remember—May 24 and 25, 1963—HSMT Convention in Honolulu. June 17-21, 1963 —ASMT Convention in Denver.

If you are planning to attend the ASMT convention, check with your Board of Directors about the possibility of being named a delegate.

## *Voice of the Students*

The year, 1943, ushered in the first medical technology program at the University of Hawaii, and since that time 166 students have graduated. There is a great need for technologists all over America, and Hawaii is no exception. Each year, the five local training hospitals find themselves overwhelmed with mountains of work, shifting technologists and a look of centralized administration of the training program, thus impeding the progress of the teaching staff and affecting student training. Since there is an increasing demand for training military recruits, Tripler Hospital Laboratory may be unable to accommodate future University of Hawaii students. Queen's, St. Francis, Kuakini, and Kaiser (which, by the way, has just become an accredited training school) are left to carry the brunt of this year's technology students, 19 in all! With such an influx, problems will become acute and will include orientation of larger groups, improving teaching methods to cover the many recent advances, increasing fringe benefits (uniforms, meals, laundry, etc.) to help the student through the final year, which for most is financially exhausting. No one can be more aware of these difficulties than our own interns who are presently in training.

A new organization, STOCP, (Student Technologists of Clinical Pathology) is in the process of being formed by University of Hawaii students majoring in medical technology in the College of Nursing.

In the past the senior interns failed in their attempt to form a similar organization, due to indifference, not only of the students, but from the graduates who forgot that they were once students of medical technology. There were others who did much in the way of encouragement, but gave little support by way of active participation. This year's senior interns have taken the initiative of organizing STOCP which will set up a constitution based on organizing, coordinating, orienting and educating. A meeting with the underclassmen in medical technology was held February 2, to introduce them to the field of medical technology and to the local hospitals.

Med Tech underclassmen are like lost orphans. They do not know what to expect of their field of study until they discover, sometimes traumatically, what it is like during the intern year. It should be realized that medical technology is a relatively unknown field to the general public, and the only way they find out about it is to be sick in a hospital.

Most people call us nurses. "Med Tech" is but a name, even to students at the University. To them our field is "full of sciences" and "terribly hard." How do we raise our status if people don't know about our job and its significance in the medical profession?

At the present time with the increasing demand for medical technologists we should be aware of the current situation and problems in our state, especially those which would lower the quality of medical technologists educated here. An active recruitment committee and a well-planned school curriculum would be most beneficial in attracting more people to the laboratory.

This appeal is not only to the registered members here in Hawaii, but to the whole medical profession, and all those interested. There is supposedly one scholarship for this profession in Hawaii, that I know of, but currently inactive. The stipend program or scholarship program for senior interns is one of the best things that could happen, and it is of prime importance to us. The development of a better benefit program in our local hospitals would be a small step but a sincerely appreciated one, because during those 12 months of interning each student is financially in debt. St. Francis Hospital has the highest praise for its benefit program developed under Dr. Chappell. Although I am presently interning at St. Francis Hospital, I have been informed of each hospital's benefit program. To keep me up to date on developments, please call my attention to any new developments so that I may inform prospective medical technologist interns who would like to know the facts.

June Won, STOCP
*President*

## *Discovery of a Wonder Drug*

Within a few months of each other, three leading pharmaceutical houses discover three miracle drugs. On closer inspection, it appears that all three products are one and the same hormone. If you're at all curious as to how more than one name can apply to the same compound, it might be worth examining the chain of events that occurs in the making of a miracle drug.

The physiologist usually discovers it first—quite accidentally, while looking for two other hormones. He gives it a name intended to denote its function in the body, and predicts that the new compound should be useful in the treatment of a rare blood disease. From one ton of beef glands, fresh from the slaughterhouse, he finally isolates ten grams of the pure hormone, which he turns over to the physical chemist for characterization.

The physical chemist finds that 95 per cent of the physiologist's purified hormone is an impurity and that the remainder contains at least three different compounds. From one of these he successfully isolates 10 mg of the pure crystalline hormone. On the basis of its physical properties, he predicts possible structure and suggests that the function of the new compound is probably different from that assigned to it by the physiologist. He changes its name and turns it over to the organic chemist for confirmation of structure.

The organic chemist does not confirm the structure suggested by the physical chemist. Instead, he finds that it differs by only one methyl group from a new compound recently isolated from watermelon rinds, which, however, is inactive. He gives it a chemical name, accurate but too long and unwieldy for common use. The compound is therefore named after the organic chemist for brevity. He finally synthesizes 10 gm of the hormone but tells the physiologist he's sorry that he can't spare even a gram, as it is all needed for the preparation of derivatives and further structural studies. He gives him instead 10 gm of the compound isolated from watermelon rinds.

The biochemist suddenly announces that he has discovered the new hormone in the urine of pregnant sows. Since it is easily split by the crystalline enzyme which he has isolated from the salivary glands of the South American earthworm, he insists that the new compound is obviously the cofactor for vitamin $B_{16}$, whose lack accounts for the incompleteness of the pyruvic acid cycle in annelids. He changes its name.

The physiologist writes to the biochemist requesting a sample of his earthworm.

The nutritionist finds that the activity of the new compound is identical with the factor PPF which he has recently isolated from chick manure and which is essential to the production of pigment in fur-bearing mammals. Since both PPF and the new hormone contain the trace element zinc, fortification of white bread with this substance will, he assures us, lengthen the lifespan and stature of future generations. In order to indicate the compound's nutritive importance, he changes its name.

The physiologist writes to the nutritionist for a sample of PPF. Instead he receives one pound of the raw material from which it is obtained.

The pharmacologist decides to study the effect of the compound on grey-haired rats. He finds to his dismay that they lose their hair after one injection. Since this does not happen in castrated rats, he decides that the drug works synergistically with the sex hormone, testosterone, and therefore antagonizes the gonadotropic factor of the pituitary. Observing that the new compound is an excellent vasoconstrictor, the pharmacologist concludes that it should make a good nosedrop preparation. He changes its name and sends twelve bottles of nosedrops, together with a spray applicator, to the physiologist.

The clinician receives samples of the pharmacologist's product for test in patients who have head colds. He finds it mildly effective in the relief of nasal congestion, but is amazed to discover that three of his head cold sufferers, who are also the victims of a rare blood disease, have suddenly been dramatically cured. He gets the Nobel prize!

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**Tabardilho,** a type of tick typhus, is probably an analog of Rocky Mountain spotted fever, and is caused by *Rickettsia rickettsii.* The tick vectors are any of several species of amblyomma.* The natural reservoirs are the opossum, dogs, the wild rabbit, and the agouti,* a rodent about the size of a rabbit. Mortality is reported to run as high as 80%.

Usually, a lesion is found at the bite site with accompanying regional lymphadenitis.* Actual onset is abrupt with severe headache, arthralgias, myalgias, prostration, extremely high fever, and a marked leukocytosis. A distinctive rash appears about the fourth febrile day; discolorations may persist for several weeks during convalescence. The pathogen grows readily in the yolk sac of the developing chick embryo.* *Tabardilho* is effectively treated by TERRAMYCIN. **illustrated*

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## *County Society News* *continued from 305*

The January 3 meeting was held at the G. N. Wilcox Memorial Hospital library. One guest was present, Dr. Joseph Battista. Drs. Webster Boyden and Samuel R. Wallis reported on the HMSA meetings which they had attended. The Secretary was instructed to invite members of the Legislature to a dinner meeting at the Wailua Golf Course Club House. The pharmacy bill will be discussed at that time. Dr. Goodhue announced his committee appointments for 1963. The meeting ended with a discussion on unlicensed physicians.

A special meeting was held on January 14 with local members of the Legislature to discuss the Rules and Regulations the Board of Pharmacy is proposing. The legislators present recommended that a letter be written to Governor Burns requesting that he not approve the rules, which they would sign. The legislators advised that none of the hospitals on Kauai would receive a subsidy as none was appropriated at the last session. Dr. Kim spoke on the status of the Mental Hygiene Clinic. He said the County of Kauai had requested that the grounds presently being used for this Clinic be returned to the County, but he would remodel the men's dormitory at Samuel Mahelona for reestablishing the outpatient mental hygiene clinic if funds were made available. Representative Fernandes recommended that this item be included in next year's Mahelona Budget. It was noted that $300,000 was appropriated in 1959 for the Kapaa Health Center but that this money was channeled off for other projects. Dr. Goodhue reported that he is recommending nominees for the HMSA Board of Directors. It was voted to assess each member $200 for 1963.

At the February 5 meeting Dr. Cockett advised that the letter written to Governor Burns as the result of the action taken on pharmacy had not been answered. The payment of $3,015.14 to cover the cost of the vaccine in Operation Swallow was approved. Dr. Goodhue reappointed Dr. Brennecke to the HMA Medical Care Plans & Fees Committee. Dr. Kim was elected HMA delegate and Dr. Fujii, alternate. Transfer of credentials of Dr. Yonemichi Miyashira from Honolulu County was requested. A letter from the Cancer Society advised that Drs. Day, Cooney and Macdonald would be available as speakers but funds were available only for two. One will be invited to the meeting on May 6. It was voted to give Sabin I and II vaccine at the various health centers to those who have not received it. The time and dates will be specified by Dr. Kim. It was voted to allow the Secretary $10.00 a month and to make him pay annual dues and assessments. The cost of direct broadcasts from Queen's was discussed. It was felt that it would be more economical if the conferences were made available on tape. In reply to a letter from Dr. Stokes it was voted that Dr. Wilkins would be invited to speak to the Society. In reply to a request from the Cancer Society it was decided that films may be shown to high school students on a voluntary basis, after the mothers had approved of them.

### Maui

The annual meeting was held on December 17 at the Central Maui Memorial Hospital's nurses' quarters in conjunction with the Woman's Auxiliary. It was noted that the minutes of the last meeting should be corrected to read "Dr. Burden in discussing Workmen's Compensation Fees suggested that the Society write a letter to the Workmen's Compensation Group reaffirming that the initial visit charge is $10." After the Treasurer made his annual report the meeting was turned over to the new president, Dr. William E. Iaconetti.

At the January 11 meeting the resignation of Dr. Wolfgang Pfaeltzer as Secretary-Treasurer was accepted and Dr. James F. Fleming was elected to succeed him. The dues for 1963 were set at $138.50 and it was decided that if the Society needed more money a special assessment would be made. ■

## *Book Reviews* *continued from 302*

recurrent rate of rheumatic fever was 2.9 per 1,000 where penicillin was given on indication only and 6.6 per 1,000 where continuous prophylaxis was given. Another departure from the usual was her short term treatment of rheumatic fever with steroids. The average duration of treatment was seven days and the drug stopped abruptly. The earlier the treatment was started at the onset of rheumatic fever, the better the results, and the less chance there was of a rebound phenomenon occurring. Clinical symptoms of fever and arthralgia were arrested in 24 to 72 hours, and reversal of cardiac enlargement occurred by the fourth to eighth day. Within one month, 80 percent of the murmurs disappeared.

This text should be read by anyone interested in rheumatic fever. Dr. Wilson's work, however, would have been more convincing had she used controls in evaluating her results.

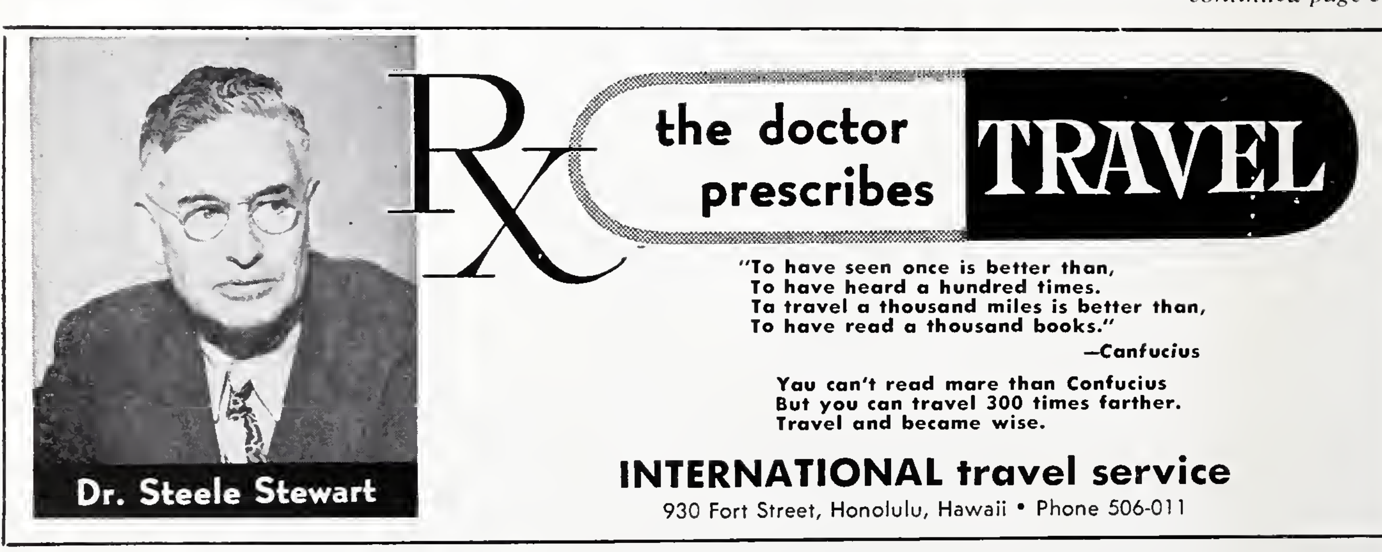
L. T. Chun, M.D.

### ★Office Procedures, 2d Ed.

*By Paul Williamson, M.D., 448 pp., $13.50, W. B. Saunders Company, 1962.*

This might well be subtitled "Every Man His Own Consultant," or "The Doctor's Do-It-Yourself Manual." It consists of 15 sections, describing office procedures in

*continued page 318*



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almost all the specialties, from nose and throat to roentgenology, not excluding psychiatry.

The material is presented with unusual, almost deceptive, clarity and simplicity, and is liberally furnished with illustrative drawings, several to each page. I would imagine the volume would be invaluable for a lonely general practitioner in an isolated region where no specialist help was available.

I cannot help but feel it could be a dangerous book to put into the hands of a man who is not aware of his limitations. For instance, I would certainly be unhappy to submit myself to cystoscopy by a doctor whose sole qualification to do it was that he had read the admittedly clear instructions on pages 153 to 159. Perhaps I was put off at the beginning when I read (pg. 9) the suggestion that a paper clip, bent into the shape of a hook, makes a useful instrument to remove foreign bodies from a child's ear canal. I could visualize the gush of blood that might follow a sudden movement by the child.

In all fairness, however, I must admit that most of the procedures described which I felt competent to judge, were very sound. If ever you are put in the position where you can't get help, and are forced to suture a tendon, drain the anterior chamber of the eye, or catheterize a eustachian tube—and don't know how to go about it—this is the book for you.

FRANCIS D. NANCE, M.D.

### ★Underwater Medicine

*By Stanley Miles, M.D., M.Sc., D.T.M.&H., Surgeon Captain, R.N., 328 pp., $10.00, J. B. Lippincott Company, 1962.*

UNDERWATER ACTIVITIES, both sport and professional, have been greatly intensified in recent years. Many new devices have been developed which increase the underwater operator's range and depth. With this has come a considerable increase in our knowledge and the recognition of the problems and hazards of the medium.

This book presents the physical medium, its problems and its hazards, and the known physical and physiological answers, with broad scope and unusual clarity. All aspects of underwater operations are presented in sufficient detail.

It is a very fine addition to the medical library of any physician whose interests or even occasional practice may include the care of underwater swimmers.

ROBERT A. ROSE, M.D.

### ★Bray's Clinical Laboratory Methods, 6th Ed.

*By John D. Bauer, M.D., Gelson Toro, Ph.D., and Philip G. Ackermann, Ph.D., 594 pp., $10.50, The C. V. Mosby Company, 1962.*

THIS POPULAR reference text is available in most clinical laboratories throughout this country. The book has been thoroughly revised, with many new procedures added. The one striking new aspect of this book is its size. No longer the pocket-sized edition, it has expanded to the size of a standard text. This is not necessarily a disadvantage, inasmuch as the print is now larger and easier to read.

PAUL Y. TAMURA, M.D.

### ★Synopsis of Genitourinary Disease, 7th Ed.

*By Austin I. Dodson, Jr., M.D., J. Edward Hill, M.D., 384 pp., $7.75, The C. V. Mosby Company, 1962.*

THIS BRIEF handbook, intended primarily for the medical student and general practitioner, covers the essentials of basic urology. Considerable space is devoted to such basic items as technic of catheterization, prostatic massage, and examination of the external genitalia. The important principles of urologic diagnosis are covered concisely, with almost no attempt at describing the more complicated procedures. The author's language is easily understood, his style readable, and the many drawings quite adequate. On the whole, this handbook deserves its place in the library of most general practitioners.

WALTER S. STRODE, M.D.

### ★Nutrition and Dietetics for Nurses

*By Mary E. Beck, 224 pp., $5.00, The Williams & Wilkins Company, 1962.*

AN UNUSUALLY clear and usable book on nutrition and dietetics. Sentences are short and many unnecessary words eliminated. However, little if any essential information is omitted. All of this is accomplished without arousing the feeling that the author is talking down to her audience. The illustrations are graphic.

Since it was written in Great Britain, the author uses some spelling which is unfamiliar; i.e., anaemia, toxaemia. On the whole the diets described are in agreement with those used today in the United States. Brand names differ but all such products are described. Where there are variations in food supply and food habits, the instructor using this book as a text can readily supplement with information which does apply locally. In Hawaii this is necessary even with texts written in the United States. For Hawaii, you can substitute papaya for rosehip syrup.

MARJORIE ABEL

### ★Medical Residents Manual

*By Frank B. Flood, M.D., Richard J. Kennedy, M.D., and William J. Grace, M.D., 311 pp., $4.95, Appleton-Century-Crofts, 1962.*

ALONG WITH the expansion of residency training programs has come a flood of manuals containing facts and technical data which the well-informed resident needs from day to day—a kind of pocket memory. Almost every large teaching institution prints such a manual for "home consumption," and some of the more elaborate of these have been printed by publishing companies of wider circulation.

*continued page 320*

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This manual by Flood, Kennedy, and Grace falls into this category. It is remarkably comprehensive; in essence, it is an abbreviated textbook of internal medicine. In addition to the usual advice on how to prepare patients for barium enemas and the like, it contains a great many facts and figures regarding differential diagnosis and treatment of most diseases to be found on the wards and in the clinics of teaching hospitals, which in house staff vernacular is referred to as a "string of pearls." Most of the information printed on its 311 pocket-sized pages is true. and much of it could help a medical resident. I was particularly impressed by the skill with which the authors have compressed the current practice of internal medicine into a little more than 300 readable pages. Many of the sections have well-documented bibliographies as well.

My chief objection is that the authors have done too good a job and have diluted the technical facts better carried in the resident's pocket than in his temporal lobe with information best suited for a textbook of medicine. They have succumbed to the temptation to reprint Cecil and Loeb on the head of a pin and have, therefore, run the risk that this book will be used as a bible rather than as a manual.

Nevertheless, I cannot help liking the book, and can recommend it as a good investment for any resident who is starting his training in internal medicine, just as long as he remembers to use the entire library as well.

JOSEPH STOKES III, M.D.

### ★The Hemorrhagic Disorders, 2d Ed.

*By Mario Stefanini, M.D., and William Dameshek, M.D., 614 pp., $21.50, Grune & Stratton, 1962.*

THIS IS one of the most confused subjects in the field of medicine but the authors have done an excellent job of putting it together. The material is up to date (as of May 1962). The first 76 pages (compared to 43 pages in the first edition—1955) deal with normal hemostasis and the authors have given a detailed account of this with tremendous effort expended and interest projected to the reader. There are over 1,500 references. Another of the excellent features of this text is the frequent use of diagrams and illustrations which are very helpful to the reader.

Criticisms are few. The omission of the excellent treatises on fibrinolysis by Dr. Sol Sherry and his workers is unfortunate. The management of thrombocytopenic states has always stirred up the experts from different centers. The reader should keep an "open mind" with reference to long term steroid therapy vs. early splenectomy.

This is an excellent book to be used as a reference by all practicing physicians. To the more sophisticated, whose interests in hematology are greater, this book should be interesting reading.

NOBORU OISHI, M.D.

### ★Cancer

*By Lauren V. Ackerman, M.D., and Juan A. del Regato, M.D., 3rd Ed., 1,296 pp., $29.50, C. V. Mosby, 1962.*

THE THIRD edition of this treatise has been enlarged to 1,296 pages, including the index. The format is much as previously although the print appears a little larger. Physically the book is well put together and it is easy to read.

The chapter on "Surgery of Cancer" has been replaced by one entitled "Surgery and Cancer" dealing with care of patients with cancer. The chapter on Radiotherapy of Cancer has been retained. Cancers of the skin, respiratory and upper digestive tracts, thyroid, mediastinum, digestive tract, genito-urinary tract, male genital organs, suprarenal gland, female genital organs, mammary gland, bone, soft tissue and eye, and Hodgkin's and leukemia are dealt with in the usual extensive fashion. There is a good bibliography after each chapter and this has been brought up to date. This latter feature is perhaps really the major asset of this edition.

The book is well and clearly written. It is a must for all oncologists and pathologists, is very valuable for all internists and surgeons dealing with cancer, and is undoubtedly a useful addition to the libraries of physicians and those in ancillary fields dealing with neoplastic diseases.

W. HAROLD CIVIN, M.D.

### Electrocardiography Fundamentals and Clinical Application, 3rd Ed.

*By Louis Wolff, M.D., 351 pp., $8.50, W. B. Saunders Company, 1962.*

THIS IS the third edition of the widely used primer of electrocardiography. Students will find it useful because the author explains physiological and electrical activity of cardiac action in the simplest terms to make a lucid presentation. He has incorporated the concepts of vectorcardiography into the interpretation of electrocardiogram.

The author has divided this text into three sections: basic principles of electrocardiography, clinical application, and arrhythmias. The sections, especially the clinical arrhythmia ones, are well illustrated and discussed.

KIKUO KURAMOTO, M.D.

### Fundamentals of Nerve Blocking

*By Vincent J. Collins, M.S., M.D., with the assistance of Emery Andrew Rovenstine, M.D., 354 pp., $9.50, Lea & Febiger, 1960.*

IN PART, this relatively small volume represents the clinical approach to the treatment of pain by nerve block techniques as practiced at Bellevue Hospital. Therefore, the author has attempted a concise discussion of a multitude of diverse conditions. Of necessity, many of the important details of complex phenomena related to pain

*continued page 322*

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have been either neglected completely or only superficially touched upon. Although it is commendably put together, including chapters on the pharmacology of local anesthetics, toxicology, physiologic mechanisms of pain, etc., one cannot help but regard this work as a sort of compendium of material already in print.

The application of chemical nerve blocking for pain syndromes and diagnosis is not new. Certainly the techniques have been worked out long ago as evidenced by the author's inclusion of many illustrations from other standard references on the subject. He does, however, present a few refreshingly new diagrams with adequate explanations in the text.

This is a very readable book with a well conceived plan of organization. A few typographical errors occur, such as "familiar" and "hyperhidroses" (p. 197) rather than "familial" and "hyperhidrosis" respectively. The inclusion of a Code of Classification of Therapeutic and Diagnostic Nerve Blocks is unique and should be of value in statistical management of therapeutic results.

In summary, this volume is recommended reading for any physician interested in a rapid survey of nerve blocking as an adjunct to the treatment and diagnosis of pain problems.

George F. Parker, M.D.

### Dermatologic Differential Diagnosis

*By Thomas B. Fitzpatrick, M.D., Ph.D., and Sheldon A. Walker, M.D., 335 pp., $7.50, Year Book Medical Publishers, Inc., 1962.*

This volume is intended not as a textbook but as a practical reference aid based on a deductive diagnostic approach to skin disorders. Various dermatoses and cutaneous manifestations of systemic diseases are classified logically according to their regional predilection, configuration and morphology, and their salient clinical features are then summarized admirably in skeletal form. The careful, accurate, and rational mode of presentation is commendable and the book will undoubtedly be very helpful to the interested clinician who has some prior knowledge of cutaneous medicine. It might prove confusing, however, to the practitioner with little dermatologic experience, since many seldom seen disorders are given equal space with the ordinary dermatoses. And the recognition that a spade is a spade because it looks like a spade is a part of dermatologic diagnosis which tends to elude deductive attempts to explain it.

Michael Schiff, M.D.

### Blood Volume Dynamics

*By H. A. Davis, M.D., C.M., Ph.D., 146 pp., $7.00, Charles C. Thomas, 1962.*

This small, readable monograph presents a wealth of information concerning a topic which the surgeon, internist, anesthesiologist, and others are continually striving to master. The format is simple and the relatively new unpublished research material is reduced to terms and formulae usable by the clinician. The various tables, some of which are lengthy, are well chosen and illustrative of the author's own careful research.

All of the material follows in logical sequence with adequately informative chapter headings. It might have enhanced the clinical value of this book to have included more representative case histories. However, this is not a serious omission.

The extensive bibliography should prove useful to anyone who wishes to pursue the subject further.

George F. Parker, M.D.

### Gynecology and Obstetrics

*By John William Huffman, M.D., 1,190 pp., $28.00, W. B. Saunders Company, 1962.*

Dr. John W. Huffman has dedicated this voluminous text to The Human Female and, in novel manner, has arranged the chapters chronologically in accordance with the growth and regression of the genitalia, i.e., from conception to senescence. In addition, he has undertaken the enormous task of integrating obstetrics and gynecology, and, in so doing, has necessarily omitted details of treatment, both medical and surgical. Admittedly, however, his primary aim has been to answer two questions about the normal and abnormal changes which occur in the female genitalia during life: what happens to them, and why does it happen?

General students of medicine will find this book a handy reference that is easy to read. Specialists in the field will find this text fairly up to date on certain subjects. The original illustrations are well done and the references at the end of each chapter are as complete as one can expect in a text of this size.

Francis Terada, M.D.

## Also Received

### Expanding Goals of Genetics in Psychiatry

*Franz J. Kallmann, M.D., Editor, 275 pp., $6.75, Grune & Stratton, 1962.*

Symposium held October, 1961, by 39 essayists. Valuable but deep.

### Ciba Foundation Symposium on Pulmonary Structure and Function

*A. V. S. deReuck, M.Sc., D.I.C., A.R.C.S., and Maeve O'Connor, B.A., Editors, 403 pp., $11.50, Little, Brown and Company, 1962.*

Twenty papers by 20 internationally known medical

*continued page 324*


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**Matlin, E.: The Obvious in Obesity, Clin. Med. 8:1071 (June) 1961.*

FORMULA: Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of 'Dexedrine' (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming]. The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

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SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetic compounds or barbiturates and in coronary or cardiovascular disease or severe hypertension.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories

*Prescribing information October 1962*

*Book Reviews* *continued from 322*

biologists and other scientists, with verbatim discussions. Indispensable to those concerned with cardiopulmonary physiology.

### ★Ciba Foundation Colloquia on Endocrinology, Vol. XIV

*G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A., Editors, 419 pp., $10.75, Little, Brown and Company, 1962.*

VERY BASIC; more about immunophysiology than most doctors could afford to know. An excellent job.

### ★Doctor and Patient and the Law

*By C. Joseph Stetler, LL.B., LL.M., and Alan R. Moritz, A.M., Sc.D., M.D., 529 pp., $14.75, The C. V. Mosby Co., 1962.*

A NEW EDITION of Louis Regan's pioneer work in this field, by a medically oriented lawyer (AMA's chief legal counsel) and a legally oriented physician (America's most distinguished forensic pathologist).

### Annals of the New York Academy of Sciences, Vol. 98, Art. 4

*William Wolf, Conference Editor, 753-1,326 pp., The New York Academy of Sciences, October, 1962.*

SERIES of 41 papers is the result of a conference on "Rhythmic Functions in the Living System" held and supported conjointly by the New York Academy of Sciences and the Foundation for the Study of Cycles, New York, November, 1961. Fifty-seven contributors.

### Ciba Foundation Study Group No. 12 on Curare and Curare-like Agents

*Edited by A. V. S. de Reuck, M. Sc., D.I.C., A.R.C.S., 103 pp., $2.95, Little, Brown and Company, 1962.*

IF YOU USE curare you ought to read this informative symposium.

### Ciba Foundation Symposium on the Exocrine Pancreas

*Edited by A. V. S. de Reuck, M. Sc., D.I.C., A.R.C.S., and Margaret P. Cameron, M.A., 390 pp., $11.50, Little Brown and Company, 1962.*

MORE ABOUT the pancreas than most doctors want to know—beautifully presented in essays and verbatim discussions.

### The Surgical Clinics of North America, Vol. 42, No. 4

*C. Frederick Fluhmann, M.D., Guest Editor, 833-1,075 pp., W. B. Saunders Company, August, 1962.*

SAN FRANCISCO number. "Progress in Gynecology and Obstetrics" by 26 contributors.

### Orthopaedic Nursing

*By Mary Powell, S.R.N., M.C.S.P., 516 pp., $8.00, The Williams and Wilkins Company, 1962.*

ORTHOPEDISTS take notice! Nurses assume a lot of responsibility in England.

### A Manual for Psychiatric Case Study, 2nd Ed.

*By Karl A. Menninger, M.D., 189 pp., $5.50, Grune & Stratton, Inc., 1962.*

PSYCHIATRIC residents would find this most useful.

*continued page 326*


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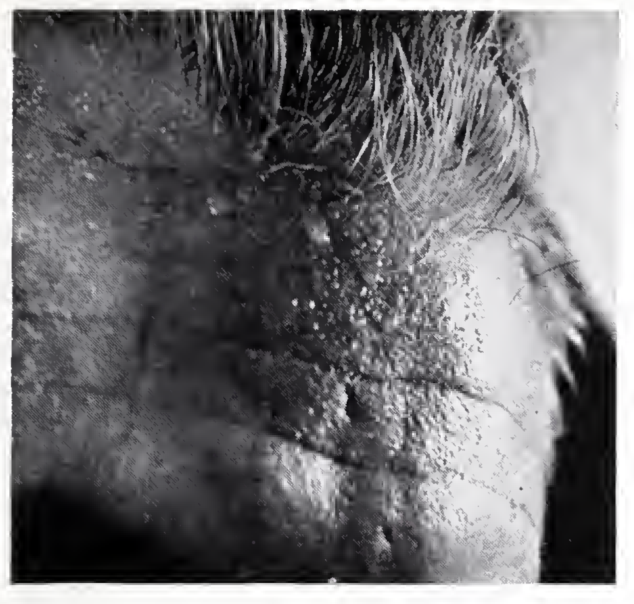

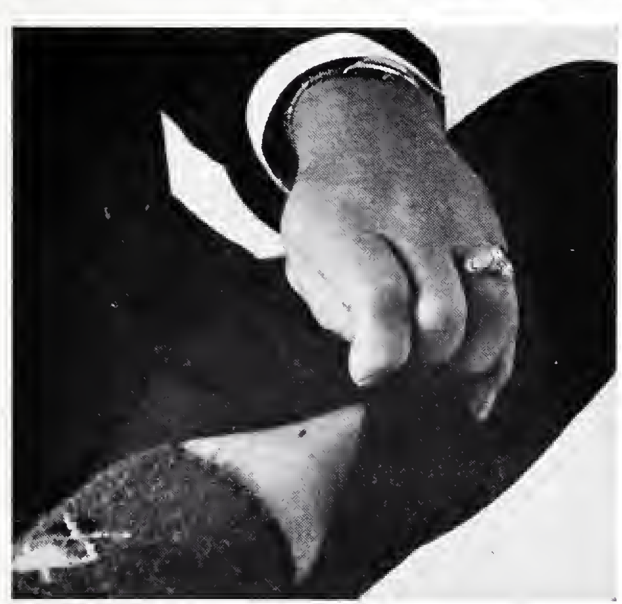
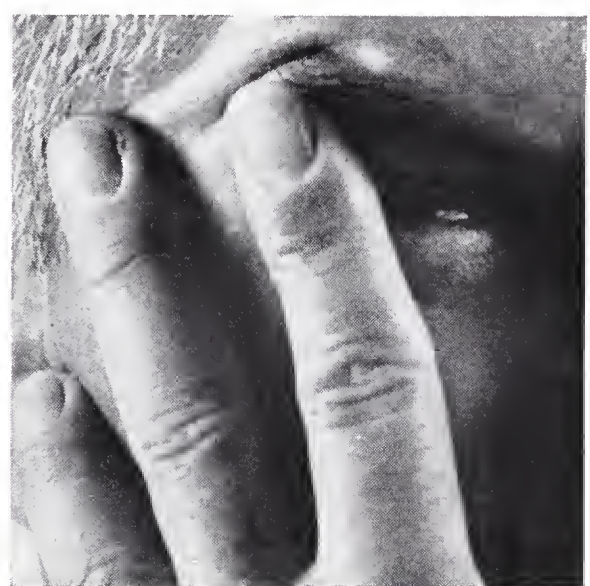

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## *Book Reviews* *continued from 324*

### Surgical Practice of the Lahey Clinic

*By members of the Staff of the Lahey Clinic, Boston, 872 pp., $17.00, W. B. Saunders Company, 1962.*

THIRD decennial republication of collected surgical reports from this justly famous institution.

### Stereoencephalotomy, Part II, Clinical and Physiological Applications

*By E. A. Spiegel, M.D., and H. T. Wycis, M.D., F.A.C.S., 504 pp., $27.00, Grune & Stratton, 1962.*

FOR NEUROSURGEONS only. Very sharp focus. A beautiful volume.

### Research Approaches to Psychiatric Problems: A Symposium

*Edited by Thomas T. Tourlentes, M.D., Seymour L. Pollack, M.D., Harold E. Himwich, M.D., 238 pp., $5.50, Grune & Stratton, Inc., 1962.*

MAGOUN'S historical account of concepts of brain organization is a fine and fascinating article. Mainly for psychiatrists.

### Heart-Lung Bypass

*By Pierre M. Galletti, M.D., Ph.D., and Gerhard A. Brecher, M.D., Ph.D., 391 pp., $14.50, Grune & Stratton, 1962.*

AN EXHAUSTIVE treatise, with abundant diagrams and 64 pages of bibliography going through April, 1961. Aimed at all members of the open heart surgery team.

### British Medical Bulletin, Vol. 18, No. 3

*R. C. Valentine, Scientific Editor, pp. 179-254, Medical Department, The British Council, September, 1962.*

A SYMPOSIUM on electron microscopy by 18 contributors.

### An Introduction to Midwifery

*By C. F. V. Smout, M.D., M.R.C.S., L.R.C.P., 119 pp., $3.50, The Williams & Wilkins Company, 1962.*

TOO ELEMENTARY for medical students, too technical for the laity, this is aimed at nurses and midwives.

### Handbook of Psychiatric Treatment in Medical Practice

*By Nathan S. Kline, M.D., F.A.C.P., and Heinz Lehmann, M.D., 124 pp., $3.50, W. B. Saunders Company, 1962.*

PRACTICAL psychiatric advice, simply phrased, for the non-psychiatrist. From Columbia and McGill.

### Primer of Clinical Measurement of Blood Pressure

*By George E. Burch, M.D., and Nicholas P. DePasquale, M.D., 141 pp., $5.50, The C. V. Mosby Company, 1962.*

ALL about blood pressure and its accurate measurement. Good bibliography, classified by subject matter.

### Progress in Radiation Therapy, Vol. 2

*Edited by Franz Buschke, M.D., 266 pp., $12.50, Grune & Stratton, Inc., 1962.*

DEEP X-RAY therapy. For radiologists. ■

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calling attention to the TV programs. The cost for 1,000 posters is $124.04. The Council decided that the committee would have to make arrangements to get this money within their budget.

ACTION:

**It was voted to approve the report of the Health Education Committee as amended.**

*Careers Committee.* Dr. Giles commented on the hard work of the Careers Committee. Dr. West expressed the hope that the committee would endeavor to secure funds from other sources for the publication of the proposed chart.

ACTION:

**It was voted to approve the Careers Committee report.**

*Diabetes Committee.* The results of the last screening program were noted.

ACTION:

**It was voted to approve the report of the Diabetes Committee.**

*Nurses Liaison Committee.* It was noted that the cost of joining the League for Nursing was only $8.00 and that the proposed standing order for Public Health Nurses had been reviewed with representatives of that group.

ACTION:

**It was voted to approve the report of the Nurses Liaison Committee.**

**It was voted to approve the standing orders for Public Health Nurses as circulated.**

*Public Relations Committee.* Dr. West asked if the Public Relations Committee funds listed in the budget represented the full $15 per capita as originally assessed. Dr. Richert spoke of the overlapping programs and expenditures among committees. Dr. Allison noted that when you add the increased allotment to the Health Education Committee, the funds for public relations would come up to the $15 increase. Dr. Lum said we were hiring a $6,000 person to effect a $650 budget. Dr. Nishijima asked if the excess funds from the Legislative Committee assessment might be used by the Public Relations Committee.

ACTION:

**It was voted that the budget as requested by the Public Relations Committee be approved and the deficit made up from general funds.**

**It was voted that the previous motion be rescinded.**

**It was voted that $1,200 of Mr. Lytle's annual salary be charged to the Legislative Committee and that this amount be removed from the budget of the Public Relations Committee.**

*Medical Care Plans & Fees Committee.* Since this report was covered in connection with the Treasurer's Report, no further discussion was asked for.

ACTION:

**It was voted to approve the report of the Medical Care Plans and Fees Committee.**

*Bylaws & Parliamentary Committee.* Dr. Allison noted the conflicts that exist between the bylaws of the HMA and those of the county societies as they relate to the election of delegates.

ACTION:

**It was voted to approve the report of the Bylaws and Parliamentary Committee.**

*Polio Committee.* Dr. Giles advised that upon receipt of information from the Surgeon General and the American Academy of Pediatrics reversing the previous stand on Type III Sabin vaccine, the Polio Committee met to review the policy set forth at its last meeting. This committee voted to recommend that Operation Swallow using Type III vaccine be scheduled if practical. Each county was contacted by telephone to determine their ideas. We still have to get in touch with Dr. Bernstein to find out how he feels in the matter. The risk was noted and Dr. Nishijima asked if we were liable if anything happens. Dr. Allison noted that the machinery for Operation Swallow has been dismantled. The public relations aspects of not going ahead with the third swallow were reviewed.

ACTION:

**It was voted to approve the recommendation of the Polio Committee.**

### UNFINISHED BUSINESS

*Contract for Public Relations Counsel.* The Council advised that the Public Relations Committee had not proceeded with this. Dr. Giles explained that he had appointed a committee of past presidents to review the executive offices, the public relations set-up, and the legislative work. This committee will make recommendations to the House of Delegates in May on what changes should be made.

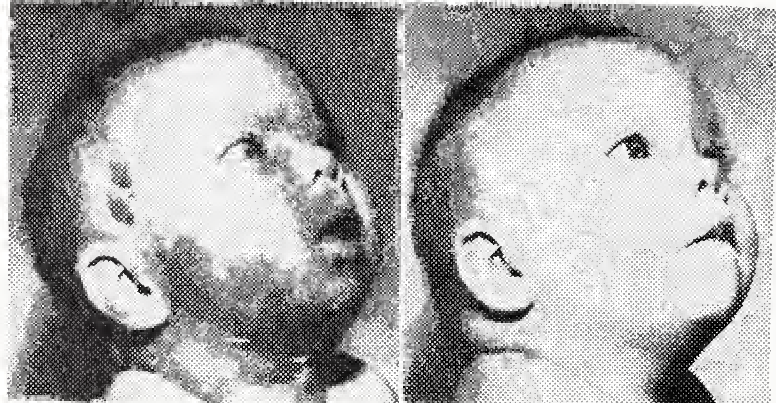
*Cancer Study.* The Council was advised that the balloting done by mail approved of the proposed study. There were ten affirmative votes, and one abstention.

*Special Meeting.* The Council was advised that the balloting done by mail approved of a special membership meeting for the presentation of the press award by a vote of nine to two.

*Official Seal.* It was noted that the Council had never

*continued page 330*

*Sympathy won't help . . .*



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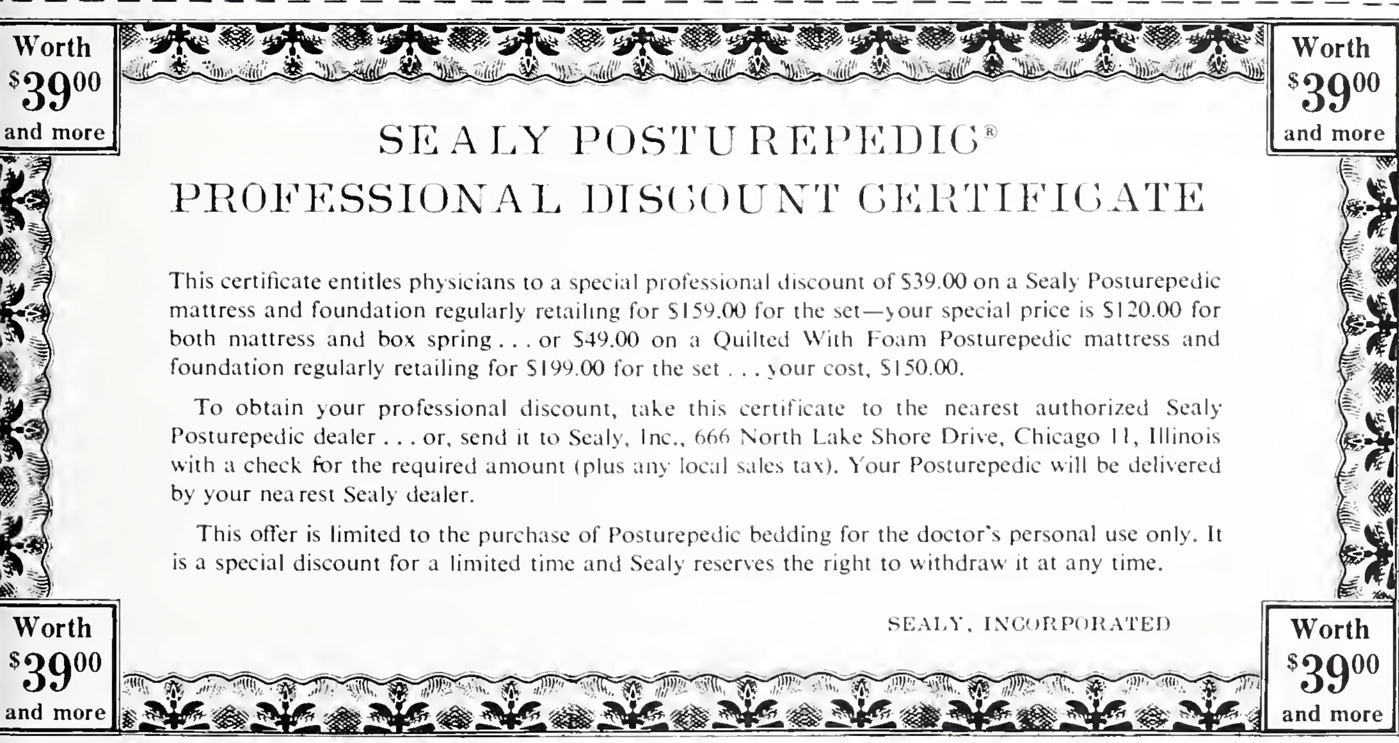

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approved of an official seal for the Association. Several years ago a preliminary sketch was submitted and this has been the basis, with minor refinements, of artwork used when a reproduction of a seal was needed. Copy of this was circulated.

**ACTION:**

**It was voted that the drawing of the seal which was circulated be approved as the official Association Seal.**

*Roster.* It was noted that many societies have rosters which include pictures and descriptive information of their members. This was brought up to the Council several years ago and was vetoed. The Council was again asked to consider publishing a roster.

**ACTION:**

**It was voted to approve the publishing of a roster of members.**

*AAPS Essay Contest.* The Council was advised that the Public Relations Committee voted not to sponsor this contest in 1963 because of the inability to get approval from the Department of Education for conducting the contest through the public schools.

**ACTION:**

**It was voted to approve the decision of the Public Relations Committee.**

*Biographical Record of Americans of Japanese Ancestry.* The Council was asked to decide whether inclusion of physicians in this roster is ethical. It was determined that no one will be included who does not pay a stipulated sum. Dr. Burden felt that there might be many reasons why physicians of Japanese ancestry might want to be included in the roster; they might want to pass it along to their children, or send copies back to Japan. Dr. Andrews thought it might look strange if no doctors were included in the roster. Dr. Nishijima said it was a matter of whether it is or isn't an advertisement.

**ACTION:**

**It was voted to disapprove inclusion of physicians in the Biographical Record of Americans of Japanese Ancestry.**

### MISCELLANEOUS BUSINESS

*FCC License.* The Council was advised that a license will be necessary in order to establish a base station for the proposed communications system to be set up in conjunction with the Physicians Exchange, and that application for license does not involve expenditure of funds.

**ACTION:**

**It was voted to allow the application for a license to be made under the Hawaii Medical Association name.**

*Kokua Samoa.* Dr. Richert advised that more physicians, and especially general practitioners, are needed in Samoa. The Samoa government will pay for first-class transportation for doctors, and their wives, as well as granting a cash food allowance and providing living quarters. Neighbor island physicians were asked to take this message back to their county societies to see if there is any one from the other islands that would like to go to Samoa for three or four weeks.

*Malpractice Insurance.* The Council was advised that there had been only one meeting on this and that nothing was available for decision at this time.

The meeting adjourned at 10:30 P.M. ■

SAMUEL D. ALLISON, M.D.
*Secretary*



that city. The couple had two sons, Francis and Howard.

In 1895, Dr. Lyman located at Madison, Wisconsin, where he conducted an extensive general practice, as well as being physician for the city and county.

In the interests of his wife's health, the doctor moved to the Islands in 1912 and located at Waimea, Kauai, in 1913, succeeding Dr. Sandow in a district which included the Kekaha Sugar Co., the Waimea Sugar Co., and the Gay and Robinson interests.

On October 21, 1917, Dr. Lyman died at Waimea at the age of 54. ■



city through Mayor Blaisdell for "leadership of Operation Swallow I and II."

**Dr. Richard Ando,** recently unanimously elected permanent Chairman of the Oahu School Advisory Council.

**Dr. Masato Hasegawa,** new Chief of Staff at Queen's Hospital. Quite a change in policy at the hospital!!

**Dr. Morton E. Berk,** State champion, Men's National Cooking Championship contest. His recipe for potato-chip–mushroom-chicken won him the title.

**Dr. C. M. Burgess,** for winning the Smithsonian Institution Award for the third time for his display of Hawaiian marine shells at the Hawaiian Malacological Society exhibit.

**Drs. Robert A. Nordyke, W. B. Quisenberry,** and **N. R. Sloan** for their recent election as Fellows of the American College of Physicians.

**Dr. M. H. Chang,** a member of the Board of Directors of the new Castle Memorial Hospital.

**Dr. Francis F. C. Wong,** who was honored for his devotion in the realm of sports by the Hilo High School Athletic Council.

**Dr. Robert H. Lee,** new President of the Lee Association of Honolulu.

## News

The Oahu Unit of the American Cancer Society has made significant contribution to the support of the new Hawaii Medical Library, which is being constructed on Punchbowl Street adjacent to the Mabel Smyth Memorial Building.

At a recent Board of Directors meeting of the Oahu Unit of the American Cancer Society, Eddie Yamasaki, Treasurer, presented Dr. Grover H. Batten, President of the Hawaii Medical Library, with the Society's check for $2,000.

The Library, which will be completed this year, is a handsome edifice designed by the prominent architect, Vladimir N. Ossipoff. The Library will house a collection of more than 30,000 volumes of medical source material. One feature of the Library will be a Periodical Room with the most definitive collection of medical journals in the State. To give some idea of the scope of this reference feature, there are already on hand 11,000 issues of periodicals for the year 1961-1962.

Dr. Batten in accepting the check said: "The completion of the Library this year will fill a long felt need in our community. The American Cancer Society's interest in the program of the Hawaii Medical Library is greatly appreciated." ■

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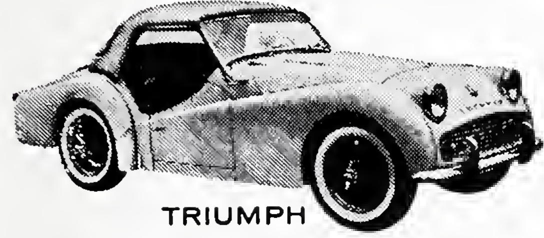


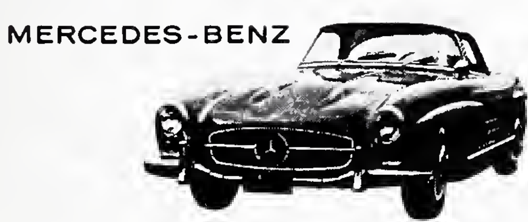


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†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

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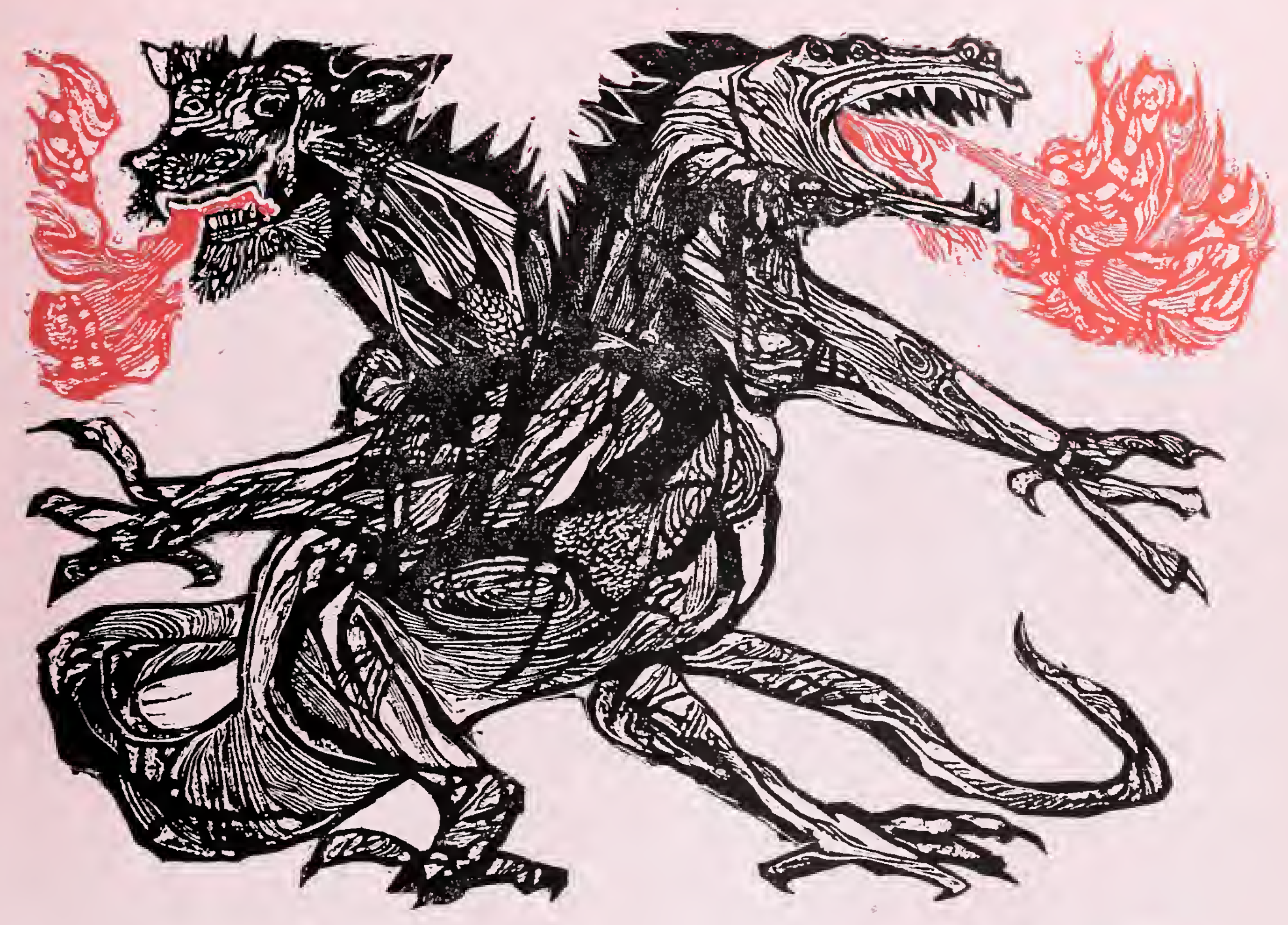

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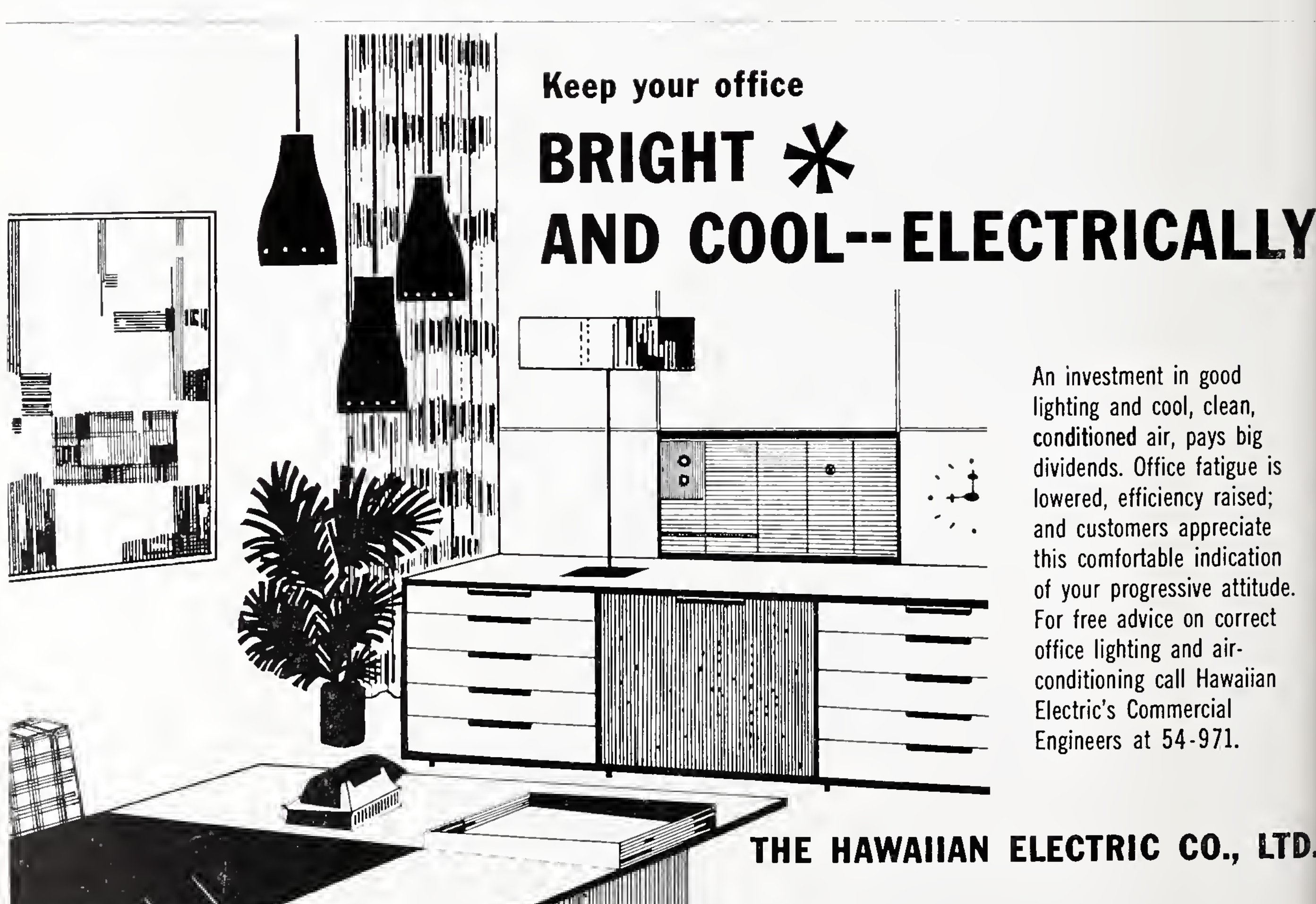

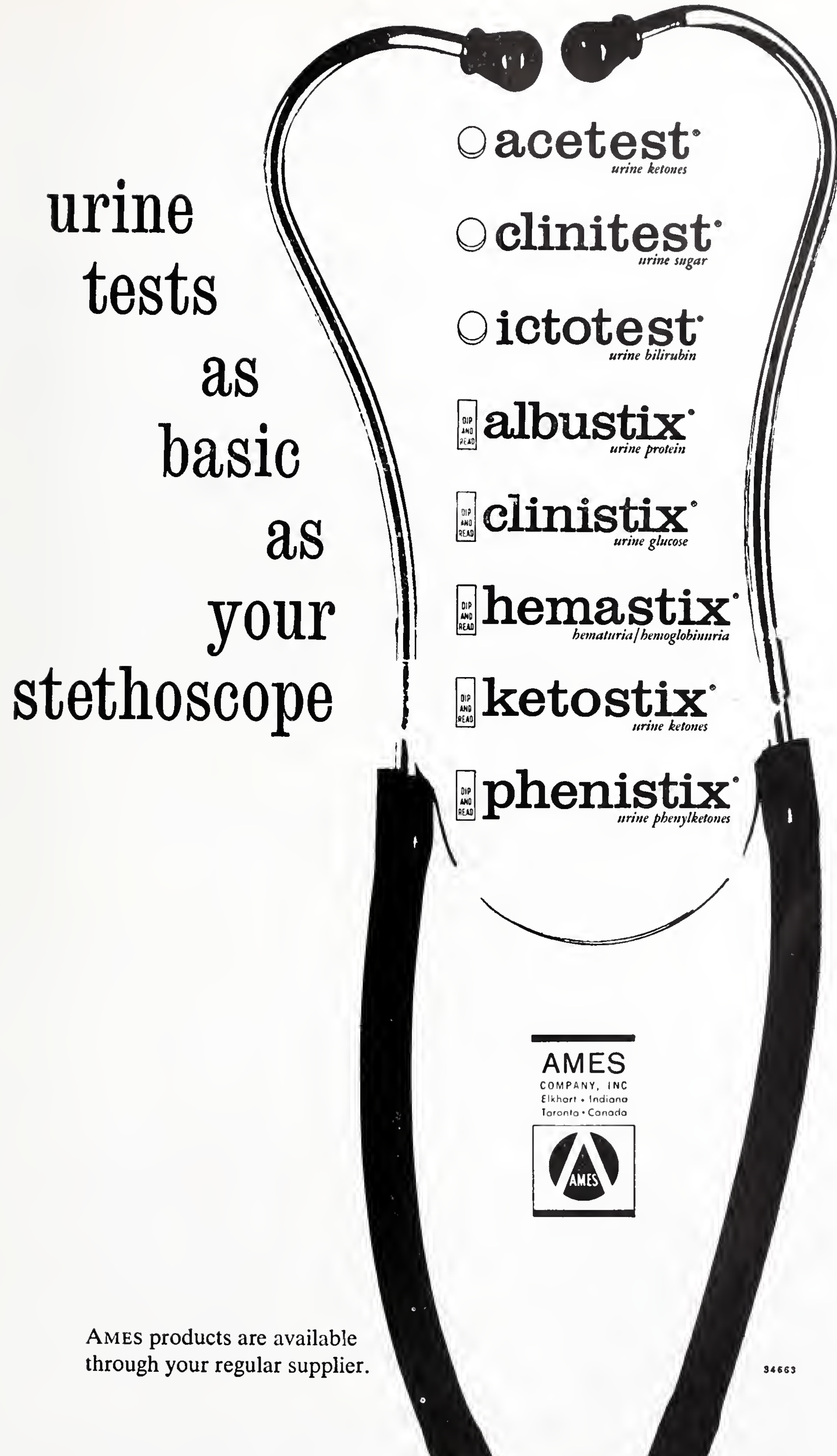
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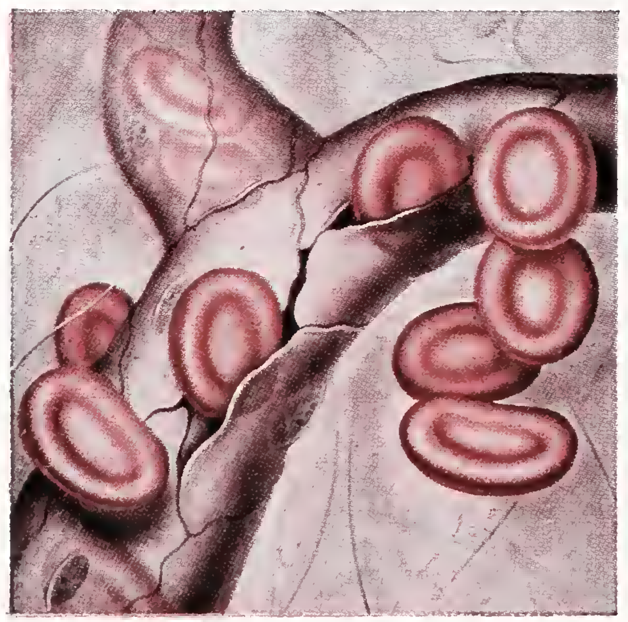
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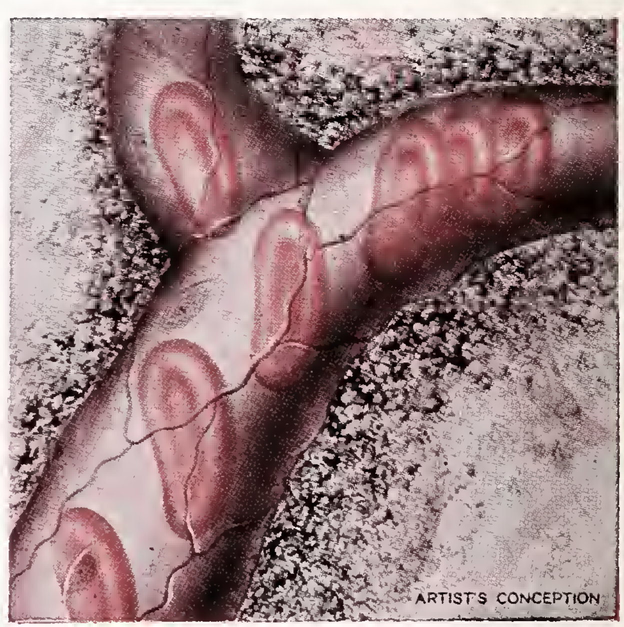

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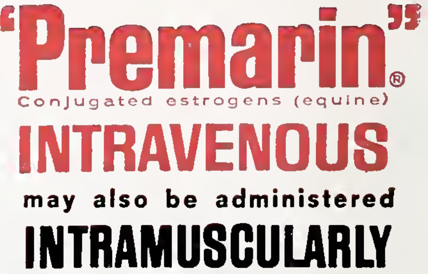


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*In this issue*

## Fish Poisoning in Hawaii

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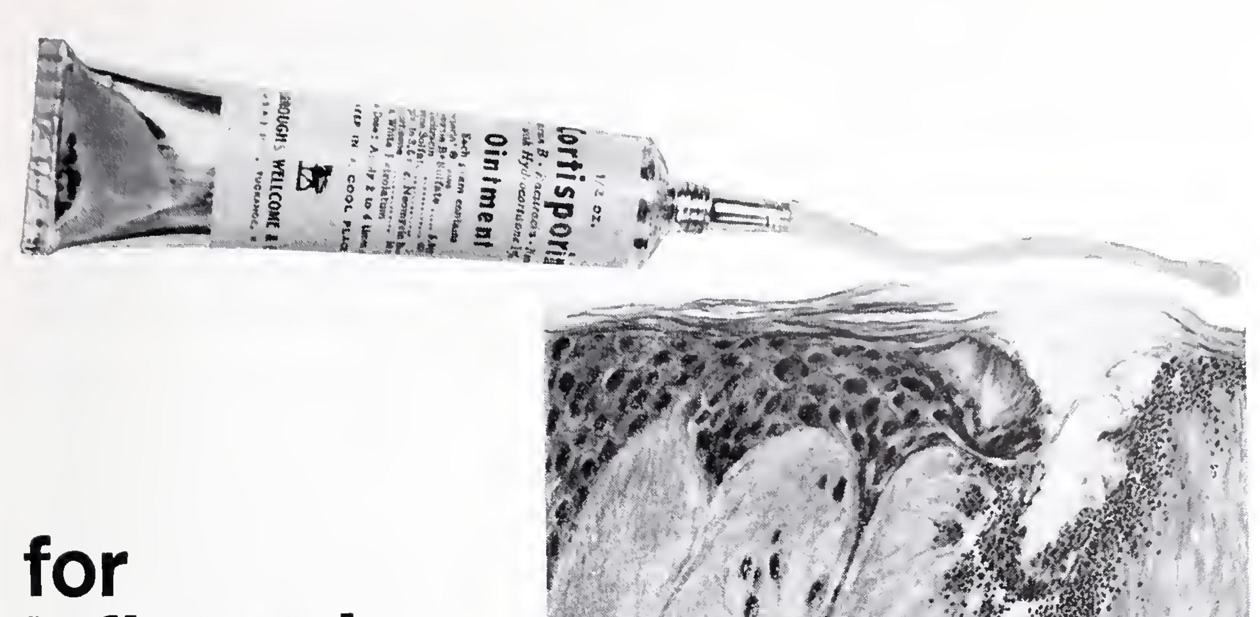

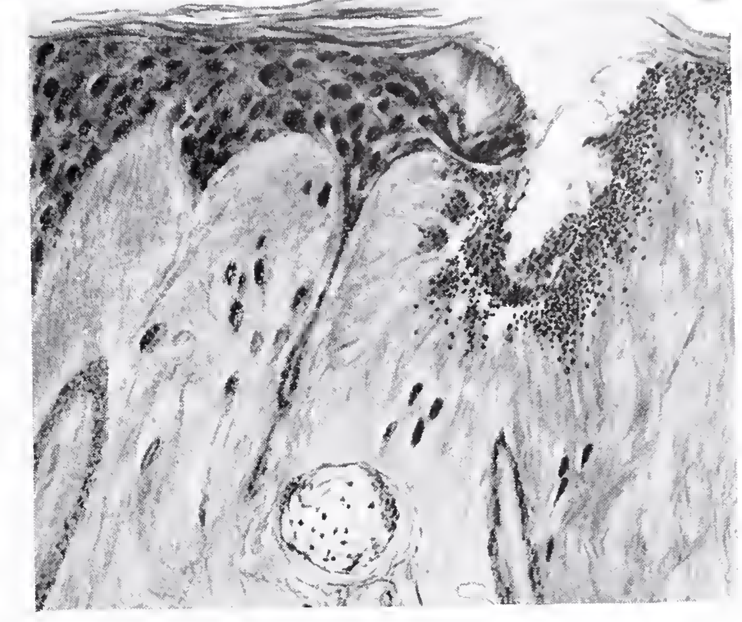

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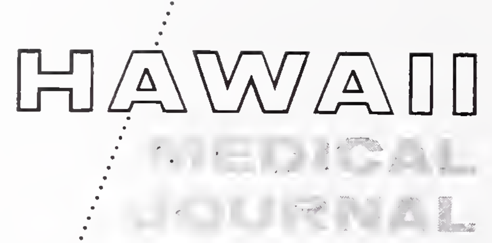


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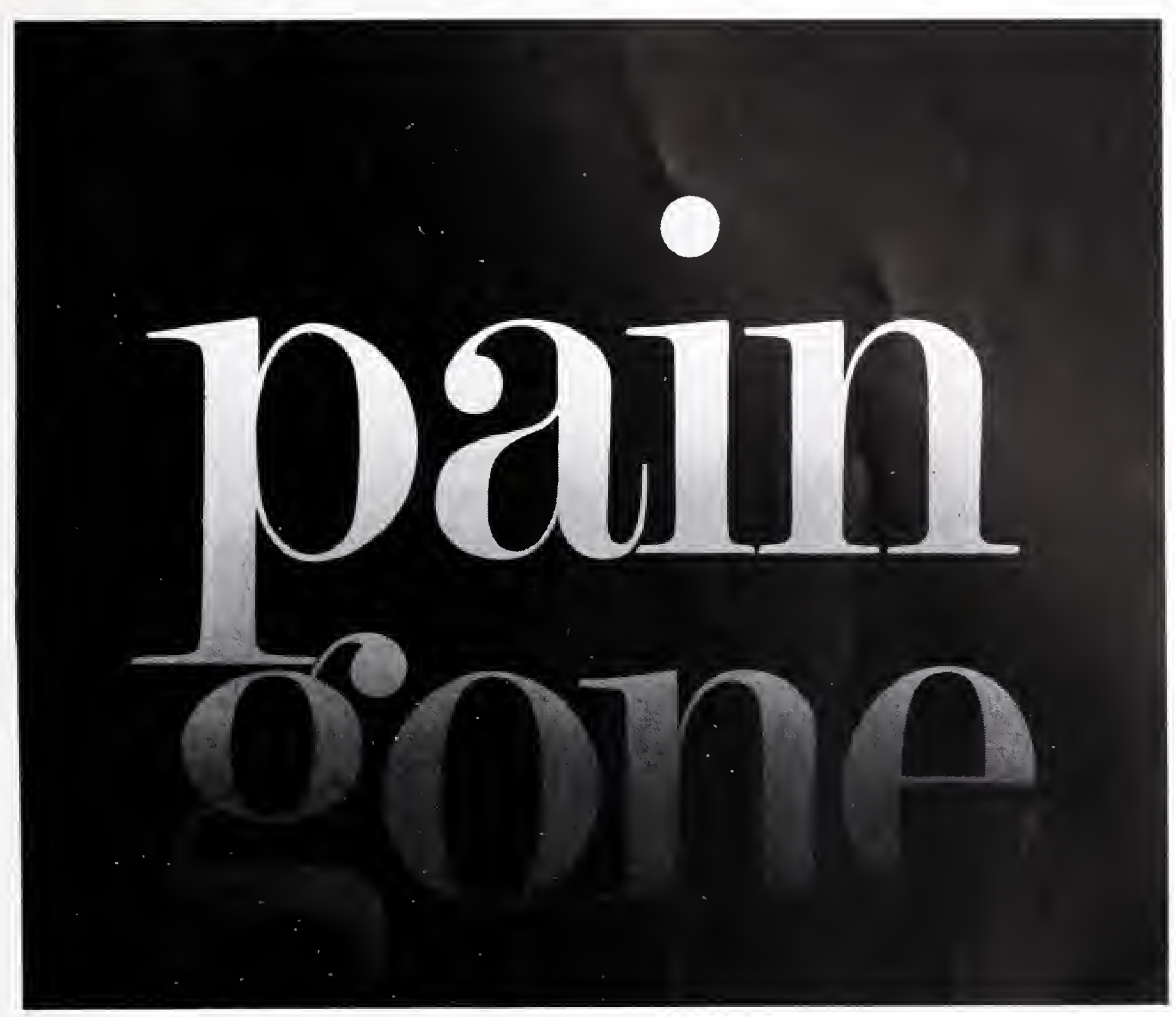


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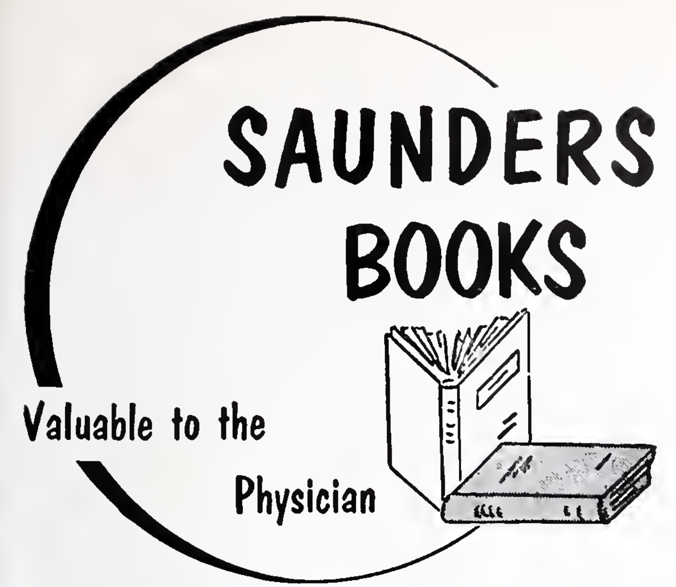


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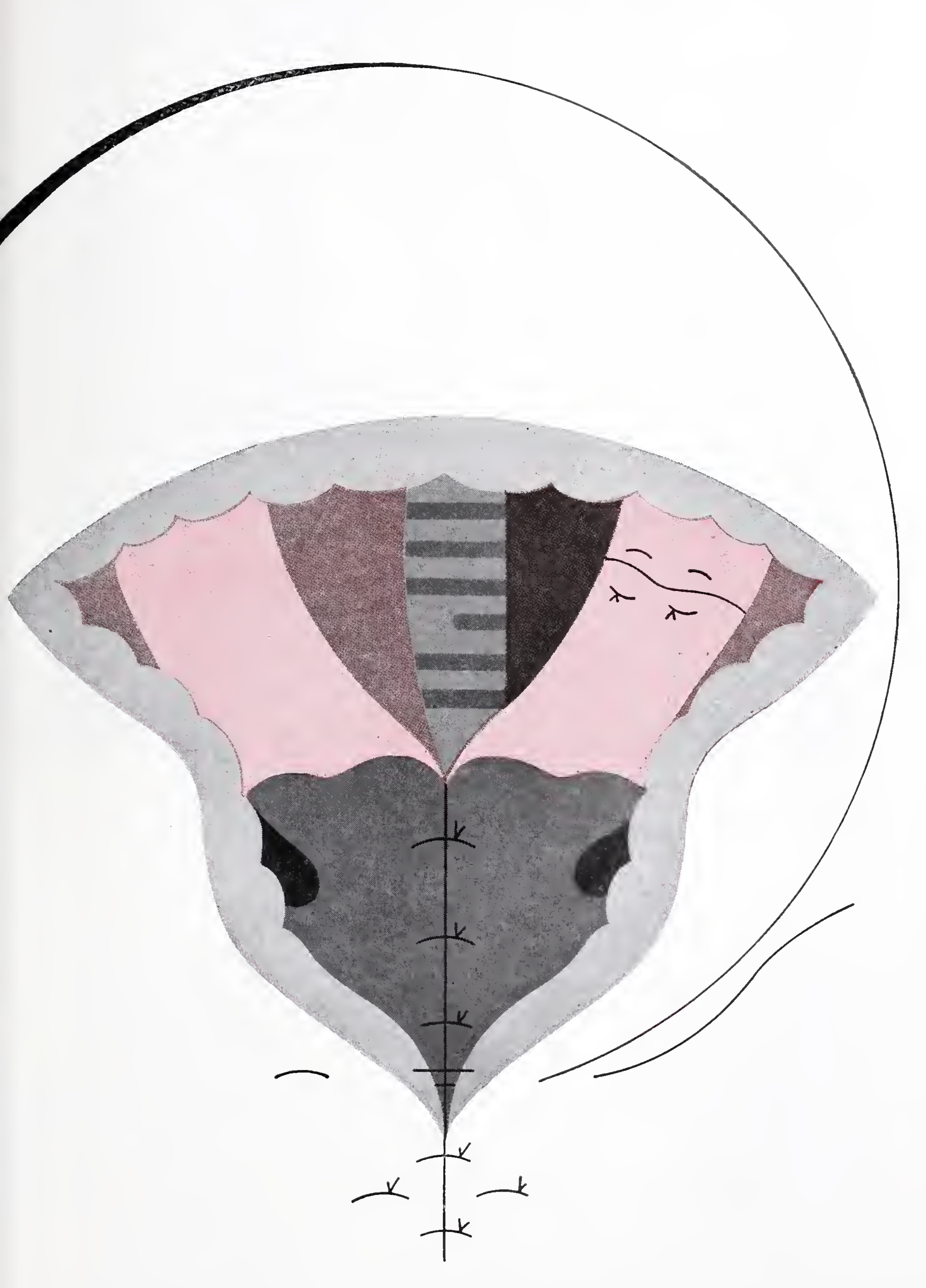

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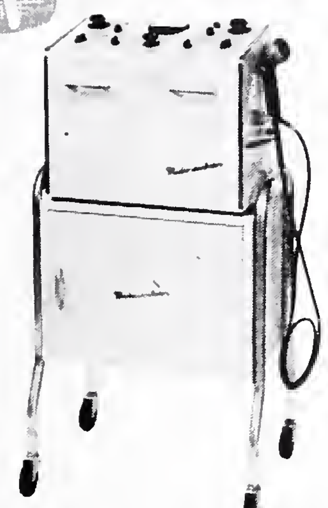

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# Reports & Snorts

England and Wales recorded 21 deaths from smallpox, 1951-1960; in the same period they had 27 deaths (mostly in infants) due to post-vaccinal encephalitis and about 20 additional deaths from other complications of vaccination against smallpox. The risk of a fatal complication was nine times higher under one year of age, than from one to four years of age. (*British Medical Journal,* Feb. 2, 1963).

• • •

*Vitamin $B_{12}$, as most doctors know, has been thought to be helpful in psoriasis; Sneddon at the Royal Infirmary in Sheffield found it cleared 43.7% of a series of 16 cases. The only trouble is that an inert placebo, similarly administered, cleared up the same number (7) of a series of 17 patients. Conclusion: vitamin $B_{12}$ does not increase the anti-psoriatic activity of the liquid in which it is dissolved.*

• • •

**The new edition of Cheatle and Cutler's *Tumors of the Breast*, by the surviving author, Max Cutler (an old friend of many in Hawaii), has been highly praised in a review by Hedley Atkins, in the *British Medical Journal*.**

• • •

Bradykinin (kallidin) seems so far to have five actions: smooth muscle stimulation, vasodilatation, increase of capillary permeability, attraction of leucocytes, and production of pain. It is released, probably from kininogen in plasma protein, by its own specific kallikrein, one of a group of enzymes which may be both species- and organ-specific. It seems so far to be every bit as important as histamine, and only a little more mysterious. (*Ann. New York Acad. Sci.* 104:1-464 [Feb. 4] 1963)

• • •

**A correspondent of John Ciardi's in *Saturday Review* offers a reassuring maxim, in case you wondered whether an electric toothbrush might damage your teeth. It isn't apt to. Tooth is stronger than friction!**

• • •

*"Is it not time that we matured sufficiently as a people to assert once and for all that the sexual purposes of human beings and their reproductive consequences are not the business of the state, but rather free decisions to be made by husband and wife?"*—RABBI ISRAEL MARGOLIES (1962).

The question is rhetorical; the answer is "Yes." Neither the law nor a physician should be responsible for deciding whether an abortion should or should not be performed. It is the potential parents' business.

**A monastery was eking out its slender income with a fish-and-chips shop, and a customer one day asked the "father" in charge, "Tell me, are you the fish friar?" "Oh, no," replied the priest. "I'm the chip monk."**

• • •

The orthodox view of the inheritance of disease is a negative view. It says that some genes are dominant and some are recessive, and that to inherit a disease you must receive the gene for it from at least one parent if the gene is dominant, but from both parents if the gene is recessive.

It seems simpler and more logical to take a positive view: that every gene is a dominant gene, and you either do have it, or you don't: if it is a disease-producing gene, and you have it, you have the disease. The "recessive" side of the picture is represented in this view simply by the absence of the gene in question—or, perhaps more accurately, its presence only in a defective, ineffective form.

Thus if you *have* the gene for normal color vision, you don't have color blindness; if you don't you do: it's the *lack* of the proper gene that does the dirty work, not the "possession" of a pair of recessive genes (or in this case, since it's sex-linked, *a* recessive gene) *for* the disease.

So if a disease is transmitted by a gene, the pattern of its inheritance is dominant—you can *get* a given gene from *either* parent, and it will do its job in you. But if it's transmitted by *lack* (or defect) of a gene; if you have it because you *don't* have a particular gene; then the pattern of its inheritance is recessive—you have to *not* get a gene from *both* parents.

• • •

**Somebody told Herb Caen, and he passed it on, that one of the worst things about being a nondrinker is that when you wake up in the morning, you know that's as good as you're going to feel all day.**

• • •

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1. Prescribing Supplements of Dietary Fluorides, Council of Dental Therapeutics, J.A.D.A., 56:591, April, 1958.
2. Fluoride Compounds, Accepted Dental Remedies, 27th Ed.:139, 1962.

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*References:* (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (4) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (5) Feldman, L. H.: North Carolina M. J. *23*:248 (June) 1962.

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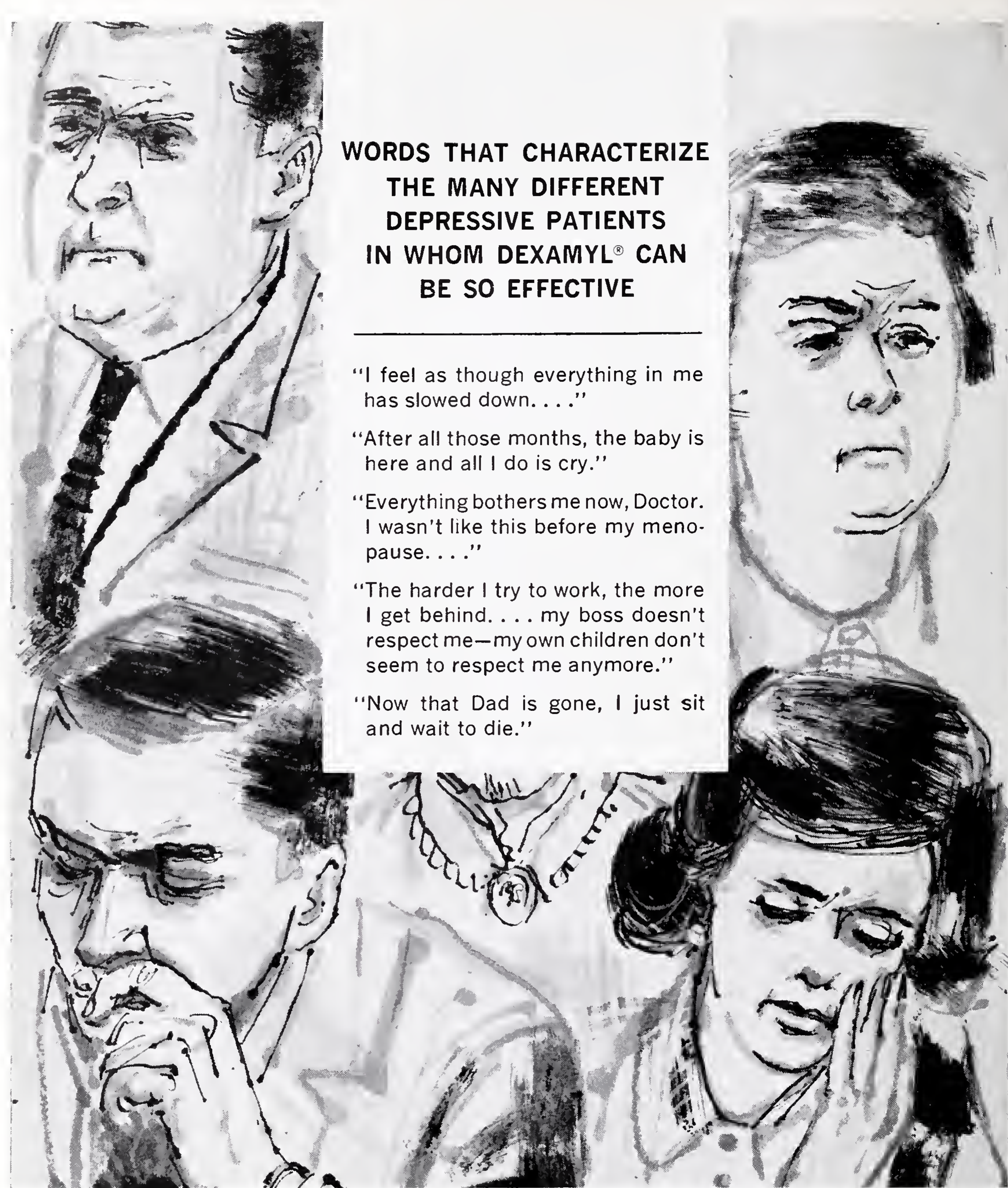


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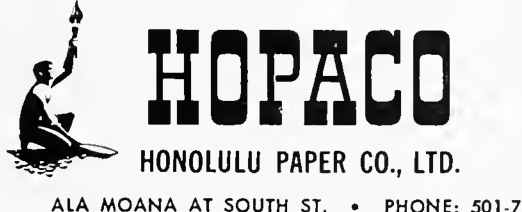


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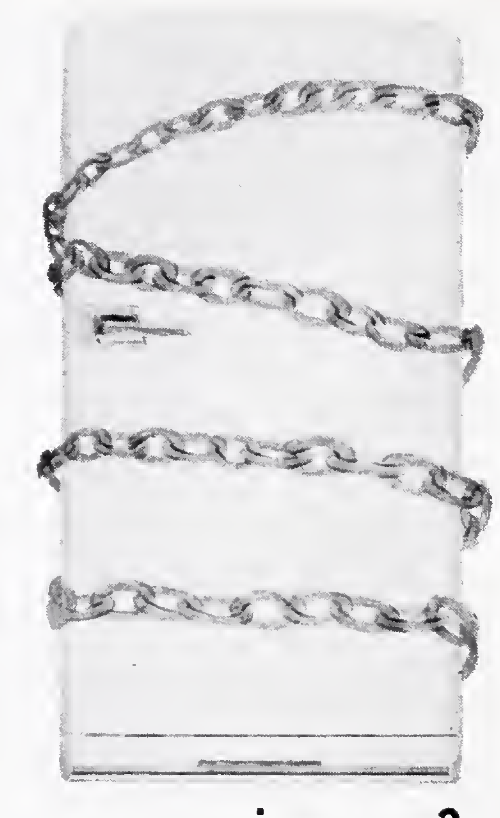

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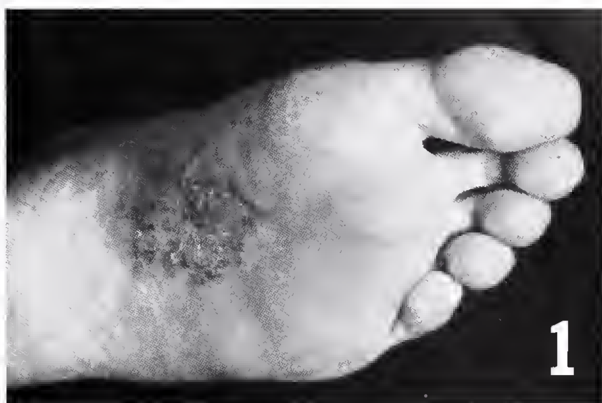
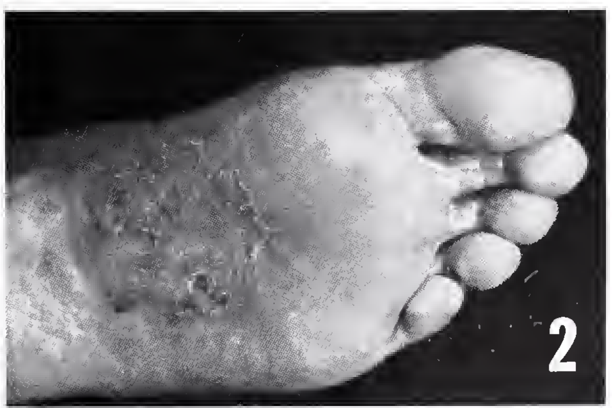
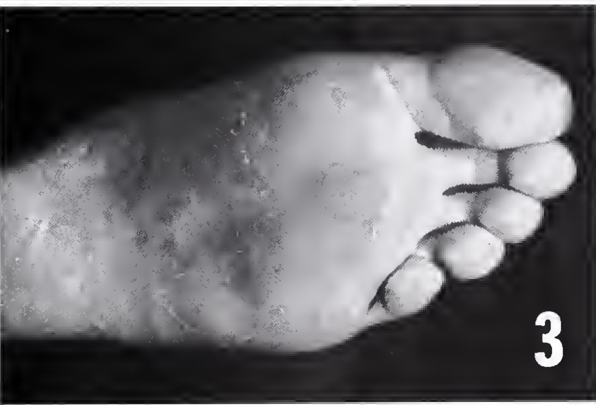
The patient was started on 0.5 gm. Fulvicin-u/f (griseofulvin, *ultra-fine*) daily. Three weeks later there was distinct improvement with only mild erythema and scaling present. After one additional week, therapy was discontinued and a second culture was negative. The patient was last seen on December 24, approximately three weeks after termination of therapy. At this time the skin was entirely normal in appearance.




**1** Plantar tinea pedis before therapy.
**2** After two weeks of therapy.
**3** Six weeks later, skin essentially normal (two weeks after termination of therapy).

***Clinical considerations:*** Although clinical studies with griseofulvin have not revealed evidence of serious toxicity, ***side effects***—as with any potent drug or antibiotic—may occur in some patients. An occasional minor decrease in leukocyte count has been observed, which was reversible when medication was discontinued. Occasionally, there may be heartburn, nausea, epigastric discomfort, diarrhea, lethargy, fatigue, psychomotor incoordination and, during the first week of therapy, headache. Studies are in progress to determine the safety of this drug during pregnancy; until the results of these studies are available, griseofulvin is contraindicated during pregnancy. ***Caution*** should be observed in patients with known penicillin-sensitivity. Should urticaria or drug rash develop, the drug should be withdrawn. ***Available*** in 125 mg., 250 mg. and 500 mg. scored tablets, bottles of 60 and 250.

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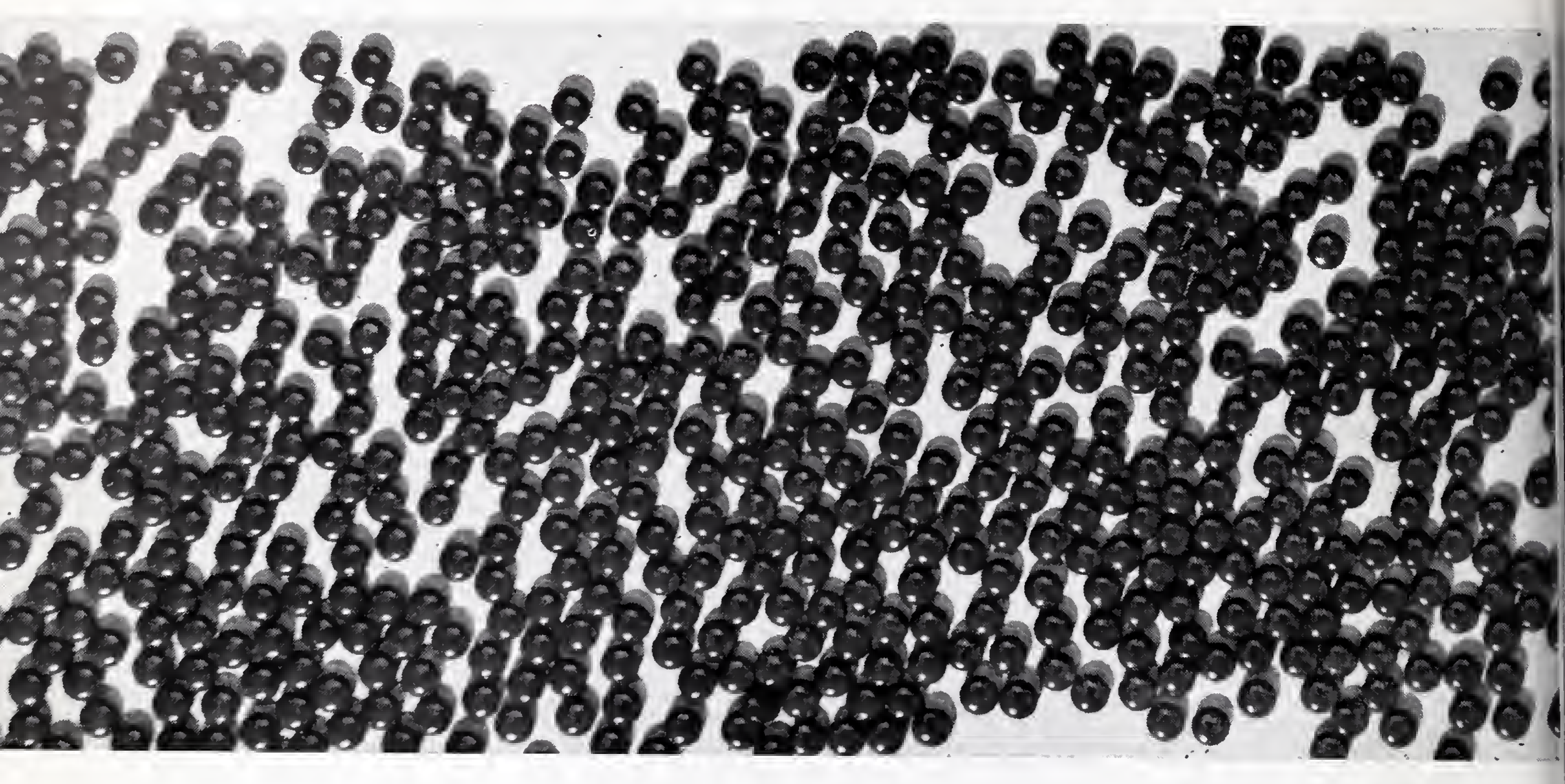
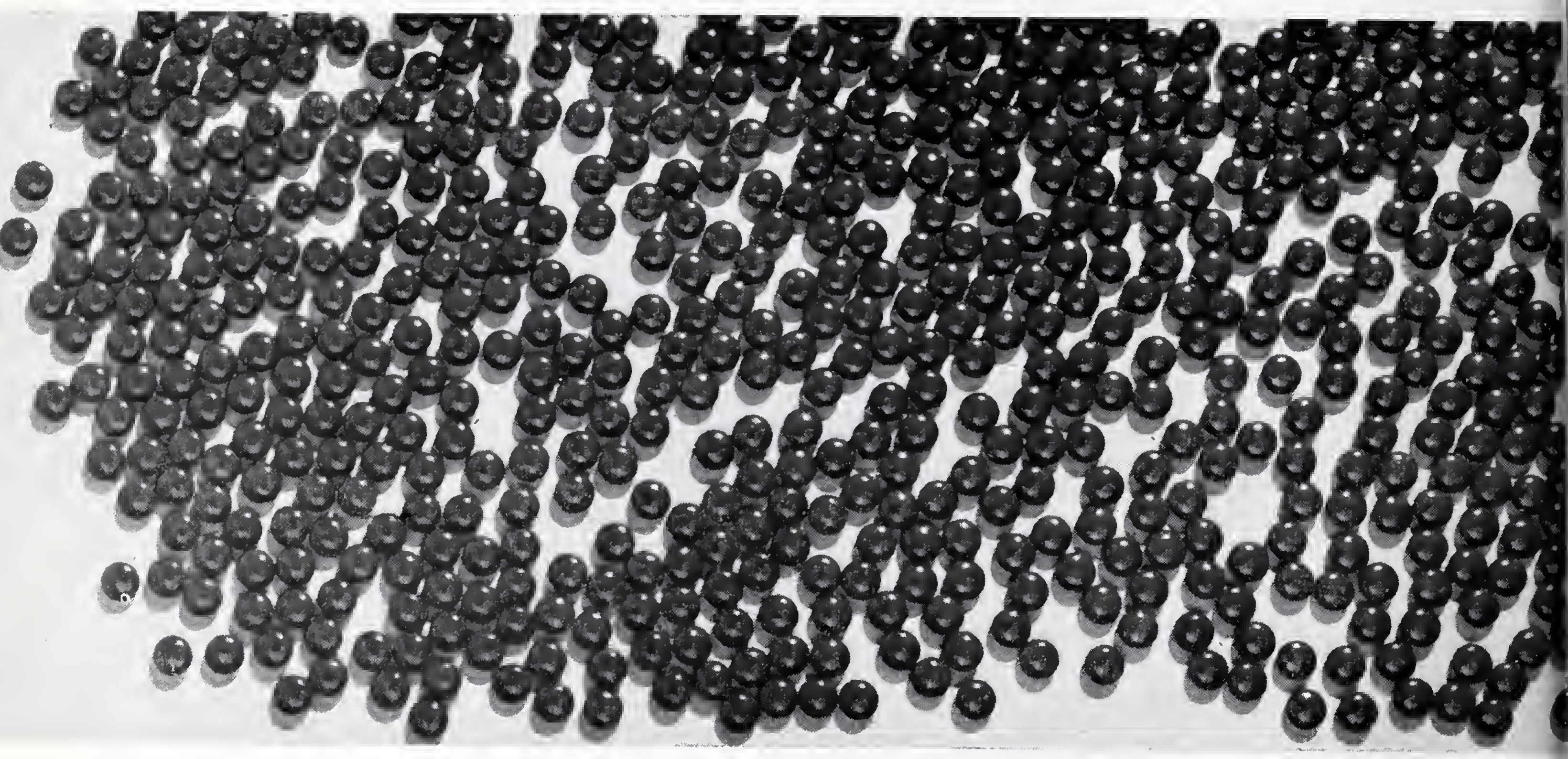


# . . . this is the other half



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*Fish poisoning is occurring more often in Hawaii in recent years, and may present you with a puzzling clinical picture to untangle.*

# Fish Poisoning in Hawaii

PHILIP HELFRICH, Ph.D.,* *Honolulu*

• *Fish poisoning has affected more than 433 persons in over 54 recorded outbreaks in Hawaii since 1900. Of the four categories of poisoning reported in Hawaii (ciguatera, hallucinatory mullet poisoning, tetraodon or puffer fish poisoning, and scombroid or histamine poisoning), only poisoning by the puffer fish has caused deaths—seven of them. Gymnothorax (moray), elasmobranch (shark) and clupeid (herring) poisoning have not been recorded in Hawaii. Ciguatera, caused by a neurotoxic substance, is the most serious hazard of all: it is a recent affliction here, difficult to predict or control, and produced by many species of fish that are highly esteemed as food; and the toxin seems to have a cumulative effect.*

OUTBREAKS of fish poisoning, or ichthyotoxism, caused by the ingestion of the flesh or viscera of fish containing toxins of nonbacterial origin, have been relatively uncommon in Hawaii, and most local physicians have seldom been confronted with such cases. A study of this problem of fish poisoning, including a search of literature and records as well as numerous personal interviews, has revealed that at least 54 outbreaks involving more than 433 persons and resulting in seven deaths have occurred in Hawaii since 1900.

* Assistant Marine Biologist, Hawaii Marine Laboratory, University of Hawaii.

Most of these outbreaks were apparently caused by toxins endogenous to the fish or acquired from sources other than the micro-organisms normally encountered on "spoiled" fish. Because outbreaks have been infrequent and usually involve only a small number of persons, physicians encountering cases for the first time have been perplexed by some aspects of the unfamiliar syndrome, particularly by manifestations of neurological involvement that are frequently observed in certain types of nonbacterial fish poisoning.

### RESEARCH FOCUSED

A recent spread of some types of fish poisoning in the central Pacific, as well as increased demands on the resources of the sea by Pacific peoples, has been instrumental in focusing the attention of researchers on this problem. This increased interest in fish poisoning in the Pacific has resulted in the initiation of a number of related research projects on various aspects of the problem at the Hawaii Marine Laboratory of the University of Hawaii, supported by national and local agencies. The Japanese have been actively engaged in research on marine fish toxins for a number of years, and recently a few workers in North America have been studying related problems.

It is the purpose of this discussion to review the presently defined categories of fish poisoning, their symptomatology, treatment, and other information

that would be of value to physicians and public health officials in recognizing and handling outbreaks. Results of past and current research will be discussed, as well as the significance of the spread of fish poisoning in the central Pacific, with emphasis on outbreaks in Hawaii. It is hoped that this discussion will be of sufficient interest to stimulate an exchange of information with those who have had first-hand experience with cases of fish poisoning, in order to expand our present knowledge of toxic fishes and to aid in our research upon them.

Fishes that are poisonous to eat are widely distributed throughout the warm seas of the world, being particularly prevalent around certain islands in the Pacific and Caribbean.[12, 15, 19, 39, 45, 47] Outbreaks of fish poisoning have occurred in almost all of the major oceanic island groups in the Pacific. In some islands, such as New Caledonia and the New Hebrides, fish poisoning is known to have been a problem for hundreds of years, while in other areas such as the Line and Hawaiian Islands it appears to be largely a problem of recent origin (Fig. 1). Inquiries made of medical officials throughout the tropical Pacific during the past four years revealed that fish poisoning of one variety or another is ubiquitous on islands within 30 degrees north and south of the equator.

### EARLY REPORTS

The first report of illness from the ingestion of toxic fish in the Pacific is believed to be that of the Spanish navigator, Fernandez de Quiros, in 1606, when he and his crew were poisoned in the New Hebrides.[42] Kaempfer[32] reports deaths among the Japanese from eating improperly cleaned puffer fish as early as 1690, and his awareness of the highly toxic qualities of this fish is evident from his statement that it, ". . . if eat [*sic*] whole, is said unavoidably to occasion death. . . ."

The famed Pacific explorer, Captain James Cook, and members of his crew were poisoned twice in the New Hebrides and New Caledonia in 1774.[14] The journals of other explorers, missionaries, naturalists, and others, contain numerous accounts of episodes of fish poisoning on various Pacific islands, attesting to a widespread existence of this condition prior to the present century.

The occupation of many Pacific islands by military forces during World War II served to emphasize the gravity of the poison fish problem, for, lacking the native's knowledge of potentially toxic species, these sojourners to the islands were often seriously afflicted.[21]

### CLASSIFICATION

Fish poisoning has been classified into a number of categories, primarily upon the syndrome manifested in cases of human intoxication and the taxonomic classification of the fish implicated. Only one type of fish poisoning (by the tetraodon or puffer fish) has been extensively investigated, and further research is required to determine whether all of the categories of fish poisoning discussed below validly reflect the action of a distinct toxin harbored by a defined taxonomic group of fishes.

Based on extensive published literature as well as numerous unpublished reports, the following categories of fish poisoning are presented with a condensation of the available pertinent information on them. This discussion will not include fishes with venomous spines or those with a reputation for aggressive attacks on humans.

### CIGUATERA POISONING

Ciguatera is a term used to describe a disease characterized by neurological and gastrointestinal symptoms resulting from the ingestion of any of a number of tropical marine reef fishes, notably (but not exclusively) snappers, groupers, ulua, barracuda, and surgeonfish.

The term ciguatera, of Spanish origin, was first used in the Caribbean area to designate intoxication caused by the ingestion of the poisonous marine snail, *Turbo pica,* which the early Spanish settlers called "cigua."[5] Unfortunately, the term gradually came into common usage and is now widely accepted as descriptive of a particular type of poisoning, due to the ingestion of certain fishes encountered around islands both in the Caribbean and the Pacific, which produces the characteristic symptoms described below.

Ciguatera is a disease that is not well understood, and a broad program of research has been undertaken at the Hawaii Marine Laboratory on the chemical isolation, identification, pharmacology, and biological origin of the toxin or toxins involved, as well as an epidemiological study of this and other types of fish poisoning in the Pacific.

It has been suggested that fish causing ciguatera become toxic through factors existing in their environment. Numerous possible sources of the toxin in the environment have been proposed, including dumped war material,[48] poisonous plankton,[30] and "flowering" coral.[42] The most plausible theory in the light of existing evidence is that the toxin originates in a benthic organism (possibly an alga) and is transmitted to other species of fish through the food chain in the process of normal feeding.[47] It has also been suggested that nuclear testing programs in the Pacific may have been instrumental in causing an increase in outbreaks of ciguatera in the Marshall Islands. The results of a recent study show that no relationship exists between radioactivity and toxicity in snappers caught near the atomic test sites in the Marshall and Line Is-

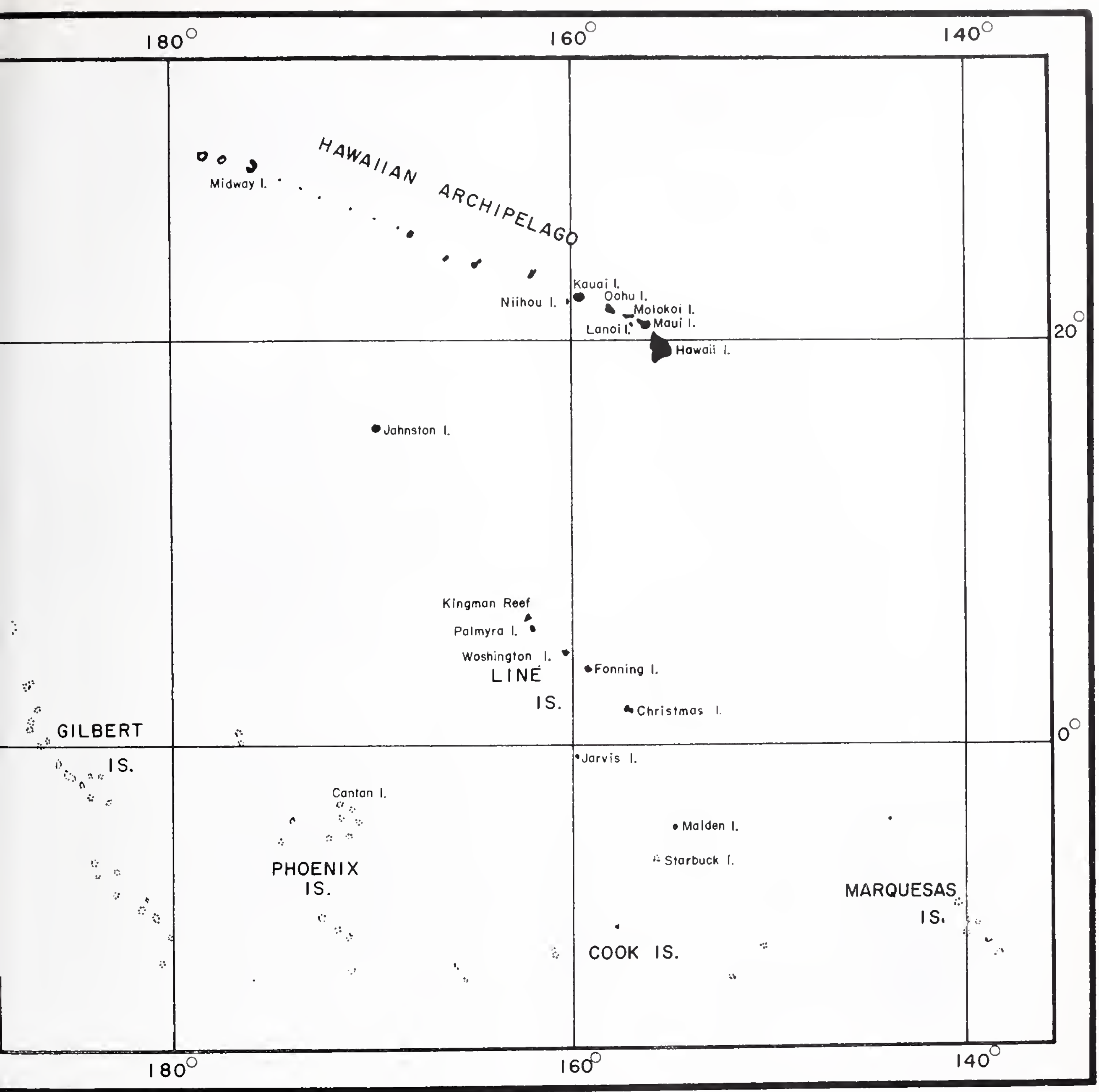
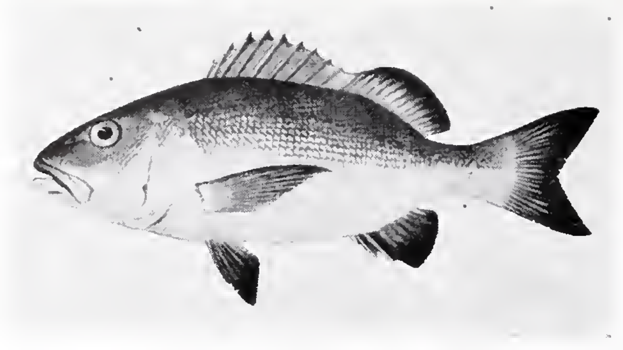



FIG. 1.—*Map of the central Pacific Ocean showing the Hawaiian Archipelago, Line Islands, and other areas pertinent to the distribution of poisonous fishes discussed in the text.*

lands, which is to be expected in the light of the past history of the poisonous-fish problem in the Pacific.[24]

Reports indicate that outbreaks of ciguatera have occurred on oceanic islands of the western, southwestern, and southern parts of the Pacific at least as long as records exist from these areas. Islands of the central Pacific, including the Line Islands, Johnston Island, and the Hawaiian archipelago have apparently been free of ciguatera until recently.[22] A spread of ciguatera to this area in the past 20 years is a source of concern to public health officials as well as the inhabitants, and its significance is discussed further below.

Species most frequently implicated in outbreaks of ciguatera include certain snappers (Lutjanidae), groupers or sea bass (Serranidae), ulua, jacks or pompano (Carangidae), barracuda (Sphyraenidae), and the surgeonfishes or tangs (Acanthuridae). Other species less frequently consumed as food, including the parrot fishes (Scaridae), wrasses (Labridae), squirrelfishes (Holocentridae) and



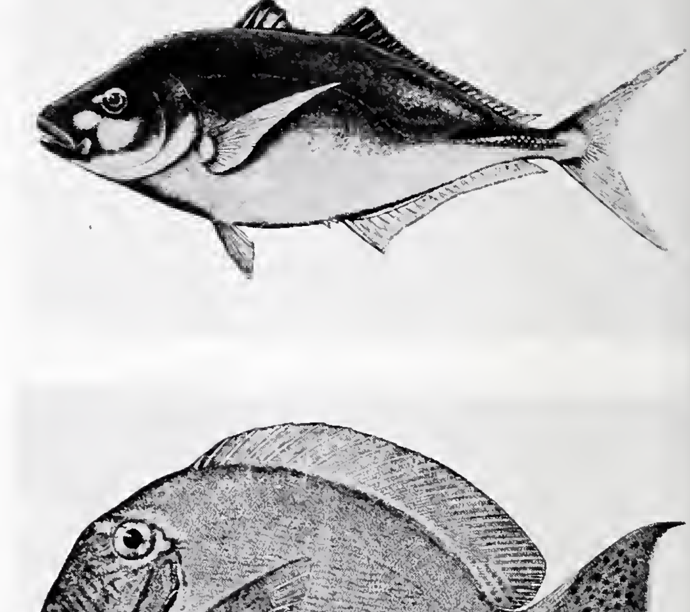


Fig. 2.—*Species representing families of fishes most frequently implicated in outbreaks of ciguatera fish poisoning. Upper left, the red snapper,* Lutjanus bohar *(Forskål), one of the most consistently toxic species in affected areas of the Pacific (after Hiyama). Lower left, the grouper or sea bass, probably* Epinephelus tauvina *(Forskål). This specimen, weighing 238 pounds, was caught at Kapoho, Hawaii, and was responsible for the poisoning of over 30 persons described in case 52, Appendix B (photo by Roy Ogata, Kilauea Art Studio, Hilo, Hawaii). Upper right, the ulua or jack,* Caranx cheilio *(Snyder), implicated in recent outbreaks at Midway Island (after Jordan and Evermann). Lower right, the surgeonfish or tang,* Acanthurus dussumieri *Cuvier and Valenciennes, implicated in three outbreaks of fish poisoning on Oahu, Hawaii (after Aoyagi).*

others may also carry ciguatera toxin.[12, 18, 19, 47] Some of the species implicated in outbreaks of ciguatera in Hawaii are illustrated in Fig. 2.

The clinical picture in ciguatera is often bizarre, and not all patients display the same symptoms, even, in some cases, when all of the individuals have eaten portions of the same toxic fish. Ciguatera can usually be recognized on the basis of a few initial characteristic symptoms that may appear from a few minutes to ten hours or more following the ingestion of a toxic fish. The first symptoms are usually experienced within about three hours after ingestion, and consist of nausea and vomiting, followed by tingling and numbness about the lips, tongue, and throat. These may be followed by any of a multiplicity of other symptoms, including abdominal pain and cramps, diarrhea, arthralgia, muscular weakness, incoordination, numbness and tingling of the extremities, malaise, chills, low-grade fever, and prostration. Hypotension, profuse sweating, dyspnea, restlessness, insomnia, headache, intermittent dizziness, dilatation of the pupils, ptosis, divergent strabismus with diplopia, reduced vision, dryness of the mouth, a metallic taste, and myalgia (particularly severe in the back and thighs) also occur. Hyperesthesia, urinary retention, and diminished-to-absent knee and ankle reflexes have been reported. Patients often experience dysesthesia that consists of a confusion of temperature sensation; when touching a cold object, the patient reports that it gives the sensation of burning, tingling, or "dry

ice," and hot objects feel cold. When tap water is swallowed, it often gives the sensation of being carbonated. In severe cases of ciguatera, shock, convulsions, muscular paralysis, and death may occur.

It appears as though the body does not rapidly neutralize or eliminate ciguatera toxin, for the recovery period is characteristically quite prolonged. In moderate cases of poisoning, most of the symptoms subside in 24 hours, with the exception of the muscular weakness, tingling, and numbness, which may last from four to seven days. During the recovery phase, some patients report vague neuralgic pain about the teeth, and intense itching,* especially on the palms and soles. In severe cases, symptoms may persist for several weeks or months, and complete recovery from sensory disturbances, weakness, and weight loss may require much longer.[5, 8, 9, 10, 12, 18, 21, 39, 45, 47]

An attack of ciguatera does not impart immunity; on the contrary, patients who have been poisoned previously report a mild recurrence of symptoms after eating a potentially toxic fish, while others who have never been poisoned experience no symptoms when eating the same fish.[17]

Usually treatment recommended for ciguatera is symptomatic, consisting initially of emptying the digestive tract by means of gastric lavage, emetics, and saline purges. A variety of other treatments have been suggested and tried with varying palliative effect, but none have been consistently successful; these include injections of calcium gluconate, injections of vitamin B complex, infusions of glucose in normal saline, phenobarbital, belladonna, paregoric, morphine, codeine, and aspirin.[3, 9, 11, 12, 18] In one outbreak of ciguatera involving five persons, procaine hydrochloride infusions were inadvertently substituted for the calcium gluconate recommended and the patients displayed a regression of symptoms and general improvement. Subsequent administration of calcium gluconate in place of the procaine hydochloride resulted in a recurrence of symptoms, followed by complete recovery of the patients within a week.[17]

A recent outbreak of ciguatera on Guam was caused by the ingestion of a portion of a 53-pound barracuda. One of the victims, a 19-year-old girl, experienced severe depression and paralysis, and treatment with hydrocortisone, Tensilon, and neostigmine seemed to have a beneficial effect.[8] Investigations in Japan, Ohio, at the Hawaii Marine Laboratory, and elsewhere indicate that the toxins found in barracuda, snappers, and ulua are similar and perhaps identical; all produced characteristic ciguatera symptoms in man and laboratory animals. The toxin from the red snapper (*Lutjanus bohar*) from the Line Islands has been the object of intensive chemical and pharmacologic studies in laboratories in Hawaii, Ohio, and California.[6, 8, 27, 28, 41] In the Hawaiian investigation it was found that the crude toxin from this fish is thermostable, initially soluble in 95 and 100 per cent ethanol, acetone, chloroform, or diethyl ether, and insoluble or only slightly soluble in water, butanol, benzene, or petroleum ether. It has been rendered in a very nearly pure state by initial extraction and washing with 95 per cent ethanol, petroleum ether, and diethyl ether, and by repeated chromatographic separations with solvents of varying polarity.[6]

No simple rapid test for identifying ciguatera toxin exists. Preliminary experiments with *Lutjanus bohar* indicate that the liver contains the highest concentration of toxin, followed by the viscera (less liver and gonads), the testes, ovaries, and muscle, in order of decreasing toxicity. Therefore, as an expedient, the liver or other portions of the viscera may be fed to susceptible animals such as cats, dogs, or mongooses at doses of 10 per cent of the weight of the test animal. If the flesh is sufficiently toxic to cause illness in man, the ingestion of such a sample will cause muscular weakness beginning with flexion of the wrists, ataxia, hypersalivation, prostration, and probably death in a test animal (mongoose or cat) within 24 hours. A roughly quantitative bioassay has been developed which entails the intraperitoneal injection of an alcohol-ether extract of the suspected sample into laboratory mice.[6, 7, 8, 41] A more refined bioassay utilizing the blocking action of the semipurified toxin at the synapse in nerve-muscle preparations is presently being perfected. Hessel and his coworkers have developed a test which records the loss of action potential in a frog sciatic nerve preparation which is bathed in a fine emulsion of the toxin.[27, 28]

### TETRAODON POISONING

Fish causing tetraodon or puffer fish poisoning are primarily from the family Tetraodontidae and are known in Hawaii by a variety of names including puffers, blowfish, balloon fish, 'o'opu-hue, makimaki, keke, or *fugu*. Puffer fish have a peculiar appearance; they are without pelvic fins, are generally feeble swimmers, and have a habit of inflating themselves when disturbed to assume a spheroid form almost twice their original size.

Many species of puffer fish occur in the tropical Indo-Pacific area. Many species have been reported to contain a very virulent toxin, and reports of human intoxications from their ingestion are numerous and widespread geographically.[12, 15, 18, 19, 55] Five species of Tetraodontidae

* The French in New Caledonia commonly refer to ciguatera as *"la gratte"* (= the itch).

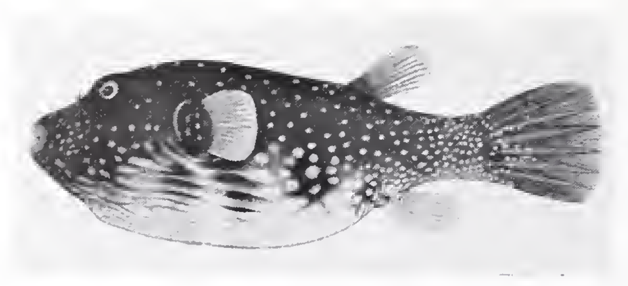


FIG. 3.—*The common puffer fish or fugu,* Arothron hispidus *(Linnaeus) implicated in four outbreaks of tetraodon poisoning in Hawaii which resulted in seven fatalities (after Hiyama).*

occur in Hawaii;[16] *Arothron hispidus* (Fig. 3) is the most common local species, and, according to available reports, the only species implicated in cases of fish poisoning in Hawaii.

The toxin in puffer fish is endogenous and appears to be concentrated in certain organs and tissues; the ovaries are said to always be toxic, while the liver, bile, skin, and flesh may occasionally be toxic. Special care in the cleaning and preparation of puffer fish can render them innocuous; normally the viscera are carefully removed under running water, and the flesh may be soaked in repeated changes of fresh water to leach out the water-soluble toxin. Ironically, the puffer fish is considered a delicacy by many Oriental people. Despite regulations in Japan requiring that persons who cook puffer fish or *fugu* commercially be specially trained and licensed, puffer fish poisoning is the greatest single cause of fatal food intoxication in Japan.

In Hawaii, seven deaths from the ingestion of puffer fish have occurred in the past 60 years, despite a general recognition by Hawaiians and Orientals alike of the potentially toxic qualities of this fish.[1, 13, 36] In Honolulu, where no special regulations control its preparation, puffer fish or *fugu* usually commands a premium price when it is available at the few restaurants and tea houses that feature this delicacy.

In addition to toxic Tetraodontidae, there are a number of other closely related families of the order Tetraodontiformes (Plectognathi) that have been reported toxic when eaten. However, in the present state of our knowledge it is not possible to say whether or not these toxins are identical or similar to that found in the puffer fish. These other closely related families include the filefishes or 'o'ilis (Monocanthidae), the boxfishes, trunkfishes, or cowfishes (Ostraciidae), the triggerfishes or humuhumus (Balistidae), the sharp-backed puffers (Canthigasteridae), and the spiny puffers (Diodontidae).

Only one case of poisoning attributed to plectognath fishes other than puffer fish is recorded from Hawaii. In 1956 an outbreak was reported from the Island of Hawaii, caused by the ingestion of the black triggerfish or humuhumu-'ele'ele, *Melichthys buniva* (see case 32, Appendix B). The nature and distribution of toxins in plectognath fishes in Hawaii are presently being studied at the Hawaii Marine Laboratory.

Puffer fish (Tetraodontidae) may be highly toxic, resulting in the onset of symptoms within ten minutes after ingestion. However, in some cases recorded, more than three hours passed before the onset of symptoms. Initial symptoms include tingling of the lips, tongue, and fingertips, followed by progression of the numbness which may involve the entire body, and extreme weakness, associated with nausea, vomiting, headache, profuse sweating, subnormal temperature, hypersalivation, dysphagia, dysphonia, dyspnea, and a constricting sensation in the chest. In severe, acute cases, the patient rapidly develops a weak, rapid pulse, hypotension, aphonia, marked dyspnea, cyanosis, and an ascending paralysis with death resulting from respiratory failure.[1, 12, 18, 36] The mortality rate of persons ingesting toxic puffers has been estimated to be greater than 60 per cent.[19] Deaths usually occur within 24 hours after ingestion; if the patient survives this time the prognosis is good.

The toxin from puffer fishes, called "tetrodotoxin" has been studied extensively and isolated by the Japanese, but the molecular structure has not been determined.[51, 52, 53, 54] A number of investigators have studied the pharmacology of tetrodotoxin, which has a curare-like action on the neuromuscular junction, depresses conductivity in peripheral nerves, and depresses the medullary center.[12, 43]

A specific antidote has not been developed for tetraodon poisoning and the treatment recommended is symptomatic. Japanese physicians, who have encountered numerous cases of this disease, recommend the following: Coramine (nikethamide, Ciba), Metrazol (pentamethylentetrazol, Knoll) or other suitable respiratory stimulants, together with artificial respiration, in event of respiratory failure; administration of Vasopressin (Parke Davis) and rapid digitalization to correct hypotension and circulatory collapse; and physostigmin in an attempt to reverse the neuromuscular block.[12, 44]

Puffer fish or *fugu* is usually prepared as a soup consisting of pieces of the flesh and liver in a thin broth. It is generally reported by those who have consumed this dish in Hawaii that it produces more profuse perspiration than might be expected from the ingestion of an equal quantity of another hot soup. Many others have reported a feeling of "warmth and well-being" and a few have claimed it causes muscular weakness and localized numbness (around the mouth), and that it is a powerful aphrodisiac.

Some of these effects may be due to the inges-

tion of small doses of the toxin, while others may be psychosomatic. The author, from personal experience, can attest only to the profuse perspiration. No research on tetraodon poisoning in Hawaii has been reported since the preliminary work of Larsen,[36] and at least a comparison should be made of the structure and mode of action of the toxin of the common local puffer, *Arothron hispidus*, with those studied extensively by the Japanese.

The lack of reported fatalities from tetraodon intoxication in recent years is probably due to a more widespread understanding of the potential dangers adjunct to the ingestion of improperly prepared puffer fish. It is improbable that local specimens have become less toxic in recent years, as checks during 1961 on the ovaries of mature female specimens of *Arothron hispidus* from Kaneohe Bay, Oahu, produced rapid fatalities when fed to mongooses in the laboratory.

No simple, rapid test has been reported to assess the toxicity of puffer fish; oral feeding to carnivorous mammals such as cats, dogs, and mongooses will result in a marked response in a few hours if the sample fed is highly toxic. A bioassay standardized by the Japanese requires extraction and partial purification of the water-soluble toxin, and injection of the extract intraperitoneally into laboratory mice.[23]

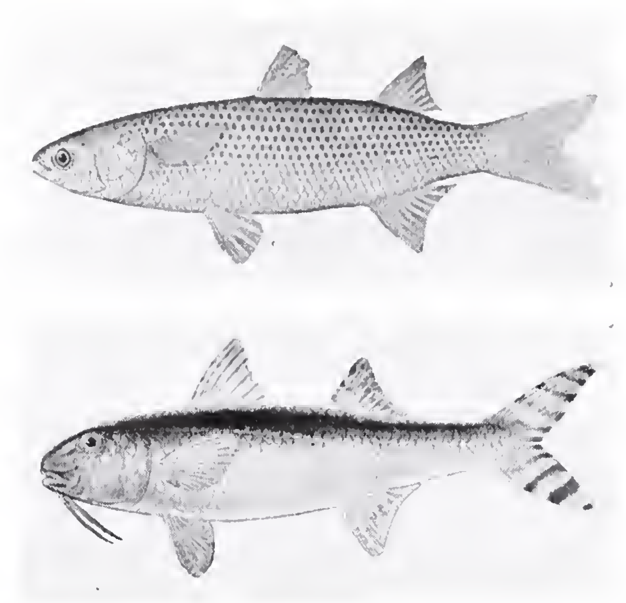


Fig. 4.—*Two species most commonly implicated in outbreaks of hallucinatory mullet poisoning in Hawaii; Upper, the common mullet,* Mugil cephalus *Linnaeus, and, lower, the goatfish or surmullet,* Upeneus arge *(Jordan and Evermann), which is also referred to locally as the "nightmare weke" (after Jordan and Evermann).*

### HALLUCINATORY MULLET POISONING

Hallucinatory mullet poisoning is a seasonal condition occurring only during the months of June, July, and August in restricted areas on the islands of Kauai and Molokai. Old residents of the affected areas report that the condition has existed for as long as they can remember, and most of them have been stricken with this poisoning at least once. The areas affected are on the northeast coast of Kauai, principally in the vicinity of Anini, but extending from Pilaa to Haena, and in a region around Pilaau on Molokai.[1, 2, 26]

The species implicated include the mullets, *Mugil cephalus* Linnaeus ('ama'ama) and *Neomyxus chaptalii* (Eyodoux and Souleyet) (uouoa); the surmullet or goatfish, *Upeneus arge* (Jordan and Evermann) (weke pueo, weke pahula, nightmare weke, or crazy surmullet), and *Mulloidichthys samoensis* (Gunther) (weke, weke'a'a); occasionally the rudderfish, *Kyphosus cinerascens* Forskal (nenue, nenue parii, manaloa), and the surgeonfish, *Acanthurus sandvicensis* (Streets) (manini or convict tang). The first and third are pictured in Fig. 4.

The toxin appears to affect the central nervous system when ingested by humans, and produces symptoms of dizziness, loss of equilibrium, ataxia, hallucinations, and mental depression if the onset of symptoms occurs when the patient is awake. If the onset of symptoms occurs while the patient is sleeping, he experiences terrifying nightmares. Other symptoms which may occur are malaise, itching or burning of the throat immediately after ingestion, muscular weakness, and partial paralysis. Gastrointestinal upset, nausea, or diarrhea are rarely reported in these cases. The onset of symptoms is from ten minutes to two hours after ingestion.

The evidence available indicates that this toxin is not a result of bacterial action, as persons have been afflicted after eating freshly-caught fish. Similar symptoms have resulted from fish that were boiled, fried, steamed, and eaten raw, and from the ingestion of various portions of the fish. Although the head alone is frequently implicated as containing the greatest concentration of the toxin, cases of poisoning were discovered in which the victim had eaten only the eviscerated body of the fish.[1, 2, 26]

Preliminary investigations of this hallucinatory mullet poisoning have stimulated interest among pharmacologists, who plan to further investigate the hallucinogenic properties of the toxin involved.

### SCOMBROID POISONING

This report has been restricted largely to acquired or endogenous toxins in live fish, believed to be the result of other than bacterial action upon the fish after capture. A departure from this categorical restriction will be made to discuss scombroid poisoning, the result of the rapid action of a strain of bacterium, producing a toxin often unaccompanied by the usual signs of putrefaction,

and, therefore, sometimes mistaken for other types of fish poisoning. Scombroid poisoning is an allergic type of intoxication, resulting from ingestion of improperly stored tuna, mackerel-like fishes, swordfishes, and others, including those known locally as ono, aku, ahi, ahi-pahala, a'u, and mahimahi. These fish comprise a group of highly esteemed pelagic species upon which most of the Hawaiian commercial fishing industry is based.

The toxin causing scombroid poisoning is not produced by the usual enterotoxic pathogens, but by certain strains of the bacterium, *Proteus morganii,* which, under proper conditions, act on histidine, a naturally-occurring substance in scombroid fish flesh.

Free histidine is known to occur in the flesh of many fishes, and it is particularly abundant in dark-fleshed fish, sometimes reaching concentrations of more than 2,000 mg/100 g. The dark flesh of such pelagic species as the frigate mackerel, *Auxis thazard* (Lacépède); the Japanese mackerel, *Scomber japonicus* Houttouyn; the mahimahi or dolphin, *Coryphaena hippurus* Linnaeus, and the striped marlin, *Maxaira audax* Philippi, contain concentrations of histidine up to two orders of magnitude greater than that found in white meat fish.[29, 49] *P. morganii,* normally found on the surface of freshly-caught fish under certain conditions, causes a decarboxylation of free histidine to produce histamine and possibly a synergistic agent known as "saurine."[33, 34]

*Proteus morganii* is a motile, gram-negative rod, 0.5 x 1.0-1.4 microns. Optimum temperature for the production of histamine by this organism is 20-25°C. In this temperature range, the decarboxylation of histidine to form histamine may be very rapid, and considerable histamine may be formed before ammonia or other putrefactive byproducts can be detected. The critical concentration for human poisoning by histamine in fish flesh seems to be about 1 mg/g.[35]

The histamine and saurine produced in improperly refrigerated fish cause a severe allergic type of reaction upon ingestion. The presence of these toxic substances, detectable by a sharp or peppery taste, may be masked by sauces or seasoning. Symptoms develop within a few minutes to three hours after ingestion and are often sudden in onset. They include erythema of the face and upper body; severe occipital headache; giant urticaria; conjunctivitis and periorbital edema; edema of the lips, tongue, and throat; respiratory distress; tachycardia; abdominal pain; malaise; or generalized weakness and giddiness. Fever and mild diarrhea may occur as well as nausea, though patients rarely vomit. The acute symptoms usually persist for eight to twelve hours, after which the patient experiences a rapid recovery; few fatalities have been reported.[12, 18]

The treatment recommended is immediate evacuation of the stomach contents, followed by the administration of antihistaminic drugs.[18]

At least two outbreaks of what appears to be scombroid poisoning, from ingestion of ahi, *Neothunnus macropterus* (Schlegel), and swordfish, have occurred in Hawaii[37, 40] (Cases 37 and 40, Appendix B), although neither was confirmed by culturing of *P. morganii* from the implicated sample. An additional outbreak of fish poisoning attributed to mahimahi, *Coryphaena hipurus,* which is known to have a high histidine content, may fall into this category, although scombroid poisoning has not been previously reported from this species, and the causative agent was not disclosed (Case 24, Appendix B).

Mahimahi, tuna, mackerel and other allied pelagic fishes are widely exploited by commercial fishermen throughout the Pacific. It should be emphasized that these fishes are not known to contain any endogenous or acquired toxin while in the sea. Strains of *P. morganii,* occurring in the normal bacterial flora, may produce the above described conditions only in improperly refrigerated specimens.

Other types of fish poisoning, unknown to the Hawaiian Islands, occur sporadically in islands to the south and east of Hawaii, and may extend their range to the Hawaiian Archipelago, just as ciguatera has. Such speculation is based on an ignorance rather than a knowledge of these diseases and their means of dissemination. Until we know more of the etiology of toxicity in the fishes themselves, we must be wary of the planned or accidental introduction of marine organisms from areas where these conditions are prevalent.

### CLUPEID POISONING

Clupeid poisoning has occurred sporadically in the Marshall Islands, New Caledonia, Fiji, the Society Islands, Indonesia, and Ceylon. It may result from the ingestion of certain herring or sardine-like fishes. The symptoms include dyspnea, cyanosis, cold sweat, painful cramps, and dilated pupils; occasionally death results. It has been suggested by Randall[47] that since the clupeids are plankton feeders, the toxic condition might be related to blooms of tropical planktonic algae, similar to the dinoflagellates which cause paralytic shellfish poisoning in temperate regions. Species which cause poisoning elsewhere do not occur in Hawaii, and closely related species are not prominent in the local fish markets.

### GYMNOTHORAX POISONING

Gymnothorax (moray eel) poisoning is a category of fish poisoning proposed by Halstead and

Lively,[21] with a syndrome similar to that of ciguatera. It differs from ciguatera in that the onset of symptoms is more rapid, and convulsions and paralysis are more prominent.

Randall[47] suggests that the difference may be only quantitative; he points out that the syndrome in moderately severe cases of ciguatera is almost identical to that encountered in cases in which the victim consumed small quantities of toxic moray eel. Ralls and Halstead[46] claim that a difference in the initial solubilities of the two toxins exists, although validity of this work has been questioned by other investigators.[6] Experimental feeding of large specimens of the moray eel, *Gymnothorax javanicus*, from Palmyra Island, indicated that these eels contained a much higher concentration of toxin per unit weight than did the most toxic red snapper, *Lutjanus bohar*, from the same area, and the symptoms produced in laboratory animals from the snappers and moray eels were identical. Moray eels of the genus *Gymnothorax* are all predacious on fishes, and they possess adaptations for capturing and ingesting relatively large prey. It is hypothesized that continued ingestion of large fishes such as snappers and groupers would allow the moray eels to acquire sizable quantities of the toxin over a period of time. The longevity of moray eels is favored by the fact that they have no known predators. If they excrete only a small percentage of the toxin ingested (as is the case with *L. bohar*, studied by Takata[50]), the high concentration of toxin in their flesh would be an indication of the quantity of toxin (in the form of toxic fish) that they had ingested.

Further elucidation of the relationships of ciguatera to gymnothorax poisoning requires the chemical isolation and identification of the toxins involved as well as ecological studies on the relationship of moray eels to species harboring ciguatera toxin. Based upon the above hypothesis, however, one might expect moray eels to become toxic sometime after ciguatera had extended into a previously unaffected area.

No cases of gymnothorax poisoning have been reported from Hawaii, although small quantities of these eels are regularly consumed locally by certain ethnic groups.

### ELASMOBRANCH POISONING

Sporadic outbreaks of elasmobranch poisoning have occurred from the ingestion of sharks, particularly shark livers, in the Line Islands, Samoa, the Society Islands, the Marshall Islands, and perhaps elsewhere. Only mild symptoms have been attributed to eating of the flesh, but more severe poisonings and deaths have resulted from ingestion of shark livers. Symptoms may begin within 30 minutes after the ingestion of a toxic liver; they include headache, nausea, vomiting, diarrhea, aching joints, heaviness of limbs, prostration, delirium, feeble pulse, diaphoresis, respiratory distress, thoracic pain, burning sensations of the tongue, throat, and esophagus, and tingling of the lips and extremities. In cases of elasmobranch poisoning, coma and death may result.[12, 19]

Little is known of the nature or mode of action of the toxin involved. It has been postulated that the toxicity of sharks is the result of their feeding upon ciguateric fish. Others feel that the intoxication in humans is due to an overdose of vitamin A. There is probably no relation to scombroid poisoning, for shark flesh contains no free histidine.[35]

Elasmobranch poisoning has not been reported from Hawaii, and it would only become a potentially serious problem if Hawaiian sharks were to be exploited commercially for human consumption. Present laws which require the labeling of packaged food items have discouraged the former practice of using shark flesh in the preparation of fish cake for local consumption, and a fishery for sharks no longer exists in Hawaii. Therefore, at the present time, the primary danger presented is not in the ingestion of sharks by humans, but vice versa.

### REVIEW OF OUTBREAKS

In the course of research on toxic marine organisms over the past four years, numerous case reports of fish poisoning were discovered. A search of the records of the State Department of Health, as well as personal interviews, resulted in the uncovering of 54 outbreaks since 1900; the pertinent data on these outbreaks are presented in Appendix B. Although undoubtedly incomplete, these data probably represent a fair picture of the relative frequency of various types of fish poisoning described. Therefore, the pattern of previous outbreaks is examined as indicative of possible trends.

Fish poisoning outbreaks of various types, occurring in Hawaii and listed in Appendix B, are sumarized in Appendix A. The data in Appendix A indicate that 42.6 per cent of all outbreaks of fish poisoning are attributable to ciguatera. Hallucinatory mullet, tetraodon, and scombroid poisoning outbreaks combined accounted for almost 30 per cent of the outbreaks, with about 28 per cent in the unidentified category. Tetraodon poisoning accounted for the only known fatalities, with a mortality rate of almost 60 percent in four outbreaks. This reported mortality rate is probably considerably higher than the actual figure, because of publicity surrounding fatalities of this type, and the lack of information on mild cases.

A compilation of outbreaks of fish poisoning from the standpoint of families of fish involved

TABLE 1.—*Compilation of families of fishes most frequently involved in outbreaks of fish poisoning in the Hawaiian Islands with the geographical area from which they originated. (Data from Appendix B.)*

| FAMILY OF FISH | GEOGRAPHICAL ORIGIN | | | | | | TOTAL | |
|---|---|---|---|---|---|---|---|---|
| | *Hawaii (Main Is.)* | *Midway* | *Line Is.* | *Johnston Is.* | *Phoenix Is.* | *Origin Not Determined* | *No.* | *%* |
| Carangidae (Ulua, Jacks, Pompano) | 4 | 6 | 1 | 1 | | 1 | 13 | 23.2 |
| Mugilidae (Mullet) | 6 | | | | 1 | 1 | 8 | 14.3 |
| Acanthuridae (Surgeonfish) | 3 | | 1 | 2 | | | 6 | 10.7 |
| Lutjanidae (Snappers) | | | 3 | | 2 | 1 | 6 | 10.7 |
| Serranidae (Sea bass) | 1 | 2 | 1 | | 1 | | 5 | 8.9 |
| Tetraodontidae (Puffers) | 4 | | | | | | 4 | 7.1 |
| Mullidae (Goatfish) | 3 | | | | | | 3 | 5.4 |
| Other | 9 | | | | | | 9 | 16.1 |
| Family not determined | 1 | | | | | 1 | 2 | 3.6 |
| TOTAL No. | 31 | 8 | 6 | 3 | 4 | 4 | 56* | 100.0 |
| TOTAL % | 55.4 | 14.3 | 10.7 | 5.4 | 7.1 | 7.1 | | 100.0 |

* This total is greater than the number of outbreaks recorded in Appendix B because three species of fish were involved in a single outbreak.

and their geographical origin is presented in Table 1. About half of all outbreaks of fish poisoning in Hawaii were attributable to fish in three families: Carangidae (uluas), Mugillidae (mullets), and Acanthuridae (surgeonfishes). Over 37 per cent of all outbreaks were caused by toxic fish imported from Midway, Johnston, and the Phoenix and Line Islands, despite a regulation prohibiting such importations.* In view of the nuclear testing and missile programs on Johnston Island and the Line Islands, further outbreaks of poisoning from fish originating in these areas might be expected unless a more active program of education and control is pursued.

An examination of the number of cases of fish poisoning occurring in periods since 1900 is presented in Table 2. Although, admittedly, greater attention has been given to fish poisoning outbreaks in the past four years, the marked increase in the number of outbreaks (particularly of ciguatera) in the five-year period, 1956-1960, may be indicative of an increase in the absolute incidence of these occurrences, and it might well warrant the attention of public health authorities.

## DISCUSSION

Of the various types of fish poisoning herein discussed, only four are likely to be encountered by the practicing physician in Hawaii: ciguatera, hallucinatory mullet, tetraodon, and scombroid. This is not to imply that other types may not become problems, or that yet undescribed ichthyotoxins may not be discovered in the Hawaiian Islands.

* Part c-1, Second Amendment to Chapter 4, Public Health Regulations of Hawaii, April, 1954.

In the author's opinion, of the types of fish poisoning likely to be encountered, ciguatera poses the greatest potential health problem in the Hawaiian Islands for the following reasons: (1) the spread of this disease to the Line Islands, Johnston Island, and Midway Island is well established,[6, 20, 22, 37, 38] and in at least four outbreaks reported from Hawaii, the characteristic ciguatera syndrome strongly suggests that the etiologic agent in the environment of the fish has invaded Hawaiian waters; (2) the condition is particularly insidious in that it defies ready detection: it is not possible to distinguish a toxic fish from a nontoxic fish without time-consuming test feeding to mammals or completion of a complex extraction and bioassay; (3) among the fishes normally affected are those highly esteemed as food, such as the carangids (ulua, papio), barracuda, and acanthurids (manini, palani, pualu), as well as a number of other reef fishes which are heavily fished by sportsmen and some commercial fishermen (practically all reef species are consumed as food by some segment of the population in Hawaii); (4) because of the vicissitudes of phenomena associated with ciguateric fishes, regulation of consumption in a general outbreak would be difficult and wasteful (for example, in the Society Islands, there is a species of fish which is toxic in one area of a bay, and nontoxic in another,[47] and there is evidence that the toxicity of fish waxes and wanes within a toxic area); and (6) the apparently cumulative effect of ciguatera toxin causes patients to display what appears to be an increased sensitivity upon repeated exposure.

Hawaii State Health Department and conservation authorities are aware of the potential problem

TABLE 2.—*Periods since 1900 during which outbreaks of fish poisoning of various categories have occurred in the Hawaiian Islands. (Based on data from Appendix B.)*

| CLASSIFICATION OF FISH POISONING | DATES | | | | | | TOTAL | |
|---|---|---|---|---|---|---|---|---|
| | *40 yrs. 1900–40 (Incl.)* | *5 yrs. 1941-45 (Incl.)* | *5 yrs. 1946-50 (Incl.)* | *5 yrs. 1951-55 (Incl.)* | *5 yrs. 1956-60 (Incl.)* | *1 Jan. 1961- 1 Jan. 1963* | *No.* | *%* |
| Ciguatera | | | | | | | | |
| a. Hawaiian origin* | 0 | 0 | 0 | 0 | 2 | 3 | 5 | 9.3 |
| b. Non-Hawaiian origin | 0 | 2 | 4 | 2 | 7 | 4 | 19 | 35.2 |
| Hallucinatory Mullet Poisoning | 2 | 0 | 0 | 2 | 5 | 0 | 9 | 16.7 |
| Tetraodon Poisoning | 4 | 0 | 0 | 0 | 0 | 0 | 4 | 7.4 |
| Scombroid Poisoning | 0 | 0 | 0 | 1 | 2 | 0 | 3 | 5.5 |
| Undetermined Classification | 3 | 1 | 5 | 1 | 4 | 0 | 14 | 25.9 |
| TOTAL No. | 9 | 3 | 9 | 6 | 20 | 7 | 54 | 100.0 |
| TOTAL % | 16.7 | 5.5 | 16.7 | 11.1 | 37.0 | 13.0 | | 100.0 |

* Hawaiian origin refers to "main Hawaiian Islands" as defined in Appendix A.

posed by the increased incidence of ciguatera; it is hoped that this publication, as well as the results of research presently being pursued, will allow the practicing physician to better understand the problem of fish poisoning and to recognize and treat cases which he may encounter.

Among other categories of fish poisoning found in Hawaii, tetraodon poisoning is not viewed as a major health problem because the potential danger appears to be well understood by those persons who regularly consume puffer fish. Carelessness, misjudgment, and ignorance by those preparing local puffer fish will probably result in occasional outbreaks, as they have in the past.

Hallucinatory mullet poisoning is more of academic interest than a threat to public health, since it is a relatively mild condition which has been restricted to the same areas for many years. Existing sanitary regulations and normal precautions will probably prevent scombroid poisoning, except for an occasional case.

## EPIDEMIOLOGICAL STUDY

Recognition of the value of more complete data on fish poisoning to aid in better understanding the problem has prompted the initiation of a broad epidemiological study of fish poisoning in the entire tropical Pacific. Cooperating in this study are the National Institutes of Health, the South Pacific Commission, and the University of Hawaii. French and English editions of an informational booklet on fish poisoning,[25] as well as questionnaires on (1) local knowledge, (2) biological aspects, and (3) medical aspects of outbreaks of fish poisoning are being distributed through the Executive Officer for Health of the South Pacific Commission to medical personnel throughout the tropical Pacific. Because of the apparently low incidence of fish poisoning in the Hawaiian Islands at the present time, the wholesale distribution of this literature in Hawaii is not planned. However, the cooperation of local physicians is solicited in reporting future outbreaks as well as information not previously reported on past outbreaks. Questionnaires are available for this purpose from the Epidemiology Branch, State Department of Health, and from the Hawaii Marine Laboratory, University of Hawaii.

## SUMMARY

Fish poisoning from the ingestion of fish containing toxins largely of nonbacterial origin have been responsible for at least 54 outbreaks involving more than 433 persons and resulting in seven deaths in Hawaii since 1900. A recent spread of ciguatera fish poisoning to areas not previously affected, including the Hawaiian Islands, has resulted in increased research on various aspects of the problem. A description of the defined categories of fish poisoning found in the Pacific is presented, together with the species implicated in each, the syndromes of the diseases in humans, and other available information. The categories discussed are ciguatera, hallucinatory mullet, tetraodon, scombroid, gymnothorax, elasmobranch, and clupeid poisoning. Only the first four categories listed have been implicated in Hawaiian outbreaks. Of these, only scombroid poisoning is known to be caused by the action of a bacterium upon the fish after capture, but, because of its very rapid development under certain conditions, it may be confused with the other categories of poisoning discussed in which fish contain endogenous or acquired toxins when alive. An analysis of past outbreaks of fish poisoning in Hawaii is presented, revealing that ciguatera from imported fish was responsible for a majority of the cases. Ciguatera fish poisoning is considered to be the most serious potential health problem in Hawaii because it has recently spread from the south and west to the Hawaiian Islands, it is difficult to detect,

it normally occurs in a number of species that are highly esteemed as food in Hawaii, its vicissitudes make prediction and control difficult, and the toxin appears to have a cumulative effect on patients receiving repeated doses. An epidemiological study of fish poisoning in the entire tropical Pacific has been initiated in order to learn more about the various categories of fish poisoning and their distribution.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REFERENCES


1. Anonymous: Fish poisoning. The Queen's Hosp. Bull. 2 (June) 1925.
2. Anonymous: Weke—a strange Hawaiian fish. The Queen's Hosp. Bull. 3 (June) 1926.
3. Anonymous: Poisonous fish. Jour. Amer. Med. Assoc. 164:118-119 (Jan. 12) 1957.
4. Anonymous: Fish poisoning, Naval Air Station, Barber's Point, Hawaii. U. S. Navy Med. News Letter 38:29 (Nov. 3) 1961.
5. Arcisz, W.: Ciguatera: Tropical fish poisoning. Spec. Sci. Rep.: Fisheries No. 27. U. S. Fish & Wild. Ser. 23 pp. (May) 1950.
6. Banner, A. H., Scheuer, P., Sasaki, S., Helfrich, P., and Alender, C.: Observations on Ciguatera-type toxins in fish. Ann. N. Y. Acad. Sci. 90:770-787 (Nov. 17) 1960.
7. Banner, A. H., Sasaki, S., Helfrich, P., Alender, C., and Scheuer, P.: A new bioassay method for toxins from fish. Nature 189:229-230 (Jan. 21) 1961.
8. Banner, A. H., Shaw, S. W., Alender, C., and Helfrich, P.: Fish intoxication: Notes on ciguatera, its mode of action and a suggested therapy. South Pacific Commission Technical Series. (In press).
9. Bartsch, A. F., Drachman, R. H., and McFarren, E. F.: Report of a survey of fish poisoning in the Marshall Islands. U. S. Public Health Ser., Div. State Ser. (Mimeo. rep., 117 pp.) (Jan.) 1959.
10. Belotte, J.: Les poissons "empoisonnés" du lagon Tahitien. Médecine Tropicale 15:232-236 (Mar.-Apr.) 1955.
11. Bouder, H., and Cavallo, A.: Essai de Traitement de la Ciguatera par la Vitamine B-6. Assoc. Med. Nouvelle-Caledonie. 11 pp. 1962.
12. Bouder, H., Cavallo, A., and Bouder, J.: Poissons vénéneux et ichtyosarcotoxisme. Bull. L'Institut Océanogr. No. 1240, 66 pp. (July) 1962.
13. Cobb, J. N.: The commercial fisheries of the Hawaiian Islands in 1903. Report U. S. Fish. Comm. for 1904.
14. Cook, J.: A voyage towards the South Pole and around the world. 3rd Ed. London. 2:112-113. 1777.
15. Fish, C. J., and Cobb, M. C.: Noxious marine animals of the central and western Pacific Ocean. Res. Rep. U. S. Fish & Wild. Ser. 36. iii + 45 pp. 1954.
16. Gosline, W. A., and Brock, V. E.: Handbook of Hawaiian Fishes. Univ. of Hawaii Press, Honolulu, ix + 372 pp. 1960.
17. Gross, H. F.: By Trial—By Error. Barracuda poisoning. J. Florida M. A. 47:172 (Aug.) 1960.
18. Halstead, B. W.: Poisonous fish-like vertebrates. Conference on Shellfish Toxicology. U. S. Dept. Health, Education & Welfare, Pub. Health Ser., App. B:37-76 (Oct. 17) 1957.
19. Halstead, B. W.: Dangerous Marine Animals. Cornell Maritime Press. vii + 146 pp. 1959.
20. Halstead, B. W., and Bunker, N. C.: A survey of poisonous fish of Johnston Island. Zoologica 39:61-67 (Aug. 16) 1954.
21. Halstead, B. W., and Lively, W. M.: Poisonous fishes and ichthyosarcotoxism: their relationship to the Armed Forces. U. S. Forces M. J. 5:157-175 (Feb.) 1954.
22. Halstead, B. W., and Schall, D. W.: A report on the poisonous fishes of the Line Islands. Acta Tropica 15:193-232. 1958.
23. Hashimoto, Y., and Migita, M.: On a method of quantitative analysis for fugu (puffer) toxin. Jap. Soc. Sci. Fish. Bull. 16:341-346 (Jan.) 1951.
24. Helfrich, P.: A study of the possible relationship between radioactivity and toxicity in fishes from the central Pacific. U. S. Atomic Energy Comm. Tech. Inf. Ser. Pub. TID-5748. 16 pp. (May) 1960.
25. Helfrich, P.: Fish poisoning in the tropical Pacific. Honolulu, Hawaii. 16 pp. (June) 1961.
26. Helfrich, P., and Banner, A. H.: Hallucinatory mullet poisoning. J. Trop. Med. & Hyg. 63:86-89 (Apr.) 1960.
27. Hessel, D. W.: Marine biotoxins II. The extraction and partial purification of Ciguatera toxin from *Lutjanus bohar* (Forskål). Tox. & Appl. Pharm. 3:574-583 (Sept.) 1961.
28. Hessel, D. W., Halstead, B. W., and Peckham, N. H.: Marine biotoxins I. Ciguatera poison: Some biological and chemical aspects. Ann. N. Y. Acad. Sci. 90:788-796 (Nov. 17) 1960.
29. Hibiki, S., and Simidu, W.: Studies on putrefaction of aquatic products —26. Spoilage of fish in the presence of carbohydrates. Bull. Jap. Soc. Sci. Fish. 24:913-915 (Mar.) 1959.
30. Hutner, S. H., and McLaughlin, J. J. A.: Poisonous tides. Sci. Amer. 199:92-98 (Aug.) 1958.
31. Jordan, D. S., Evermann, B. W., and Tanaka, S.: Notes on a rare fish from Hawaii. Calif. Acad. Sci. 4th Ser. 16:674 (Nov. 14) 1927.
32. Kaempfer, E.: The History of Japan (English edition). Vol. I, p. 134. London. 1727.
33. Kawabata, T.: Poisoning by putrefaction. Allergy-like food poisoning. Kagaku (Tokyo) 25:336-341 (July) 1955.
34. Kawabata, T., Ishizaka, K., and Miura, T.: Studies on the food poisoning associated with putrefaction of marine products. I. Outbreaks of allergy-like food poisoning caused by dried seasoned saury and canned seasoned mackerel. Bull. Jap. Soc. Fish. 21:335-340 (Sept.) 1955.
35. Kimata, M., in Borgstrom, G.: The histamine problem. Fish as Food. Vol. 1, pp. 329-352. Academic Press, New York. 1961.
36. Larsen, N. P.: Tetraodon poisoning in Hawaii. Proc. 6th Pac. Sci. Cong. 5:417-421 (Aug.) 1939.
37. Lee, R. K. C., and Pang, H. Q.: An outbreak of fish poisoning in Honolulu, Hawaii. HAWAII MED. J. 4:129-132 (Jan.-Feb.) 1945.
38. Lee, R. K. C., and Pang, H. Q.: Ichthyotoxism—Fish poisoning: a report and a review. J. Trop. Med. 25:281-285 (May) 1945.
39. Loison, G.: Poisonous fish of the South Pacific. The South Pac. Comm. Quart. Bull. 29-31 (Oct.) 1955.
40. Mann, W. L.: Fish poisoning in Culebra-Virgin Islands area. U. S. Navy Med. Bull. 36:631-634 (Oct.) 1938.
41. McFarren, E. F., and Bartsch, A. F.: Application of the paralytic shellfish poison assay to poisonous fishes. J. Assoc. Agr. Chem. 43:548-554 (Aug.) 1960.
42. Mills, A. R.: Poisonous fish in the South Pacific. J. Trop. Med. & Hyg. 59:99-103 (May) 1956.
43. Murtha, E. F.: Pharmacological study of poisons from shellfish and puffer fish. Ann. N. Y. Acad. Sci. 90:820-836 (Nov. 17) 1960.
44. Nishikawa, Y., and Nishikawa, G.: Review on Poisonous Fishes (1-12) Tokyo Iji-shinshi 69:253-352 (Apr.) 1954.
45. Phisalix, M.: Animaux Venimeux et Venins. Chapt. IX Poissons Toxicophores. 487-628. Masson & Cie. Paris. 1922.
46. Ralls, R. J., and Halstead, B. W.: Moray eel poisoning and a preliminary report on the action of the toxin. Amer. J. Trop. Med. & Hyg. 4:136-140 (Jan.) 1955.
47. Randall, J. E.: A review of Ciguatera, tropical fish poisoning, with a tentative explanation of its cause. Bull. Mar. Sci. Gulf & Carib. 8:236-267 (Sept.) 1958.
48. Ross, S. G.: Preliminary report on fish poisoning at Fanning Island. Med. J. Australia 2:617-621 (Nov. 22) 1947.
49. Simidu, W., in Borgstrom, G.: Nonprotein nitrogenous compounds. Fish as Food. Vol. I, 353-384. Academic Press, New York. 1961.
50. Takata, M.: Poisonous fish studies. Reef and Inshore Game Fish Management Research Job Completion Report (Mimeo) Investigation proj. No. F-5-R, 7(4), Div. of Fish & Game, Terr. of Hawaii. 1956.
51. Tsuda, K., and Kawamura, M.: The constituents of the ovaries of globefish. VII. Purification of tetrodotoxin by chromatography. J. Pharm. Soc. Jap. 72:771-773 (June) 1952.
52. Tsuda, K., and Kawamura, M.: The constituents of the ovaries of globefish. VIII. Studies on tetrodotoxin. Pharm. Bull., Tokyo 1:112-113 (June) 1953.
53. Yokoo, A.: Chemical studies on tetrodotoxin. Rept. III. Isolation of Spheroiding. Nippon Kagaku Zasshi 71:590-592 (Nov.) 1950.
54. Yokoo, A., and Morosawa, S.: Studies on the toxin of a globefish. Rept. V. Comparison with tetrodotoxin. J. Pharm. Soc. Jap. 75:235-236 (Feb.) 1955.
55. Yudkin, W. H.: Tetraodon poisoning. Bull. Bingham Oceanogr. Coll. 9:1-18 (Feb.) 1944. ■

Appendix A.—*Compilation of fish poisoning outbreaks in Hawaii described in Appendix B.*

| Classification of fish poisoning based on available evidence | No. of outbreaks recorded | No. of persons afflicted | Fatalities | Percent deaths in persons afflicted | Percent of total outbreaks attributed to this category of fish poisoning | Case No. (Appendix B) |
|---|---|---|---|---|---|---|
| Ciguatera | | | | | | |
| a. Fish originating in main Hawaiian Is.* | 4 | 38+ | 0 | 0 | 7.4% | 33, 43, 51, 52 |
| b. Fish originating in other than main Hawaiian Is. | 19 | 183+ | 0 | 0 | 35.2% | 11, 12, 15, 16, 17, 21, 22, 29, 35, 38, 39, 41, 42, 44, 47, 48, 49, 53, 54 |
| Hallucinatory Mullet Poisoning | 9 | 50+ | 0 | 0 | 16.7% | 7, 9, 25, 26, 27, 28, 30, 31, 46 |
| Tetraodon Poisoning | 4 | 12 | 7 | 58.3% | 7.4% | 1, 3, 4, 6 |
| Scombroid Poisoning | 3 | 57+ | 0 | 0 | 5.5% | 24, 37, 40 |
| Undetermined Classification | 15 | 93+ | 0 | 0 | 27.8% | 2, 5, 8, 10, 13, 14, 18, 19, 20, 23, 32, 34, 36, 45, 50 |
| TOTALS | 54 | 433+ | 7 | | 100.0% | |

* The "main Hawaiian Islands" refers to the populated islands of Hawaii, Maui, Molokai, Lanai, Oahu, Kauai, and Niihau.

Appendix B.—*Reports of outbreaks of fish poisoning from Hawaii.*[1]

| No. | Date and site of outbreak in Hawaii | Species of fish and place caught | No. of persons involved | Symptoms | Source of information |
|---|---|---|---|---|---|
| 1. | April 1903 Kamalo, Molokai | 'O'opu-hue or Makimaki." *Arothron hispidus.* Place caught unknown. | 1 (1 death) | Tightness and obstruction in breathing; giddiness, tingling, burning and creeping sensations; nausea, vomiting, involuntary purging; rapid, irregular heart action; tendency to syncope; cold hands and feet; failing voice, vision, and hearing; body bathed in cold perspiration; pupils markedly dilated; face pale; great prostration; delirium; convulsive twitching of limbs and muscles of face and body. | Report of A. Mouritz, M.D., Mapulehu, Molokai, in Cobb, J. N., 1904. *The Commercial Fisheries of the Hawaiian Islands in 1903; Report U. S. Fish. Comm. for 1904,* p. 500. |
| 2. | 1909—Aboard Cruiser Tennessee at Honolulu | Not recorded. | Not recorded. | Not recorded. | Mann, W. L., 1938. *U. S. Navy Med. Bull.* 36:631-634. |
| 3. | 1910—Federal Immigration Sta. | "Puffer fish." Probably *Arothron* sp.; place caught unknown. | 7 (3 deaths) | Symptoms not reported, only "Three died, four were very sick." | Anonymous 1925. Fish Poisoning, *Queen's Hospital Bulletin* 2(1). (Nils P. Larsen, M.D., of Honolulu claims authorship of this report.) |
| 4. | 1924—Waialua, Oahu | "Dried eggs of Puffer fish." Probably *Arothron* sp.; place caught unknown. | 1 (1 death) | Symptoms not reported, only "She (the victim) died within four hours." | Same as above. |
| 5. | Prior to 1925 Molokai | "Ulua" (Family Carangidae). Caught on the sheltered (south) side of Molokai. | 6 | General ill-feeling and apprehension, nausea, dizziness and tingling in the fingers and toes and all over the body, feeling as if they had been drugged. Two felt and acted definitely intoxicated as with alcohol. In 24 hours all symptoms disappeared. | Same as above. |

[1] Only those outbreaks which occurred in Hawaii are recorded (i.e. the fish was ingested here although it may not have been caught in Hawaii). Cases in which the outbreak took place elsewhere and the victims were brought to Hawaii for treatment are not included in this compilation. Common names of fish as in report or scientific names after Gosline and Brock, 1960.

| NO. | DATE AND SITE OF OUTBREAK IN HAWAII | SPECIES OF FISH AND PLACE CAUGHT | NO. OF PERSONS INVOLVED | SYMPTOMS | SOURCE OF INFORMATION |
|---|---|---|---|---|---|
| 6. | 1925—Honolulu | "Puffer fish." Probably *Arothron* sp.; place caught unknown. | 3 (2 deaths) | Onset 3½ hrs. after ingestion; weakness, nausea, vomiting, severe headache, general numbness; two deaths in few minutes after onset of symptoms. | Larsen, N. P., M.D., *Proc. Sixth Pac. Sci. Congress* 1939. 5:417-421. |
| 7. | 1927 (?) Molokai | "Weke pueo." *Upeneus arge;* place caught unknown. | 30 to 40 | Delirium and "mental paralysis" | Jordan, D. S., B. W. Evermann, and S. Tanaka. 1927. *Proc. Calif. Acad. Sci.* 4(16):20. |
| 8. | 1936—Molokai | "White ulua." Probably *Carangoides ajax;* caught near the mouth of Waialua stream, Molokai, Hawaii | 3 | Nausea, vomiting, tingling of the skin. Medical treatment received. | Personal interview with Mr. Daniel Naki, Waialua, Molokai. |
| 9. | 1939 or 1940 Pilaa, Kauai | "Mullet." Probably *Mugil cephalus;* caught near Pilaa, Kauai. | About 12 | Drowsiness, extreme weakness in legs, feeling of impending death; frightening dreams. | Report by Mr. George Akau, Bureau of Pure Food & Drugs, Dept. of Health, T. H. |
| 10. | Mid-August, 1943 Honolulu | Flatfish, "Pakii" or " 'Ui'ui." Probably *Bothus mancus;* about 100 yds. off Kuhio Beach (Waikiki, Honolulu). | 2 | Fish fried and eaten at evening meal, a few hours after capture. Onset of symptoms about 5 hrs. after ingestion; symptoms in-included nausea, vomiting, diarrhea, parched feeling in throat, nightmares and mental depression. Symptoms subsided about 4½ hours after onset. | Report by Dr. Yoshio Kondo, Bishop Museum, Honolulu. |
| 11. | Nov.-Dec. 1944 Honolulu | *Variola louti;* caught at Midway Is., Hawaiian Arch. | 24 | Onset—4 to 6 hours; vomiting, diarrhea, severe aches and pains in extremities; feeling of numbness in hands and feet. | Lee, R. K. C., M.D., and H. Q. Pang, M.D. 1945. HAWAII MED. JOUR. 4(3):129-132. Also in *Amer. Jour. Trop. Med.* 1945. 25(3):281-285. |
| 12. | Nov.-Dec. 1944 | "Black Sea Bass," *Serranus (=Epinephelus) fuscoguttatus;* caught at Christmas Is. | 14 | Onset—2 to 6 hours; vomiting, diarrhea, severe aches and pains in extremities, feeling of numbness in hands and feet. | Lee, R. K. C., and H. Q. Pang. 1945. HAWAII MED. JOUR. 4(3):129-132. Also in *Amer. Jour. Trop. Med.* 1945. 25(3):281-285. |
| 13. | Feb. 1946 Waipahu, Oahu | Unident. "red fish"; caught at Waipio Pt., Oahu, Hawaii. | 12 | Onset 1 hour after ingestion; complete collapse, prostration; shock; extremities cold and clammy; severe diarrhea and dehydration. Pulse 30-40; BP 80/60.[2] | M. M. Chandler, M.D., Waipahu Hospital, Waipahu, Oahu, in report to Dept. of Health, T. H. |
| 14. | June 1947 | "Snapper" (Lutjanidae), "Ulua" (Carangidae) and "Mullet"; place caught unknown. | 12 | Onset 4 to 5 hours after ingestion; stomach cramps, headache, burning and numbness of lips and cheeks, vomiting, diarrhea, and paralysis of arms and legs. Recovery in 24 hours. | Report of Mr. Jack P. Kapua, Pure Food & Drugs Bureau, Dept. of Health, T. H. |
| 15. | Sept. 1947 Honolulu | "Red Snapper." Probably *Lutjanus* sp.; caught in vicinity of Christmas Island, Line Islands. | 16 | Not recorded. | *Honolulu Star-Bull.,* 3 Oct. 1947 and Report of R. K. C. Lee, M.D., Dept. of Health, T. H. |
| 16. | 28 Sept. 1947 Honolulu | "Red Snapper." Probably *Lutjanus* sp.; caught at Fanning Island, Line Islands. | 4+ | Onset within ½ hour after ingestion; nausea, vomiting, diarrhea, "numbness of body," and a stinging sensation. | Report of Mr. Andrew S. Orlando, Pure Food & Drugs Bureau, Dept. of Health, T. H. |
| 17. | Dec. 1947 Honolulu | "Red Snapper." Probably *Lutjanus* sp.; caught in vicinity of Christmas Island, Line Islands. | 17 | Chills, diarrhea, tingling and numbness about mouth, pains and weakness in legs, headache, dizziness, and burning sensation of mouth when drinking cold water. | Report of R. K. C. Lee, M.D., Dept. of Health, T. H. |

[2] Laboratory tests on implicated fish revealed that the causative agent was probably staphylococci.

| NO. | DATE AND SITE OF OUTBREAK IN HAWAII | SPECIES OF FISH AND PLACE CAUGHT | NO. OF PERSONS INVOLVED | SYMPTOMS | SOURCE OF INFORMATION |
|---|---|---|---|---|---|
| 18. | Dec. 1947 Honolulu | "Mahimahi," *Coryphaena hippurus;* place caught unknown. | 31 | Employees of Libby, McNeill & Libby Co. became very ill after eating in company's cafeteria; detailed symptoms not reported. | Report of Mr. George Akau, Pure Food & Drugs Bureau, Dept. of Health, T. H. |
| 19. | About 1948 Hilo | "White Eel." Probably *Conger marginatus;* caught in a trap on island of Hawaii, exact location unknown. | "Several" | Patients became violently ill; symptoms both gastrointestinal and neurological with recovery in 5 to 7 days. Remains of eel fed to cat which developed paralysis of limbs and died from respiratory arrest. | Personal correspondence from W. S. L. Loo, M.D., Hilo, Hawaii. |
| 20. | Oct. 1949 Honolulu | "Surgeonfish and other unidentified varieties"; caught at Johnston Is. | 10 | Not recorded. | Report of Mr. George Akau, Pure Food & Drugs Bureau, Dept. of Health, T. H. |
| 21. | Aug. 1950 Honolulu | "Black Bass" (Sea Bass). Probably a serranid; caught at Canton Is., Phoenix Islands. | 5 | Onset 12 to 36 hours after ingestion; abdominal pain, diarrhea, tingling and numbness of hands and feet; when drinking water it tasted hot and salty; showering caused itchiness over the entire body, fetal movements ceased during 3 days of sickness in pregnant women. | Lewis M. Nutting, Pure Food & Drugs Bureau, Dept. of Health, T. H. |
| 22. | Feb. 1951 Maui | "Manini," *Acanthurus triostegus triostegus;* caught at Palmyra Is. | 31 | Vomiting, diarrhea, abdominal pain, nausea, tingling and numbness about the mouth, extreme weakness, pains in joints of arms and legs, reversal of temperature sensation; itchiness of soles and palms. | Reports of Mr. George Akau, Dept. of Health, T. H., and T. G. Lathrop, M.D., Dept. of Health, Wailuku, Maui, Hawaii. |
| 23. | 1953-1955 (?) Maalaea, Maui | "Akule," *Trachurops crumenopthalmus;* caught at Maalaea Bay, Maui, Hawaii. | 5+ | Gastrointestinal upset; numbness and tingling about the mouth.[3] | Report by W. B. Patterson, M.D., Puunene, Maui, and personal interview with one of the victims. |
| 24. | 17 Aug. 1954 Honolulu | "Mahimahi," *Coryphaena hippurus;* caught 30-40 miles SE of Diamond Head, Oahu, Hawaii. | 51 | Onset 15-30 minutes after ingestion; resembled histaminic reaction; diarrhea, nausea, vomiting, headache, flushing, some conjunctival congestion. No neurotoxic symptoms. | Report of James R. Enright, M.D., Chief, Bureau of Epidemiology, Dept. of Health, T. H. |
| 25-28. | Between May and Aug. 1954-1959 (4 separate outbreaks) Molokai | "Mullet," *Mugil cephalus;* caught in Palaau region of Molokai, Hawaii. | 4 | Onset 2 hours after ingestion; dizziness, loss of balance, pounding heart. Symptoms of short duration (about 1 hour), and the same in all four outbreaks. | Personal interview with victim at Kaunakakai, Molokai. |
| 29. | 1955 Honolulu | "Red Snapper." Probably *Lutjanus* sp.; caught at Canton Is., Phoenix Islands. | 4 | Diarrhea, extreme weakness, difficulty in breathing, decreased heartbeat, numbness of lips, hands, and feet; warm water felt cold and penetrating. | Mr. Y. S. Lee and Mr. K. K. Tomomitsu, Food & Drug Inspectors, Dept. of Health, T. H. |
| 30. | 1955-56(?) Kaunakakai, Molokai | "Mullet," *Mugil cephalus;* caught at Palaau, Molokai, Hawaii. | 1 | Dizziness, loss of equilibrium, ringing in ears, tingling sensation over entire body; duration about 30 min. | Personal interview and correspondence with victim at Kaunakakai, Molokai. |
| 31. | 1956 Molokai | "Mullet," *Mugil cephalus;* caught at Palaau, Molokai, Hawaii. | 1 | Onset of symptoms 10 minutes after ingestion—included nausea, vomiting, tingling sensation of skin. (Fish prepared and eaten 20 minutes after being caught.) | Personal interview with victim at Pukoo, Molokai. |
| 32. | Sept. 1956 Kohala | "Humuhumu-'ele'ele," *Melichthys buniva;* caught near Mahukona, Hawaii. | 1 | Onset 14 hours after ingestion; pain, muscle spasm in arms and legs, severe pain in wrists and ankles. No nausea or vomiting. More severe effects after ingestion of portion of the same fish 3 weeks later.[4] | Personal correspondence from F. L. Tabrah, M.D., Kohala, Hawaii. |

[3] Fishermen report that Akule "spoil" rapidly after removal from water. Conflicting evidence exists as to the freshness of these fish when eaten, and therefore bacterial action cannot be ruled out as the causative agent in this case.

[4] Second ingestion caused more severe symptoms including an overpowering lethargy and a feeling of cold and painful feet. A burning pain in soles continued for almost 12 months requiring Demerol occasionally to enable the patient to work.

| NO. | DATE AND SITE OF OUTBREAK IN HAWAII | SPECIES OF FISH AND PLACE CAUGHT | NO. OF PERSONS INVOLVED | SYMPTOMS | SOURCE OF INFORMATION |
|---|---|---|---|---|---|
| 33. | 10 Oct. 1956 Honolulu | "Palani," *Acanthurus dussumieri;* speared on the Mokuleia side of Kaena Pt.. Oahu | 1 | Onset of symptoms about 24 hours. Symptoms included vomiting, diarrhea, numbness about the mouth, hypersalivation, prickling sensation on palms of hands, tingling and itching over entire body, intermittent periods of aching joints during which time the patient could not stand (duration of about 30 min.), and insomnia. Tingling and numbness persisted 3 days. 2 cats ate the head and suffered ataxia, loss of appetite. | Reported by Mr. Michio Takata, Terr. Division of Fish & Game, and F. I. Gilbert, M.D., Honolulu. |
| 34. | 30 July 1957 Honolulu | Specimen not seen; from description thought to be "Weke-'ula," *Mulloidichthys auriflamma;* place of capture unknown. | 3 | Onset of symptoms 3½ hours after ingestion; duration 4 hours. Symptoms included intermittent numbness of fingertips, tongue and mouth, and chills. | Reported by Mr. Michio Takata, Terr. Division of Fish & Game, Honolulu, Hawaii. |
| 35. | October 1957 Wahiawa, Oahu | Specimen not seen; from description it appears to be a Gray Snapper, probably *Lethrinus* sp.; caught at Canton Is., Phoenix Islands and brought to Honolulu frozen. | 2 | Onset of symptoms 2-3 hours after ingestion of the fish fried. Patients hospitalized with severe vomiting and diarrhea, hypersensitivity of extremities to cold, inability to drink cold water. | Reported by Mr. K. K. Tomomitsu, Food & Drug Inspector, Terr. Dept. of Health, Honolulu. |
| 36. | 1958 Kauai | "Manini," *Acanthurus sandvicensis;* caught in the Pilaa-Haena region, Kauai, Hawaii. | 1 | Patient reported "poisoned" from eating Manini; symptoms not recorded. | Report of Mr. George H. Akau, Bureau of Pure Food & Drugs, Terr. Dept. of Health, Honolulu. |
| 37. | 26 Aug. 1958 Honolulu | "A'u" or "Swordfish"; species unknown. Caught either off Hilo, Hawaii, or the Waianae coast of Oahu. | 4+ | Onset of symptoms 15 minutes after ingestion. Symptoms included diarrhea, nausea, vomiting, throbbing headache, and hot-flushed face. A four-year-old victim developed urticaria. Duration of symptoms was about two hours. | Reported by Mr. K. K. Tomomitsu and Mr. Y. S. Lee, Bureau of Pure Food & Drugs, Terr. Dept. of Health, Honolulu. |
| 38. | May 1959 Honolulu | "Grouper," *Cephalopholis argus;* caught at Palmyra Island, Line Islands. | 4 | Onset of symptoms about 10 hours after ingestion, included tingling about mouth, numbness in extremities, nausea, and lethargy. Remains fed to mongooses produced kills at 10% and 20% body weight equivalent doses. | Report of Col. F. L. Boling and Maj. F. Clayton, U.S.A.F., Hickam Air Force Base, Hawaii. |
| 39. | Oct.-Nov. 1959 | "Thick-lipped Ulua, Pig Ulua, or Butaguchi," *Caranx cheilio,* caught in lagoon at Midway Is.[5] | 25+ | Numbness and tingling about the mouth and extremities; weakness in legs; reversal of temperature sensation, insomnia, nausea, vomiting, diarrhea. | Report of W. M. M. Robinson, M.C., USN, Medical Officer, U. S. Naval Station, Midway Is., and Banner *et al.*, *Ann. N. Y. Acad. Sci.* 90(3):770-787. |
| 40. | 1 Sept. 1959 Honolulu | "Ahi," *Neothunnus macropterus* bought from a Honolulu fish market, place caught unknown. | 2 | Severe cephalgia, pounding and frontal, (histamine type), circumoral tingling, diffuse irregular erythema, severe sensation of burning in skin but no itching, conjunctival congestion, BP normal, pulse 112. Nausea w/o vomiting. Symptoms abated after IV inj. antihistamine. Patient thought fish tasted "hot" or "wrong" at time of ingestion. | Report of R. Butler, M.D., Honolulu, Hawaii, to State Dept. of Health. |

[5] Periodic sampling of this species from Midway Lagoon was carried on during 1960. Samples produced ciguatera syndrome in laboratory animals.

| NO. | DATE AND SITE OF OUTBREAK IN HAWAII | SPECIES OF FISH AND PLACE CAUGHT | NO. OF PERSONS INVOLVED | SYMPTOMS | SOURCE OF INFORMATION |
|---|---|---|---|---|---|
| 41. | Nov. 1959 Kaneohe, Oahu | "Ulua," *Caranx ignobilis;* caught off channel at west end of Palmyra Is., Line Islands. | 1 | Onset of symptoms about 20 hrs. after ingestion; diarrhea, headache, dizziness, unsteady gait, flushed feeling, malaise around lips, tongue, and throat, aching joints (especially in hips), weakness in legs, lethargy, burning sensation when touching cold objects. Mild symptoms persisted for 5 days. | Personal interview with patient by author. |
| 42. | 11 Dec. 1959 Kailua, Oahu | "Ulua" (Carangidae), species unknown; fish caught off Johnston Is. | 3 | Onset of symptoms about 12 hrs. after ingestion; weakness in limbs, lethargy, dizziness, metallic and carbonated taste when food ingested, aching joints, burning sensation when touching cold objects, itchiness of skin over the entire body. No vomiting or diarrhea. Mild symptoms persisted about 7 days. | Personal interview with patient by author. |
| 43. | 2 Mar. 1960 | Thought to be "Palani" (*Acanthurus dussumieri*) bought from Honolulu fish market; place caught unknown.[6] | 2 | Attending physician familiar with *ciguatera* from other areas and stated symptoms similar including nausea, vomiting, paresthesia, numbness in extremities, reversal of sensations of heat and cold. | Report of H. L. Arnold, Sr., M.D., Honolulu, Hawaii. |
| 44. | 18 June 1960 | "Ulua" (Carangidae), species unknown; caught at Midway Is., Hawaiian Arch. | 4 | Onset of symptoms 5 hours after ingestion; included numbness of leg muscles and joints, reversal of temperature sensation, burning pains, sweating. Diarrhea, fever, headache not present. Examined by physician who diagnosed it as acute food poisoning. Lab tests on fish tend to confirm *ciguatera* fish poisoning. | Mr. Thomas M. Naito, Food Inspector, Pure Food & Drugs Div., State Dept. of Health. |
| 45. | 25 June 1960 Hauula, Oahu | "Black Hinalea," an unidentified labrid fish, and the ovaries of the sea urchin, *Podophora atrata* both caught in shallow water at Hauula, Oahu. | 1 | Onset of symptoms about 18 hours; weakness of legs, nausea, later swollen feeling in tongue and hand, numbness in cheeks and tingling in fingers (like pins and needles). | Report by victim's physician, Mary A. Glover, M.D., Kaneohe, Hawaii, and personal interview with the patient. |
| 46. | 25 Oct. 1960 | Unidentified species of "Weke" (Mullidae). Place caught unknown. (Obtained from peddler.) | 2 | Dizziness; paresthesia; temporary paralysis; ineffectual attempts to urinate; malaise; feeling of floating in the air; mental anguish; nightmares. | Report of Teru Togasaki, M.D., Honolulu, Hawaii. |
| 47. | 29 Oct. 1960 | Ulua, believed to be *Caranx cheilio,* caught in lagoon, Midway Island. | 8 | Burning and tingling about the mouth; tingling in extremities; weakness in legs; pain in joints; reversal of temperature sensation; malaise, nausea, vomiting, and diarrhea. | Report of M. A. De Harne, M.D., Wahiawa, Oahu, and James Enright, M.D., State Dept. of Health, Honolulu, Hawaii. |
| 48. | 1 June 1961 | "Kahala, Amberjack, or Yellowtail," *Seriola dumerilii,* (Carangidae) caught at Midway Island. | 12 | Diarrhea; vomiting; tingling and numbness in the extremities; sensation of electric shock experienced when touching objects. Adult patients later developed hives. | Report of K. K. Tomomitsu, Food & Drug Inspector, Bureau of Pure Food & Drugs, State Dept. of Health, Honolulu, Hawaii. |

[6] The remains of the implicated fish were discarded before they could be examined, but the physician asked the patient to purchase another fish just like the one that had poisoned him. The patient purchased a "palani" (*Acanthurus dussumieri*). It should be noted that this species is very similar to two other species commonly found in the local fish markets, *Acanthurus mata,* and *Acanthurus xanthopterus,* and the three species might be easily confused by those not familiar with the rather subtle distinguishing characteristics. The fish purchased by the patient was fed to test animals with negative results.

| NO. | DATE AND SITE OF OUTBREAK IN HAWAII | SPECIES OF FISH AND PLACE CAUGHT | NO. OF PERSONS INVOLVED | SYMPTOMS | SOURCE OF INFORMATION |
|---|---|---|---|---|---|
| 49. | 20 July 1961 Naval Air Sta. Barber's Pt., Oahu | "Rainbow Runner, Kamanu, or Hawaiian Salmon" *Elagatis bipinnulatus* (Carangidae) caught in shallow water off Eastern Is., Midway. | 6 | Tingling and numbness about lips, tongue and throat; abdominal cramps; diarrhea; numbness and tingling of hands and feet; malaise, slow heart rate; restlessness; insomnia; peppery taste and thirst; dysesthesia; itching palms and soles; hypotension. Neurotoxic symptoms prolonged. | Report of CWO R. J. Mazza, Sanitation Officer, U. S. Naval Station, Barber's Point, Hawaii. Also *U. S. Navy Medical News Letter* 38(9):29, 1961. |
| 50. | 1 Apr. 1962 Kealia, Kauai | "Marlin" (species unknown) caught near Kauai. Fish weighed 520 lbs.; only the head and liver were known to be involved in intoxications. | 3 | Onset of symptoms about 12 hrs. Liver eaten on 2 occasions; after 1st meal patient experience frontal headache, after 2nd meal, patient and wife both experienced nausea, vomiting, diarrhea, aching joints, and weakness in legs. Weakness persisted for 8 days. Face began to peel 3rd day after ingestion. One patient who both handled and ingested the liver experienced exfoliating dermatitis of hands after 7 days. A 3rd person ate only the head and experienced drowsiness and "heaviness of legs." | Peter Kim, M.D., Samuel Mahelona Memorial Hospital, Kealia, Kauai. |
| 51. | 9 Apr. 1962 Honolulu | "Palani," *Acanthurus dussumieri* caught off the Waianae coast of Oahu and sold in a Honolulu fish market. Two fish involved—about 9" and 18" in length. | 5 | Fish appeared wholesome when prepared. Fish boiled and eaten; onset of symptoms about 10 hours after ingestion. Symptoms included headache, malaise, tingling of extremities, aching of joints and teeth, generalized weakness, abdominal cramps, sore throat, and diarrhea (black stools). One victim had been previously poisoned; his symptoms persisted for 3 weeks. In others, symptoms lasted 1½ weeks. | Reported by Mr. K. K. Tomomitsu, Food & Drug Inspector, State Dept. of Health, and R. C. Durant, M.D., Honolulu. |
| 52. | 9 July 1962 Island of Hawaii | "Black Sea Bass" possibly *Epinephelus tauvina* caught at Kapoho Beach. Fish weighed 238 lbs. | 30+ | Symptoms in order of frequency reported: "tired feeling" or weakness in arms and legs, diarrhea, vomiting, prickling and itchiness of palms and soles, itching of mouth, itching of fingers, "tender tongue," "stomach distress," hives, swollen lips, itchiness over the entire body, rash 2-3 days after ingestion. Stomach of fish appeared to be the most highly toxic. | Report of Mr. Horace Kawamura, Area Sanitarian, Hawaii State Dept. of Health. |
| 53. | 7 Sept. 1962 Waianae, Oahu | "Red Snapper" (species unknown) from lagoon, Canton Island, Phoenix Is. | 2 | Onset of symptoms about 4 hrs. Numbness of facial area and extremities, severe diarrhea, vomiting, prostration, and sensitivity to cold. One victim was hospitalized for 3 days. | Report of Mr. K. K. Tomomitsu, Food & Drug Inspector, Bureau of Pure Food & Drugs, State Dept. of Health. |
| 54. | 24 Oct. 1962 Midway Is. | "Ulua" (species unknown) caught near lagoon reef; total length—20 inches. | 1 | Onset of symptoms 90 minutes after ingestion with sudden extreme fatigue, nausea, feeling faint. Other symptoms—chills, sweating, stiff neck, cold liquids burned when swallowed, diarrhea, itching and burning of skin, abdominal cramps, aching muscle (especially thighs), aching joints, reversal of temperature sensation over entire body. Patient responded well to neostigmine therapy. | Robert L. Altman, M.D., Pearl Harbor Naval Shipyard Dispensary, Hawaii. |

# *The President's Page*

I believe that it is pertinent at this time to review the activities of the Legislative Committee and the Legislative Advisor. We have had two years now of this organizational structure. The first year a true test of our effectiveness could not be had because of the fact that the first session of the Legislature under which our organization functioned was a budget session. As a consequence, bills were limited to financial items mainly and this, generally, presented no great test to us.

This year the Legislature has had a Democratic majority and the bills introduced have presented a true test of our capacity to develop a professional, concentrated liaison with other health groups and with the members of the Legislature. Our organization has demonstrated that it can be effective in advising the Legislature on various public health matters and upon matters which pertain to affairs of the medical profession and hospitals.

Our Legislative Advisor in my estimation has been particularly effective in bringing our viewpoint to the Legislature. He has also been very effective in bringing to the Legislators a clearer idea as to our sincerity and desires in obtaining for our State the best and most smoothly functioning care of the sick which can be had anywhere in the world. He has been able to participate in our discussions and the evaluations of the opinions and motives of the various members so that he has obtained the complete picture of us as we really are. I feel he has been able to transmit that to some degree to the members in the Legislature with whom he works. This, I feel, is the most effective public relations activity that can be undertaken at this time. Our adviser Mr. Honda has also been a tremendous help in creating and directing our activities in legislature and other matters.

A few bills have given rise to some uneasiness and dissatisfaction among those of us who have the good of the community and the medical profession at heart. In most instances we have been able to come to an understanding with those with whom we have discussed our problems. This understanding has come about from a spirit of cooperation and good will which is much better and developed to a higher degree in my knowledge than in the past many years.

The efforts of our Association and other phases of activities of developing understanding in all the people in our state should continue and these efforts will not go unrewarded.

Th. Giles MD

# Editorials

[*see also page 389*]

## Whither Medical Licensing?

From conversations with medical educators both during the Congress on Medical Education and since, we have been more than ever impressed by their critical, if not outright hostile attitude toward medical licensing laws and Boards of Medical Examiners.

Many of the medical educators adopt the view that, as there are now no unapproved medical schools in the United States, it is a ridiculous waste of time to subject graduates of approved schools to licensing examinations after they have graduated. The educators believe that under the present system of education, where the student is subjected to four years of training and close observation, it is superfluous to require him to pass still another examination before he can be licensed to practice his profession. Others believe that the student should take the three parts of the National Board examinations at the proper time and, having obtained the certificate he should be allowed to practice in any state without exception.

After returning from Chicago we were discussing these problems with the Dean of one of the leading medical schools in the country. The discussion finally reached the point at which we asked the direct question, "Do you think the State Boards of Medical Examiners have any legitimate functions at all?" His reply was that the functions of the Boards should be limited to the examination of graduates of foreign medical schools and the handling of disciplinary problems. . . .

Many of us are opposed to the senseless obstacles to licensure placed in the paths of graduates of approved United States and Canadian medical schools. Although most agree that licensing is one of the few remaining states' rights and should remain so, we are disturbed by the difficulties which a few recent graduates encounter in initially obtaining licenses; the trials of many older physicians in moving from one part of the country to another are too well known to warrant discussion.

As far as the disciplinary functions of the Board are concerned, these cannot be exercised in regard to the recent medical graduate who has not had time to prove himself either for good or evil. It has been pointed out by others that until suitable tests are devised to screen applicants for such qualities as honesty, integrity, dedication and emotional stability, the Boards cannot exercise their disciplinary powers until after the physician has encountered trouble. Meanwhile we must continue to count on the medical schools to eliminate students with unmodifiable bad traits before they have a chance to reach disciplinary boards. . . .

Regardless of the opinions of many educators that state board examinations should be abolished and of many members of the Federation that endorsement policies should be greatly liberalized, neither will be accomplished in the foreseeable future. . . .

The foregoing editorial appeared in the April, 1963 issue of the *Federation Bulletin,* monthly publication of the Fedcration of State Medical Boards of the United States. It represents the viewpoint of the Editor, Dr. R. C. Derbyshire, of Santa Fe, Mexico, and probably that of a substantial number of members of State Medical Boards. It will repay thoughtful study and rcflection.

Hawaii's Board of Medical Examiners is empowered by law to excuse from examination only candidates who hold the diploma of the National Board of Medical Examiners. All others must be examincd by our State Board. It is a good examination, and a fair one, designed by the Professional Examination Service of the American Public Health Association, and it eliminates an occasional foreign graduatc from a very inferior school (since under our law no foreign school is so bad that we will not liccnse its graduates if they can pass the examination). It also eliminates approximately the tcn or fifteen per cent of candidates with the least ability to write an acceptable multiple-choice examination; on the whole, this mcans the ones with the lowest "IQ," as IQ is measured. It is also pretty hard on a doctor who is more than ten or fifteen years out of school, particularly if he has become an accomplished specialist.

To say that it is "difficult" to justify the practice of routinely examining a young man who has graduated from an American or Canadian medical school within the past five or ten years, in order to see whether he knows enough medicine to practice it, is surely an understatement. The examination would be twicc—nay, ten times—as valuable if it were postponed for ten years, and then given to see whether he had kept up with medicine sufficiently during the decade.

Hawaii's Medical Practicc Act poses other problems—the year's residencc clause; praetice by unregistered, unlicensed physicians "under the direction and with the approval" of licensed physicians; licensure by one department and revocation and suspension of licenses by another; and others. The problcm is a complex one. At the moment, a conscientious and upright Board of Medical Examiners seems to be doing an effective job despite the shortcomings of the law.

HAWAII MEDICAL JOURNAL

# This Is What's New!

• Michigan immunologists have demonstrated that **mice** can be effectively **immunized against lymphatic leukemia.** Active immunity was achieved by introducing heat-damaged cancer cells into the animals and passive immunity was accomplished by using whole blood, liver, and spleen preparations from immune mice. (*J. Infectious Dis.* [Jan.-Feb.] 1963.)

• Clinical pathologists at the National Cancer Institute describe **intranuclear inclusion bodies** in plasma cells of patients suffering from the various types of **multiple myeloma** as well as **macroglobulinemia.** The inclusion bodies can be readily identified in Giemsa-stained smears of bone marrow. The bodies are PAS-positive and probably represent nuclear elaboration of glycoprotein. (*Blood* [Mar.] 1963.)

• In a gastrointestinal journal, a note of caution is sounded regarding **gastric hypothermia.** The author suggests that an **atrophic nonfunctioning gastric mucosa** achieved by severe cold trauma is **not** a desirable therapeutic goal. He advises that the technique be withheld from general use until data have been subjected to proper statistical analysis. In the same issue a group of investigators in New York believe the method "may be of some value" in the management of massive upper gastrointestinal bleeding where the bleeding cannot be controlled by other means. (*Am. J. Digestive Dis.* [Feb.] 1963.)

• Diagnosticians in Minnesota were able to diagnose **mitral insufficiency** due to **ruptured papillary muscle** following **myocardial infarction** in two cases. The mitral regurgitation resulted in severe left ventricular failure. The ruptured muscle was repaired via open-heart surgery, but both patients expired very soon after surgery due to second myocardial infarcts. (*Am. J. Cardiol.* [Feb.] 1963.)

• The good life has its hazards. A German eye physician reports **cataracts, retinal detachments, subluxation of the lens,** and so forth, from **popping champagne corks,** especially plastic ones. (*Literature Review, CIBA* [Jan.] 1963.)

• English neurologists, confirming the studies of others, find a **low incidence** of **brain tumors** in patients with **epilepsy** of **late onset.** After careful study of the patients by all means available, no cause for the epilepsy was found in approximately three-quarters of the group. (*Brit. M. J.* [Feb.] 1963.)

• The degree or lack of bedfastness among patients in a general hospital suggests drastic changes in **hospital design** and personnel. A study of patients in general hospitals reveals that **one-third were bedfast,** one-third were able to be up and about throughout the day and **one-third** were **in bed** only **part** of the day. (*Lancet* [Jan.] 1963.)

• **Hepatic necrosis** was attributable to **Fluothane anesthesia** in eleven patients reported in two different articles in the same medical journal. The anesthetic, which is very similar to chloroform, causes lesions in the liver identical to chloroform-induced hepatic necrosis. (*New Eng. J. Med.* [Mar.] 1963.)

• **Anti-cancer serum** has been used in patients with a variety of cancers, apparently with objective **improvement.** The hyperimmune gamma globulin is prepared by injecting animals with tumor antigens and using the specific antibodies produced to treat patients with leukemia and other malignancies. No cures are reported in this small series. (*Cancer* [Mar.] 1963.)

• Workers in Chicago studied 110 children with their first attack of **rheumatic fever.** The purpose of the study was to determine the adequacy of penicillin treatment prior to the development of rheumatic fever. The authors concluded that in **100 of the 110 patients** the penicillin or other **antibiotic therapy was inadequate** in that 84 per cent of the cases of rheumatic fever had been preventable. More disturbing to this reviewer is a note that ten of the patients had **adequate penicillin therapy** and **still developed rheumatic fever.** (*J.A.M.A.* [Mar.] 1963.)

• Mechlorethamine hydrochloride, a **nitrogen mustard,** has been used at Cleveland Clinic in the treatment of 81 patients with **systemic lupus erythematosus.** The mustard-treated group had a lower mortality rate than those not treated with mustard. The nitrogen mustard was most effective in patients with the **nephrotic picture.** (*Arch. Derm.* [Mar.] 1963.)

• A 29-year-old man with long-standing **paraplegia** and recently acquired squamous cell **carcinoma over the sacrum** was treated successfully with radical surgery. The upper half of his body was cut away from the paralyzed, cancerous lower half. The **hemicorporectomy** took six and one-half hours and convalescence was uneventful except for jaundice. (*Surgery* [Nov.] 1962.)

FRED I. GILBERT, JR., M.D.

# In Memoriam – Doctors of Hawaii

This is the forty-fourth installment of In Memoriam—Doctors of Hawaii.

## Vitaro Mitamura

Vitaro Mitamura was born in Tokyo, Japan, on February 14, 1882. He was the son of Toshiyuki and Kei (Matsuyama) Mitamura. His father was a surgeon-general in the Japanese Navy. While still an infant, he was adopted into the family of an uncle, also a physician.

DR. MITAMURA

His earliest education was received in a a Tokyo grammar school. He came to Hawaii at the age of seven, and attended primary school in Kilauea, Kauai. Later he was a student at both Central and McKinley High School in Honolulu. His medical degree was obtained from the University of Michigan in 1909.

Dr. Mitamura was on the surgical staff at the State Hospital of Michigan until 1912.

Returning to Honolulu in 1912, he began private practice and specialized in surgery and gynecology.

In 1934, Dr. Mitamura moved to Hilo where he established the Mitamura Clinic.

Dr. Mitamura and Chozu Harada were married on April 4, 1914, in Honolulu. They had three children: Robert, Dorothy, and Iris.

Dr. Mitamura was a member of the Hawaii Medical Association, the Japanese Medical Association, the Mochizuki Club, and the Cosmopolitan Club of the University of Michigan.

He died on January 30, 1947, in Hilo within a few days of his 65th birthday.

## Chirin Uesu

Chirin Uesu was born on February 8, 1883, in Gushikawa mura, Aza Nishiroku, Shimajiri gun, Okinawa. He was the son of Chisai Uesu.

He studied at the Okinawa Prefecture Medical School and was graduated in 1907. He received his M.D. degree in Japan in 1911. His internship was served at the Jyuntendo Hospital surgical department in 1911. He did special work at the Tokyo Saisei gakkai in 1907 and at the Jyuntendo Hospital in 1911.

Dr. Uesu practiced for a short while in Naha, Okinawa. He then came to Hawaii in September, 1912. He passed the examinations of the Territorial Board of Medical Examiners in February, 1913, and began his practice in Hilo. For many years the doctor was in charge of the Uesu Hospital in that city. During his years in Hawaii, he twice visited Japan.

Dr. Uesu and his wife, Yoshi, had one son, Tomohide. The young doctor Uesu is a graduate of Keio Medical School in Tokyo and served his internship at the Sacramento Hospital in California.

On December 11, 1924, Dr. Uesu died in Hilo, Hawaii, at the age of 41.

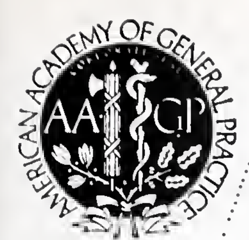
## William Dutcher Whitman

William Dutcher Whitman was born July 5, 1873, in Caledonia, Nova Scotia, the son of Zoeth and Bessie (Harlow) Whitman.

DR. WHITMAN

He attended high school in Caledonia. In 1901, he graduated from Tufts Medical School in Boston, following which he served for six months as house officer at Boston City Hospital. Dr. Whitman then went to Tauton, Massachusetts, where he was surgeon at the Taunton Emergency Hospital for three years. After serving at the hospital, he went to Westport, Nova Scotia, to practice for a short time and then returned to Taunton to become house doctor at Emergency Hospital. Subsequently, he left Taunton to settle in Lockport, Nova Scotia, where he engaged in private practice until 1912 when he came to Hawaii.

*continued page 390*




# *Hawaii Academy of General Practice*

WHAT DO THE GP'S WANT OF A GENERAL HOSPITAL?

They want the privilege of admitting their patients to any general service: medical, surgical, pediatric, or obstetric.

They want the right to care for such hospitalized patients within their respective capacities to do so, and in conformity with reasonable rules and regulations.

They want representation on every hospital committee.

WHAT DO THE GP'S EXPECT TO OFFER IN RETURN?

They expect to serve on the various hospital committees as active participants in discussions, and to work when assignments so decree.

They would be glad to help in the teaching of the house staff—*if* the curriculum were organized in such a way that the attending GP, his patient, and the intern assigned to that admission could be as one during that patient's hospital stay. If that intern could follow that admission through history and physical initially, consult that attending about orders, and then follow the case closely with his attending throughout, it would be a valuable educational experience for both doctors. And what's more, the patient would benefit thereby.

The GP's would be glad to help in the OPD—*if* the hours of sick call were set for the convenience of the busy "attending" rather than for the 9 o'clock intern.

Most GP's would be glad to participate in a hospital-sponsored program wherein interns or residents could be assigned to the doctors' private offices for brief periods. The experience gained in the practical aspects of medical practice, concerning personnel, reception, business management, scheduling, and public relations should be invaluable in orienting the house staff to their future.

The GP's would be glad to serve duty hours in hospital emergency rooms, if needed, either alone when no house staff is available, or to supervise and assist the latter.

They would also be glad to serve in hospital operating and delivery rooms as a second doctor when such is needed.

GP's could assist in the teaching of nurses.

GP's could be included in the roster of staff physicians called upon to do physical exams on hospital personnel or hold sick call for them.

WHAT DO GP'S SPECIFICALLY WANT IN THE OR AND DR?

They want to be able to use these two important facilities freely, as adjuncts to the type of practice they do in their private offices. They want to have the privilege of performing operations and procedures commensurate with past training, previous experience, and present capability.

They also wish to be allowed to learn by controlled and supervised experience. They do not think it is fair or honorable of their specialist colleagues to deny the GP the opportunity of bettering his skill and knowledge in surgery or in obstetrics and gynecology.

The GP feels he has a basic right to be with his patient, who is to turned over to the jurisdiction of a surgeon or obstetrician for a specific procedure temporarily. He understands full well the obligation of the hospital to its residency teaching program, but he cannot grant the abrogation of the right of his private patient to receive the best care. In this instance, it is in the patient's best interest to have two qualified and licensed physicians at his operation. If his own physician, the GP, feels inadequate to the position, or feels that his patient's best interest would be served, or at least not jeopardized, by the GP's withdrawing in favor of the surgical resident, then it should be up to the GP to make that withdrawal. Of course, the surgeon also has the right, in the patient's best interest only, to choose his first assistant.

AAGP RECOMMENDATIONS IN 1963

At the annual meeting of the AAGP recently concluded in Chicago, the assembled delegates firmly urged a change in hospital accreditation procedures: *That accreditation be a function of the AMA and not of the JCAH,* and that:

(a) No hospital be accredited where there was arbitrary discrimination.

(b) No accreditation be allowed where a physician's privileges could not be increased by training or experience—such as inhospital training.

(c) No hospital would be accredited which did not allow the referring physician the opportunity to assist in surgery on his own patients.

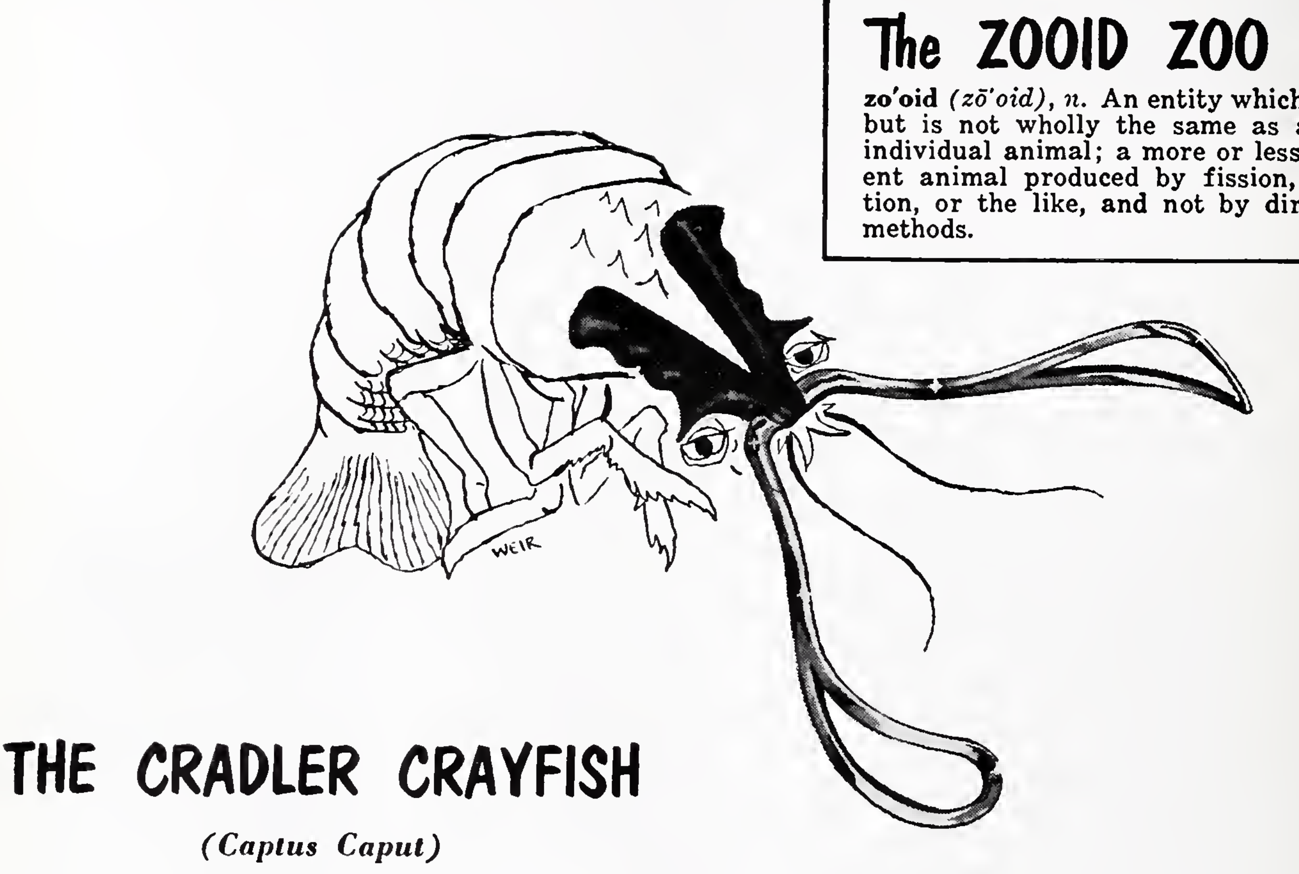
(d) Demonstrated ability should be the sole criterion for privileges.

J. I. FREDERICK REPPUN, M.D.
*Secretary*

(Advertisement)

## The ZOOID ZOO Series

**zo'oid** *(zō'oid), n.* An entity which resembles but is not wholly the same as a separate individual animal; a more or less independent animal produced by fission, proliferation, or the like, and not by direct sexual methods.

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HAWAII MEDICAL JOURNAL

# Book Reviews

## ★Psychosomatic Obstetrics, Gynecology, and Endocrinology

*Edited by William S. Kroger, M.D., with 75 contributors, 820 pp., $19.50, Charles C. Thomas, 1962.*

For the practicing physician caring for female patients in this frenetic jet age, this comprehensive book will prove to be extremely useful and instructive. That this is so is reflected by the current acceptance of the fact that the endocrine glands do not function autonomously of the higher cortical centers and that the percentage of patients with gynecologic complaints in association with fear, tension, anxiety, worry, and emotional conflicts are ever increasing in number. The various authors repeatedly stress that the majority of the problems can be recognized and treated by the interested physician who has a basic understanding of the psychiatric principles involved. Comprehensive practical methods of treatment for a large number of common obstetrical and gynecological problems are discussed at some length.

In criticism, one cannot help but feel that the value and use of hypnosis as a therapeutic tool has been overemphasized and that hypnosis should probably not be employed by those physicians untrained in psychiatry. Appropriately enough, however, psychiatric consultation is advocated for those patients demonstrating major psychoneuroses and psychoses.

In conclusion, then, this book can be enthusiastically recommended to all physicians treating female patients, realizing that, of course, organic components may be present even in those women suffering from psychosomatic problems.

James H. Lambert, Jr., M.D.

## Coronary Heart Disease, The 7th Hahnemann Symposium

*Edited by William Likoff, M.D., and John H. Moyer, M.D., with the assistance of Sheldon R. Bender, M.D., Albert N. Brest, M.D., Leonard S. Dreifus, M.D., Paul Novack, M.D., and Bernard L. Segal, M.D., 483 pp., $17.75, Grune & Stratton, 1963.*

A compendium of all the salient features of coronary heart disease up to April, 1962, from pathogenesis to rehabilitation, this book includes individual lucid and educational papers by most of the outstanding men in this field.

There is much room for disagreement with some of the articles but in those instances this may well be counter-balanced by the material in the next article.

There is one of the finest treatises on coronary disease that I have ever read. Much of what is included is the result of work done by the authors. These men are preeminent in their field, thus giving the material a sense of positivity and authority that is frequently lacking in other treatises.

It is to be regretted that many of the articles have no illustrations, although I would be quite certain that in the original presentation at the Hahnemann Symposium there were slides accompanying the paper.

The general stature of the book, however, is such that I would recommend it to all physicians interested in heart disease and for those men who are particularly concerned with treating heart disease and are specialized in that field, I would consider it a well worthwhile addition to their library.

Morton E. Berk, M.D.

★ means highly recommended.

## Electrocardiography Fundamentals and Clinical Application, 3rd Ed.

*By Louis Wolff, M.D., 351 pp., $8.50, W. B. Saunders Company, 1962.*

This is the third edition of this widely used primer of electrocardiography. Students will find it useful because the author explains physiological and electrical activity of cardiac action in the simplest terms to make a lucid presentation. He has incorporated the concepts of vectorcardiography into the interpretation of electrocardiogram.

The author has divided this text into three sections: basic principles of electrocardiography, clinical application, and arrhythmias. The sections, especially the clinical arrhythmia ones, are well illustrated and discussed.

Kikuo Kuramoto, M.D.

## Local Analgesia: Abdominal Surgery, 2nd Ed.

*By Sir Robert Macintosh, D.M., F.R.C.S., (Edin.), F.F.A.R.C.S., M.D. (hon. causa), and R. Bryce-Smith, M.A., D.M., F.F.A.R.C.C., 82 pp., $5.00, Williams & Wilkins Company, 1962.*

The authors tell their story largely in pictures and with a minimum of text—"a method of fact-presentation deceptively time-consuming." Their style of writing, though almost terse, is sparked with just enough British witticism to break up the page after page of line drawings. No doubt one could read and mentally digest this monograph in a single evening, but I'm quite sure it would take a considerable amount of practice to master this single approach to surgical analgesia with complete assurance of success.

Presuming the reader has knowledge of the pharmacology and toxicology of local anesthetic agents, the text and its multitude of well chosen, artistic, diagrammatic illustrations provide what the authors intended—a method of local analgesia for abdominal surgery. Most of the references are historical and standard in the field of block analgesia.

In summary, this book is worthwhile reading for the surgeon and anesthesiologist. There are many pearls sprinkled among its eighty pages.

George F. Parker, M.D.

## ★Current Diagnosis and Treatment

*By Henry Brainerd, M.D., Sheldon Margen, M.D., Milton J. Chatton, M.D., and Associate Authors, 843 pp., $9.50, Lange Medical Publications, 1963.*

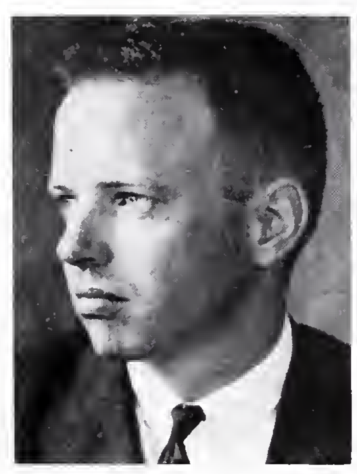
This is another book by Lange Medical Publications, so well-known for their *Physicians' Handbook* and many other paperback editions which have proved themselves over a period of many years. This comprehensive treatise covers not just medicine but all related fields, such as obstetrics and gynecology; eye, ear, nose, and throat; etc. The format is easy to use because there are double columns on each page and a clearly legible form.

The points for diagnosis, clinical findings, laboratory findings, etc., are well made and treatment is gone into with a minimum of verbiage and a maximum of helpfulness. Where feasible, tables have been used, which saves a tremendous amount of time and gives the "meat" without undue searching. An example of this is the lotions and emulsions which are used for skin disease which are listed in order with prescriptions for each one, instructions, remarks, and the properties of the substances involved.

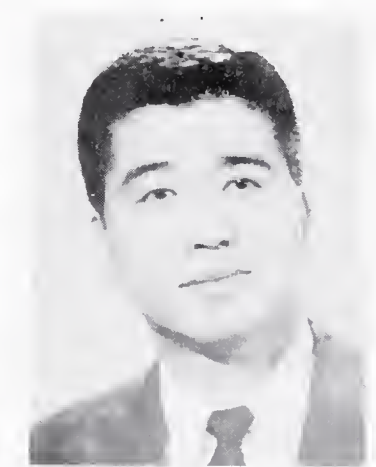
I would not consider this necessarily as a substitute for

*continued page 396*

# New Members



**Richard B. Joseph, M.D.**
1133 Punchbowl Street
Honolulu 13
Otolaryngology
University of Kansas Medical School, 1956
Internship—Tripler General Hospital, Honolulu
Residency—State University of Iowa, Department of Otolaryngology



**Charles C. Kimura, M.D.**
1833 N. King Street
Honolulu 17
Pediatrics
Tulane University School of Medicine, 1956
Internship—Charity Hospital, New Orleans
Residency—Tulane Service, Charity Hospital, New Orleans
St. Louis Children's Hospital, St. Louis

**John S. Smith, M.D.**
1133 Punchbowl Street
Honolulu 13
Orthopedics
Stritch School of Medicine, Loyola University, 1955
Internship—Tripler General Hospital, Honolulu
Residency—Tripler General Hospital, Honolulu

**Marciano F. Aquino, M.D.**
1697 Ala Moana Blvd.
Honolulu 16
Surgery
University of Santo Tomas, 1954
Internship—St. Vincent Charity Hospital, Cleveland
Residency—Evangelical Deaconess Hospital, Cleveland

**James J. Ball, M.D.**
1000 Ward Avenue
Honolulu 14
Internal Medicine
University of Maryland, 1955
Internship—Georgia Baptist Hospital, Atlanta
Residency—Tripler General Hospital, Honolulu

**Henry T. Oyama, M.D.**
1684 Kalakaua Avenue
Honolulu 14
Surgery
Boston University School of Medicine, 1957
Internship—Massachusetts Memorial Hospital, Boston
Residency—Boston Veterans Administration Hospital, Boston

# County Society News

## Hawaii

There were no guests present at the February 8 meeting. Dr. Joseph Stokes' proposal for two-way conferences with Queen's was discussed. Action on this was deferred pending receipt of additional information. Dr. Woo reported the possibility of the Heart Association's holding a Cardiac Rehabilitation Institute on April 5. Dr. Wipperman presented the Disaster Committee's report and advised that he had written to Governor Burns to request medical supplies and equipment for the Hilo Airport. The guest speaker for the scientific program was Dr. Ernest Jawetz who spoke on "Principles of Antibiotic Therapy."

The March meeting was held at the Hilo Hotel on March 22. The request of the Philippine Consulate for an examining physician was again discussed. It was voted to submit a roster of all the physicians. Members were asked to attend the HMA annual meeting. Dr. Ruth Oda accepted one of two positions sponsored by the U. S. Children's Bureau for the April 29–May 3 institute to be held in Honolulu. Dr. Wipperman reported on the Claims Review Committee which examines one out of every 10 claims and holds the doctor responsible for claims made out by their secretaries. Dr. M. L. Chang's request for funds for a tape recording made by the Heart Association was granted. The scientific portion of the meeting included a talk by Dr. Robert Wilkens on "Recent Advances in Cardiac Therapy."

Two guests were present at the April 16 meeting, HMA President Frederick L. Giles, who spoke on the aims and policies of the State Association, and Dr. George Mills, who explained the relative value study which is being conducted on a statewide basis. A letter from the Department of Social Services requesting a replacement for Dr. Woo was noted. Dr. Woo's resignation leaves a vacancy in the North and South Hilo districts. The South Hamakua district is also vacant and Dr. Wipperman is temporarily serving this district. It was voted to donate $25 to the Hilo League of Women Voters. It was voted to subscribe to Audiodigest at a cost of $400.14 a year. The Heart Association and the Cancer Society will each contribute $200. Dr. Okumoto was asked to investigate the problems that arise in rural areas relative to signing death certificates in cases of accidental or unattended deaths.

## Honolulu

The March 5 meeting was called to order at 7:30 P.M. and 147 members were present. Two new members, Drs. Bunzo Nakagawa and Rodman B. Miller, were introduced. The members were asked to order their supplies of "Prescription for Safety," flyers to go out with the monthly bills. Dr. Richard K. C. Lee spoke on the various public health and medical education programs currently offered and contemplated by the University of Hawaii. He introduced their Director of Student Health Services, Dr. Lovett. Dr. Mills spoke on the current activities of the Foundation and the meeting ended with a progress report by Dr. Hunter on the pending fee survey.

Over 200 members attended the February 5 meeting which included a film presentation by Dr. Casimer Jasinski entitled "Management of Mass Casualties" and a paper on "Infectious Syphilis Is Here Again" by Dr. Harold Johnson. Resolutions honoring deceased members Eijiro Nishijima, Mon Fah Chung, and Gardner Black were read. The following new members were welcomed into the Society: Winfred Chang, William J. T. Cody, Lowell G. McLellan, Bal Raj Mehta, and Kazuo Teruya. The Hawaii Medical Association's annual press award was presented to Mrs. Pat Millard of the *Advertiser* by Dr. Frederick L. Giles. Dr. Tomita announced that Dr. R. Varian Sloan was presented with a Merit of Honor award from Mayor Blaisdell for his recent efforts in the Operation Swallow program. Dr. Hunter brought the membership up to date on the activities of the HMA Medical Care Plans and Fees Committee.

## Kauai

At the February 25 meeting Dr. Cockett read a letter from Governor Burns which stated he would look into the pharmacy matter and notify the Society of his actions. Dr. Y. Miyashiro was welcomed into the Society. In answer to Dr. Stokes' proposal to set up telephone communications for monthly medical-surgical conferences, and Kauai's alternate suggestion of taping the programs, Dr. Stokes advised that others had voiced the same opinion and this is being considered.

A lengthy discussion on the HMA Medical Care Plans & Fees Committee meetings was held, especially the recommended changes in the HMSA set-up. The areas covered were the payment for medical care rendered during the aftercare period following surgery.

Dr. Wade explained how this was handled in Honolulu. The surgeon refers the case to an internist and both physicians are paid. Maui's objection to the assignment of benefits was noted. The proposed revision of income levels were mentioned, as was the suggestion to eliminate the provision for naming a panel from which HMSA can select its board members. There were varying opinions from the members. Dr. Boyden felt the present proposal was a result of a meeting several years ago when it was suggested that Honolulu County was equipped and competent to handle the Medicare program. He said the advocates for the Stockton Plan might be in back of the present action. Dr. Fujii said he found no objections. Dr. Miyashiro noted a discrepancy in the fees charged on Kauai. Dr. Boyden pointed out that if there are no individual contracts, HMSA lacks authority to police the doctors. Dr. Brennecke said he would defer his opinion.

Dr. Wallis stated that there are some people in the HMA who would do much to undermine the HMSA. He expressed concern over the possible increased costs to HMSA and suggested this be discussed at a special meeting. Dr. Cockett felt the HMSA was a going concern and doing well for all and it was best to leave it that way. Dr. Wade spoke in favor of defining certain areas such as minor surgery and establishing specific postoperative care periods. Dr. Kim felt the medical section was in good order. Dr. Goodhue stated he had read the report and on first reading found nothing out of order, but was willing to listen to others. Dr. Boyden suggested that the HMA's recommendations to discontinue setting up a panel from which HMSA could select its representatives not be accepted. Dr. Brennecke agreed.

After a motion by Dr. Boyden that the Kauai County Medical Society disapprove of all the HMA recommendations lost by a vote of five to four, a motion to vote on each change individually was passed. It was voted to continue to suggest a panel to the HMSA. It was also voted that the Medical Committee and the Review Committee of the HMSA have the power to enforce disciplinary action rather than have this action carried out by the in-

*continued page 390*

## SUMNER PRICE, M.D.
## 1899-1963

Here was a man of indomitable spirit, of unconquerable will—a man who worked on and took an active part in the life of the community until a blow was struck from which he could not recover.

Here was a man from whom we can all learn a lesson in courage—to keep striving on in the face of deadly disease and human opposition.

Six years ago Sumner Price had his right lung removed for cancer. Because of extension of tumor into surrounding tissues, his prognosis was poor. Yet Sumner Price was never one to let the odds get him down. Surely it wasn't pure chance and heroic medical measures that made him the one person in 20 who survives cancer of the lung five years. No one who knew Sumner Price will believe that his determined spirit didn't play a large part in his going on with his work, instead of resting at his beach home, awaiting the Grim Reaper.

Three years ago another personal tragedy befell Dr. Sumner Price, which, added to his health problems, should surely have relegated him to the ashheap. Anyone *but* Sumner Price. When he found himself no longer in charge of The Queen's Hospital, of which he had been medical director from 1944-57 and administrator from 1950, surely then he would content himself with sitting under a palm tree, dreaming of past battles, past glories.

*Not* Sumner Price. He put his vast knowledge of the medical community and of hospital administration at the disposal of the State Department of Health, serving as Chief of the Hospitals and Medical Facilities Branch. They would have had to look a long way to get someone for this post with the experience and ability that Dr. Price brought to it.

In this position, serving the whole community, Sumner Price spent his last year, yea, his last days.

Aaron Sumner Price began his life in Athens, Ohio, in the closing days of the past century. He was born November 27, 1899. He went through grade school, and completed his high school and undergraduate college work in the Buckeye State.

He received his doctorate in medicine from the University of Louisville in 1924, and completed internship under the auspices of Oklahoma State University.

Choosing the field of pathology, Sumner Price became associated with New York University and Bellevue Hospital College of Medicine in 1926, remaining there until 1932. At that time he became director of laboratories at New York Polyclinic Hospital and associate professor of pathology at the allied medical school, until 1942, at which time he served for a year with the Army Air Force.

He came to Hawaii in October of 1943, to be director of laboratories for The Queen's Hospital. He remained in this post until 1951, meanwhile becoming medical director and administrator.

Sumner Price was a leader of men, never a follower. And he was a teacher, but he was able to learn from his experiences until his final fatal illness.

When other men would have been bitter, Sumner Price could be above such a common, human failing. He had the great will and the great capacity to be philosophical regarding his fate, but to work on in spite of it.

He was proud of his triumph over cancer. And it was a triumph. His demise was attributed to arteriosclerotic changes, including a massive cerebral infarct. But no evidence of cancer remained in his body. Radio-gold and nitrogen mustard had done their work, but Sumner Price had helped.

To his former interns and residents at Queen's, Dr. Price will be remembered as an august father figure, almost olympian in his bearing and in execution of his duties as administrator, but at the same time a warm human being, with whom one could discuss problems with some hope of redress.

To those doctors in Hawaii who did not know Sumner Price, we can only say, you missed a great experience.

We are all the poorer for his passing.

There was a man!

Doris R. Jasinski, M.D.

## MON FAH CHUNG, M.D.
## 1891-1962

Dr. Mon Fah Chung died of cardiac failure at The Queen's Hospital on December 18, 1962. He was born in Honolulu on June 20, 1891, son of Chung Yee En and Ho Fcok Yin. He married Ruth Shui Yin Yap of Honolulu in Boston, Massachusetts, November 11, 1922.

Dr. Chung was one of the first specialists in Hawaii by education and training. After graduating from Punahou in 1910, he worked for six years as clerk, cashier, and then assistant manager of the B. F. Dillingham Co., Ltd. He was also a notary public during this period. He entered Harvard University in 1916, and received his M.D. from Harvard Medical School in 1922. He served his internship and residency at Rhode Island Hospital in Providence, specializing in neurology. In 1924, he was offered an instructorship in neurology at Peking Union Medical College. He remained in China for two years.

The urge to enter private practice brought Dr. Chang back home to Honolulu in 1926. He was immediately appointed visiting neurologist at Queen's, St. Francis, Children's and Leahi Hospitals. He was also a member of the Commission on Insanity for the Territory of Hawaii.

Dr. Chung belonged to many organizations, both professional and civic. During the first World War, he was in the Harvard Unit of the R.O.T.C. and later in the Medical Reserve Corps of the Army. He was a Past President and life member of the Honolulu County Medical Society.

Dr. Chung was a 32nd degree Mason, member of Roosevelt Lodge No. 42 F. and A.M., Providence, Rhode Island; Ming Te Lodge of Perfection, Valley of Peking, Orient of China; Honolulu Consistory No. 1, Valley of Honolulu, Orient of Hawaii A. and A.S.R.I.U.S.; Aloha Temple; also a member of the Harvard Club of Hawaii, Chinese University Club, Hawaii Chinese Civic Club, Y's Men's Club, Y.M.C.A., F.F. Fraternity and former president of Chinese Students Alliance.

He was the author of two scientific papers of note, namely, "A Study of 34 Cases of Rapidly Developing Syphilitic Paraplegia" in the *Archives of Dermatology and Syphilology*, and "Thrombosis of the Spinal Vessels in Sudden Syphilitic Paraplegia" in the *Archives of Neurology and Psychiatry*.

Dr. Chung was loved by many because of his devotion to duty and an unusual sense of humor. He led a well-rounded and full life. His hobbies included tennis during his active career and then, in his later years, he became an orchid fancier. At one time he possessed some of the most beautiful blooms in Honolulu.

Dr. Mon Fah Chung is survived by his wife, Ruth; two daughters, Elaine and Mei Chih; and several grandchildren.

Samuel L. Yee, M.D.

HAWAII MEDICAL JOURNAL

# Notes and News

## Names in the News

**Dr. H. H. Walker**, Hawaii Goveronr, American College of Physicians, and **Col. R. J. Hoagland**, chief of Medicine (Tripler Hospital) were prominently featured with **Dr. F. M. Hanger**, President of the American College of Physicians.

**Dr. David L. Pang**, President, Hawaii Academy of General Practice, participated in the opening session of the Hahnemann Alumni Medical Meeting at Tripler.

Maria Louisa Ramirez Mabanog became the bride of **Dr. Marcelino J. Avecilla** recently in Honolulu.

**Dr. R. Varian Sloan** has been appointed chairman of the AAGP's Commission on Legislative and Public Policy.

The cutting of a spreading poinciana tree which served as a landmark at S. King St. and Kapiolani extension caused some publicity for **Dr. K. Inouye** on whose property it had stood.

Legislative bills have created political activity for members of the medical profession.

Testifying against the so-called "Maryland Bill" was **Dr. George Mills.** He was one of several representatives for the Bishop Estate.

**Dr. Robert Kemble's** testimony (as a private citizen) was against the appointment of the Director of Social Services. He felt that the appointee had "limited experience and I simply wonder if he is qualified."

The University of Hawaii's budget request for its infirmary underwent a blistering attack by **Dr. T. Tomita**, President of HCMS, at the Senate Ways and Means Committee hearing.

**Dr. John Chalmers** ably "carried the ball" for the medical profession during a hearing on SB 701 which would have amended the present laws to permit registered nurses to dispense drugs from hospital pharmacies.

**Dr. T. Nishigaya** was one of three panelists speaking on medical problems on the aged at the Honolulu Council of Churches meeting on the Problem of Aging.

**Drs. Pershing Lo** and **Charlotte Florine** contributed greatly to the success of a workshop sponsored by the Hawaii Federation of Business and Professional Women's Clubs.

*continued next page*

## WILLIAM THOMAS DUNN
## 1881-1962

The Island of Maui, and in particular the people of Lahaina, suffered a great loss with the death of Dr. Bill Dunn.

Dr. William Thomas Dunn was born May 13, 1881, at Youngstown, Ohio, the son of Richard Henry and Mary Ardron Dunn.

He went to work in the steel mills of Ohio at the age of 12 when his father died. He later worked as a chemist for the U. S. Steel Company. In 1902 he became a brakeman for the Erie Railroad. Dr. Dunn was awarded his high school diploma after presenting his Bachelor of Science degree from Penn State College in Mines and Metallurgy in 1908 to the Board of Education in Youngstown. He coached at Harrisburg Academy in Pennsylvania for a year, then entered the University of Pennsylvania and received his Doctor of Medicine degree there in 1913. He served his internship at The Queen's Hospital and was appointed resident physician January 1, 1915.

In 1916, he married Hazel Alma Eskew, surgical nurse at Queen's at the time. They had one son, William E. Dunn, and two daughters, Mary E. Hawkins and Eleanor Clements. There are five granddaughters, and one great-grandson, born soon after Dr. Dunn's death.

After he left The Queen's Hospital he was appointed physician and surgeon for Makaweli Plantation on the Island of Kauai and was there from 1915-1922. He later engaged in private practice in Hilo, Hawaii, with the late Dr. Osorio. Later he returned to the mainland and for almost two years was physician and surgeon for Spreckels Securities Company in San Diego, California.

In 1926 he was appointed physician and surgeon for the Pioneer Mill Company, Lahaina, Maui, where he was Superintendent of the Pioneer Mill Company's Hospital. He retired from Pioneer Mill Company in 1947. It was during this period with Pioneer Mill Company that he was President of the Maui County Medical Society and later the Territorial Medical Society.

Dr. Dunn was a keen sports enthusiast. He was nicknamed "Mother" when he was freshman class President and was leading his class across the campus in a challenge to the sophomores. "There goes Mother Dunn and his chickens," someone shouted and the name lasted. He was Captain of the Varsity football team and was the first All-American Center picked by Walter Camp for his original All-American Team. He was also a member of the track team and holder of the College Record at Penn State for the Hammer Throw.

The late Walter Camp wrote an article in *Collier's* in 1906 about him and this is an extract.

> Dunn, of Penn State, was the best centre of the season, and it was he who led his team to such remarkable results, a good deal of it depending upon Dunn himself. He weighs just under two hundred, is something over six feet in height, and absolutely reliable in his passing, secure in his blocking, active in breaking through, and in diagnosing plays. He was a stumbling block to Yale, and proved to be a similar difficult proposition for all teams that met Penn State. Some idea of his record and accomplishments may be gathered from the fact that his team was never scored upon save by Yale, although their schedule included games with Yale, Carlisle Indians, and the Navy. Captain Dunn's team defeated the Carlisle Indians, and performed a similar feat with the Navy. He persistently broke through and blocked kicks. Able to run the hundred inside of eleven seconds, he was down under his own side's kicks with the ends. Beyond all, and giving him added worth, are his earnestness of purpose and character.

He was a member of The Masonic Lodge, Pennsylvania; Shriner's Aloha Temple; The Barton Cooke First Obstetrical Society of the University of Pennsylvania; Phi Rho Sigma Medical Fraternity; Sigma Alpha Epsilon Fraternity; Hawaii Industrial Medical Association; American Defense Society; and a First Lieutenant, Medical Corps, National Guard of Hawaii, in 1916.

Dr. Dunn died November 17, 1962, at his home in Kahana on the Island of Maui, at the age of 81.

WILLIAM E. IACONETTI, M.D.

**Drs. Randal A. Nishijima, Dr. L. Q. Pang,** and **Dr. Burt O. Wade** are newly elected directors of the HMSA.

HMA—KTRG-TV program, "Call the Doctor," had general discussions on cancer of the womb and breast, gout, venereal disease, Asian flu and abortion. Participants included **Drs. Tomita, Hirschy,** and **Jeanette Chang.**

**Dr. M. S. McCarthy** has been named to the Advisory Board of the Catholic Social Services.

**Dr. M. L. Silver** has been elected the head of the Portlock Community Association. **Drs. Bob and Marie Faus** are social chairmen. Dr. Silver also heads the John Hopkins Alumni Association of Hawaii.

"Big Brothers of Hawaii," an organization to provide Child Welfare Services, lists **Drs. G. F. Schnack, M. Hasegawa,** and **T. Nishigaya** on its roster.

**Dr. Leo Bernstein** was confirmed as State Health Director.

The public was urged by **Dr. Ira Hirschy** of the State Communicable Disease Division to get flu shots.

Hospital rate "hike" was predicted by **Dr. F. Giles** when State aid to medical indigents cutback was announced.

**Dr. David Katsuki** is beaming over the new wing, recently dedicated at the Maluhia Hospital.

Doctors, Dentists, Druggists annual golf tournament received some publicity with a picture of a dentist, a druggist and **Dr. B. Allen Richardson.**

**Dr. J. W. Devereux** is minus a safe and $1,200 cash and checks, after a recent burglary of his office.

**Dr. Robert Marks,** Chief of State TB Department, seemed very happy with the new $30,000 mobile x-ray unit—this new unit will help studies regarding the high rate of TB in Hawaii.

**Dr. Richard K. B. Ho** presented "traits of glue sniffers" at a meeting at the Children's Hospital.

**Dr. M. A. Glover** spoke her piece on military conscription in a recent Letter to the Editor.

**Dr. Herbert Nam,** Korean Chamber of Commerce President, was a leading figure in a recent testimonial by the KCC honoring elected Korean legislators.

**Dr. Paul Yoder** and **Dr. Sau Ki Wong** were lay readers at Lenten observance of Ash Wednesday at St. Andrew's Cathedral.

**Dr. Richard Ando** and **Mr. Edwin H. Honda,** HMA's legislative consultant, seemed most likely choices for Gov. Burns' appointment to the State Board of Education.

U.H. Regents **Drs. L. Q. Pang, R. You,** and **P. Okumoto** were prominent figures at the recent installation ceremonies of Dr. Thomas H. Hamilton, as President of the University of Hawaii.

**Dr. R. Frederick Shepard** keeps plugging physical restoration and the Rehabilitation Center of Hawaii.

Careers Day, sponsored by the HMA, received considerable favorable publicity recently. Headline, feature stories and pictures of doctors and students evoked fine public response. Some of the prominently pictured doctors were **K. Wilcox, Richard Ho, J. Lambert,** and **C. T. Druecker.**

Editorial on "Toward a United Fund" caused much comment from **Drs. George H. Mills** and **B. W. D. Fong.**

**Dr. Doris Jasinski** was credited with the idea of anti-smoking posters now gracing prominent spots in service stations.

"Cancer Crusade is education as well as fund raising," said **Dr. Grover Batten** at a meeting of the 1963 Crusade's trades and industry committee.

**Drs. Qnisenberry** and **Batten** were panelists at a recent seminar for 50 High School students and spoke on the pros and cons of smoking.

## Awards

A $1,000 award will be given for the most outstanding original manuscript submitted to the *International Journal of Medicine in Industry* in 1963 devoted to the topic "The Future of Health in Industry."

For further information, write Industrial Medicine and Surgery, P. O. Box 306, Tamiami Station, Miami 44, Florida.

## Congratulations to . . .

**Dr. Ann B. Catts,** new Diplomate, American Board of Pathology.

**Dr. W. H. Kurashige,** new president, Hawaii Dermatological Society, and **Dr. T. E. Emura,** Secretary-Treasurer.

**Dr. Richard K. C. Lee** for being awarded the Crumbine Award, an inscribed old brick, for being one of two outstanding public health workers in the U.S.

**Drs. Cora Au** and **D. Y. Lahr,** new Fellows of the American College of Obstetricians and Gynecologists.

**Dr. M. E. Berk** for coming in second at the National Cook-out contest. He was one of 25 National finalists.

## The Ailing

**Dr. Linus C. Pauling** luckily escaped with minor injuries when he was the innocent victim of a head-on crash at the Makiki Round Top Drive. A passenger in the other car was fatally injured.

**Dr. William Walsh** is mending after some surgery at Queen's.

**Dr. Jay Kuhns** is in Queen's for a check-up.

**Drs. E. K. Chung-Hoon** and **J. A. Hathaway** were pretty close to their "maker" recently when their chartered plane crashed after landing at Kalaupapa, Molokai. They were on a routine monthly charter and escaped with minor injuries. The plane, a total wreck, exploded a few seconds after they got out.

## Traveling Doctors

**Dr. A. Y. Wong,** President of the Hawaii Industrial Physicians, recently attended a convention of Industrial Medical Societies of America in Washington, D. C.

**Dr. H. M. Johnson** enjoyed the comforts of Hot Springs, Va., when he presented a paper on "Relapsing Polychondritis" before the American Dermatological Association.

**Dr. Cyrus W. Loo** was guest speaker at the North American Clinical Dermatological Society Medical conference at Hollywood, Florida. His talk was on Graphoanalysis.

Seen in Chicago and actively participating in its proceedings were **Dr. R. V. Sloan** and **Dr. Edmund Lee** at The American Academy of General Practice's annual meeting early in April. Both served as delegates from the local chapter.

Also in Chicago were HMA President-elect **Dr. Rodney West, Dr. T. Tomita,** HCMS President, and **Dr. A. Ivy,** gobbling up materials at the AMA's legislative conference for State Medical Associations.

**Dr. Ralph B. Cloward** made a 10-day circuit of Chicago, Boston, and Madrid, Spain, operating in medical centers in each of these cities. On the way back he attended the Harvey Cushing Society Meeting in Philadelphia.

In March **Dr. Barton R. Becker** attended the workshop on "Reconstructive Middle Ear Surgery" in Chicago.

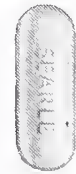
## Visiting Dignitaries

Doctors at the Tripler General U. S. Army Hospital were hosts to two medical groups recently exchanging medical knowledge in scientific programs. They were the Alumni Association of Hahnemann Medical College, led by **Dr. Charles S. Cameron,** its President, and the American College of Physicians, which featured its National president, **Dr. Franklin M. Hanger,** of Staunton, Pa.

**Dr. A. E. Bennett** of Lafayette, Calif., psychiatrist,

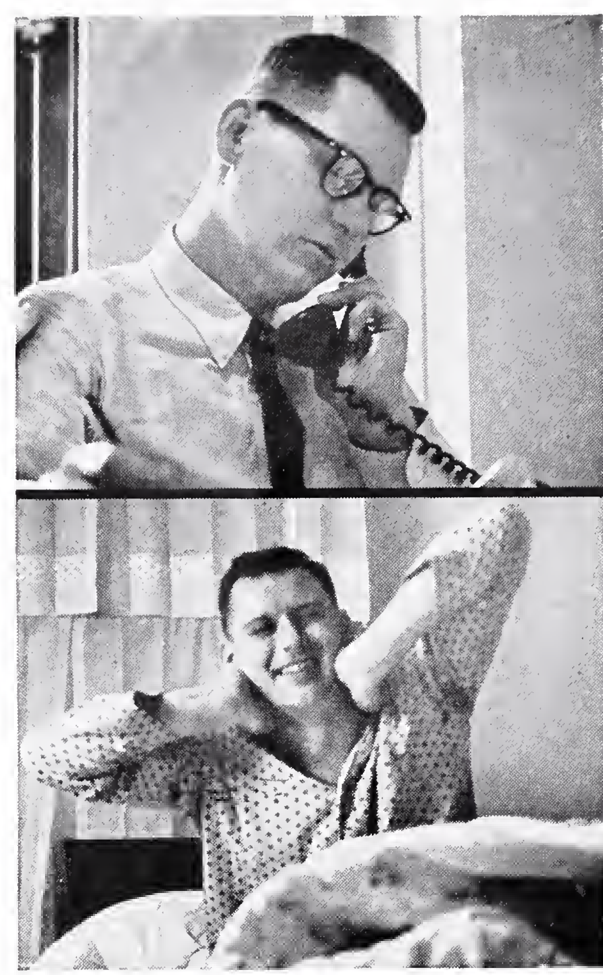
*continued page 393*

Sustained high-level protection in peptic ulcer




all day

all night



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Glaucoma; severe cardiac disease.

*Possible Side Actions:*
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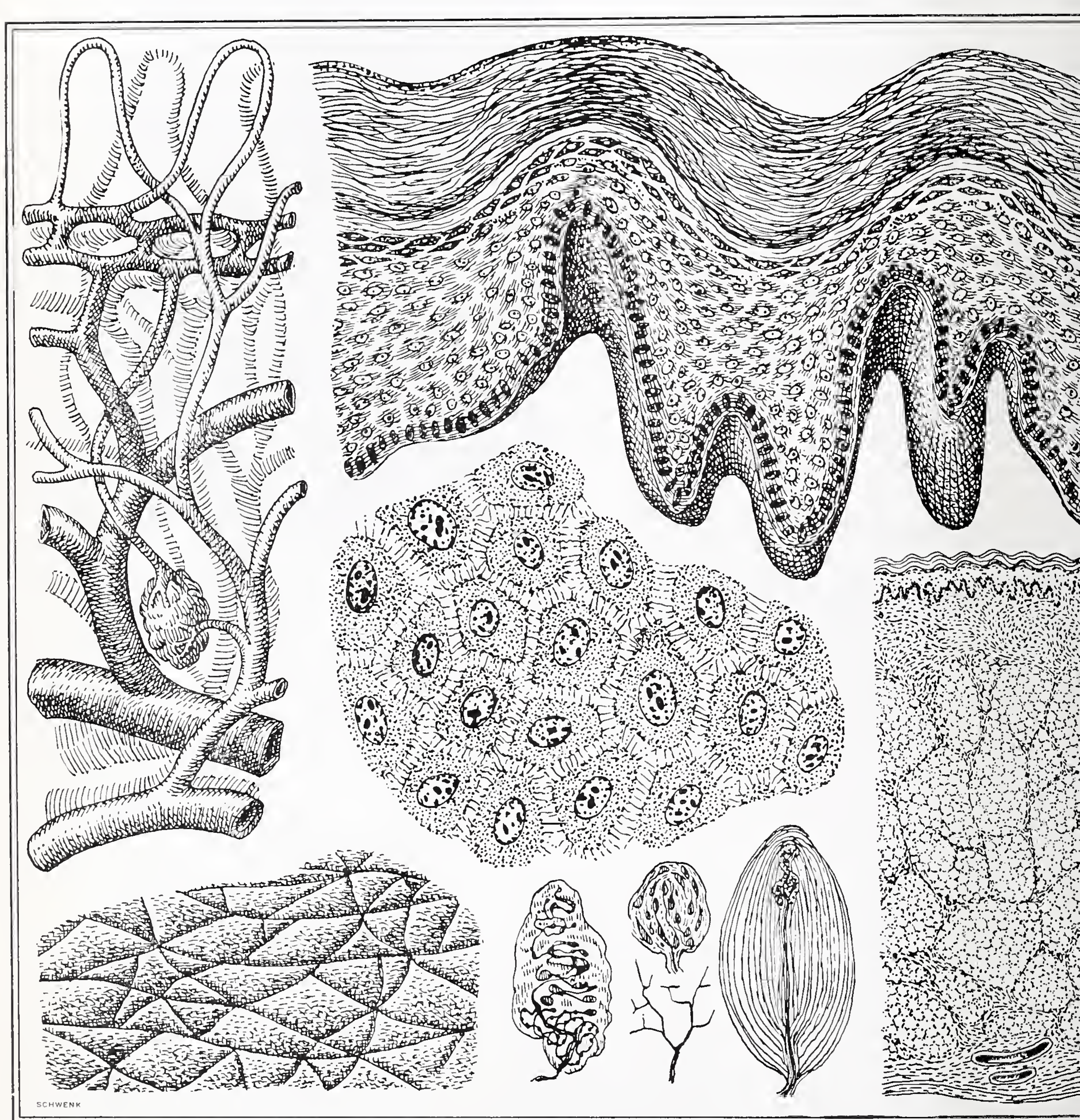
1. Asher, L. M.: The Choice of Anticholinergic Drugs in the Treatment of Functional Digestive Diseases, Amer. J. Dig. Dis. 4:260-275 (April) 1959.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ARISTOCORT Triamcinolone is indicated when anti-inflammatory, anti-allergic action of glucocorticoids is desired. SIDE EFFECTS of glucocorticoids generally: Cushingoid effects, hirsutism, leucopenia, purpura, vertigo, fatigue, increased hyperglycemia, osteoporosis, gastrointestinal hemorrhage, cataracts, growth suppression in children and increased intracranial pressure. Other glucocorticoid effects thought more likely to occur with triamcinolone: reversible weakness of muscles and flushing of face.

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FORMULA—Tablets (scored) containing 1 mg., 2 mg. or 4 mg. of triamcinolone. Syrup — 2 mg. of triamcinolone diacetate per 5 cc. (5 mg. of triamcinolone diacetate is equivalent to 4 mg. of triamcinolone).

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# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

*Editor:* NELLIE CHEREVAS, St. Francis Hospital Laboratory

## *News Briefs*

This is a little note to those registered technologists who, year after year have seen the name of Lall G. Montgomery, M.D., on their correspondence from the Registry, and have wondered about the man behind the name. Their curiosities have at last been satisfied by an article appearing in the December, 1962, issue of *Hospitals*. This is a most interesting personal portrait, well worth reading in its entirety.

For the last 22 years Dr. Montgomery has been chairman of the Board of Registry. His interest in medical technologists goes back even before then. The article deals with the unusual hobbies and interests of our good friend, and gives a resumé of the history of the Registry and medical technology field.

Technologists, identify yourself. Get your ASMT emblem from President Betty Hughes. May be purchased at 15¢ each.

Dr. Bernard Winters, pathologist at The Queen's Hospital, was the guest speaker for our January regular monthly meeting. His plan for quality control in our Honolulu hospitals was presented and received with enthusiasm. Though a pilot project will soon be set up using pig serum, the hospitals are expected to start saving and freezing their own nonjaundiced serum to obtain their own pools. Start that saving now—if you want to be in on the fun and excitement.

Several announcements were made that should be of interest to the general membership. Miss Ann Stegmaier has been selected to serve on the Licensing Advisory Board for the next three years. She has also been chosen to be the HSMT's nominee for the Corning Award for Line Technologist of the Year. Our petition for incorporation was presented to the State Treasurer's office. (This was approved on January 16, 1963. A copy of our Bylaws has also gone in, according to law. Every future change in the Bylaws must be presented to the State Treasurer's office within 30 days of acceptance.)

Would you like to attend some special workshop or refresher course on the mainland, but feel you can't afford the trip? An ASMT member can be allowed up to $200 travel expenses if his application is approved. By whom? Read your Micro News thoroughly each time it arrives!

The following Hawaii students are now interning in Honolulu:

KAISER—David Ho, 4441 Sierra Dr.; David Hashimoto, 3511 Kaau St. KUAKINI—Gail Oyama, 1041 Prospect St.; Patsy Matsunaga, 2427 Palolo Ave. QUEEN'S—Roy Mashiba, 697 S. King St.; Ronald Okada, 1540 Magazine St.; Joyce Fisher, 3910 Paki Ave.; Barbara Ishimoto, 232 Kaliponi St. ST. FRANCIS—Del Adlawan, 1758 Lusitana St.; Beverly Davis, 2377-A E. Manoa Rd.; Phyllis Morita, 164 N. Judd St.; June Won, 2604 Waolani Ave. TRIPLER—Larry Broel, 425 Ena Rd., Apt. 502C; Gloria de la Cruz, 1923 Puowaina Dr.; Marilyn Enos, 44-702-A Kaneohe Bay Dr.; Sally Downey, 2004 Skyline Dr.; Judith Harada, 1719 Nuuanu Ave.; Caroline Kanechika, Box 483, Waipahu; Joanne Kurisu, 854 Ailuna St.; SFC Jon Russ, Det., AMEDS, USA Tripler Gen. Hosp.; SFC Francis Sexton, Det., AMEDS, USA Tripler Gen. Hosp.; Eileen Takushi, 2514 Huene St.

An unusually large group of members and students gathered at Leahi Hospital on February 11 to attend a special Civil Defense demonstration. The location of the six 200-bed mobile hospital units on Oahu was explained, the lab kits were opened and examined, and the proper use of the hospital sterilizer was pointed out. The one item sorely needed was a microscope. Since none are supplied with the laboratory kit, each technologist is asked to bring her own. This imposes quite a problem. If your own hospital is gone during a disaster, you will volunteer for a mobile hospital. However, chances are that the microscopes will also have gone. In the meantime, the Civil Defense people will attempt to purchase (very reasonably) some used monoculars—ugh, shades of high school days! One other problem—the biologicals which must be kept refrigerated are not stored with the mobile units. Check with a member who was at the meeting and have it explained to you where these are located. The members of the Board of Health who conducted the meeting were Drs. Wilcox and Jasinski, and Mr. Abe Miyasaka.

A dinner meeting was held at the Green Turtle on February 25, 1963, with a prominent guest speaker and his charming wife, Dr. and Mrs. Derrick Brian Jelliffe. Dr. Jelliffe, currently the Unicef Professor of Pediatrics and Child Health at the Medical School of Kampala, Uganda, East Africa, was in Honolulu for a short time as the visiting Professor of Pediatrics at Children's Hospital. His interesting topic was "Problems in Medical Technology in Africa."

Be proud of the title you have earned. Order your MT(ASCP) uniform emblems direct from the Registry or through your HSMT treasurer for only 15¢ each.

## *How to Kill an Association In 13 Easy Steps**

1. Stay away from meetings.
2. If you do come, find fault.
3. Decline office or appointment to a committee.
4. Get sore if you aren't nominated or appointed.
5. After you are named, don't attend board or committee meetings.
6. If you get to one, despite your better judgment, clam up until it's over. Then sound off on how things really should be done.
7. Do no work if you can help it. When the Old Reliables pitch in, accuse them of being a clique.
8. Oppose all banquets, parties and shindigs as being a waste of the members' money.
9. If everything is strictly business, complain that the meetings are dull and the officers a bunch of old sticks.
10. Never accept a place at the head table.
11. If you aren't asked to sit there, threaten to resign because you aren't appreciated.
12. Don't rush to pay your dues. Let the directors sweat; after all, they wrote the budget.
13. Read mail from headquarters only now and then; don't reply if you can help it.

## *The Chairman's Beatitudes**

Blessed are those who attend meetings regularly and on time, and who remind or invite others to come.

Blessed are those who speak up at meetings, to bring out the points and to contribute their own experience.

Blessed are the brief, because they win the good will of the others.

Blessed are those whose participation is good-humor, for they brighten up the meeting and prevent disruption, despite any differences in opinion.

Blessed are those with perspective, who acknowledge to themselves, if not to those present, that conditions of others may be different, and hence their points of view.

Blessed are those who can face opposition without taking offense or feeling a personal criticism where none was intended.

Blessed are those who volunteer willingly, for they gain in influence and position with each added service.

Blessed are those who, having accepted a responsibility, discharge it promptly and give a good accounting of their performance.

Blessed are those who voice appreciation in front of their fellow members, so that those who have earned approval may enjoy it in good season and feel rewarded.

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## *In Memoriam* *continued from 376*

On April 19, 1906, Dr. Whitman married Miss Nelda Peters of Westport, Nova Scotia. The Whitmans were the parents of William McKinnon, Alma Peters (Mrs. Thomas Frazier), and Robert Borden, who died in 1960 in California.

From 1913 to 1931, Dr. Whitman served as government physician and as plantation doctor at Hakalau and Laupahoehoe on the Big Island. In 1932, he became physician for the Parker Ranch at Kamuela. Upon his retirement in 1942, the doctor moved to Honolulu.

Dr. Whitman died October 25, 1961, in Honolulu at the age of 88.

He was a member of the Hawaii Medical Society, the British Club Taylor Lodge No. 61, F.&.A.M., and the International Order of Foresters. ■

## *County Society News* *continued from 381*

dividual society. It was further voted that individual contracts between HMSA and each physician be continued, rather than the execution of contracts between each county society and HMSA.

At the March 18 meeting there was one guest, Dr. Kidder. After the Treasurer's report, a letter from Senator Miyake was read in which he outlined changes to be instituted in the bill on pharmacy. It was recommended that a further letter be sent to the Governor and the component HMA societies suggesting that a licensed physician, or his designated assistant, be permitted to dispense drugs as they are at the present doing and that the Board of Pharmacy be placed under the Department of Health's jurisdiction.

Dr. Kim advised that he would like to give Swallow III on Kauai after Dr. Bernstein has given approval. He advised that the funds collected during Operation Swallow are still in the bank in spite of the recommendation that they be transferred to the Red Cross.

After a discussion on the HMA Legislative Assessment it was recommended that each member mail in his check, and that Dr. William Beierwaltes be invited to speak on Kauai May 24.

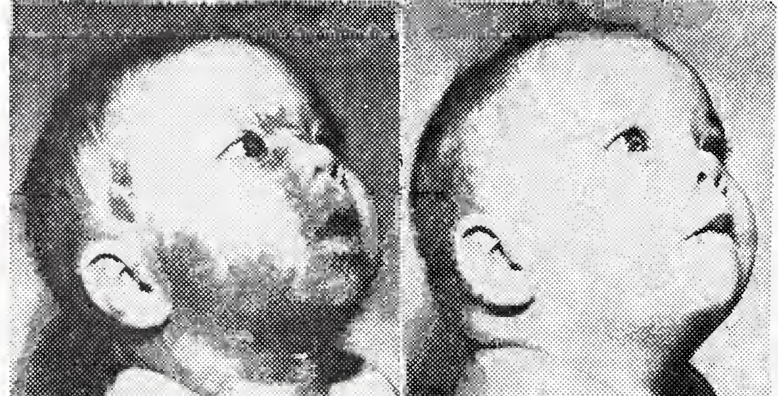
It was also recommended that the Secretary write to Senator Doi recommending that Dr. Bernstein's appointment be approved.

No action was taken on WICHE's invitation to have one of the Kauai members attend its annual meeting. A letter from Dr. Masato Hasegawa inviting one doctor and two nurses from Kauai to attend a symposium on premature care was read. Dr. Boido had stated that he desires to attend. No action was taken. It was voted to establish a loan closet for terminal care of patients at home. It was recommended that the hospitals continue to investigate radiologist applicants.

In the absence of Dr. Goodhue the March 25 meeting was called to order by Dr. Fujii. A letter from the Pharmaceutical Manufacturers Association was read in which SB 594 was outlined, and the reasons for opposition were stated. Since there will be no April meeting, Dr. Frank

*continued page 393*


*Sympathy won't help . . .*



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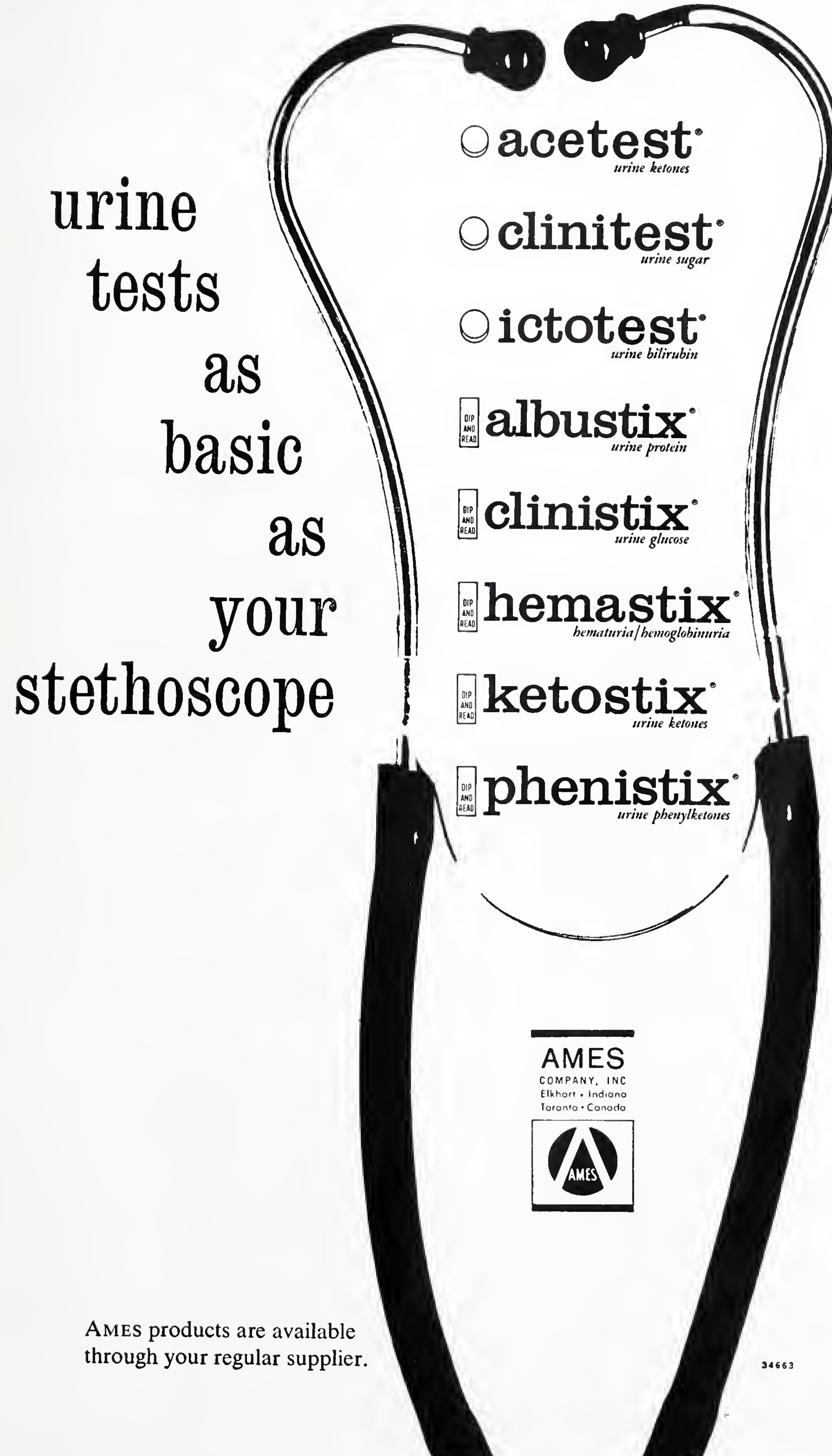


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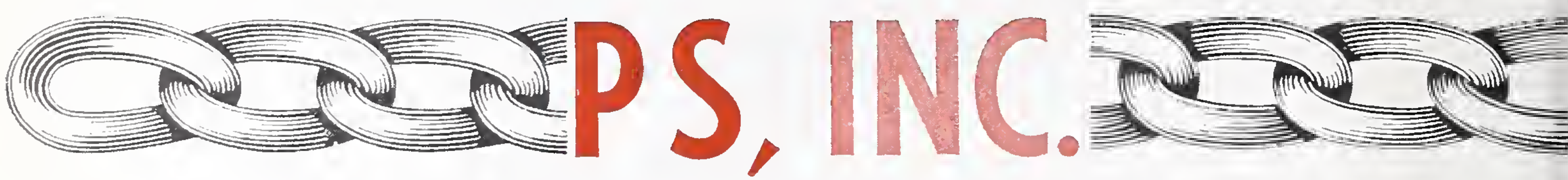


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Spencer will be invited to hold an educational meeting in conjunction with the Kauai Unit of the American Cancer Society in May. The guest speaker, Dr. Robert Wilkins, spoke on hypertension and told of the Goldblatt series of experimental studies on animals.

## Maui

One guest was present at the February 12 meeting, Dr. Hamilton Anderson. Dr. Rockett was elected as second alternate delegate. A letter from Dr. Joseph Stokes III relative to developing two-way radio conferences was favorably received. It was voted to write to Governor Burns stating that Maui County concurs with the views of the Kauai County Medical Society. The Secretary was instructed to notify the National Foundation that Maui County Medical Society would cooperate with the Operation Swallow III program. The Secretary was also instructed to write a letter to the Central Maui Memorial Hospital staff asking that a Utilization Committee be formed.

A lengthy discussion followed on the HMSA (Lum) report. It was agreed that the HMSA Review Committee is doing well and should be continued as is, between the individual doctor and the HMSA. Second choice is that the HMSA should contract with the State. The majority of members were in favor of having the County Society submit a panel of three names from which the HMSA might select one member for its Board. It was decided that the HMSA should not penalize participating doctors for late billing until after 90 days. It was recommended that there be no change in the method of payment for nonparticipating HMSA physicians. The second choice is that a patient be permitted to sign an assignment slip. No action was taken relative to multiple procedures in view of their handling in the RVS. ■



recently spoke at a public meeting on social drinking and alcoholism.

**Dr. Robert J. Ellingson,** Associate Professor of Medical Psychology with the Nebraska Psychiatric Institute at the University of Nevada's College of Medicine, lectured at the Children's Hospital, Kapiolani Hospital and at the University of Hawaii. Ellington's specialty is the study of brain waves in infant. He was sent to Hawaii by the NIH.

**Dr. Robert W. Wilkins,** chairman and director of the Boston University Division of Medicine, was keynote speaker at the biennial Western Conference of anesthesiology. Dr. Wilkins is also a past president of the American Heart Association.

## Condolences

To **Dr. and Mrs. William G. Davis,** formerly of the Big Island, now urological resident at the Denver General Hospital, for the loss of their seven-year-old son William David in an automobile accident in Denver, Colorado.

To **Dr. F. C. Spencer** for the loss of his dear wife Jan, who passed away quite unexpectedly. Mrs. Spencer was active in Auxiliary and community activities, being the first President of the State Association's Auxiliary.

To **Dr. Dorothy Natsui** on the loss of her husband, **Dr. Fred La Fon.**

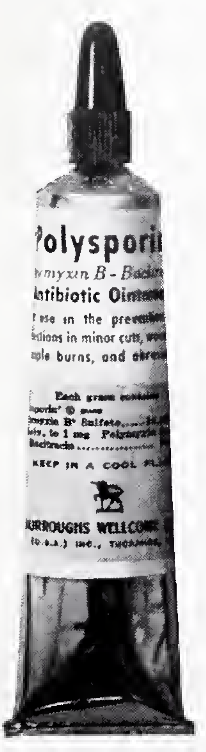
## New Officers

**Dr. Henry T. Oyama,** general surgeon, has opened an office at 1684 Kalakaua Ave.

**Dr. Sorrell A. Waxman,** pediatrician, is now associated with **Dr. Calvin Sia** at 1305 Kalakaua Ave.

*continued page 394*


**in treating topical infections, no need to sensitize the patient**



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Notes and News continued from 393

## Hawaii Doctors in Print

"The Highly Developed Art of Medicine in Old Hawaii" is the title of **Dr. Nils P. Larsen's** article in *Ciba Journal* No. 24, Winter 1962/63. **Drs. Rodney T. West** and **Robert A. Nordyke** collaborated on a paper on "The Use of the Renogram in Obstetrics and Gynecology," which appeared in the January-February, 1963, issue of the *Western Journal of Surgery, Obstetrics and Gynecology*. Visitor **Dr. Leon Rosen** had three papers published in the January, 1963, issue of the *American Journal of Hygiene*.

*Postgraduate Medicine* published **Dr. Donald F. B. Char's** paper on "Collagen Diseases in Children; Problem of Diagnosis" in March, 1963. Honolulu pathologists **W. H. Civin** and **Kazushi Tanaka** wrote "Cancer Arising in Thyroglossal Dust Remnant" for the March, 1963, issue of *Archives of Surgery. Excerpta Medica—Cancer* picked up **Dr. Walter B. Quisenberry's** paper on "Ethnic Differences and Socio-cultural Factors in Cancer in Hawaii" in January, 1963. The same article appeared in the January-March, 1963, issue of the Philippine Journal of Cancer.

Three recently published volumes contained chapters written by **Dr. Ralph B. Cloward:** *Clinical Neurosurgery* included "New Methods of Diagnosis and Treatment of Cervical Disc Disease," *Wiederherstellungschirurgie und Traumatologie* included "Surgical Treatment of Traumatic Cervical Spine Syndromes," and *Clinical Orthopaedics and Related Research* included "Legions of the Intervertebral Disks and Their Treatment by Interbody Fusion Methods: The Painful Disk."

"The Highly Developed Art of Medicine in Old Hawaii" is the title of **Dr. Nils P. Larsen's** article in the Winter 1962/63 issue of the *Ciba Journal*. ■

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*Book Reviews* *continued from 379*

the compendiums with which we are familiar in the fields of pharmacology and materia medica, but for everyday utilization by the physician in any field of practice, this is by far the best book of its sort that I have seen. I recommend it highly and I am sure that if it is on the physician's shelf it will be used as much as if not more than any other book in his collection.

MORTON E. BERK, M.D.

**Bailliere's Handbook of First Aid, 5th Ed.**

*By Arthur D. Belilios, M.B., B.S. (LOND.), D.P.H. (ENG.), Desmond K. Mulvany, M.S. (LOND.), F.R.C.S. (ENG.), F.R.C.P. (IREL.), and Katharine F. Armstrong, S.R.N., S.C.M., D.N. (LOND.), 469 pp., $3.50, Williams & Wilkins Company, 1962.*

INDEED A REMARKABLE WORK, and probably the most complete handbook on first aid I have ever had the privilege of reading. It is complete in every detail and covers first aid from A to Z. The chapters on Shock and Resuscitation have been completely revised and rewritten in keeping with the most up-to-date trends. The details of all types of artificial respiration are most exact and particularly clear are the directions for proper, mouth-to-mouth resuscitation. Pictures and diagrams are used freely and clearly throughout the work.

The price of the book is moderate and it should prove a most popular household item with physicians as well as the laity.

JAMES G. MARNIE, M.D.

**★Synopsis of Roentgen Signs**

*By Isadore Meschan, M.A., M.D., with the assistance of R. M. F. Farrer-Meschan, M.B., B.S. (Melbourne, Australia), M.D., 436 pp., $11.00, W. B. Saunders Company, 1962.*

DR. MESCHAN has cut the fat and scraps from two of his previous publications, leaving the firmest meat of roentgen signs for digestion. Purposely slanted toward medical students, generalists, and newcomers to radiology, this book employs a straightforward one-two-three-four outline approach to salient features of diagnosis. Profusely illustrated with simple diagrams and well reproduced roentgenograms, the book is truly a synopsis, suitable for quick reference. A quiz at the end of each chapter emphasizes the important points for the reader to remember. The book would be helpful to teachers of roentgenology in organizing lecture series.

R. G. RIGLER, M.D.

## Also Received

**Synopsis of Neurology**

*By Francis M. Forster, B.S., M.D., 223 pp., $6.75, The C. V. Mosby Company, 1962.*

COAT-POCKET SIZE compendium, clearly and concisely written, not as a comprehensive text but as a guide and refresher. It would be a most useful desk-reference volume.

**Protein Metabolism, Influence of Growth Hormone, Anabolic Steroids, and Nutrition in Health and Disease, An International Symposium Sponsored by Ciba**

*Edited by F. Gross, 521 pp., Springer & Verlag, 1962.*

ENDOCRINOLOGY is getting mighty complex. Here are essays and verbatim discussions by some experts.

**Examination Review for Practical Nurses**

*By Arlene Speelman, R.N., M.S., 328 pp., $4.25, G. P. Putnam's Sons, 1962.*

MUCH IS EVIDENTLY expected of LPN's today. How many RN's—or MD's for that matter—can identify foods as productive of alkaline or acid ash?

*continued page 398*

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## Book Reviews *continued from 396*

### Ciba Foundation Study Group No. 13 on Resistance of Bacteria to the Penicillins

*By A. V. S. de Reuck, M.S.C., D.I.C., A.R.C.S., and Margaret P. Cameron, M.A., 125 pp., $2.95, Little, Brown and Company, 1962.*

Many a practical gem can be found in this excellent symposium but the going is generally pretty heavy.

### Medicine in The United States and The Soviet Union

*By George A. Tabakov, M.D., 310 pp., $4.95, The Christopher Publishing House, 1963.*

Interesting reports and speculations by a distinguished Americophile Bulgarian pediatrician-teacher-editor, practicing in Marshallville, Ohio, since 1958.

### A Laboratory Guide in Chemistry, 4th Ed.

*By Joseph H. Roe, 262 pp., $3.75, The C. V. Mosby Company, 1963.*

For chemistry teachers and their students.

### A History of Nursing, From Ancient to Modern Times: A World View, 5th Ed.

*By Isabel M. Stewart, R.N., A.M., Anne L. Austin, R.N., A.M., 516 pp., $5.75, G. P. Putnam's Sons, 1962.*

The part about Florence Nightingale is exciting and impressive. Condensed from a four-volume work, aimed at student nurses, this fifth edition is still a school text, not a popularization.

### British Medical Bulletin, Vol. 19, No. 1

*Medical Department, The British Council, January, 1963.*

A symposium on Respiratory Physiology, by 26 different authors.

### ★Endocrine and Metabolic Aspects of Gynecology

*By Joseph Rogers, M.D., 189 pp., $8.00, W. B. Saunders Company, 1963.*

From genetics through 17-alpha-hydroxyprogesterone to counselling, in 175 pages, with a good index.

### Direct Psychoanalytic Psychiatry

*By John N. Rosen, M.D., 253 pp., $7.00, Grune & Stratton, Inc., 1962.*

The title says it.

### Ultramicro Methods for Clinical Laboratories, 2d Ed.

*By Edwin M. Knights, Jr., M.D., Roderick P. MacDonald, Ph.D., and Jaan Ploompuu, 213 pp., $6.75, Grune & Stratton, Inc., 1962.*

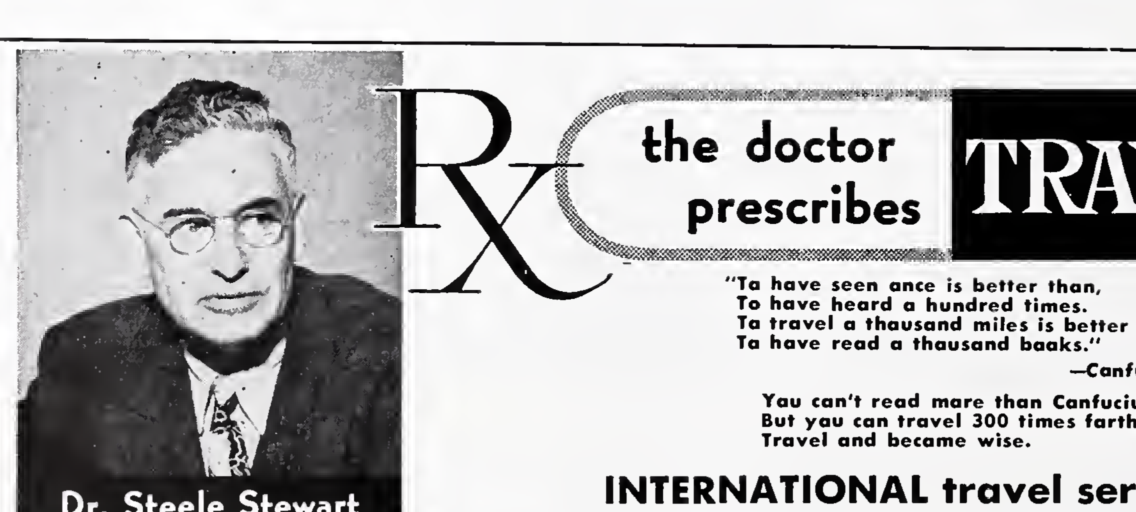
Clinical pathologists should own this practical Michigan (Detroit and Flint) handbook of laboratory procedures.

### Synopsis of Pediatrics

*By James G. Hughes, B.A., M.D., 1,031 pp., $9.85, The C. V. Mosby Company, 1963.*

Memphis pediatrics, in a pocket (overcoat, that is) edition.

*continued page 400*

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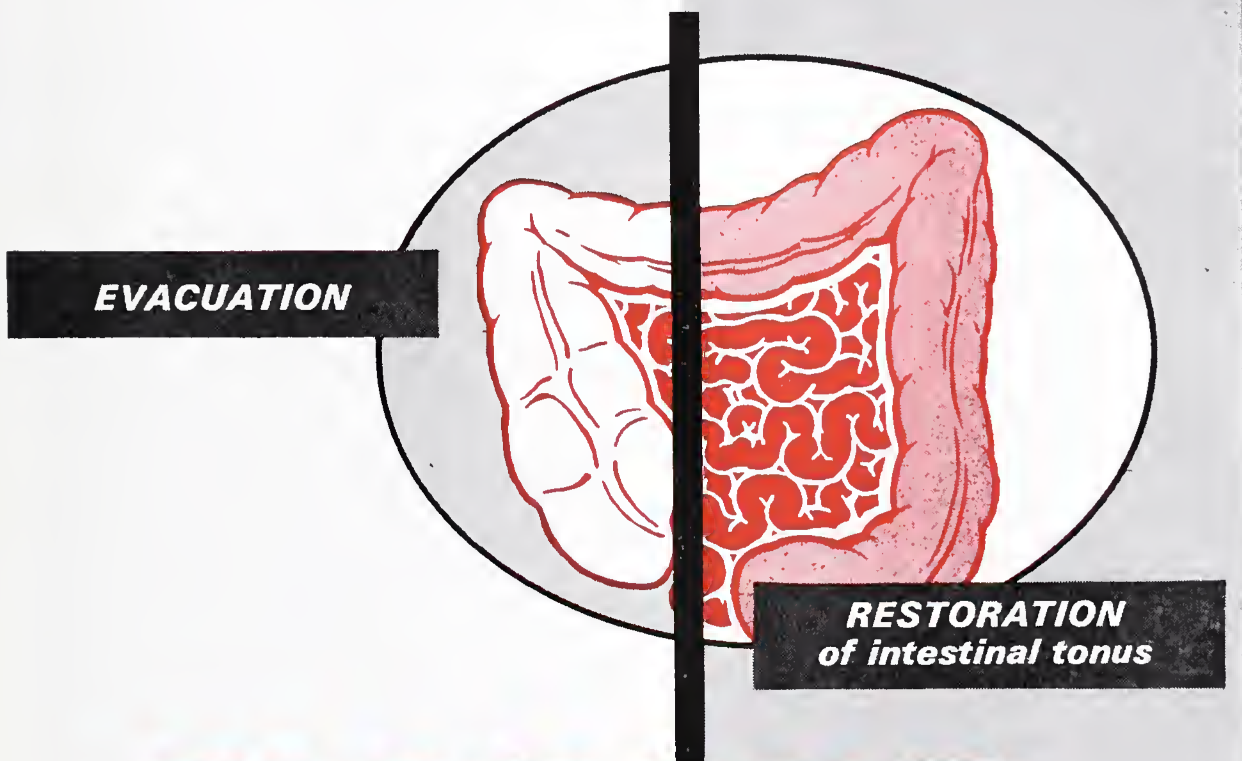


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*Book Reviews continued from 398*

**Textbook on Virology, 4th Ed.**
*By A. J. Rhodes, M.D., F.R.C.P., F.R.S.C., and C. E. van Rooyen, M.D., D.Sc., M.R.C.P., F.R.C P., 600 pp., $13.50, The Williams & Wilkins Company, 1962.*

FOR VIROLOGISTS or young, eager nonvirologists. A beautiful volume!

**Clinical Disorders of Iron Metabolism**
*Edited by Ernest Beutler, M.D., Virgil F. Fairbanks, M.D., and John L. Fahey, M.D., 267 pp., $8.75, Grune & Stratton, Inc., 1962.*

HEMATOLOGISTS will want to own this U.S.C. product.

**Lymphedema: Causes, Complications and Treatment of the Swollen Extremity**
*By Stephen A. Zieman, M.D., M.A., F.A C S., F.I.C S., 161 pp., $6.25, Grune & Stratton, Inc., 1962.*

A PRACTICAL manual on management of a difficult problem.

**Pneumoconioses**
*A. J. Lanza, M.D., Editor, 154 pp., $7.50, Grune & Stratton, Inc., 1963.*

LUCKY you come Hawaii!

**Physiology of the Circulation in Human Limbs in Health and Disease**
*By John T. Shepard, M.D., M.Ch., D.Sc., 416 pp., $12.00, W. B. Saunders Company, 1963.*

MAYO CLINIC diagnostic and therapeutic gems.

**The Medical Clinics of North America, Vol. 46, No. 6**
*Richard J. Bing, M.D., Guest Editor, pp. 1,419-1,728, November, 1962.*

TWENTY CONTRIBUTORS to this issue deal with selected aspects of pathophysiology, evaluation, and treatment of heart disease. The cumulative index for 1960 through 1962 is also included in this volume.

**Pediatric Clinics of North America, Vol. 9, No. 4**
*Arild E. Hansen, M.D., and Charles F. Ferguson, M.D., Editors, pp. 877-1,234, November, 1962.*

A SYMPOSIUM on Nutrition and Nutritional Problems and Ear, Nose and Throat Problems, with 29 contributors that includes a special article "A Caution about Digoxin Dosage in Infants and Young Children" by Samuel Kaplan, M.D.

**The Surgical Clinics of North America, Vol. 42, No. 6**
*Jonathan E. Rhoads, M.D., Guest Editor, pp. 1,385-1,679, W. B. Saunders Company, December, 1962.*

METHODS of improving morbidity and mortality rates in standard operations, by 47 contributors. Includes three-year cumulative index (1960, 1961, 1962).

**Progress in Medical Genetics, Vol. II**
*Edited by Arthur G. Steinberg, Ph.D., and Alexander G. Bearn, M.D., 378 pp., $12.75, Grune & Stratton, Inc., 1962.*

A VALUABLE volume, but for the expert rather than the beginner.

*continued pa-e 402*

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*Book Reviews* *continued from 400*

**Erythropoiesis**

*Leon O. Jacobson, M.D., and Margot Doyle, Ph.D., Editors, 399 pp., $6.75, Grune & Stratton, 1962.*

ESSAYS and verbatim discussions. Very well produced.

**★Photographic Illustration for Medical Writing**

*By Donald J. Currie, M.D., and Arthur Smialowski, A.R.P.S., 116 pp., $7.50, Charles C. Thomas, 1962.*

THIS CANADIAN volume is the best of its kind—practical, beautifully and profusely illustrated, and authoritative. Every physician-writer and medical photographer should own it.

**Surgery for Nurses**

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A CURIOUS BOOK. For example (p. 223), it says, "The central painful core [of a corn] consists of 'twisted' nerve fibers." Very British style, naturally.

**★Yearbook of Obstetrics and Gynecology—1962-1963 Series**

*J. P. Greenhill, M.D., 620 pp., $8.00, Year Book Medical Publishers, 1962.*

THE YEARBOOKS are indispensable, we believe, to the specialists in their respective fields. This one has two intriguing prefaces—one on presidential addresses, the other on Personal Peeves! Abbreviations, jargon, and research grants are lambasted.

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*By E. J. Somerset, M.B., D.O.M.S., M.S., 171 pp., $8.50, Williams & Wilkins Co., 1962.*

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**The Innervation of Blood Vessels**

*By T. A. Grigor'eva, 442 pp., Pergamon Press, 1962.*

NEW CONCEPTS in the pathophysiology of vascular disease. Not for your office desk, though.

**The Common Headache Syndromes: Biochemistry, Pathophysiology, Therapy**

*By Adrian M. Ostfeld, M.D., 86 pp., $4.50, Charles C. Thomas, 1962.*

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*By Peter M. F. Bishop, D.M., F.R.C.P., 100 pp., $5.75, Charles C. Thomas, 1962.*

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**★Atlas of Tumor Pathology Sec. 1, Fascicle 3: Melanotic Tumors of the Skin**

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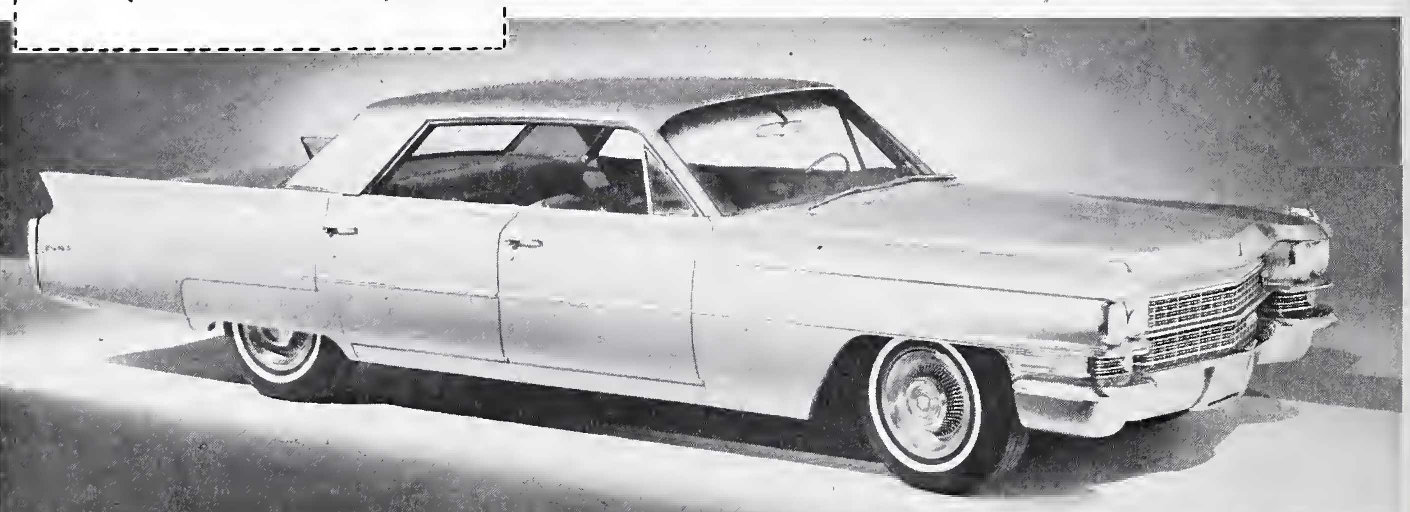

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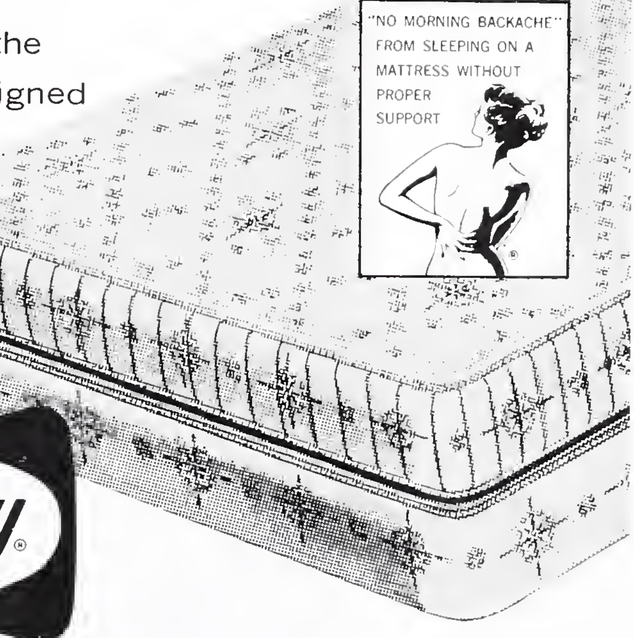


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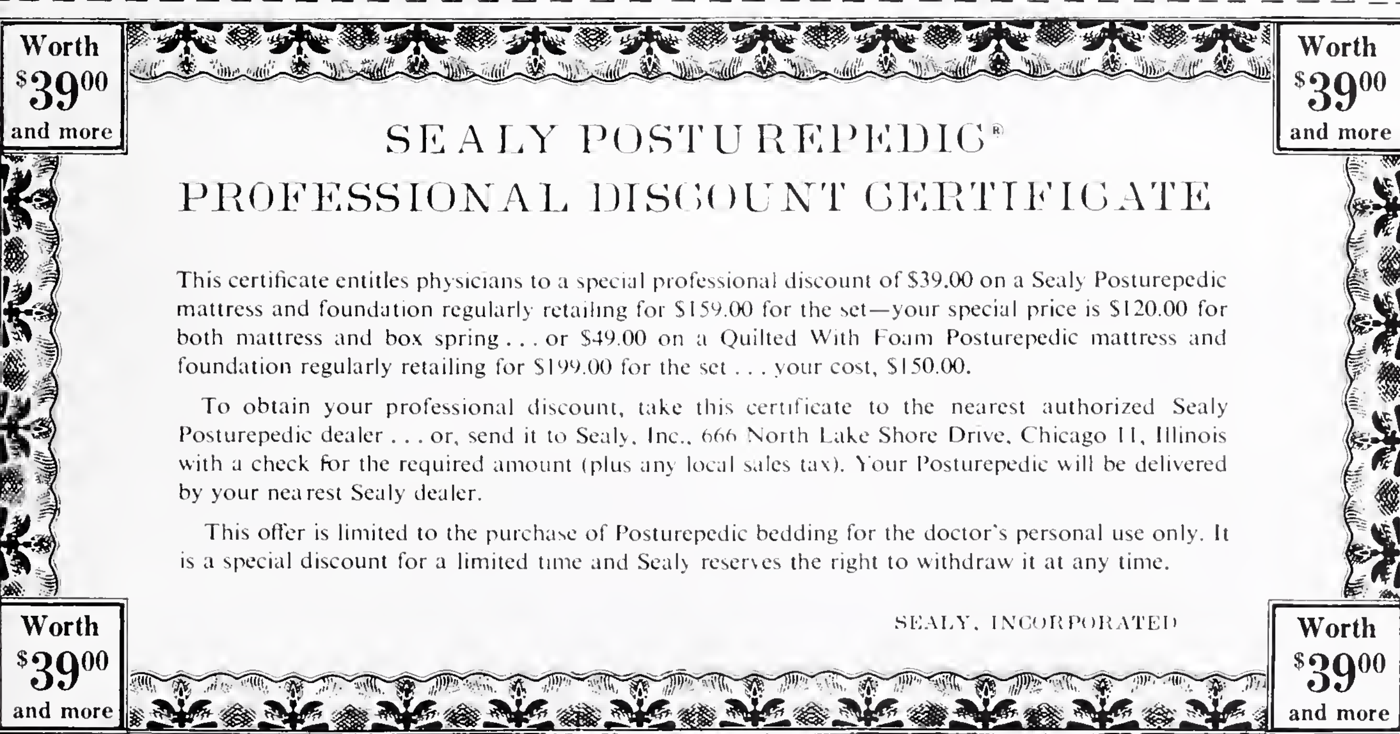

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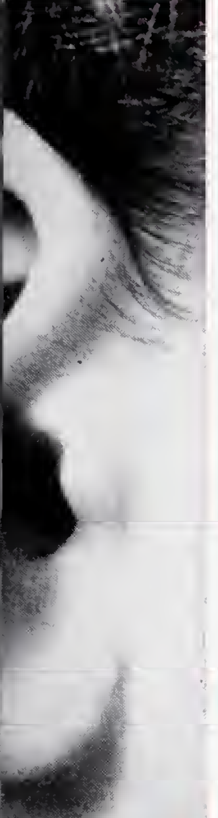

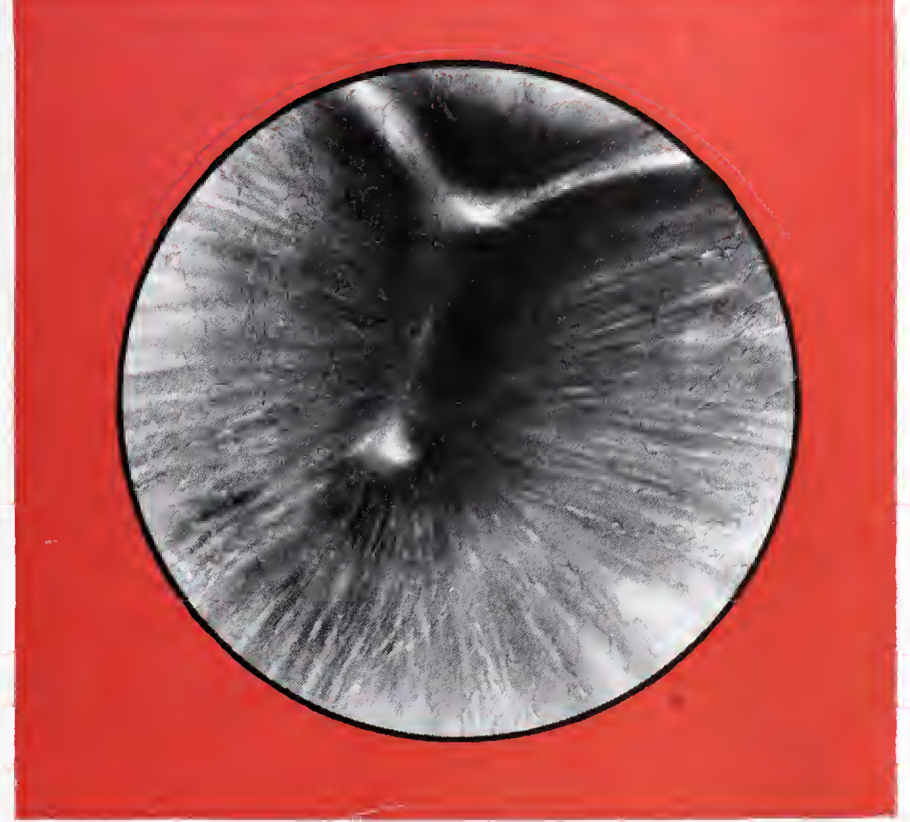

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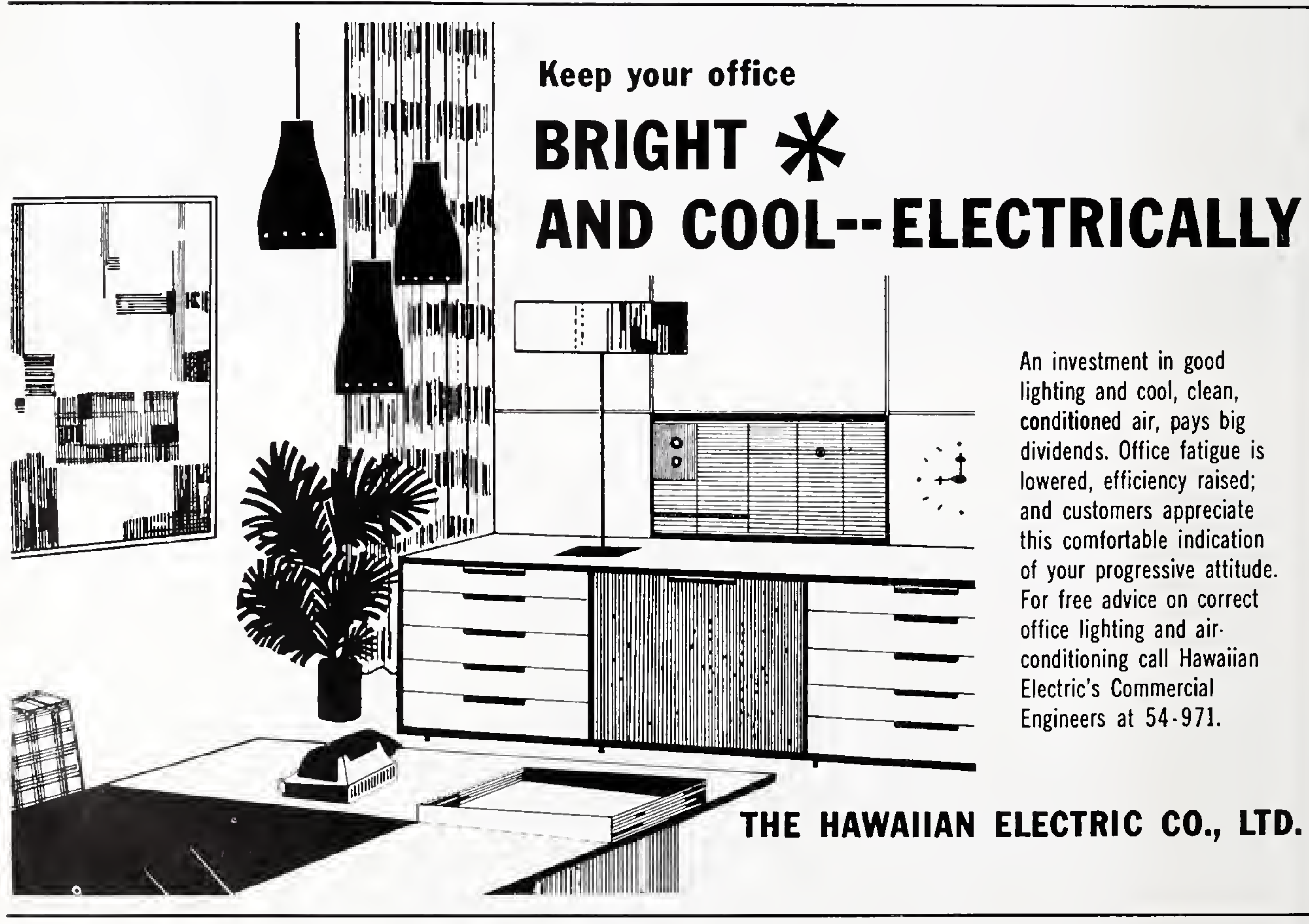

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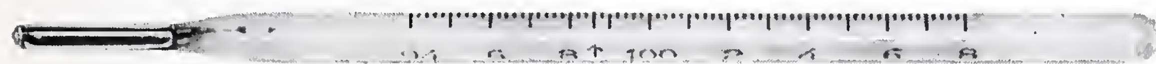

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*Transatlantic Telephone Symposium. *The Effect of Estrogens in the Menopause*, Amsterdam/New York, 1959. Transcript available on request.

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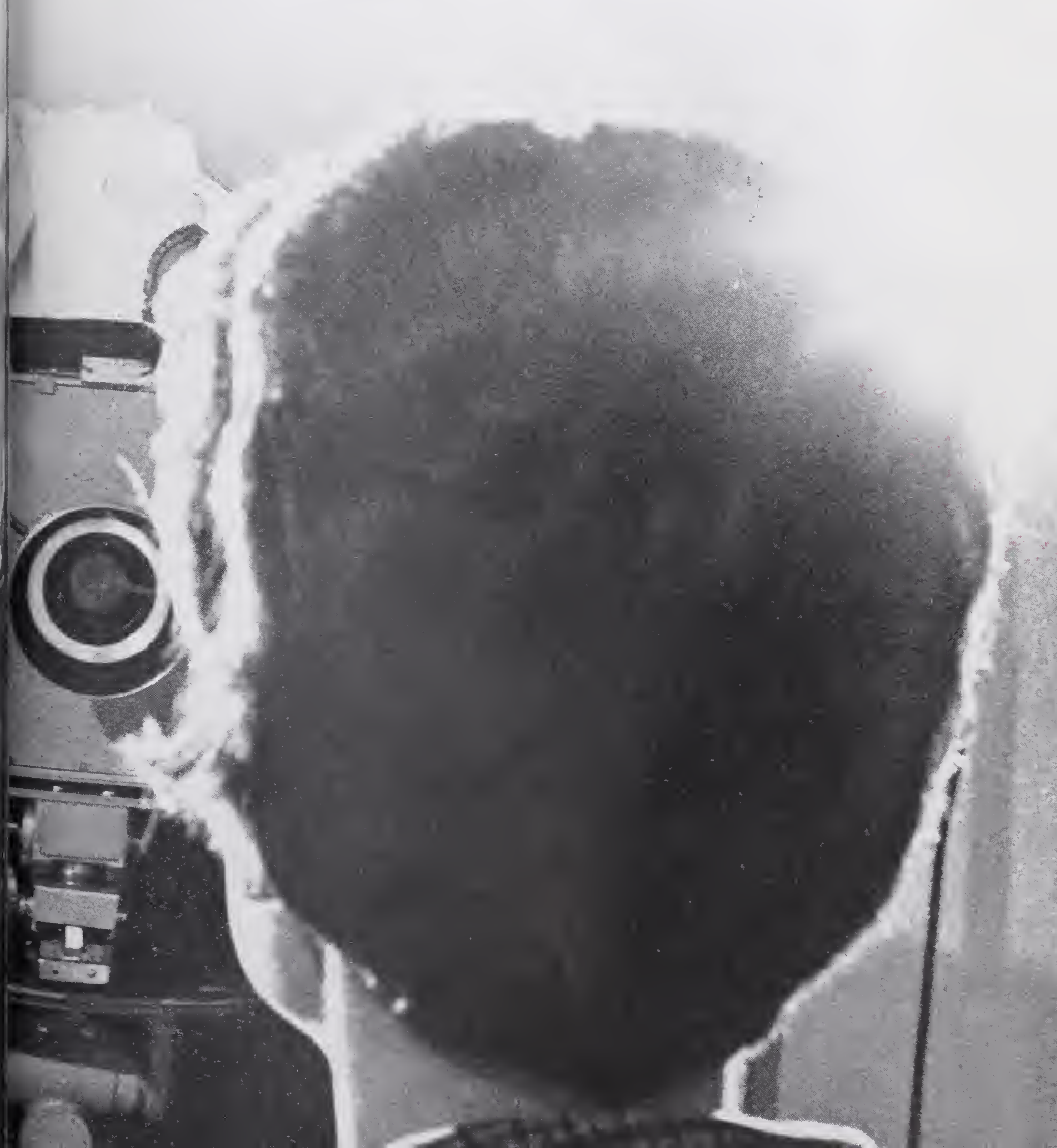

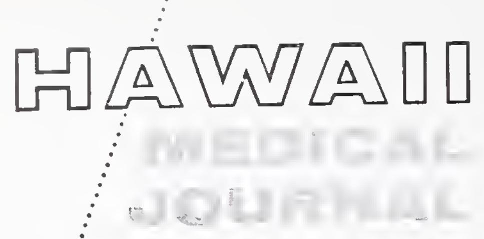

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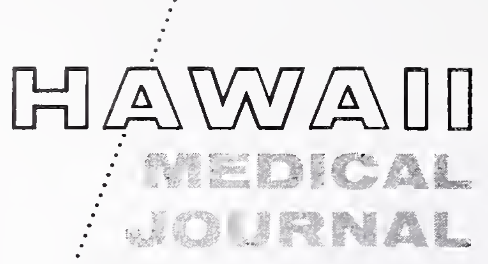


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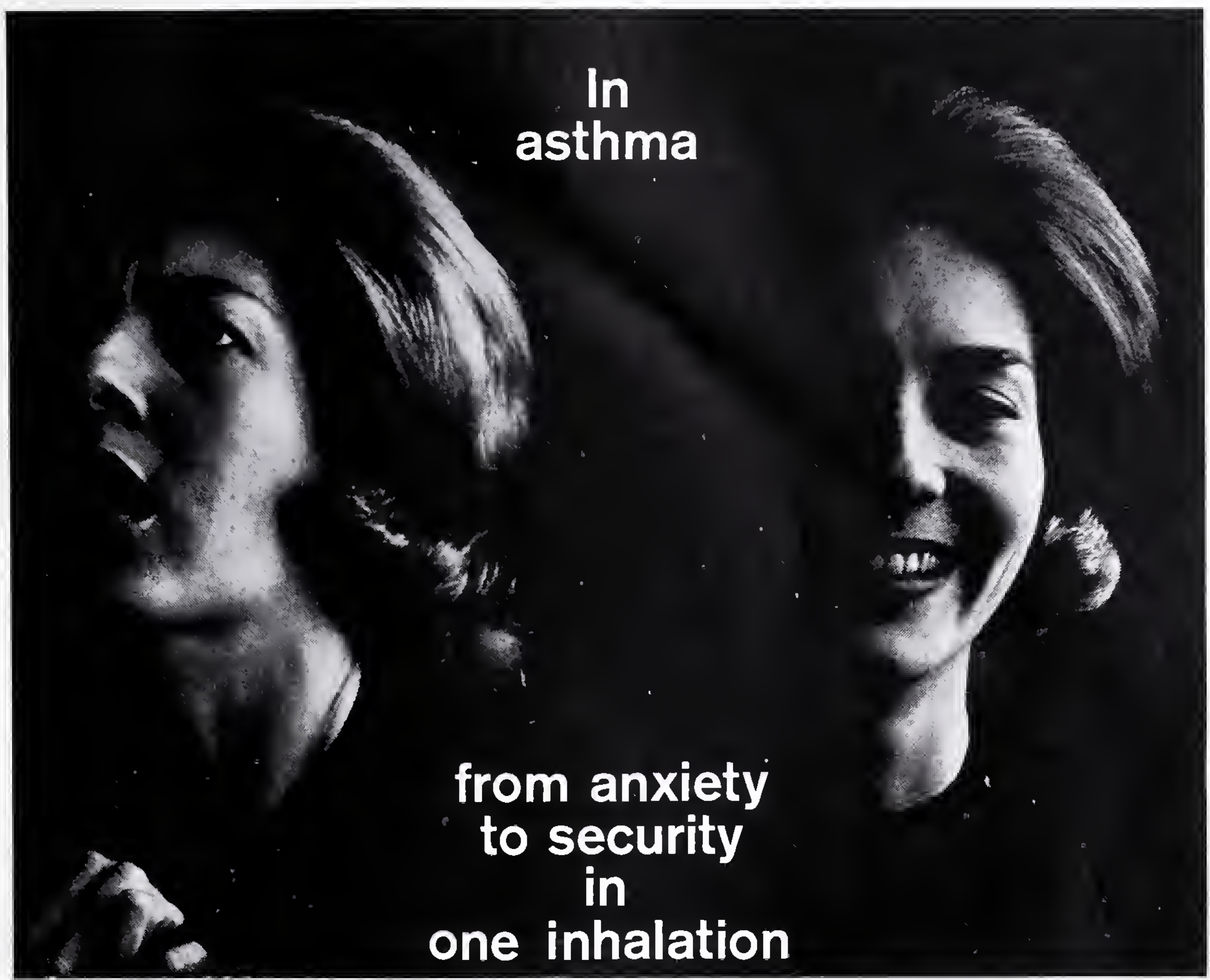


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*Franklin, William, and Lowell, F. C.: *Am. Pract. & Digest Treat.* 1:1161, Nov., 1950.

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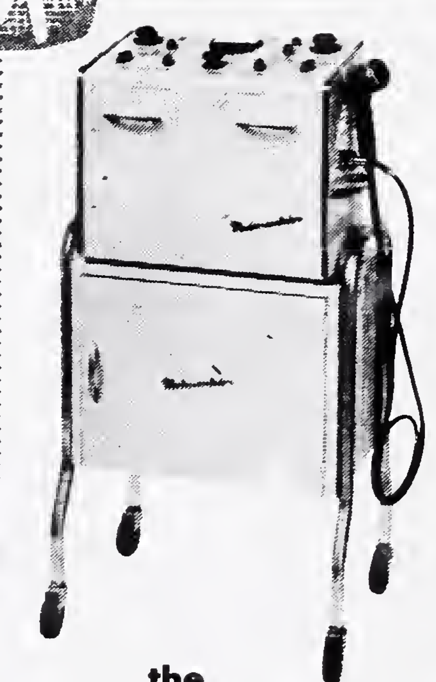

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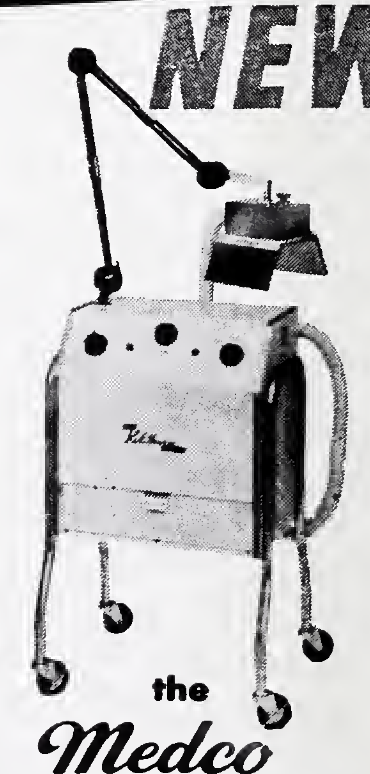

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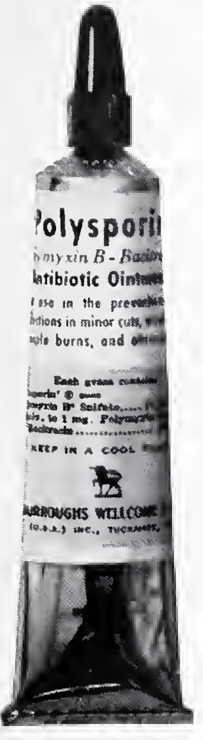

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HAWAII MEDICAL JOURNAL

# Reports & Snorts

Compulsion isn't always a bad thing. Diphtheria occurred in Hawaii every year up through 1954—never less than one case, and five or more in every year but two. (There had been no deaths from it since 1945.) In 1955 diphtheria immunization was required for school entry—and in six of the ensuing eight years no cases of diphtheria occurred. In 1943, after we had been compelled (by the military governor) to submit to typhoid immunization, the annual case load of typhoid fever fell abruptly from 101 cases (about double the annual average for the previous decade) to four cases; and though it went up to nine in 1946, it has never been over three since—and in seven of the last 13 years, no cases have occurred.

• • •

*"Alkylation" is a familiar term to doctors; most know that nitrogen mustard is an "alkylating agent," useful against some kinds of cancer. "What is alkylation?" is useful too, as a ploy to put an overly knowledgeable fellow in his place. He probably won't know.*
*An "alkyl" group is an alcohol group minus its characteristic terminal hydroxyl: methyl and ethyl radicals are simple alkyl groups. In alkylation, much more complex and elaborate alkyl groups attach themselves to the compounds being alkylated. In the case of nitrogen mustards, the attachment occurs preferentially to the phosphoric acid portion of DNA molecules, putting them out of commission — by alkylation.*

• • •

*Poor Flubber! The evidence that it was causing a skin eruption could hardly have been skimpier—but Flubber was up against the Division of Accident Prevention of the United States Public Health Service in the Department of Health, Education and Welfare of the United States of America—and it never knew what hit it. Let this be a warning to you, if you were thinking the Federal Government couldn't be too hard to get along with.*

• • •

A baseball umpire of notoriously brutal disposition decided to reform, and to start with he asked his little boy to sit on his lap. The boy refused, naturally—since the son never sets on the brutish umpire.

John R. Haserick (Cleveland Clinic) suggests a scorecard for diagnosis of systemic LE. Points are assigned to findings as follows: Positive LE test, $1\frac{1}{2}$; one point each for positive Wassermann (or other STS), pleurisy, sun sensitivity, discoid LE, purpura, or hemolytic anemia; $\frac{1}{2}$ point each for LE in the family, arthritis, rheumatic fever, high globulin, high sedimentation rate, positive Coombs test, anemia, or leucopenia. A score of two points means "LE diathesis" and arouses strong suspicion; a higher score may justify the actual diagnosis. If you're interested, send to Cleveland Clinic for their new free booklet (by Haserick and Killam) on LE.

• • •

Cardiac pacemakers are generally agreed to be the best bet for the future of victims of serious heart block. Mercury batteries in current models may last four to six years. Newest experimental models, however, are powered by ceramic, silicon-covered crystal transducers—one kind being activated by arterial pulsations and one by movements of the diaphragm. They work fine in dogs, and will surely work in humans too. They should last at least as long as the patients they're planted in.

• • •

Tom Swifties can have a medical bent, too. How do you like (the question is purely rhetorical: don't answer it) these? "I'm certain my Wassermann is all right," said Tom positively. "Surgery would do you no good at all," he said cuttingly. "You mean it's quinsy?" she inquired throatily. "A proctoscopic examination is what you need," he observed penetratingly. "That's not an ulcer, it's just acid indigestion," said the doctor sourly.

• • •

French and American diets differ considerably. In 1960 the average Frenchman ate 216.7 lbs. of bread (84.4 in U.S.), 150 lbs. potatoes (102 in U.S.), 81 lbs. fresh vegetables (106 in U.S.), 90 lbs. fresh fruit (161 in U.S.), 120 lbs. meat (161 in U.S.), 19 lbs. poultry (34 in U.S.), 22 lbs. fish (10.4 in U.S.), 28 lbs. cheese (8.4 in U.S.), 20.5 lbs. butter (7.5 in U.S.), 3.7 lbs. margarine (9.4 in U.S.), 115 eggs (334 in U.S.), and drank 88 qts. fresh milk (151 in U.S.), 7.3 lbs. coffee (15.7 in U.S.), 0.8 qts. fruit juice (10 in U.S.), 9 qts. soft drinks (49.5 in U.S.), 140 qts. wine (3.6 in U.S.), 37.5 qts. beer (63 in U.S.), 2.7 qts. liquors (4.8 in U.S.).

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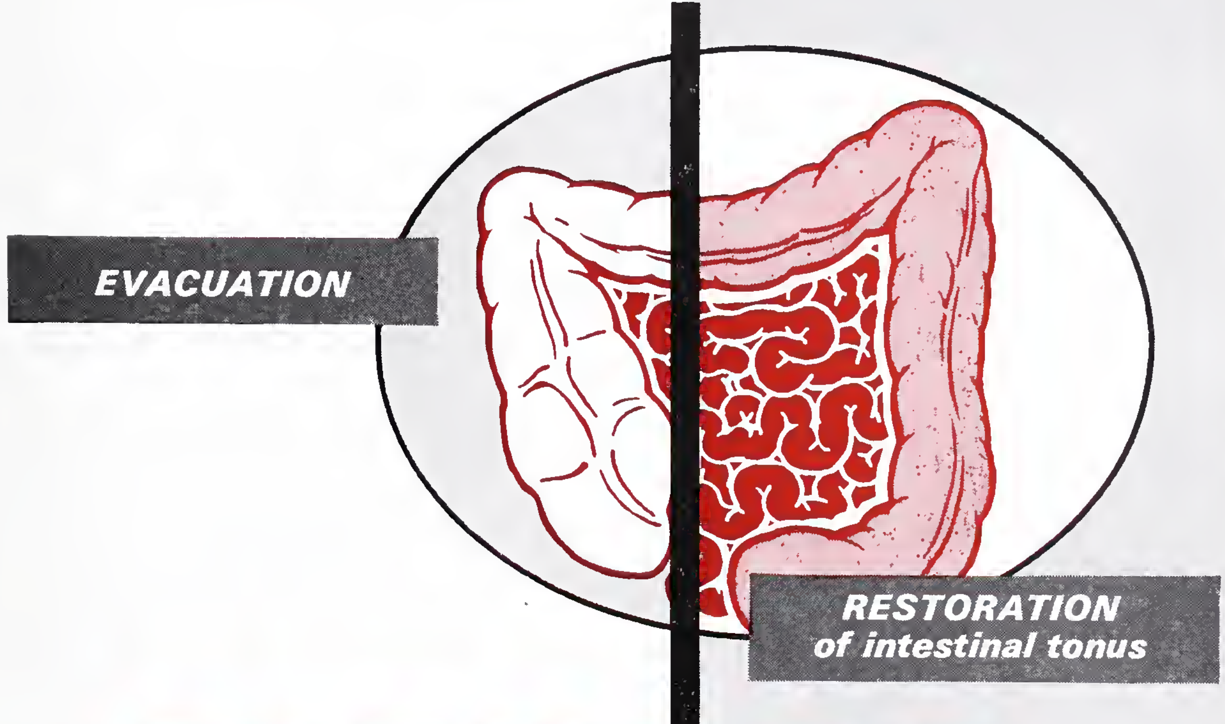


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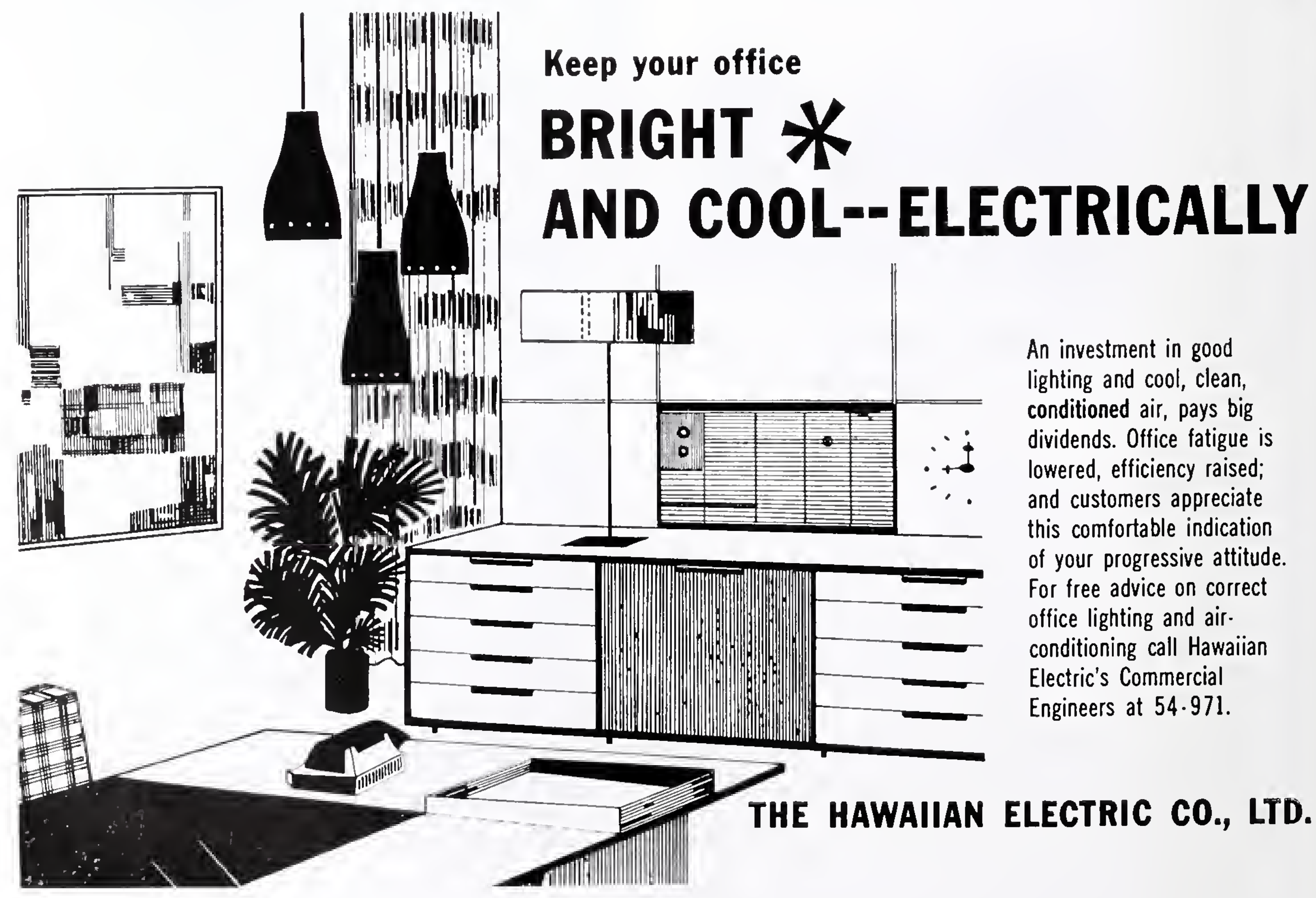

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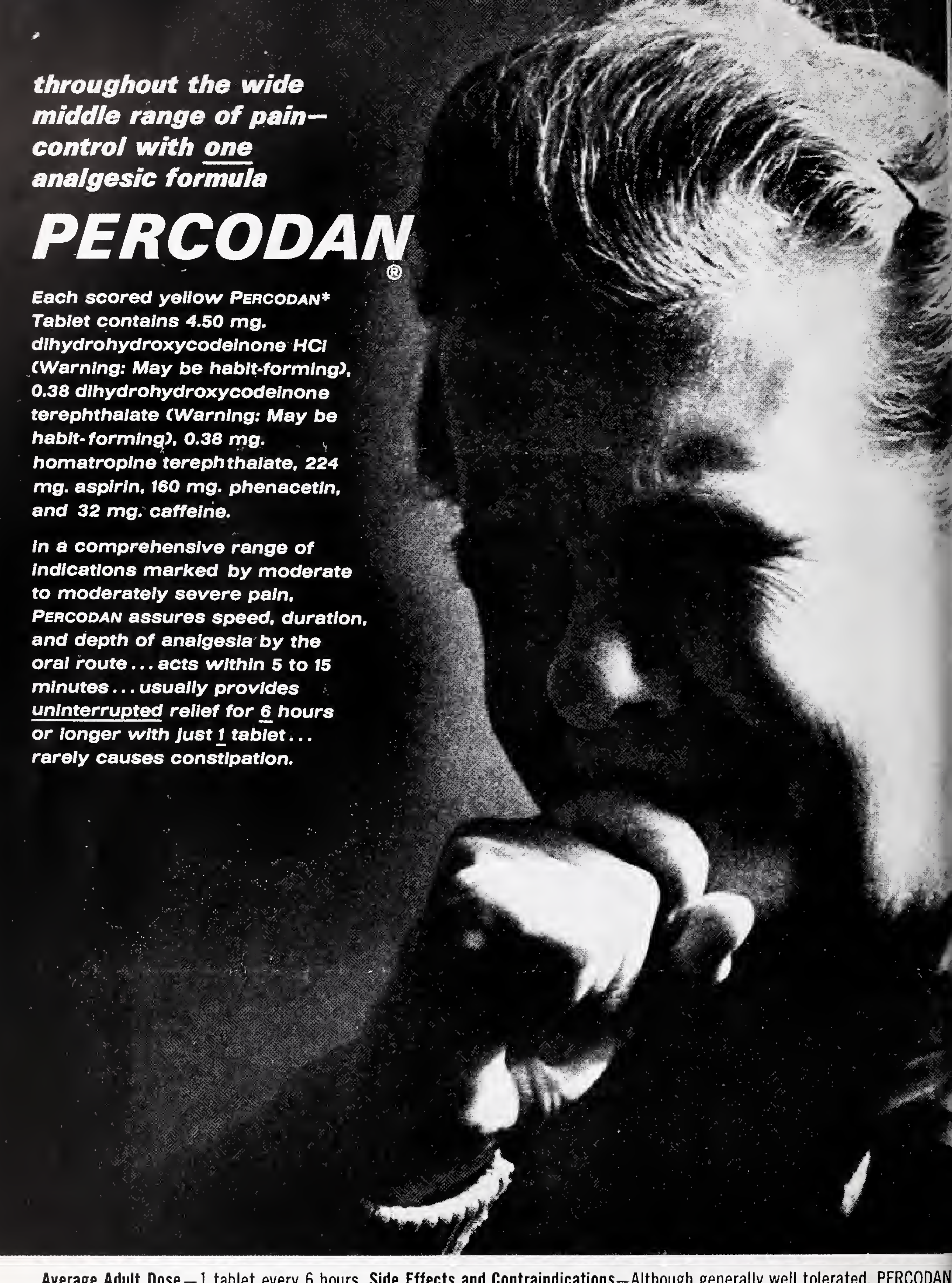


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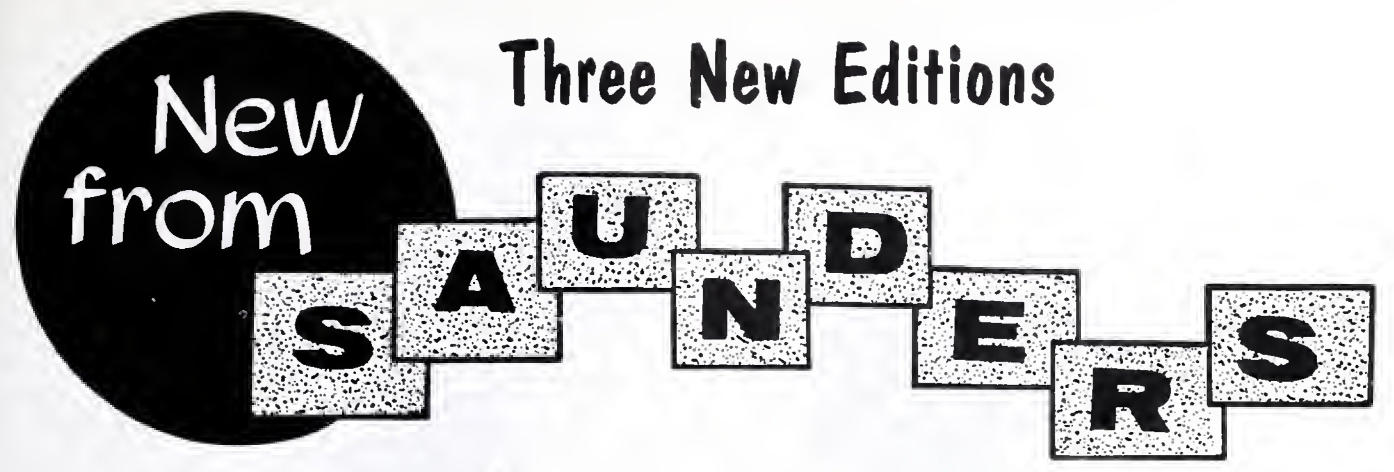



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*Did you know it could have serious CNS sequelae?*

# Roseola Infantum

W. F. MOORE, JR., M.D., *Honolulu*

• *Eyelid edema characteristically precedes the eruption of roseola, and irritability and even convulsions are fairly familiar concomitants of the disease. Less well known is the fact that serious neurological sequelae, ranging from mild transient hemiparesis to diffuse cerebral damage with mental retardation, may rarely occur.*

ROSEOLA INFANTUM (exanthem subitum) was recognized as a syndrome of infancy a century ago. It was considered an atypical form of rubella until Zahorsky[1] championed its status as a separate childhood illness when he reported his experience with 33 cases in 1910. In spite of its general acceptance today as a clear-cut clinical syndrome, roseola remains a puzzle as to etiology and may yet prove to be one form of an already well-known viral disease. The purpose of this paper is to review current knowledge of this disease.

## CASE REPORT

An 11-month-old girl was admitted to Kauikeolani Children's Hospital on April 15, 1962, following a convulsive seizure at home. Her past history was uneventful, except for a transient episode of pallor, limpness, and fever following her second DPT-polio immunization at three months of age. She had been well on the day of admission until around 5:30 P.M. when she was noted to be fussy and to have a rectal temperature of 104°. She was examined by a physician who noted a diffuse pharyngeal injection but otherwise normal findings. Treatment was begun with demethylchlortetracycline. One hour later she developed a grand mal seizure lasting about seven or eight minutes (according to her parents), following which she was taken to the hospital.

Soon thereafter she had a second convulsion, during which she choked on vomitus and became apneic. Phenobarbital, 100 mg parenterally, was required to control the convulsion; spontaneous respirations began after her airway was cleared.

Physical findings on admission included diffuse pharyngeal injection, mild injection and dullness of both tympanic membranes, and heavy sedation from the barbiturate.

White count was 15,200 (40 per cent polys, 9 per cent stabs, 44 per cent small lymphocytes); hemoglobin, 11.1 grams per 100 ml; normal urinalysis. Lumbar puncture yielded clear fluid under normal pressure, containing no cells, 18 mg per cent protein and 130 mg per cent sugar.

She was treated with penicillin for a presumed acute tonsillitis, and anticonvulsive therapy was continued with 30 mg of phenobarbital every eight hours. Her temperature continued to fluctuate to 103° over the following 2½ days. White count on her second hospital day was 9,850 (66 per cent polys); on her third day, 4,900 (73 per cent polys).

On April 18 (56 hours after admission), her rectal temperature dropped suddenly to 96.4°. Six hours later a fine macular rash appeared on her face and shoulders and spread to the rest of her body within the next 24 hours. She was discharged from the hospital on April 19 with a diagnosis of roseola infantum and febrile convulsion. Anticonvulsant therapy was discontinued upon discharge.

At 7:00 A.M. the morning following discharge she had a mild grand mal seizure lasting less than one minute. Thirty minutes later on examination in the hospital emergency room she seemed alert and showed only the roseola rash. Phenobarbital was restarted in a dose of 30 mg three times a day. An eight-point electroencephalogram 10 days after hospital discharge was normal. She is now taking 15 mg of phenobarbital once a day. Her last examination in September was normal.

Received for publication January 9, 1963.

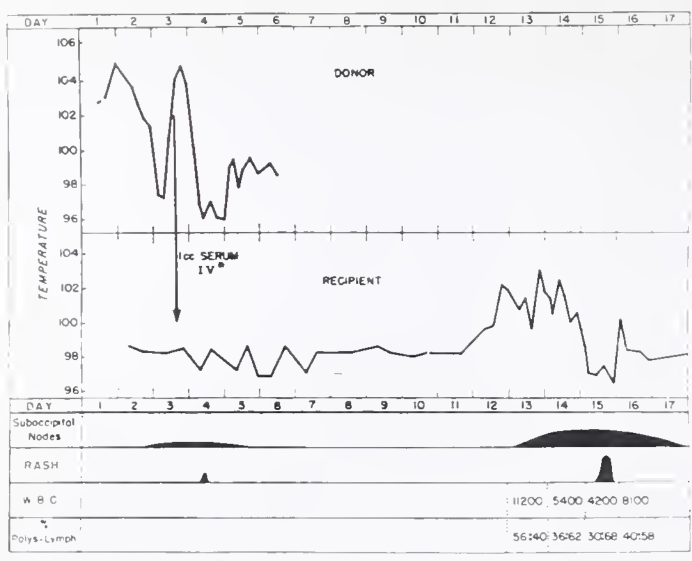
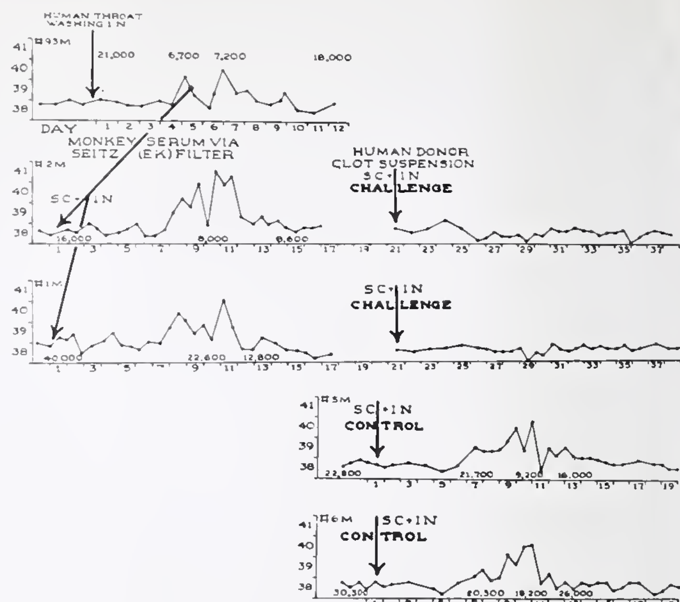

FIG. 1. *Direct transmission experiment. Serum taken from an 18-month-old infant in the pre-eruptive stage of exanthem subitum and given to a suitable recipient produced characteristic disease picture nine days later. (From Kempe* et al: J. Pediatric. *37:561)*

### INCIDENCE

Almost all cases of roseola occur in children between the ages of six months and two years. A few cases have been described in older children[2] and adults. Some of these instances deviate so far from the usual experience as to suggest that there may have been confusion with some other disease.

The method of spread remains unknown but is generally considered to be by nasal droplet. The degree of communicability must be low, since known contact of a healthy child with an infected infant will rarely result in disease, even though the infant so exposed may develop the infection at a still later time. Commonly, one of twins may have the disease and the other twin escape.

### VIRAL ETIOLOGY

The cause of roseola is still unknown. It is generally considered to be a virus, in view of the similarity of the clinical course of roseola to known viral exanthems, the failure of isolation of any one bacterial agent from both blood and throat cultures, and the infrequency of the case-to-case contact transmission characteristic of most bacterial infections.

It has been hypothesized that the responsible cause is some virus which is ubiquitous in healthy adults and older children, and to which they may be immune as a result of past exposure or insusceptible on the basis of constitutional resistance. One such virus is herpes simplex, which is widely distributed in healthy adults, yet only occasionally provokes evidence of infection under the provocation of some inrelated illness or injury. Immune bodies to herpes are present as a rule in adults but are absent in the age period in which roseola is prevalent.

A second possibility is that some fossil infection may be responsible—one which was a cause of epidemic disease centuries ago and to which constitutional immunity is present in adults. The agent could be present as a latent infection in adults; susceptibility to the pathogen might exist only in the immunologically immature.

Lastly, roseola, as we now recognize it, may be a viral disease which has an entirely different clinical picture in older children and adults. Lending support to this hypothesis is the variation which occurs in the clinical picture of ECHO 9 virus infection, in which a morbilliform rash is common among children but infrequent in adults.[3]

In 1950, Drs. Kempe, Shaw, Jackson, and Silver[1] reported a fascinating study on the etiology of roseola infantum. In their study, blood was drawn from an 18-month-old donor on the third febrile day of an illness later proved to be roseola. Within five minutes thereafter, the blood cells were separated from the serum and under aseptic conditions one cc. of serum was injected intravenously into a six-month-old susceptible recipient who had had no previous illness. The serum was simultaneously shown to be bacteria-free by suitable bacteriologic examination. Nine days after injection the recipient developed typical roseola. Some of the donor's serum, injected subcutaneously into Macaca mulatta monkeys, produced a febrile illness with leukopenia in four to five days.

Throat washings taken on the second day of the recipient's febrile illness were inoculated by intranasal spray into two monkeys after the inoculum was rendered bacteriologically sterile with penicillin and streptomycin. On the fifth day after inoculation both monkeys developed a fever which lasted four days. In Monkey No. 93M (Fig. 1) the white blood count dropped from 21,000 to 6,700 with the onset of fever, and rose to 18,000 on the twelfth day after inoculation. Serum from this monkey, taken on the second febrile day, was filtered and given subcu-

taneously and intranasally to two monkeys (Nos. 2M and 1M). As illustrated, both monkeys developed a febrile illness on the eighth day after inoculation. These monkeys and two control monkeys (Nos. 5M and 6M) were inoculated subcutaneously and intranasally with the original human donor's blood clot with the results illustrated—the convalescent monkeys (Nos. 1M and 2M) failed to show illness, the control monkeys developed a febrile illness associated with leukopenia on the seventh day.

Temperature is always elevated but can vary widely in elevation and duration from infant to infant; some infants spike temperatures to 105°, and others to 101° rectally at most. Even with very high fever, it is common to find the infant eating normally and playing actively. The fever usually persists three to four days, then drops precipitously to subnormal levels (as in this patient) just before the appearance of the rash.

### EARLY DIAGNOSIS

One of the most interesting and, to me, almost pathognomonic signs noted in roseola is edema of the upper eyelids[5] (Fig. 2). This characteristically appears the day before the eruption, and is out of proportion to episodes of crying. It is often associated with reddening of the lid margin but there is no conjunctival injection, photophobia or periorbital edema.

Examination of the ears usually shows minimal dullness and injection of the tympanic membranes. The pharynx is always injected although this varies in degree. Occasionally the tonsils are covered with a filmy exudate. The occipital nodes are usually enlarged, but not to the degree seen in rubella.

There is nearly always a history from the mother of softer stools during the pre-eruptive phase. Occasionally frank diarrhea occurs and occasionally vomiting is seen at the outset.

Probably the most common neurologic sign attributed to this disease is irritability, out of proportion to the fever and more often noted in roseola than in other febrile illnesses. It seems to me to be most noticeable after the appearance of the rash.

Prominence of the anterior fontanel has been reported[6] and was attributed by the author to edema of the underlying cerebral tissue. Lumbar puncture in these infants yields normal fluid. I have seen one such infant, with prominent fontanel and normal cerebrospinal fluid, who subsequently erupted with roseola.

Convulsions are well recognized as a common occurrence in roseola. Meigs and Pepper in a textbook written in 1870[7] reported 'headaches, restlessness, sometime mild delirium and even, it is said, though we have never seen them, with slight convulsive phenomena." The reported incidence varies

FIG. 2. *Edema and erythema of upper eyelids in patients with roseola infantum. (From Berliner, B.C.: Pediatrics 25:1034)*

febrile convulsions had roseola. This frequency of association of convulsions with roseola has prompted many men to treat with aspirin *and* phenobarbital any infant under two years who has a febrile illness.

### SERIOUS CNS SEQUELAE

Within recent years reports of serious sequelae of roseola have appeared in the literature. These sequelae, involving to date 22 infants in nine reports,[11-19] ranged in severity from mild hemiparesis lasting two days to diffuse cerebral damage and mental retardation. In 1959, Burnstine and Paine[19] from the Children's Medical Center in Boston reported six children with residual encephalopathy following roseola infantum, one of which might be presented in detail:

This male child was well and developed normally until 15 months of age. Twenty-four hours after the onset of a febrile illness, he was found comatose by his parents with a temperature of 105.6° followed by a right-sided clonic convulsion lasting two hours. He was comatose for two days after this, and on the fourth day after the convulsion a right hemiparesis was noted, as well as the classic eruption of roseola. Examination of the spinal fluid on the day of the convulsion, and again two days later, was negative. Six months after the illness, at the age of 21 months, the child sat up, and twelve months from illness, at 27 months, he walked. He has never developed any speech, however, and seems grossly mentally defective. There is a right hemiparesis and probably a right homonymous hemianopsia. Pneumoencephalogram (Fig. 3) showed general dilatation, especially the left lateral ventricle, with shift to left.

Their comments follow:

> The pathological basis of the sequelae in our cases is speculative, and a number of possibilities exist:
>
> 1. Cerebral thrombosis is suggested by the focal seizures and the precise localization in some, as well as the lack of inflammatory changes in the cerebrospinal fluid.
>
> 2. Anoxia probably occurred in three cases . . .

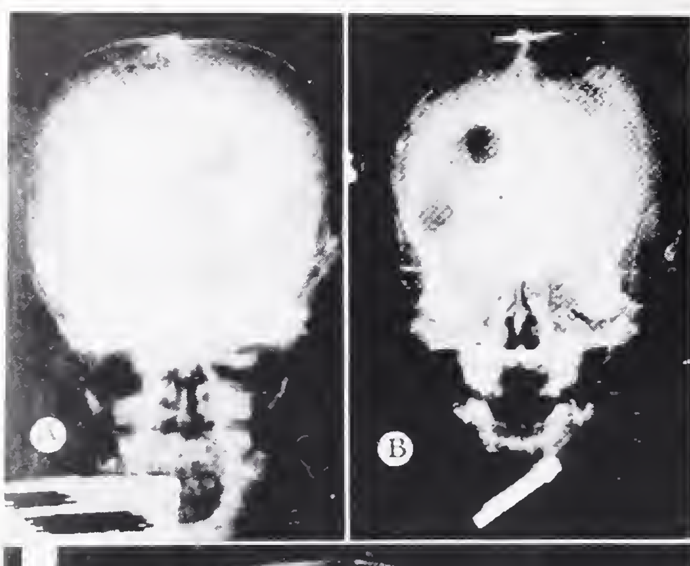

FIG. 3. *Pneumoencephalogram made at age 3 years; 21 months after onset of right hemiparesis at time of roseola at age 15 months. (Left and right are reversed in A) (From Burnstine* et al: A.M.A. J. Dis. Child. *98:144.)*

> Asymmetric lesions, including hemiplegia, can almost certainly be based on anoxia . . .
>
> 3. A postinfectious encephalitis with the classic perivascular demyelination seems a less likely etiology, as the complications have appeared prior to the appearance of the rash . . . , are sharply localized, and are accompanied by normal cerebrospinal fluid.
>
> 4. The possibility of a specific encephalitis or encephalomyelitis due to the roseola virus has been suggested . . .
>
> 5. The effect of prolonged convulsions must also be considered, as well as the effect of high temperatures, alone or in combination with other suggested factors.
>
> 6. A single and irreversible original lesion of vascular or other nature might cause both the convulsion and the 'residual' encephalopathy so readily attributable to it.[19]

Laboratory studies show a leukopenia during some stage of the illness. This most characteristically appears 24 hours before the rash, as in this reported infant. Differential count usually shows a lymphocytosis.

The rash of roseola is macular and appears first behind the ears and on the neck, spreads to the face and then to the entire body. The macules are discrete but may, particularly on the face, coalesce as the rash begins to fade. It usually persists three days but may be present only a few hours. The palms and soles are not involved. In my experience those infants with the mildest fever have the mildest rash.

While permanent immunity seems to follow recovery from the first attack, second bouts of roseola have occurred in the same infant. I have seen such second infection within three months of the first. The second episode is always mild.

## SUMMARY

Roseola infantum remains an enigma as to etiology, but well documented in its clinical picture—so well documented that it is one of the few exanthems that can usually be predicted by the alert practitioner. Faced with an infant whose temperature is elevated, whose pharynx is moderately injected, whose upper eyelids appear puffy, who does not appear particularly ill, and whose white blood cell count is below normal, one can say with almost the assurance of "Ivory Soap" purity (99 and 44/100 per cent), "Mother, your baby has roseola. By tomorrow the rash should be out." Let us hope that the physician is fortunate enough to have her call next day to acclaim the accuracy of his prediction. And while he may be reassured by the thousands of infants each year in whom the disease runs a benign course, he must also be aware that serious neurological sequelae may result.

1000 Ward Avenue

## REFERENCES

1. Zahorsky, J.: Roseola infantum, J.A.M.A. 61:1446 (Oct.) 1913.
2. Letchner, A.: Roseola infantum (a review of 50 cases), Lancet 2:1163 (Dec.) 1955.
3. Sabin, A. B., Krumbiegel, E. R., and Wigand, R.: ECHO type 9, virus disease, A.M.A. J. Dis. Child. 96:197 (Aug.) 1958.
4. Kempe, C. H., Shaw, E. B., Jackson, J. R., and Silver, H. K.: Studies on the etiology of exanthema subitum (roseola infantum), Pediat. 37:561 (Oct.) 1950.
5. Berliner, B. C.: A physical sign useful in diagnosis of roseola infantum before the rash, Pediat. 25:1034 (June) 1960.
6. Oski, F. A.: Roseola infantum. Another cause of bulging fontanel, Am. J. Dis. Child. 101:376 (Mar.) 1961.
7. Meig and Pepper: Diseases of children, quoted by Zahorsky, J., J.A.M.A. 61:1446 (Oct.) 1913.
8. Berenberg, W., Wright, S., and Janeway, C. A.: Roseola infantum (exanthem subitum), New Engl. J. Med. 241:253 (Aug.) 1949.
9. Letchner, A.[2]
10. Möller, K. L.: Exanthema subitum and febrile convulsions, Acta Paediat. 45:534 (Sept.) 1956.
11. del Mundo, F., Cordero, L. S., and Rodriguez, S.: Pre-eruptive roseola encephalitis (a review of 2 cases) J. Philippine Med. Ass. 31:622 (Nov.) 1955.
12. Ritchken, J.: Roseola infantum: a common cause of infantile convulsions, Central African J. Med. 3:50 (Feb.) 1957.
13. Glanzmann, E., cited by Windorfer,[16] cited by Burnstine.[19]
14. Berenberg, W. *et al.*[8]
15. Holliday, P. B., Jr.: Pre-eruptive neurological complications of the common contagious diseases—rubella, rubeola, roseola, and varicella, Jr. Pediat. 36:185 (Feb.) 1950.
16. Windorfer, A.: Das Dreitagefieber—exanthem der kleinen kinder, exanthema subitum, Deutsche Med. Wchnschr, 79:1201 (Aug.) 1954.
17. Rosenblum, J.: Roseola infantum (exanthema subitum) complicated by hemiplegia, Am. J. Dis. Child. 69:234 (April) 1945.
18. Posson, D. D.: Exanthem subitum (roseola infantum) complicated by prolonged convulsions and hemiplegia, J. Pediat. 35:235 (Aug.) 1949.
19. Burnstine, R. C. and Paine, R. S.: Residual encephalopathy following roseola infantum, A.M.A. J. Dis. Child. 98:144 (Aug.) 1959.

*Liver injury presents special problems, and few surgeons acquire much experience with it.*

# Liver Injuries

LOUIS S. ROCKETT, M.D., *Wailuku, Maui*

• *Of 20 cases of liver injury admitted to The Queen's Hospital in a four-year period, 16 were due to nonpenetrating injuries, 5 incurred while riding in a car and 5 while driving it. Three stab wounds and a bullet wound made up the cases of penetrating injury. In half the cases other organs or structures were also injured. Operative intervention in all cases was followed by recovery without complications in half the cases. Only three died, two early, from hemorrhage, and one 11 days later, from infection.*

WHILE liver injuries are not uncommon, the number seen by the individual practitioner is usually small. We therefore felt it worth while to report a series of cases seen in recent years at The Queen's Hospital.

From 1956 through 1959, inclusive, 20 cases of liver injury due to external violence were admitted to The Queen's Hospital. Sixteen were due to nonpenetrating and four were due to penetrating injuries. The penetrating wounds were three stab wounds and one bullet wound. The nonpenetrating wounds were due to moving automobile accidents in 10 cases, and in five of these the victim was the driver of the vehicle.

The injuries were further classified into severe (12), moderate (4), and mild (4). The severe injuries are those that would probably have caused death without surgical intervention, or that did cause death. The moderate are defined as those that were symptomatic but with less evidence of shock and blood loss. The mild are those that might very well have recovered without complications in the absence of surgical intervention. The case of bullet wound of the liver and one instance of stab wound were mild, but surgical exploration was indicated by the nature of the injury.

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### ADDITIONAL INJURIES

There were 10 cases in which, in addition to the liver, other organs or structures were injured. Fractured ribs were noted as being present in seven cases, ruptured spleen in four, severe contusion of the pancreas in one, fracture of the kidney in one, laceration of the stomach in one, ruptured urinary bladder in one, bilateral pneumothorax in one, and laceration of the gall bladder in one. However, no case of multiple injuries was included in this series unless it was felt that the liver injury itself was sufficiently severe to cause death or serious symptomatology.

While a few patients presented with very little evidence of serious injury, in most instances (14 cases) the patient was in shock when brought to the emergency room, or shock developed soon after. Abdominal pain, tenderness, and rigidity were frequently present when the patient was first seen. If not, they developed soon after the patient came under observation. These findings were usually most pronounced, of course, in the right upper quadrant. The presence of associated rib fractures seemed to cloud the picture a great deal, the upper abdominal symptoms at first being attributed to the fractured ribs in several cases.

The longest period of observation prior to surgical intervention was 48 hours. X-rays of the abdomen seemed to provide little useful information as far as the liver injury was concerned. Needle aspiration of abdomen was reported in only four cases. It yielded a bloody aspirate in three and was negative in one. In one case, in which 5 cc of blood were aspirated from the abdomen, exploration was delayed for 24 hours. The reason for this delay is not clear.

These patients were, of course, invariably operated upon. In most instances, the patient was taken directly to surgery from the emergency room after a period of resuscitation. Three patients were operated on in spite of continuing state of shock. Blood was administered freely before, during, and after surgery. The average amount of blood estimated to be present in

the peritoneal cavity at surgery was 1,750 cc, varying from 60 cc to 4,000 cc. The average amount of blood used was 2,100 cc, varying from none to 6,000 cc in individual cases.

The incision was usually vertical upper abdominal, most often over the right rectus muscle. In three cases a combined thoraco-abdominal incision was made, and in one case a transverse upper abdominal incision was deemed proper.

### TREATMENT OF BLEEDING

In the actual treatment of the liver injury, Gelfoam or Oxycel packing was invariably used. In most instances the liver lacerations were sutured with chromic catgut on large, atraumatic needles. However, some of the seemingly more serious lacerations were not sutured, the surgeon apparently not wishing to disturb a quiescent situation. In one case, the falciform ligament was freed from the abdominal wall and sutured over a liver defect. Excision of the left lobe of the liver was performed once. Excision of a large, necrotic portion of the right lobe of the liver was carried out once at a subsequent operation.

In only two cases were obvious arterial bleeders clamped and ligated within the liver. In two cases the surgeons felt that hemorrhage from lacerations over the dome of the liver was controlled by pressing the liver upwards against the diaphragm. Postoperative hemorrhage was believed to have been arrested in one instance by elevating the foot of the bed, allowing the liver to fall up against the diaphragm. (This patient expired.)

The abdomen was drained, usually through lateral stab wounds, in all but three cases. Interestingly enough, the three undrained cases did well and recovered without complication. It must be admitted, however, that these were classifiable as mild injuries.

Antibiotics were used in all cases and included penicillin, streptomycin, erythromycin, tetracycline, Chloromycetin, novobiocin, and Kanamycin. Neomycin and Dakin's solution were used to irrigate persistently draining sinuses in one case, apparently with some benefit. All cases save one were placed on nasogastric suction for a few days postoperatively.

The average period of hospitalization was 35 days, ranging from two to 185 days. Ten cases recovered without complication. Three patients died, two within 72 hours of injury from continuing hemorrhage and one after 11 days from infection in and about the liver. Four patients developed jaundice in the immediate postoperative period, probably due to severe liver injury and infection. Four had spontaneous drainage of necrotic material probably representing liver abscesses, through their original drain sites. Two required surgical drainage of liver abscesses. One of these underwent seven operative procedures for treatment of recurrent postoperative hemorrhages, drainage of multiple abscesses in and about the liver, and excision of sinus tracts. He is at present alive and symptom-free.

### COMMENT

Liver injuries are always potentially serious, although probably many are overlooked and the patients recover without complication. Treatment should be directed toward control of hemorrhage and infection. Gelfoam or Oxycel packing is valuable, but suturing will generally be necessary in addition. Mass ligation of large amounts of hepatic tissue by these sutures is undesirable and should be avoided if possible, as hepatic necrosis may result. Resection of part or all of a lobe of the liver might be preferable under some circumstances.

Addition of a thoracic component to the incision may occasionally be necessary to control bleeding from the dome or posterior margin of the liver. Free drainage should always be provided.

The one instance of biliary tract injury was a 1-cm laceration of the gall bladder. This was sutured. Larger lacerations may require cholecystectomy or cholecystostomy if the patient's condition is too precarious. It would require great courage to withhold antibiotics from these patients, although the specifically indicated antibiotics are not clearly defined.

As for needle aspiration of the peritoneal cavity, when there is sufficient suspicion of intraperitoneal injury to warrant needle aspiration, then surgical exploration is warranted. In other words, when one feels he should poke a needle, he should poke a knife. Nevertheless, in patients whose symptoms and signs are obscured by stupor or coma due to alcoholism, severe shock, or head injury, a positive peritoneal aspiration for blood is very valuable and should be followed by exploratory laparotomy as soon as feasible. A negative aspiration means nothing and should not influence one's decision.

It has been suggested that a fine polyethylene tube may be threaded through the aspirating needle and left within the peritoneal cavity. Blood may then appear within the tube by capillarity within an hour or so, and is as significant as a positive needle aspiration. ■

99 So. Market St.

*Dairy cattle and mongooses in Hawaii are fairly extensively infected with Q fever. Humans aren't.*

# A Survey for Q Fever In the State of Hawaii

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● *A serological survey to determine the possible presence of Q fever in the State of Hawaii is reported. Results of laboratory tests on the blood of man, mongooses, and cattle are given. Based on survey findings, it appears that Q fever exists in a significant percentage of dairy cattle and mongooses within the State of Hawaii.*

Q fever, also termed nine-mile fever, Balkan grippe, and epidemic hiberno-vernal bronchopneumonia, is an acute systemic disease caused by Rickettsia burneti. In man, the portal of entry is through the respiratory tract and the infection may result from direct contact with livestock or indirectly by exposure to infectious aerosols containing dust from contaminated premises.

The onset is sudden and is evidenced by such nonspecific symptoms as recurrent headaches, loss of appetite, chills, and fever. Pulmonary involvement occurs in the majority of those infected and varies greatly in severity from a very mild inflammatory reaction to a pronounced interstitial pneumonia[1].

### DIFFERENTIAL DIAGNOSIS

Based on the history of the patient and clinical observations, the disease may appear similar to dengue, psittacosis, typhoid, paratyphoid, influenza, infectious hepatitis, or bacterial pneumonia. The routine clinical laboratory tests are of little value in making a differentiation, and the diagnosis is accomplished either by the isolation of the organism from sputum, spinal fluid, or urine, or by the demonstration of the specific antibodies against Rickettsia burneti by serological tests[2].

Diagnosis of Q fever by either the complement-fixation or agglutination test is considered highly satisfactory for general use[3]. Since the serological tests are more rapid, less time consuming, and eliminate the hazard of laboratory infection which accompanies the isolation method, they have become the accepted method for routine laboratory determination of infection with Rickettsia burneti.

Within recent years it has been noted that Q fever is being recognized in an increasing number of states throughout the mainland. Illness resulting from infection with Rickettsia burneti has not been reported within the State of Hawaii. However, it was logical to assume that this organism could have been introduced to the Islands in many ways and, in particular, by the necessary importation of dairy cattle from the western areas of the mainland United States.

### SEROLOGICAL METHOD

As a primary study, it was decided to conduct a serological survey of the blood from cattle located

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in as many regions of the four counties within the State as possible. If a significant percentage of these cattle carried antibodies against Q fever antigen, a blood-titer rise in serological negative guinea pigs was to be attempted by the inoculation of milk from these cattle. If this proved successful, creation of a serological rise in an additional group of guinea pigs by inoculation of splenic suspensions from the initial group of guinea pigs was projected. Through the cooperation of the Hawaii State Department of Agriculture, a total of 7,904 bovine blood samples were obtained and tested. The selection of these herds was done in such a manner as to give a representative cross section in both number and area of the counties of Maui, Honolulu, Kauai, and Hawaii.

It was further determined to include as many mongooses as possible, to reduce the possibility that the serologically reactive cattle were only those who had developed the titer prior to their shipment to the State of Hawaii. Since no importation of mongooses has occurred in Hawaii since 1900, it was decided that this would be the test animal of choice to represent the so-called native animals of the Islands. Unfortunately, it was not possible to purchase mongooses and capture of this animal alive was difficult. The mongoose is an extremely wary and intelligent animal. While it was relatively easy to capture the first one in a given area, the successive trappings became increasingly difficult and it was unusual to capture more than four animals in the same locality, even though the remaining free animals did not leave the area. In addition, it was quite a problem to acclimate the mongoose to a caged environment so that almost forty per cent of the captured animals died within the first week from self-induced traumatic injury. For this reason, the total number of mongooses available for bleeding was limited to 68. The majority were trapped in various areas at Schofield Barracks, and a small number were obtained from a dairy farm in the rural area of Haleiwa. However, if animals survived the first week of captivity, no further morbidity or mortality was noted.

In the event that the cattle or mongoose blood demonstrated a complement-fixing titer to Q fever it was decided to test as many human sera as possible. The human serum was limited to that coming from individuals having a clinical diagnosis of atypical viral pneumonia or from dairy or sugar cane field workers. The selection of only these specific groups of workers was based on the high percentage of positive serological results obtained from testing the mongoose sera and the knowledge that a great number of these animals could be found living in the cattle yards and sugar cane fields. Since Rickettsia burneti is highly resistant to drying and has repeatedly been isolated from the excreta of infected animals, it was thought possible that human infection in Hawaii could have resulted from aerosol dissemination of the organism in dry bovine or mongoose feces.

Both bovine and human sera were subjected to the capillary tube agglutination test (CAT) with antigen supplied by the USPH Rocky Mountain Laboratory, Hamilton, Montana. All sera showing a rise in titer were again tested by the complement-fixation method in order to reach an end point. It was originally planned to use the same method of testing on the mongoose blood but it was found that the capillary tube agglutination test was not satisfactory with this animal's blood and that it was necessary to use the complement-fixation test on this group throughout.

#### MILK SURVEY

Based on the fact that a surprisingly large percentage of cattle and an even larger percentage of mongoose blood sera were serologically positive for Rickettsia burneti, fresh milk samples were then obtained from a number of those cattle on the island of Oahu showing high titers. These samples were individually screened by the capillary agglutination test and the positive milk samples were then pooled. This milk was then introduced intraperitoneally, 0.5 ml per animal, into guinea pigs which had previously demonstrated no serologic titer to Q fever. In addition, these animals were obtained from a colony in which no infectious diseases were known to be present. The temperatures of these animals were taken daily for eight days prior to the injection and also throughout the test.

All guinea pigs were examined daily following the injection of the milk, but no significant clinical changes were noted in any of the animals during the entire observation period. In a few of the animals there was a slight rise in temperature above normal between the fifth and seventh day, with a corresponding loss of appetite. However, in all there was a return to the normal temperature and a renewed interest in feed by the ninth day. In none of these animals was any other change noted nor did any deaths occur.

A number of these animals were sacrificed on the seventh day following inoculation, all organs were examined and the spleen removed for further testing. The remainder of the animals were sacrificed 30 days following injection with the milk, and the same procedure followed.

The control animals were observed in a similar manner. This latter group was serologically negative when sacrificed 30 days after the beginning of the test and all organs appeared normal.

The necropsy findings in the test animals sacrificed both at the seventh and thirtieth days were confined to the spleen. This organ was enlarged but never more than twice the size of the corresponding control

animals. In two of the test animals sacrificed at seven days following injection, there was a considerable quantity of clear exudate in the peritoneal cavity. This material proved to be bacterially sterile. There were no lesions at the point of injection or any changes in the other organs examined.

### SUMMARY AND CONCLUSIONS:

The serological results obtained in this survey indicate that Rickettsia burneti infection exists in a significant percentage of dairy cattle and mongooses within the State of Hawaii.

The results obtained by the random testing of the blood of 1,425 beef cattle failed to show any significant infection. This may be due to the fact that beef cattle are rarely brought from the mainland of the United States to the Islands. Also, unlike dairy cattle which are kept in the close confines of barns and corrals throughout the milking season, beef cattle are on range the entire year and are not exposed to the same aerosol concentration of dried cattle or mongoose droppings.

Although 623 human sera were examined, it was not possible to demonstrate the presence of antibodies against Rickettsia burneti in any of the specimens. This was particularly surprising since only those individuals having a clinical diagnosis of atypical viral pneumonia or working in close contact with cattle or mongooses were chosen for testing.

It is concluded that the causative agent of Q fever exists in a significant percentage of dairy cattle and mongooses within the State of Hawaii. Since all milk sold to the public in Hawaii is pasteurized properly, there appears to be no possible means of introduction of the microorganism in this manner. While it is known that Rickettsia burneti has been shown to infect through the inhalation of aerosols containing the organism, at present there is no evidence to indicate that Q fever is of any public health significance to the residents of this State. ■

TABLE 1.—Results of serological survey for Rickettsia burneti burneti

| SPECIMEN | LOCALE | NUMBER TESTED | RESULTS | | |
|---|---|---|---|---|---|
| | | | *Neg.* | *Pos.* | *% Pos.* |
| Human | State-wide | 623 | 623 | 0 | 0.0 |
| Mongoose | County of Honolulu | 68 | 28 | 40 | 58.8 |
| A. Dairy | County of Honolulu | 4749 | 3457 | 1292 | 27.2 |
| | County of Maui | 154 | 154 | 0 | 0.0 |
| | County of Hawaii | 788 | 648 | 140 | 17.8 |
| | County of Kauai | 788 | 522 | 266 | 33.8 |
| Total | | 6479 | 4781 | 1698 | 26.2 |
| B. Beef | County of Honolulu | 107 | 106 | 1 | 0.9 |
| | County of Maui | 1071 | 1069 | 2 | 0.2 |
| | County of Hawaii | 247 | 247 | 0 | 0.0 |
| Total | | 1425 | 1422 | 3 | 0.2 |

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### REFERENCES

1. Hornibrook, J. W., and Nelson, K. R.: An institutional outbreak of pneumonitis, Pub. Health Rep. 55:1936-1944 (Oct.) 1940.
2. Smadel, J. E., Snyder, M. J., and Robbins, F. C.: Vaccination against Q fever, Am. J. Hyg. 47:71-81 (Jan.) 1948.
3. Robbins, F. C., Rustigian, R., Snyder, M. J., and Smadel, J. E.: Q fever in the Mediterranean area: report of its occurrence in Allied troops. III. The etiological agent, Am. J. Hyg. 44:51-63 (July) 1946.

*The new mood-ameliorating tranquilizers can be fatal in excessive doses.*

# Fatal Reaction to Tranylcypromine (Parnate)

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• *An 18-year-old girl who had been depressed for about a month, and had presumably been taking 10 mg of Parnate (tranylcypromine, a monoamine oxidase inhibitor) twice daily for about 18 days, took an estimated seventeen 10-mg tablets with suicidal intent and died within about 12 hours, despite hospital treatment.*

MONOAMINE OXIDASE inhibitors are now commonly used in the treatment of depression both for inpatient and outpatient care. Many reports of good results with them have appeared in the literature[1,2] and some warnings on their side effects are seen,[2,3] but very few reports of overdosage are found.[4,5,6,7] Because of the unfortunate outcome, and as a further alert in using these agents, the following case is described.

## CASE REPORT

This 18-year-old single, unemployed woman had been under a psychiatrist's care about one month for depression. She had always been well and without serious illness in the past. She had been taking tranylcypromine (Parnate) 10 mg twice daily for two weeks and when she was seen four days before death the drug and dosage had been renewed with 25 tablets of 10 mg each.

She continued unchanged until the evening before admission to the hospital when she became irritable and more depressed and spent the evening in her room alone. She was awake much of that night, according to her parents, who heard but did not see her.

In the morning her father found her wandering around the house irrational and only partially clothed. Her skin was not warm, however. Another physician was called to the house at 12 noon and because of the behavior he gave 75 mg of Demerol IM as sedation to get her into an ambulance. Later a presumptive suicide note, started about 8:00 P.M., and the empty bottle formerly containing the Parnate were found. All other drugs and known toxic materials around the house were accounted for.

About 20 minutes after the injection the patient experienced fever and sweating, and went into decerebrate rigidity. When she arrived at the hospital about 2 P.M. her temperature was 106°F., respiration 18, pulse, 140; blood pressure was 100/60. Her skin was very warm and flushed, without cyanosis. Physical examination was otherwise unremarkable except for wide, fixed pupils and decerebrate rigidity.

Laboratory reported a normal blood count with a hematocrit of 42, blood glucose of 150 mg%, Ca of 4.0 mEq/L, and P of 2.9 mEq/L. Serum Na, $CO_2$, and Cl were normal; K was 6.1 mEq/L. Urinalysis showed 1+albumin, no sugar, and microscopically 150-300 WBC/HPF, 3-5 RBC/HPF, many bacteria, and no casts. Lumbar puncture showed normal pressure, 75 mg% protein, 126 mg% glucose, 4,750 RBC/$mm^3$ (99% crenated), and 23 WBC (76% lymphocytes) per cu mm. Culture and India ink preparation were negative. Blood level of barbiturates was zero. Gastric lavage yielded a few cc of clear colorless fluid containing no arsenic, salicylate or barbiturate.

Blood pressure fell to 60/40, so 15 mg of metaraminol (Aramine) was given IM within half hour of admission, with return of pressure to 100/70. During the lumbar puncture, cardiac arrest occurred for several seconds.

About two hours after admission clonic movements of the arms and face began, and 2 grains of phenobarbitol were given IM and 1 grain IV over 30 minutes, with no effect. Shortly after, profound cyanosis and apnea appeared. Intubation with bag breathing was difficult due to muscle rigidity and was unsuccessful in relieving the cyanosis. Salicylates and external cooling had no effect on the temperature, which remained at 108°F. Blood pressure fell again

Dickson-Bell Clinic.
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Epinephrine

Norepinephrine

Serotonin

Tranylcypromine (Parnate)

The site of action and interference is illustrated below.

$RCH_2NH_2 \xrightarrow{MAO} RCOOH$ (MAO inhibition)

FIG. 1. *Structural formulas of epinephrine, norepinephrine, serotonin, and tranylcypromine, showing their similarity to one another.*

to unobtainable levels and could not be raised with intravenous Levophed. The patient expired about 6½ hours after admission to the hospital.

At the autopsy table the lungs, brain, and kidneys were congested and the large and small bowel were filled with blood without actual ulceration of the mucosa. No other bleeding was seen. Microscopically there was early gastrointestinal mucosal necrosis with submucosal hyperemia, cloudy swelling of the liver parenchyma and renal tubules, and hemorrhagic pulmonary edema. No sites of inflammation were seen in the brain or meninges.

## DISCUSSION

Monoamine oxidase is an enzyme found widely throughout animal tissue including nervous tissue, liver, blood vessel walls, and endocrine glands. It is the enzyme for the main metabolic pathway, oxidative deamination, of monoamines. These monoamines, also widely distributed in small concentrations in various body tissues, include the important compounds of epinephrine, norepinephrine, tyramine, and serotonin, among others. Many of their physiological actions, such as vascular constriction by epinephrine, are known but their means of accomplishing them is a mystery. It is known, however, that the monoamine oxidase inhibitors work by interfering with the enzyme reaction by competitive inhibition, as is easily visualized by seeing the chemical formula of several monoamines and the monoamine oxidase inhibitor, Parnate (Fig. 1).

In animal tissue analysis, these MAO inhibitors increase the concentrations of the monoamines and decrease the amounts of their metabolic end products as expected. Baldredge *et al.*[7] showed the same in the blood and urine of their patient for the first few days that she was studied after ingesting the drug. Physiologically, MAO-treated animals display definite sympathomimetic signs of mydriasis, peripheral blood vessel constriction, and increased motor actiivty.

However, the striking clinical picture in overdosage by these agents[4,5,6,7] (marked hyperpyrexia, muscle rigidity with clonic movements, and disorientation with irrational behavior followed by respiratory and vascular collapse) is unexplained by known actions of the various known monoamines. Most probably other monoamines, or other metabolic products, are involved.

However, an alternate explanation, in view of the gastrointestinal mucosal necrosis, toxic changes in the liver, and acute renal failure in this case, could be an acute hypersensitivity reaction. Interestingly, injection of Demerol seemed to trigger the rigidity and hyperpyrexia in our patient. The other published severe toxic reactions all occurred in patients receiving monoamine oxidase inhibitors combined with other psychotherapeutic agents. Comparisons of dosages and estimation of a toxic dose are hard to make because of the multiple agents being used.

At present there is no chemical test for these compounds, but indirect evidence of their presence can be obtained by determining levels of various monoamines and their metabolic end products in the urine and blood.[8] Even in these determinations one must be certain that monoamines have not been given to the patient as happened in the present case.

To date, no antidotes have been successful, though Benadryl, sodium phenobarbital and intravenous calcium were tried in Baldredge's case,[7] and intravenous Cogentin was used in another case.[6] Supportive care, including external cooling, tracheostomy, and pressor agents, as needed, should be used. Possibly large doses of a neuromuscular junction blocking agent, such as curare, might have been successful in relieving the rigidity and in allowing better assisted respiration.

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## REFERENCES


1. Voelkel, A.: Clinical experience with amine oxidase inhibitors in psychiatry, Ann. New York Acad. Sc. 80:680-686 (Sept. 17) 1959.
2. Lurie, M. L., and Salzer, H. M.: Tranylcypromine (Parnate) in ambulatory treatment of depressed patients, Am. J. Psych. 118:152-55 (Aug.) 1961.
3. Bailey, S. D., *et al*: Comparison of Iproniazid with other amine oxidase inhibitors including W-1544, JB 516, RO 4-1018 and RO 5-0700, Ann. New York Acad. Sc. 80:562-68 (Sept. 17) 1959.
4. Davies, G.: Side-effects of Phenelzine, Brit. Med. J. 1019 (Oct.) 1960.
5. Luby, E., and Domino, E. F.: Toxicity from large doses of Imipromine and an MAO inhibitor in suicidal attempt, J.A.M.A., 177:68 (July 8) 1961.
6. Babiak, W.: Case fatality due to overdosage of a combination of Tranylcypromine (Parnate) and Imipromine (Tofranil), Canad. M.A.J., 85:377 (Aug. 12) 1961.
7. Baldredge, E. T., Miller, L. V., Haverback, B. J., and Brunjes, S.: Amine metabolism after an overdose of a monoamine oxidase inhibitor, New Eng. J. Med., 267:421-6 (Aug. 30) 1962.
8. Sjoerdsma, A.: Techniques for measuring monoamine oxidase inhibiting activity in man, J. Neuropsychiat. 2(Suppl 1):159-162 (Feb.) 1961.

# *The President's Page*

At about this stage of the game most doctors are wondering about the status of the King-Anderson Bill in Washington, and what is being done at the present time by the AMA to counteract the further extension of the socialization of medicine. Along with this, many doctors are wondering about what they might do to help stem the pressure from the present administration, whose aim seems to be to gradually tie us all up in one big bundle and direct our activities and our lives from the supposedly great "fountainhead of wisdom" which is located in Washington, D. C.

During April, May and June, I attended a National Medicine-Legislative Conference put on by the AMA in Chicago, a meeting of WICHE in San Francisco which discussed the medical man-power in the West, the national meeting of the American College of Obstetrics and Gynecology in New York, and the annual AMA meeting in Atlantic City. Besides this, I visited several medical centers and spent several days in Washington visiting our legislators, and the Washington office of the AMA. I have, therefore, had many recent contacts with practicing physicians, educators, legislators, AMA officials, and other Americans in various walks of life. The following conclusions are crystallized out of what I saw and heard.

The first thing we should all realize, and in realizing it act accordingly, is that the old party labels do not mean anything in the present day state of our national politics. The terms "Republicans" and "Democrats," and whatever you might think they happen to mean on the national level, should be forgotten. Remember, I am speaking of national politics, and not state or local politics, because here the situation is often quite different. Nationally the majority of the legislators, who are not just sheep following the Democratic Administration willy nilly, should be divided into Socialists and Free-enterprisers, and as I have said above, such a division has little to do with party labels. The Socialists, however, would rather be called Liberals, because this gives a more palatable connotation to their ruthless bureaucratic group in Washington whose chief aim is to enslave the people of the U.S.A. and not to liberate them. The word liberal is also intended to give a lulling connotation of tolerance, good fellowship, forward thinking, and progressiveness, which unfortunately too many of the shallow and tired thinking voters of this country swallow, in contradistinction to Conservatism, which automatically suggests to them such things as stuffed shirts, hard headedness, die-harders, unprogressiveness, etc. So let's call these groups by their true names . . . Socialists and Free-enterprisers, or any other names which will denote their true political aims. Therefore, if we are against the bureaucratic control of our profession and against the socialization of medicine in the U.S.A. we should throw in our lot with the Free-enterprisers, Republican or Democratic.

The next election (November, 1964) will be the most significant election since 1932. The outcame of this election, if it turns more left instead of right, could mean a complete change in our way of life and an abrogation of the visions of our founding fathers and the free-enterprise system through which our nation became what it is today. Therefore, our only salvation lies in making sure that this does not happen. What can we do? We can only make sure that we are not hot-rodded down the road, to complete socialization, by electing to congress and to the White House only those who may be classed as Free-enterprisers, and by defeating those who profess socialistic ideals, either because of convictions or because of supposed political expediency.

This we can start doing right now, today, (1) by using whatever influence we have in trying to get qualified Free-enterprisers to run for national offices; (2) by enlisting other professionals, businessmen, and workers in the support of our cause (note the recent awakening of the wheat farmer); (3) by giving immediately and by continuing to give greater financial support to HAMPAC, AMPAC, Free-enterprise candidates, and to whichever party in your community has the maintaining of the Free-enterprise system in the professional as well as the business fields as one of the strong planks in its platform; and lastly (4) by becoming realistic and mature voters. Forget the fact that a certain candidate was your classmate, is a relative, or is of a certain racial descent when you cast your vote. Vote only for those candidates whom you have reason to believe will support you, the medical profession, and all others who feel that the salvation of this great country of ours lies in the maintenance of the system of free enterprise.

It is my hope, and I feel that it is my duty as President of your state medical association, to get this message over to you in order that we may work together with a common, realistic purpose in helping to preserve the heritage of medicine in this country, a heritage which has been handed down to us and which it is our duty to work for and maintain in order that we can unashamedly pass it on to our younger colleagues and colleagues yet to come, and most importantly—and let us never forget this—to our patients! ■

Rodney T. West M.D.

# Editorial

## "Medical Ethics and Controlled Trials"

To paraphrase Stevenson, one might say that there are medical men, and classes of medical men, who stand above the common herd; and of all these few stand in a more elevated place than the competent biostatistician.

Sir Austin Bradford Hill, Professor Emeritus of Medical Statistics at the University of London, delivered the Marc Daniels Lecture before the Royal College of Physicians on January 8 last, and it has been published[1] under the above title. In it he carefully and wisely analyzes the basis for our attitude toward controlled trials of new treatments: the needs, the alternatives, and the ethical considerations involved.

He gives short shrift to the dicta of the Ethical Committee of the World Medical Association, which would forbid him* to see whether his wife would sleep better if he gave her a cup of warm milk at night. They also insist on the informed consent of the patient under all circumstances; whereas, as Sir Austin points out, there are circumstances under which this is not only unnecessary but a complete obstacle to the success of the trial.

His positive philosophy for our guidance embodies a series of "general questions answered in a specific setting," as follows:

1. *Is the proposed treatment safe or . . . unlikely to harm . . . the patient?* The risk must be balanced against the possible gain from the test, of course.

2. *Can a new treatment ethically be withheld from any patients . . . ?* The answer depends, it is pointed out, on how serious the disease is, and how effective old treatments are, and other circumstances.

[1]Hill, A. B.: Medical ethics and controlled trials, Brit. Med. J. 5337:1043 (Apr. 20) 1963.
*On the ground that he is not a physician!

3. *What patients may be . . . allocated randomly to different treatments?* Only those, says Sir Austin, for whom the doctor really does not know whether the treatment being tested, or the "control" treatment, would be preferable. Think this one over!

4. *When is it necessary to obtain the patient's consent to his inclusion in a controlled trial?*

As a rule, says Sir Austin, if the participation in the study will involve danger, or pain and discomfort, or if the participant is a well person voluntarily submitting to an experimental procedure. But if, for all you know, the trial medicine is safe, and is no more or less likely to be helpful than the "control" treatment, then consent need not be obtained.

5. *Is it ethical to use a placebo or dummy treatment?* Yes, says Sir Austin, unless there is already a known treatment of accepted effectiveness. For instance, it would not have been ethical to test cortisone, in rheumatic fever, by comparison with dummy tablets, when aspirin was available as a therapeutically effective basis for comparison.

6. *Is it proper for the doctor not to know what the treatment is?* Yes, says Sir Austin, so long as his ignorance could not be harmful to the patient. If he cannot be sure of this, then another doctor, who can safely remain in ignorance of what is being administered, should be brought in to evaluate the results.

The basic motivation underlying these questions is Sir Austin's insistence that the unique and real ethical problems posed by the doctor-patient relationship must be understood, respected, and met by the conditions of any medical experiment. And the responsibility for this must be borne not by the physician experimentalist alone, but also by the biostatician who is attempting to advise and guide him. ■

## New Anti-Caries Trace Element: Molybdenum

The fact that fluorine is an essential mineral nutrient—a trace element without which firm, decay-resistant tooth enamel cannot be made—is now too well established to be contradicted without laying oneself open to a charge of having failed to examine the published evidence. Opposition to the prevention of this preventable disease by providing fluorine, where it is deficient, in the only vehicle in which there is clear evidence for its effectiveness and safety—namely, drinking water—is now based almost exclusively on the curious issue of the immorality of compulsion.

We will not be compelled, these persons say, to drink water made nutritionally adequate by artificial means. Nothing is said of the morality (or immorality) of compelling hundreds of thousands of children to subsist on nutritionally inadequate water, and condemning them to grow up with relatively soft, vulnerable tooth enamel.

An editorial in the current *British Medical Journal*[1] outlines the basis for the newer knowledge that not only fluorine, but also molybdenum, in trace quantities, has a caries-preventive effect. The evidence for this in human children is indirect, but in rats both direct and indirect evidence has been established.

Since molybdenum is known to be helpful when ingested in food (i.e., vegetables grown in soil containing sufficient molybdenum), we need not face the grim prospect of convincing the public—and some of our own profession—that yet another element needs to be added to the public water supply.

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[1]Dental Caries and Trace Elements (editorial), Brit. Med. J. 5337:1039 (Apr. 20) 1963.

## Watkins & Sturgis to the Rescue

If the appearance of the type in this issue takes you back to 1942, when Watkins Printery (now Watkins & Sturgis) printed the *Journal,* you are not deceived: Watkins printed this one too, as a special service to an old customer. Our regular plant, the Star-Bulletin Printing Company, was closed by the strike against the newspapers on June 21, with the Editor and Managing Editor in Atlantic City at the AMA meeting and the copy lying on a desk waiting to be sent to the printer.

The problems of producing our magazine by offset lithography instead of by the usual letterpress would have been moderately difficult; producing it—as we had to—by a mixture of the two has presented real problems. We are grateful to Al Watkins and his staff for coming to our rescue, and we present, with pride, our first "strike issue"—and, we trust, our last!

## Many Thanks to the Photographers

. . . who made possible the "rotogravure" section of the annual meeting report in this issue of the *Journal.* We can't tell you whose is which, or vice versa, but we're grateful to Physicians News Service for sending us pictures taken by Robert Wenkam for the *Medical Tribune,* where some of them appeared. We also thank Drs. Liljestrand and Cloward, the *Hawaii Times,* and the *Advertiser* for their contributions. ■

# Hawaii Academy of General Practice

THE PSYCHIATRISTS HAVE A NAME FOR IT

"Compartmentalized thinking" is the term they apply to the inconsistent sort of attitudes and thinking that so many of their psychoneurotic patients exhibit to a greater or lesser degree.

One need not search far to find a friend, apparently normal, whose sometimes violently expressed ideas are often contradictory. But this he will deny vigorously, if you throw it up to him, because he is like Janus—one face cannot look upon the other.

Witness the Republican who criticizes the Democrat for fiscal deficit dementia on the one hand, yet campaigns all out for a greater share of federal monies to be spent in Hawaii. Witness the Fluoridationist, rabid on the subject of curing the entire population's dental ills perforce, who is equally emphatic against the centralized management upon which Medicare is dependent. Witness the Surgical Society, which emphatically denies GP's the right to participate in the fee for a surgical service, a smaller or larger part of which service the GP provides, and that now condones such "splitting" of the fee at The Queen's Hospital because of a lack of interns.

True, the fee for assisting is to go to another qualified surgeon—heaven forbid that a capable GP be permitted into the sanctum sanctorum, and certainly not to earn a fee for assistance on his own patient! But no matter how you paint the rusty iron hulk, the rust will show through.

To avoid being termed a compartmentalized thinker, one must develop principles that will be consistent in morality no matter what the circumstance.

THE PRIME EVIL OF FEE SPLITTING

The prime evil of fee splitting is as paramount as the wagering angle in life insurance: You may insure any person's life, for which you pay the premiums, so long as it is *not* to your interest to accomplish the termination of that life. The insured person has to be worth more to you alive than dead, or the policy becomes null and void. As between physicians, it is morally wrong to induce referrals by offering kickbacks, because the patient's life or limb is jeopardized by a pecuniary interest.

If I were to charge by the mile or the minute, and if you assisted me and took care of some of the miles or minutes, I would be criticized if I did not reduce my fee by the miles and minutes you did for me. The man who wanted the job done would not care a whit whether he makes out two checks, one to each of us in proportion to each his work, or one check to me for the whole, the division of which would be no concern of his.

So do most lay people look upon doctors and their concern over fee splitting. Most of them could not care less how the fee is divided, and would be more concerned if the fee is the greater bcause our ethics *prevent* it from being divided.

It is equally valid in the contractual business world, however, that those purveyors of goods and services who give rebates, discounts and other come-hithers are looked upon with a certain measure of suspicion—their wares must surely be of a cheaper grade and poorer quality. In matters of medical care, the profession is expected to keep out such cut-rate practitioners.

As in so many things, we humans pass blanket laws, like fluoridating the public water supply, even though the specific benefit or correction is very local, because we are afraid to face up to the local problem.

So it has been in relation to HMSA and its restrictive clause on assistant's fees, and the division of the limited benefit in the Surgical Schedule. It was cowardly of the Honolulu County Medical Society to refuse to permit the proper division of a fee for divided services. The national example, Medicare, sets the precedent by dividing fee benefits in obstetrical care, and this is financed through HMSA.

Compartmentalized thinking: It is perfectly ethical to divide an obstetrical fee according to divided services, but it is still "wrong" to divide a surgical fee according to who does the work.

Who knows? Perhaps the exigencies of the short service at Queen's Hospital will accomplish a retribution long overdue.

J. I. FREDERICK REPPUN, M.D.

*Secretary*

HAWAII MEDICAL JOURNAL

# This Is What's New

• The antidepressant, TOFRANIL (imipramine hydrochloride), caused FETAL ABNORMALITIES in seven out of twelve pregnant rabbits. The abnormalities consisted of encephalocele, spina bifida, abnormality of the palate, and limb abnormalities. The author suggests that the drug should be used with considerable caution in women during the childbearing period. (*Lancet* [Mar. 23] 1963).

• TOLBUTAMIDE, the sulphonylurea most commonly used in the treatment of diabetes, has a rather potent ANTITHYROID EFFECT as measured by radioiodine and other studies, but no cases of clinical hypothyroidism or thyroid enlargement due to this drug have been reported. (*J. Endocrinol.* [Dec.] 1962).

• A new technique for REPAIR OF COARCTATION OF THE AORTA in infants has been suggested. This consists of incising the aorta longitudinally through the coarctation and closing the incision transversely: like the Kocher procedure for pyloric stenosis. The transverse suture line is only carried about half way around the vessel, thus leaving room for growth without later constriction. (*Circulation* [May] 1963).

• MEASLES VACCINE has proved to be 100 PER CENT EFFECTIVE in protecting children against measles, according to abstracts of the National Tuberculosis Association, June, 1963. Noting that over 80 per cent of children inoculated with the attenuated virus developed a fever in excess of 100° and approximately 50 per cent of the children developed a fleeting rash, it is probably more correct to say that approximately 100 per cent of children inoculated with attenuated measles virus developed an extremely mild case of measles without complications such as encephalitis, and so on.

• VASCULAR NEUROSURGEONS are overcoming the problem of visualizing all of the arterial circulation of the brain with one injection and at the same time delineating a single brain vessel with detail. By using catheterization of the subclavian artery via a percutaneous puncture beneath the clavicle, they were able to get excellent visualization in 50 cases WITHOUT CEREBRAL COMPLICATIONS and only minor extracerebral complications. (*J. Neur. Surg.* [Mar.] 1963).

• In the treatment of ACUTE LEUKEMIA IN ADULTS, British workers found that the addition of MASSIVE DOSES OF CORTICOSTEROIDS combined with 6-mercaptopurine is HARMFUL. A lower dose of corticosteroid, two tablets four times a day, produced a slight advantage over the control (no steroid) group. The authors concluded that corticosteroid therapy in acute leukemia in the adult had little to add to 6-mercaptopurine. (*Brit. Med. J.* [Jan. 5] 1963).

• The evidence that HASHIMOTO'S THYROIDITIS is GENETICALLY DETERMINED is strengthened by the report of this disease in MOTHER AND DAUGHTER. Previous evidence of this has consisted of high titers of thyroid autoantibodies throughout family groups and two pairs of monovular twins with Hashimoto's thyroiditis. The exact mode of inheritance remains unknown. (*J. Clin. Endocrinol. & Metab.* [May] 1963).

• A New Yorker questions a 100-year-old death certificate. GENERAL STONEWALL JACKSON, tragically shot by one of his own men on patrol, died nine days later with a diagnosis of pleural pneumonia. The New York pathologist believes it was PULMONARY EMBOLISM and massive pulmonary thrombosis —with fat embolism as an outside possibility. (*Arch. Int. Med.* [May] 1963).

• Naval medical officers recommend "that only one person palpate the spleen gently, twice weekly" in patients with infectious mononucleosis. This advice was given because the one incident of SPLENIC RUPTURE in over 500 cases of proved INFECTIOUS MONONUCLEOSIS followed too VIGOROUS PALPATION OF THE SPLEEN by a ward medical officer. (*Ann. Int. Med.* [Feb.] 1963).

• There is general agreement among scintoscanners that thyroid nodules that are "HOT" (in regard to radioiodine uptake) are BENIGN. COLD nodules, that is, those with low radioiodine uptake, on the other hand, may be benign but are FREQUENTLY MALIGNANT. Two more cases are now added to the small sprinkling of cases that have appeared with CARCINOMATOUS HOT THYROID NODULES. These reports are disconcerting, to say the least. (*Ann. Int. Med.* [May] 1963).

• THERMOGRAPHS, photographs dependent upon the infrared emissions of living tissue, have been used in the diagnosis of superficial and deep vascular lesions. Human skin, an almost perfect infrared emitter, registers its differences in vascularity on the thermogram. An area of DECREASED BLOOD FLOW due to arterial occlusion of an extremity can be mapped out on the thermogram. (*Sci.* [May 24] 1963).

• Dr. Roy Grinker takes his colleagues to task for the unwise use of lysergic acid diethylamide, LSD-25. He notes that latent psychotics are disintegrating under the influence of the drug; a new form of psychopathology is being created and psychic addiction to the drug is being developed. (*Gen. Psychiatry* [May] 1963). ■

FRED I. GILBERT, M.D.

HAWAII MEDICAL JOURNAL

# News & Notes

## Cardiology Program

A nine-month program in Cardiology will be offered by the Institute for CardioPulmonary Diseases at the Scripps Clinic and Research Foundation in La Jolla, California, beginning September 15, 1963. This intensive tutorial program is designed for the practicing physician who desires thorough instruction or for the physician who is finishing formal training and wants a final intensive orientation in cardiology.

## Dermatology Convention

The Pacific Dermatologic Association will meet in Honolulu at the Hilton Hawaiian Village Hotel September 12 to 17, 1963. The expected attendance is 300-400.

## Traveling Doctors:

Dr. R. M. Beddow recently spent two months at the University of California Medical Center studying with Dr. Peter Forsham and his metabolic unit.

Dr. Charles S. Brown visited Bangkok, Saigon, Hong Kong, and Japan, but was "thrown" out of Burma on a visa technicality.

Drs. I. J. Larsen and William H. Gulledge were two of a four-man medical team sent to the Marshall Islands to help victims of a recent polio epidemic there.

Dr. Teru Togasaki represented the Honolulu League of Women Voters at the National Council meeting in Washington, D.C. There she visited all of Hawaii's congressmen and had pictures taken with Senators Fong and Inouye which were published in the *Star-Bulletin*.

## Visitors

Hawaii was honored by having Dr. Edward R. Annis, President-elect of the AMA, address the session at the 107th meeting. His short visit was timely and well utilized, almost every minute being devoted to some local medical purpose. His statement that "Rotarians own the town, Kiwanians run it, and the Lions enjoy it," drew favorable comments.

HMA's Mental Health Conference held in June featured Drs. Robert Garber (N.J.), Edward Greenward (Topeka, Kansas), Howard Kern (Maryland), William Sheeley (Washington, D.C.) and Millard B. Bethel (Illinois).

Dr. Charles H. Bauer (Cornell Medical Center) served as a consultant at the institute for physicians and nurses on Care of Premature Infant.

Dr. Oscar Thorup, former Queen's Hospital intern and now Associate Professor of Medicine at the University of Virginia, has returned to lecture local physicians on leukemia and anemia.

## In the Public Eye

HMA's weekly TV spectacle "Call the Doctor" is gaining status and receiving commendations. The program's format is diversified with films showing Cesarean section and an appendectomy. There was an hour-long program featuring Dr. Edward R. Annis and local politico Frank F. Fasi, who talked on Medical Care of the Aged. Other subjects discussed were Ulcers, High Blood Pressure, Beach Hazards, Leukemia, Measles, and Surgery for Deafness.

Honolulu County Medical Society announced that the $84,000 profit from Operation Swallow had been split up—$50,000 to the Hawaii Medical Library, $29,700 to a Health Exhibit, Bishop Museum, and $5,000 to the Department of Health for polio vaccine.

The Kaiser Hospital offered type 3 Sabin polio vaccine to its insured members. Dr. Philip Chu made the announcement.

## New Faces:

Dr. Daniel D. Palmer (dermatology) has opened his office at the Professional Center Building.

Dr. Dorian Paskowitz' new location is at 2492-C Kalakaua Ave.

## Condolences

Dr. Clarence W. Trexler died at The Queen's Hospital, June 7, 1963.

Dr. and Mrs. Allan Leong lost their infant son.

Dr. Donald M. Wright died at The Queen's Hospital, July 25, 1963.

Dr. Harold R. McKeen, Jr., died June 20, 1963.

## Names in the News:

Improvement of HMA's PR with the local press was clearly indicated by the excellent coverage of the 107th Annual Meeting.

The presence of Dr. Edward R. Annis helped a lot, also our imported speakers—Drs. J. P. Cooney, Emerson Day, R. W. Miller, M. C. Tainter, and Ian MacDonald.

The unveiling of a presidential plaque bearing the names of past presidents "smoked" out a few ex-presidents. Their picture with the plaque was good copy in the newspaper. Those present and pictured were Drs. Fred L. Giles, Lyle Phillips, Joseph Palma, R. B. Faus, J. E. Strode, E. F. Cushnie, Paul Withington, Toru Nishigawa, D. G. Bell, F. J. Pinkerton, J. A. Burden, and S. L. Yee.

Dr. L. Clagett Beck was elected President of Lanakila Crafts—he was also one of the feature speakers on a workshop on nursing homes.

Medical self-help classes were held by Dr. Casimer Jasinski.

Drs. Colin McCorriston, Dr. H. Manayan and Dr. James Cherry were available for questions after picture showings on cancer at three local theatres.

Availability of $120,000 to study prospects of a six-year medical curriculum at the University of Hawaii was announced by Dr. R. K. C. Lee.

Dr. and Mrs. William B. Patterson were beaming with pride on the occasion of their daughter's winning a recent high school essay contest and a trip to Washington, D.C.

Recent torrential rains on Oahu caused Dr. Leo Bernstein to issue statements to potential visitors to not worry about health hazards arising from them.

Dr. and Mrs. R. E. Hoo failed to recover damages for a 1959 traffic accident.

Dr. George Goto, chairman of the Maternal and Perinatal Mortality Study Committee of the HMA, was extensively quoted in a feature article on "Abortion."

Fluoridation of water on the Big Island got a speedy O.K. by the Board of Supervisors. Testifying for the bill were Drs. Frank Tabrah and R. P. Henderson.

Reporter "Scoops" Casey's curiosity about Hawaii Heart Association funds caused a feature article to be written which involved Drs. Joseph Stokes, III, Gerald Rosenblatt, and Louis Buzaid.

Dr. J. Kuhns recently underwent a check-up at The Queen's Hospital.

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# Book Reviews

## ★Current Therapy 1963

*Edited by Howard F. Conn, M.D., 775 pp., $12.50, W. B. Saunders Company, 1963.*

THE FIFTEENTH EDITION of this book, which has become the best single treatment reference for the diseases most commonly encountered by the practicing physician, is now available. In addition to the editor, Dr. Howard Conn, there are twelve consulting editors and several hundred contributors. The many contributors write from obvious firsthand experience with the diseases which they describe. The print is large and the paragraphs readable. Somehow the editor has resisted the temptation to have each volume grow like a child, a bit larger every year. The 1963 edition is, in fact, a bit smaller, a few pages less, than the 1961 edition. It is the type of book that belongs in the physician's office and not in a relatively inaccessible library.

F. I. GILBERT, JR., M.D.

## ★Atlas of Obstetric Technic

*By J. Robert Willson, M.D., M.S. 304 pp., $14.50, C. V. Mosby Co., 1961.*

THE OBSTETRICIAN who wishes to improve or re-evaluate his technique will find this volume most informative. It is devoted to special technical material which in many instances is based on the assumption that the practitioner is familiar with the aspects of anatomy, physiology, and the diagnostic and therapeutic methods of management. Since proper execution of special maneuvers depends on thorough knowledge of normal mechanisms of labor and delivery, these are completely reviewed at the beginning of the text. In general, the outline of contents is very orderly and inclusive of most obstetrical problems. Certain operations for conditions that complicate pregnancy have been omitted since the author contends that these are well presented elsewhere. This is also the first text, to my knowledge, that has deleted those rarely indicated and performed destructive procedures in obstetrics. The illustrations are especially well done; the sketches are of excellent size and accurate proportions; there are a total of 55 plates with several containing 10 - 12 sketches and a few up to 26 per plate.

One cannot fully appreciate this outstanding contribution except by his own perusal.

S. J. BUIST, M.D.

## ★Preventive Pediatrics: Child Health and Development

*By Paul A. Harper, M.D., 798 pp., $14.95, Appleton-Century-Crofts, 1962.*

THIS TEXT by Dr. Paul A. Harper of the Johns Hopkins School of Medicine is a masterpiece of organization, as comprehensive and up to date in its material as is humanly possible for any one man to achieve. Everyone in the practice of medicine, particularly pediatricians, should have this volume in his library as a reference book for information that he neds in his day-to-day practice. Anything that one wants to know is contained in this volume and its method of presentation is novel and up to date in that it presents the problems and their solutions from the viewpoint of the team approach.

The author is to be congratulated on this magnificent and unique contribution to pediatrics.

JOSEPH PALMA, M.D.

★ means highly recommended

# Also Received

## ★Intestinal Biopsy, Ciba Foundation Study Group No. 14

*Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret Cameron, M.A., 120 pp., $2.95, Little, Brown and Company, 1962.*

NO PATHOLOGIST or gastroenterologist should overlook this fascinating little volume. Such pictures! And the verbatim discussions are, as always in Ciba publications, excellent.

## Bilharziasis, Ciba Foundation Symposium

*Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A., 433 pp., $11.50, Little, Brown and Company, 1962.*

BASIC AND EXCELLENT, but we have no bilharziasis in Hawaii.

## How to Score High on the Medical College Admission Test

*By Morris Groff, M.D., and Edward C. Gruber, M.S. Ed., 64 pp., $4.00, Arco Publishing Co., Inc., 1963.*

WE CAN ALL be very grateful that we got into medical school without having to go through anything like this. We might have gone into law instead.

## An Rh-Hr Syllabus, The Types and Their Applications, 2d Ed.

*By Alexander S. Wiener, M.D., F.A.C.P., F.C.A.P., and Irving B. Wexler, M.D., F.A.A.P., 108 pp., $4.50, Grune & Stratton, Inc., 1963.*

ONLY a hematologist or a geneticist would be able to use this detailed information.

## Modern Clinical Psychiatry, 6th Ed.

*By Arthur P. Noyes, M.D., and Lawrence C. Kolb, M.D., 586 pp., $8.00, 1963.*

A TEXT for students, primarily, but the two-column format makes for a readable presentation and a practicing physician would find it a useful reference.

## Toohey Medicine for Nurses, 6th Ed.

*Edited by Arnold R. Rollin, M.D., D.P.M., 675 pp., $7.50, The Williams & Wilkins Company, 1963.*

"HAEMOPHILIA," "leukemia," and "polycythaemia" strike strangely on an American retina. Aside from the strong British flavor, though, this is a concise and orderly text.

## Medicine and the State

*By Matthew J. Lynch, M.D., M.R.C.P., Lond., F.C.A.P., and Stanley S. Raphael, M.B., B.S., Lond., 449 pp., $9.75, Charles C. Thomas, 1963.*

TWO CANADIANS have meticulously weighed state medicine the world around, and have found it wanting.

## Justice and Injustice

*By Edmund Bergler, M.D., and Jöost A. M. Meerloo, M.D., 170 pp., $5.75, Grune & Stratton, Inc., 1963.*

THE EFFECT of the subconscious on a sense of justice is provocatively explored in this small volume.

*continued page 490*

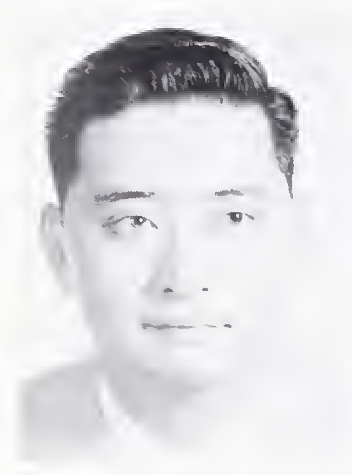
HAWAII MEDICAL JOURNAL

# New Members

**Robert Weiner**
1697 Ala Moana Blvd.
Honolulu 15, Hawaii
Internal Medicine
University of Chicago, 1943
Internship—Michael Reese Hospital, Chicago
Residency—Norwegian American Hospital, Chicago and
Fellowship University of Illinois

**Ann B. Catts**
P. O. Box 861
Honolulu 8, Hawaii
Pathology
Woman's Medical College of Pennsylvania, 1956
Internship—The Queen's Hospital, Honolulu
Residency—Wilmington General Hospital, Wilmington, Del.;
St. Christopher's Hospital, Philadelphia, Pa.;
The Queen's Hospital, Honolulu

**Sorrell H. Waxman**
1305 Kalakaua Avenue
Honolulu 14, Hawaii
Pediatrics
University of Toronto, Faculty of Medicine, 1956
Internship—The Queen's Hospital, Honolulu
Residency—Kauikeolani Children's Hospital, Honolulu



**Herbert M. Nakata**
1481 South King Street
Honolulu 14, Hawaii
Pediatrics
St. Louis University School of Medicine, 1956
Internship—St. Vincent Charity Hospital, Cleveland
Residency—St. Vincent Charity Hospital, Cleveland, and
Cleveland Clinic, Cleveland

**Emiko Sakurai**
4050 Tantalus
Honolulu 14, Hawaii
Pediatrics
Toho University Medical School, 1950
Internship—St. Mary's International Hospital, Tokyo and
St. Francis Hospital, Honolulu
Residency—St. Francis Hospital, Honolulu; The Queen's Hospital, Honolulu; and
Michael Reese Hospital, Chicago

**Adela G. Sanidad**
1697 Ala Moana Blvd.
Honolulu 15, Hawaii
Internal Medicine
College of Medicine, University of Santo Tomas, 1952
Internship—St. Francis Hospital, Honolulu
Residency—St. Francis Hospital, Honolulu, and Franklin Square Hospital, Baltimore, Maryland

**Edna Watt Schrick**
1697 Ala Moana Blvd.
Honolulu 15, Hawaii
Pediatrics
Washington University Medical School, St. Louis, 1934
Internship—New Haven Hospital, New Haven, Conn.
Residency—Children's Hospital, St. Louis, Mo.

**Kazuo Teruya**
1133 Punchbowl Street
Ear, Nose, Throat
University of Loma Linda, 1958
Internship—Los Angeles County Hospital, Calif.
Residency—Los Angeles County Hospital, Calif..

# *County Society News*

## Kauai

Guests present at the May 6 meeting were Drs. Emerson Day, O. D. Pinkerton, and Joseph Battista. Correspondence included letters on the pharmacy bill, and a report on the Medical Care Plans and Fees Committee recommendations, including Dr. Brennecke's resignation. A report was given on the HMA annual meeting. It was concluded that the Kauai Medical Society was done an injustice by the House of Delegates in electing Dr. Allison and that they should have met with the Kauai physicians before such action was taken. A letter of protest was authorized to be sent to the Honolulu County Medical Society. Dr. Pinkerton was asked to comment on this. He advised that the only reason for the selection was that a president from a neighbor island would be unable to be in Honolulu often enough to carry out the tremendous work now involved in the carrying out the duties of president.

Dr. Kim recommended that Operation Swallow III be instituted, the cost to be covered by the $1500 balance left over from the previous Swallows.

Dr. Day spoke on the prevention of cancer through research and education, and told of the organization and work done in the Sloan Kettering Clinic.

Dr. Pinkerton spoke on the procedures to be used in establishing a Relative Value Schedule for Hawaii and urged the doctors to complete the survey form as soon as possible.

The June 3 meeting was held in the G. N. Wilcox Memorial Hospital Library. The President announced that Drs. S. R. Wallis and Burt O. Wade had been appointed to the HMA's Medical Care Plans and Fees Committee. An answer from Dr. Tomita to the Society's protest relative to the last State election was read as was a letter from Dr. C. M. Burgess on the same subject.

In view of Dr. Bernstein's position on Swallow III, implementation of this program was abandoned for the present and it was voted to hold the funds accruing from this project in escrow.

The Society voted to support the Hawaii Visitor Bureaus fund drive on an individual basis. It was also voted to ask the local newspaper to carry an article informing high school students that if they were interested in a career in medicine, they should contact their family physician who would discuss the matter with them.

The Society was advised that the HMSA is in the process of establishing eligibility standards for nursing homes. In answer to an inquiry, it was advised that HMSA has not authorized payment to an internist for diagnosis and treatment of thyroid conditions on the same basis as a surgeon who performs a thyroidectomy. In answer to a letter from Mr. J. R. Veltmann it was voted to approve the recommendation that Dr. Toru Nishigaya be appointed to the position of Assistant Medical Director of the HMSA. No action was taken on a letter from Dr. Joseph Stokes II relative to prophylactic treatment of rheumatic heart disease. It was voted to invite Dr. Stokes to address the Kauai County Medical Society in August. The meeting closed with a talk by Dr. William Beierwaltes on thyroid disease.

## Honolulu

Approximately 200 members were present at the April 2 meeting which included a panel discussion on "Socio-Economic Aspects of Medicine," moderated by Dr. George Mills. The panelists included Messrs. Bernard Stern of Unity House, Walter Whitcomb of the Mason's Union, Charles Kendall from the HGEA, and A. S. Reile from AFL-CIO, plus Mrs. A. Q. McElrath from the ILWU. The following new members were welcomed into the Society: Drs. Marciano F. Aquino, James John Ball, Charles C. Kimura, Henry T. Oyama, and John S. Smith.

The meeting closed with a report from the outgoing Executive Secretary, Mr. Howard Pearce, who cautioned the doctors to work together as a unit and not in individual special-interest groups.

# *Our Presidents*

Ex-President Toru Nishigawa
confers with
Past President Frederick L. Giles

Mr. Hugh Lytle
greets
Ex-President J. A. Burden

President-elect Samuel D. Allison
meets with Kauai's low net
golf winner Sam Wallis

# HAWAII MEDICAL ASSOCIATION

**107th ANNUAL MEETING**
**MAY 2 - 5**
**HONOLULU**

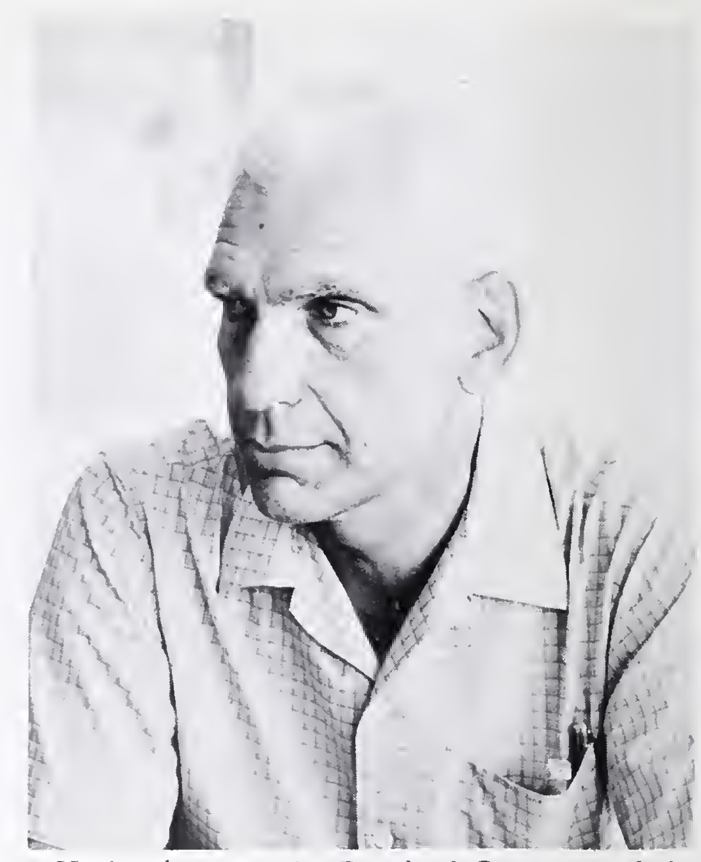
# *Congratulations*

Newly elected officers
Herbert Y. H. Chinn,
Rodney T. West,
Samuel D. Allison,
Randal A. Nishijima
flank outgoing President Giles and
AMA President-elect Annis

Dr. Varian Sloan
receives the
Annual Robins' Award
for
community service

Dr. Ichitaro Katsuki admires his plaque,
presented to him as
dean of the medical profession
in Hawaii, while his sons
Drs. Sanford, Robert, and David
look on.

# *Our New President*



Rodney T. (for Thomas) West was born in Wailuku, Maui, on December 23, 1910—thus he is a *keiki o ka aina* (son of the soil, or native son). His father came here in 1900 from Sydney, Australia. His mother was born of German parentage on the day that her parents landed in these Islands after sailing around the Horn.

Rod's home has always been in the Islands except for a few years when he was a small boy. His family moved to Yakima, Washington. However, they returned to the Islands and he grew up on Parker Ranch and at Hawi in Kohala, on Hawaii. At the age of twelve he came to the Honolulu Military Academy. When the Academy became the "Farm School," an adjunct of Punahou, he went to Punahou, where he was graduated in 1927.

His formal training for medicine began at Northwestern University in Evanston, Illinois. "Formal," that is, because he had been prescribing for his contemporaries since he can't remember when. They tell of being given water with pink vegetable coloring by him when he was in first grade. All through military school and Punahou he was called "Doc." His mother would pack him off to school with a full complement of Zymole Trokeys and Camphor Petrogen, which he administered for the always prevalent URI's. Also, he was ever on hand to extract kiawe thorns and bandage cuts and scratches. When he was granted his Territorial license at the age of 24 he was told that he was the youngest doctor to ever start practicing in the Islands. They didn't know the half of it—he had been "practicing" since he was six years old!

In his freshman year at Northwestern Medical School he met Mary Ann Carlisle, from Florida, who was studying dramatics at Chicago Musical College and later graduated from Northwestern. After medical school he came home, bringing Mary Ann with him, to intern at The Queen's Hospital.

After 18 months there he was in general practice for six years with Dr. Rudolph Benz. From 1941 to 1945 he served with the Navy, becoming a flight surgeon and attaining the rank of full Commander. Upon return to the Islands he was plantation physician at Olaa, Hawaii for a year. He joined the Straub Clinic in 1947, and after some postgraduate work, and a preceptorship under Dr. Herbert Bowles, he was certified by the American Board of Obstetrics & Gynecology in 1958.

He has been on the Board of Governors of the Honolulu County Medical Society longer (13 years) than anyone else. He was Treasurer twice. He went no further the first time because he was called into the service. After the second time around, he became its President in 1957. In 1940 he was Chief of Staff of St. Francis Hospital, and held the same position at Kapiolani Hospital in 1953. For five years he was chairman of the Medical Committee of H.M.S.A. In the years just before the war he was the doctor for Punahou, in whose Alumni Association he has been active for years.

Rod's hobbies are legion: mainly stamps, photography, travel, swimming, orchids, and music (during the war his quarters on Johnston Island were not marked Quarters "E" but "Carnegie Hall"—the Women's Motor Corps of the Red Cross, to whom he had taught First Aid, sent him a piano.) Keeping in touch with friends is a hobby of his—his fraternity still has a round robin letter going which he started in the first year of internship at Queen's. History and geography have a particular fascination for him. He is an inveterate collector of maps—always reading historical novels or history, constantly making reference to a map. Listening is one of the things he does best, a useful talent in an obstetrician!

The Wests have three children: Jo-Anne, Kenneth, and Rod, Jr. Jo-Anne, married, teaches Spanish and South American History in Anaheim, California. Kenneth is a Senior in electrical engineering and Rod, Jr., has another year at Hawaii Preparatory Academy at Kamuela.

Rod's partners have learned through the years to rely on his judgment in matters administrative and fiscal as well as in matters obstetrical. Our Hawaii Medical Association is undoubtedly in for another year of competent, effective, devoted leadership.

# 107TH ANNUAL MEETING HAWAII MEDICAL ASSOCIATION

## HONOLULU, HAWAII

May 2 through May 6

The annual meeting for the one hundred and seventh year of corporate existence of Hawaii Medical Association was held in Honolulu. The following program was presented.

## SCIENTIFIC PROGRAM

Premeeting Events

Fireside Chats—sponsored by the Hawaii Thoracic Society and the American College of Chest Physicians, Hawaii Chapter

Panel Discussions

Cancer Etiology
Moderator: Dr. James P. Cooney
Panelists: Drs. Jerome Kern, Ian Macdonald, Noboru Oishi, Maurice L. Tainter

Cancer Epidemiology
Moderator: Dr. Grover Batten
Panelists: Drs. Emerson Day, Paul T. Bruyere, Robert W. Miller, Walter B. Quisenberry

Patterns in Cancer Pathology
Moderator: Dr. Grant N. Stemmermann
Panelists: Drs. W. Harold Civin, Robert E. Kellenberger, Paul Y. Tamura, I. L. Tilden

Cancer Detection
Moderator: Dr. Emerson Day
Panelists: Drs. Y. Fukushima, Philip J. W. Lee, John M. Ohtani, I. L. Tilden

Cancer Therapy, Part I
Moderator: Dr. Ian Macdonald
Panelists: Drs. Emerson Day, Albert K. S. Chun, Robert A. Nordyke, Francis M. Terada

Cancer Therapy, Part II
Moderator: Dr. Ian Macdonald
Panelists: Drs. Edward C. Wo Lum, Mor J. McCarthy, L. Q. Pang, Maurice L. Tainter

Some Problems in Cancer
Moderator: Dr. James W. Cherry
Panelists: Drs. James P. Cooney, Emerson Day, Ian Macdonald, Robert W. Miller, Maurice L. Tainter

Papers

Evaluation of a Program of Cancer Detection
Dr. Emerson Day

Selective Therapy of Head and Neck Cancer by Surgical and Radiation Therapy
Dr. Ian Macdonald

Fedicare Facade
Dr. Edward R. Annis

Presidential Address
Dr. Frederick L. Giles

Some Recent Research in Childhood Leukemia
Dr. Robert W. Miller

Viruses and Cancer
Dr. James P. Cooney

## SOCIAL PROGRAM

Cocktails and Dinner Dance, Oahu Country Club
Picnic for physicians, at the home of Dr. Harry L. Arnold, Jr.

## MEETINGS

House of Delegates, Mabel Smyth Bldg.
Fireside Chats, Mabel Smyth Bldg.
Scientific Program, Princess Kaiulani Hotel
Woman's Auxiliary, Hawaiian Village Hotel

## PARTICIPATING DELEGATES

Hawaii County:
Nicholas Steuermann
Ruth E. Oda

Kauai County:
None

Maui County:
Marion Hanlon

Honolulu County:
Robert Benson
Morton E. Berk
William W. L. Dang
Bernard W. D. Fong
Unoji Goto
A. S. Hartwell
William S. Ito
Robert T. S. Jim
Patrick T. Lai
Allan Leong
Gail G. L. Li
Carl B. Mason
Richard D. Moore
Richard S. Omura
O. D. Pinkerton
Don E. Poulson
R. Frederick Shepard
R. Varian Sloan
A. L. Vasconcellos
Frederick B. Warshauer
Bernard J. B. Yim

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William W. L. Dang
Patrick Lai
Richard S. Omura

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Nicholas Steuermann, *Chairman*
Bernard W. D. Fong
Marion Hanlon
Gail G. L. Li
Richard D. Moore
A. L. Vasconcellos

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Frederick B. Warshauer

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Robert F. Bailey
Albert K. S. Chun
Keith F. O. Kuhlman
James G. Marnie
Noburo Nakasone
Paul Y. Tamura
Samuel D. Allison

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A. Y. Wong, Maui

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Edmund L. Lee
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Sumner Price
Walter B. Quisenberry
R. Frederick Shepard
Norman R. Sloan
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George Suzuki
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Hastings H. Walker
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Clyde Ishii, Kauai
Edmund A. Tompkins, Maui

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Peter Kim, Kauai
K. Izumi, Maui

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Cesar B. DeJesus
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Raymond H. Hiroshige
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Fred M. K. Lam, Jr.
Leon E. Mermod
J. I. Frederick Reppun
Louis G. Stuhler
Robert S. Rigler
Roy T. Tanoue
Milton Traeger
John R. Watson
W. H. Wilkinson
R. P. Wipperman, Hawaii
Burt O. Wade, Kauai
E. B. Underwood, Maui

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Michael M. Okihiro

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Homer R. Benson
Chew Mung Lum
Carl B. Mason
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R. P. Wipperman, Hawaii
Burt O. Wade, Kauai
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W. E. Iaconetti, Maui
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T. T. Tomita, Honolulu
J. Alfred Burden, past president
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John Chalmers
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George Goto
Richard K. C. Lee
Toru Nishigaya
L. Q. Pang
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George F. Schnack

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Fugate Carty
Duke Cho Choy
Fred Lam, Sr.
F. D. Nance
Satoru Nishijima
J. I. Frederick Reppun
K. S. Tom
Clarence A. Wyatt

### Maternal and Infant Mortality Study Committee
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Mario P. Bautista .......... 1965
Samuel Buist .......... 1964
John C. Carson .......... 1965
Robert G. Dimler .......... 1964
*Katherine J. Edgar .......... 1964
*Ross Hagino .......... 1963
John Hanley .......... 1963
Richard K. B. Ho .......... 1963
Robert T. S. Jim .......... 1964
C. C. McCorriston .......... 1965
Joseph T. Nishimoto .......... 1965
Noboru Ogami .......... 1964
John Ohtani .......... 1964
Thomas K. Oshiro .......... 1965
Albert L. Shimamura .......... 1963
*Calvin Sia .......... 1964
Grant N. Stemmerman .......... 1964
*John R. Stephenson .......... 1965
Paul G. Stevens .......... 1965
*Mitsuo Tottori .......... 1965
*Philip Watt .......... 1963
James Wong .......... 1964
Jack S. Woodruff .......... 1964
W. H. Wilkinson .......... 1964
Paul T. Caldwell, Hawaii .......... 1965
Ruth E. Oda, Hawaii alt. .......... 1965
M. A. Brennecke, Kauai .......... 1965
Clyde Ishii, Kauai alt. .......... 1965
E. D. Willett, Lanai .......... 1965
W. B. Patterson, Maui .......... 1963
W. G. Pfaeltzer, Maui alt. .......... 1963
Paul G. S. Stevens, Molokai .......... 1965

*denotes members of Infant Mortality Study Committee. Date indicates year term expires.

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Chew Mung Lum
George H. Mills
Richard D. Moore
O. D. Pinkerton
J. I. F. Reppun
H. E. Crawford, Hawaii
James Mitchell, Hawaii
M. A. Brennecke, Kauai
W. E. Iaconetti, Maui

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Kwong Y. Lum
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Y. T. Wong
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Peter Kim, Kauai
J. K. Wallis, Maui

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William Ito
Casimer Jasinski
Donald Jones
Arthur Molyneux
George H. Nip
M. H. Chang, Hawaii
P. M. Cockett, Kauai
A. Y. Wong, Maui

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Webster Boyden, Kauai
John Chalmers
Edward Cushnie
Toru Nishigaya

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Toru Nishigaya
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G. Y. Tomoguchi, Hawaii
K. K. Fuji, Kauai
J. F. Saunders, Maui

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Ira Hirschy
Richard K. B. Ho
Ichiro Nadamoto
Donald E. Poulson
Harold M. Sexton
Pete T. Okumoto, Hawaii
Peter Kim, Kauai
R. J. McArthur, Maui

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Kenneth Chinn
William Gulledge
Robert Jim
Harold T. Kimata
Edmund Lee
P. H. Liljestrand
K. Y. Lum
Edward Matsuoka
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P. Howard Liljestrand, Legislative committee chairman
Sau Ki Wong, Careers committee
Toru Nishigaya, National legislative representative
A. L. Vasconcellos, Association of Professions
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Henry L. Yim
Henry Bockrath, Hawaii
P. M. Cockett, Kauai
M. L. Hanlon, Maui

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James W. Cherry
Ralph B. Cloward
Joseph C. Finney
John P. Frazer
Unoji Goto
Casimer Jasinski
Gail Li
John C. Milnor
William F. Moore
I. L. Tilden
Francis Wong, Hawaii
William Goodhue, Kauai
Edmund A. Tompkins, Maui

## ADVISORY COMMITTEES

### Mabel L. Smyth Memorial Bldg., Board of Management

Date indicates expiration of term
Toru Nishigaya, Chairman, December 31, 1963
H. Q. Pang, December 31, 1964
Donald C. Marshall, alternate, December 31, 1963

### Bureau of Crippled Children

Date indicates expiration of term

| Name | Term |
|---|---|
| Katherine J. Edgar | 1964 |
| Unoji Goto | 1964 |
| W. J. Holmes | 1965 |
| Merton Mack | 1963 |
| Carl Mason | 1965 |
| Ichiro Nadamoto | 1963 |
| Calvin Sia | 1964 |
| Edward Y. F. Wong, Hawaii | 1965 |
| Ruth Oda, Hawaii alternate | 1965 |
| M. A. Brennecke, Kauai | 1965 |
| Clyde Ishii, Kauai alternate | 1965 |
| W. B. Patterson, Maui | 1963 |
| W. G. Pfaeltzer, Maui alternate | 1963 |
| Edwin D. Willett, Lanai | 1965 |
| Paul G. Stevens, Molokai | 1965 |

### Bureau of Tuberculosis

Wallace W. S. Loui, Chairman
L. Clagett Beck
Raymond G. Chang
Edgar S. Childs
Unoji Goto
John T. Kometani
Edmund L. Lee
Robert H. Marks
Clifford Mirikitani
Hastings H. Walker
Francis F. C. Won
Robert P. Henderson, Hawaii
Peter Kim, Kauai
Edmund Tompkins, Maui

### Woman's Auxiliary

Homer R. Benson, Chairman
Ralph M. Beddow
Scott S. Brainard
Doris Jasinski
Robert Y. Katsuki
Ed B. Helms, Hawaii
Kenneth Fujii, Kauai
Lester Kashiwa, Maui

### Bureau of Venereal Disease

John F. Chalmers, Chairman
Samuel D. Allison
Harry L. Arnold, Jr.
Edward D. Emura
Charlotte M. Florine
Koon Sun Fong
Ira Hirchy
Andrew L. Morgan
Linus Pauling, Jr.
S. Kasamoto, Hawaii
F. H. Tong, Maui

## AD HOC COMMITTEES

### Association of Professions

A. Leslie Vasconcellos, Chairman
W. Harold Civin
R. T. Kainuma
M. H. Lichter
Robert Miyamoto, Hawaii
K. Fujii, Kauai
Joseph E. Andrews, Maui

### Medical Practice Act

B. Allen Richardson, Chairman
Samuel D. Allison
Leo Bernstein
Thomas F. Fujiwara
Kikuo Kuramoto
Richard K. C. Lee
Irvin L. Tilden
Raymond C. Yap
Samuel L. Yee
S. Mizuire, Hawaii
William W. Goodhue, Kauai
E. T. Shimokawa, Maui
PLUS members of the Board of Medical Examiners

### Investigation Committee

J. Alfred Burden, Maui, Chairman
William N. Bergin, Hawaii
Webster Boyden, Kauai
Edward Cushnie
Toru Nishigaya

## SPECIAL APPOINTMENTS

The National Foundation's Health Scholarship Committee—C. M. Burgess
Inter-Professional Coordinating—Leabert R. Fernandez, Theodore T. Tomita
Oahu Health Council—E. F. Cushnie, Unoji Goto
Advisory Committee to the Division of Mental Health—K. Y. Lum
Medical Advisory Committee to the Department of Social Services—
George H. Mills, B. A. Richardson, M. H. Chang, Vernon G. Boido, Joseph E. Andrews
Advisory Committee to the University of Hawaii—Bernard W. D. Fong

## PROCEEDINGS OF THE HOUSE OF DELEGATES

### 107th Annual Meeting of the Hawaii Medical Association

The first session of the House of Delegates of the Hawaii Medical Association was called to order by the President, Dr. Frederick L. Giles, at 1:15 p.m., May 2, 1963, in the Mabel Smyth Auditorium, Honolulu.

Present: Drs. Frederick L. Giles, J. A. Burden, Rodney T. West, Samuel D. Allison, Thomas H. Richert, Robert P. Henderson, Theodore T. Tomita, William E. Iaconetti, Robert Miyamoto, Homer R. Benson, Chew Mung Lum, Randal Nishijima, Burt O. Wade, Nicholas Steuermann, Ruth E. Oda, Robert Benson, Bernard Fong, William Ito, Allan Leong, A. L. Vasconcellos, Frederick Warshauer, Patrick Lai, William Dang, Robert Jim, Gail Li, R. Varian Sloan, Richard Moore, Unoji Goto, A. S. Hartwell, Carl Mason, O. D. Pinkerton, Frederick Shepard, Bernard Yim, Marion Hanlon. Dr. Morton Berk arrived at the meeting after the roll was called. Alternates present were Drs. Ralph Beddow, Kenneth Chinn, George Goto, Elmer Johnson, Richard Omura, and Don Poulson.

In addition, Dr. Tomita appointed Alternate Richard Omura to replace Grover Batten and alternate Don Poulson to replace Walter Ozawa. Dr. Iaconetti's request to seat J. K. Wallis in place of Edward Underwood was denied on the grounds that the Bylaws and Parliamentary Committee had ruled that there would be no seating of pro tem delegates who had not been elected by their county societies and this ruling had been circulated to all counties prior to the meeting.

The minutes of the May 3-6, 1962, meeting were approved as published.

The reports of the President, Secretary, and Treasurer, as well as those of the four county societies were referred to the Reference Committee on Parliamentary Affairs.

The reports of the standing and special committees were referred as indicated in the Delegates' Handbook.

Resolutions entered prior to the meeting were referred as indicated in the Handbook. One additional resolution was entered at this time (#4) and was assigned to the Reference Committee on Public Health.

The House recessed at 2:00 p.m., and the reference committee hearing began.

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The second session of the House of Delegates was called to order on Friday, May 3, 1963, at 2:00 p.m. The Secretary called the roll. All members present for the first session were accounted for except Drs. Nicholas Steuermann, and Chew Mung Lum, and alternates Ralph Beddow, and I. Nadamoto. Dr. R. Frederick Shepard was seated after the roll was called. In addition, Dr. Randal Nishijima was present for the second session.

## PUBLIC HEALTH REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your reference committee on Public Health gave careful consideration to the matters referred to it and makes the following report:

### CANCER COMMITTEE

The Cancer Committee received one communication from the Cancer Commission during the year. This was to approve a project to survey stomach cancer amongst Japanese in Hawaii. This project is to be conducted under the direction of the National Cancer Institute and coordinated and administrated by the Department of Public Health at the University of Hawaii. The Cancer Committee met on December 10, 1962, and unanimously approved the project and forwarded it to the Council of the HMA.

On March 28, 1963, the Cancer Committee met to discuss SB-232, which asks for an appropriation of an unspecified amount to be used by the Department of Health as "state assistance in a cancer test program throughout the state of Hawaii." The Committee unanimously felt that the availability of the cytology screening program in Hawaii is equal to or better than that of any community in the United States, and that there is no need for subsidization of a cancer cytology project. This was reported to the Legislative Committee of the HMA.

Gail G. L. Li, M.D.

No suggestions for next year's program are submitted as activities of the Cancer Committee are dependent on communications from the Cancer Commission, whose annual report follows:

*Report of Cancer Commission to Cancer Committee of the Hawaii Medical Association:* The Cancer Commission has been mainly concerned with the operation and progress of the Hawaii Tumor Registry during 1962-1963. The Registry is progressing satisfactorily with a number of problems arising which are mainly concerned with keeping reports from the individual hospitals up to date. The Commission urges each member of the Cancer Committee to take a personal interest in the various hospital registries, and to do what he can to facilitate up-to-date reports. The Commission wishes to emphasize the importance of the Hawaii Tumor Registry to the future of an adequate cancer control program in Hawaii.

The Central Registry compiled accumulated data for the years 1960 and 1961 on a statewide basis, and some of this material will be presented at the Hawaii Medical Association meeting in May of 1963. We hope that this will demonstrate to physicians the importance of the work the Hawaii Tumor Registry is engaged in.

The Commission had several meetings with Dr. Calvin Zippin of the University of California relative to the establishment of a Cytology Registry in Hawaii, and went on record against such a Registry at the present time, particularly upon the scale envisioned by Dr. Zippin.

The Commission approved in principle an epidemiologic study of gastric cancer in Hawaii by the National Cancer Institute, the study to be conducted under the auspices of Dr. Richard K. C. Lee and the University of Hawaii.

I. L. Tilden, M.D.
*Acting Chairman*

*Cancer Committee*

The Committee approves the report without comment.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

### EXAMINING BOARD FOR HANSEN'S DISEASE

During the past year this Examining Board met on six occasions, examining five different patients, one patient having been examined on two occasions. The Examining Board met under the directorship of Dr. Edwin K. Chung-Hoon. The other members were Drs. Harold M. Johnson and Claude V. Caver. Dr. Harry L. Arnold, Jr. substituted for Dr. Caver on one occasion. Two of the patients were admitted to Hale Mohalu Hospital, and the other three are being treated as outpatients.

The program of the Examining Board seems to be working well, and at this time I have no particular recommendations.

Michael M. Okihiro, M.D.

*Examining Board for Hansen's Disease*

Committee approves the report, without comment.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## CHRONIC ILLNESS AND AGING COMMITTEE

This year primary focus was on developing a master plan of action programs for the aging in Hawaii.

The Governor's State Conference on Aging, held in Honolulu on October 24-25, 1962, brought forth a "Plan for Action" with priority items from fifty odd recommendations for action programs. Published report of the "Plan" is available without cost from the Commission's office.

This Committee welcomes any suggestion or thought relating to the implementation of the plans.

*Implementation of the Plan of Action:* In order to adequately implement the action programs, we feel it is necessary to make the State Interim Commission on Aging permanent.

Senator Sakae Takahashi and Representative Howard Miyake, the majority leaders in the Senate and the House respectively, have introduced bills at the request of the Commission Chairman. These bills are supported by this Committee.

This Committee is grateful to the many doctors and their friends for their valuable aid in pushing the bills and takes this means to thank them. At this moment the fate of the Permanent Commission Bill is uncertain. Continued help will be needed.

*Future Activities of this Committee:* Implementation of the State Commission on Aging "Plans for Action" will require the strong support of Hawaii Medical Association. It is hoped that physicians of this State will take an active lead in bringing to fruition adequate programs. This may obviate such questions as "Doctor, what are you doing for us old folks other than fighting 'medicare'?"

With Senator Smathers of Florida taking over the chairmanship of the U. S. Senate Committee on Aging, the AMA Legislative Council feels that the emphasis will change from purely political to a more realistic program development. This has been the objective and endeavor of this Committee. Hawaii's doctors have now an opportunity to participate in community activities and demonstrate what doctors can do, not only for old folks but the community, State, and Nation.

This Committee, therefore, recommends that HMA take steps to get this message across to its general membership by whatever means it has at its command.

*Other Recommendations:* The change of State administration; the resignations of Rev. Harry Komuro as chairman of the State Interim Commission, and Mrs. Faye as its executive secretary; and the anticipated change in the commission make-up will all increase the need for greater effort on the part of this Committee to continue to guide and support the on-going programs in the area of chronic diseases and aging.

This Committee recommends that HMA continue to support the State Commission on Aging, the Independent Living Project, the St. Francis Coordinated Home Care Program, voluntary health insurance programs, adequate Kerr-Mills implementation, and other programs relating to chronic disease and aging. Health maintenance, institutional care, rehabilitation, research, and home care programs deserve continued support at state, county, and community levels through active physician participation.

SHOYEI YAMAUCHI, M.D.

*Chronic Illness and Aging Committee*

Committee approves the report, without comment.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## HEART COMMITTEE

This committee met on one occasion this past year with representatives of the Department of Health. Approval of a film entitled "Pulse of Life" concerning resuscitation was given. Aspects of diet manuals and dietary instructions under the auspices of the Department of Health were discussed. The use of notification forms to physicians and patients as regards x-ray reports was touched upon.

A small but useful function is served by this committee, which should be continued.

BERNARD J. B. YIM, M.D.

*Heart Committee*

Committee approves the report without comment.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## ADVISORY COMMITTEE TO THE BUREAU OF CRIPPLED CHILDREN

*Review of Fee Schedule Adopted by HMA:* The Crippled Children Section's (formerly Bureau of Crippled Children) Advisory Committee met on February 8 and heard a brief review of the fee schedule adopted by HMA. It was pointed out that the Crippled Children Section was encountering some resistance with the hospital laboratory and x-ray departments. Although in some instances the schedule pays them more than in the past, the hospitals feel that HMA does not have the right to negotiate for them. One of the physicians stated that the Relative Value Study is set up for doctors in practice, not for employees of hospitals.

It was voted that the Crippled Children Section negotiate directly with the Hawaii Hospital Association regarding laboratory and radiology fees.

*Report of Progress on Fee Schedule for Orthodontists:* Dr. Edgar reported that the Crippled Children Section will be meeting with a committee of the Hawaii Society of Orthodontists on February 18 to negotiate a fee schedule.

*Review of Procedures Used in the Selection of Physicians for Crippled Children's Services:* Dr. Edgar stated that CCS rarely makes a selection of doctors for services. This is done only when the referring physician or the family does not have a preference. However, if CCS is asked to make a selection, they do select specialists on a rotation basis. The CCS keeps its list of specialists up to date and adds new names as new physicians come into the community. This subject is being brought to the attention of the Committee because criticisms come up rather frequently and Dr. Edgar wanted to make it clear that CCS is not usually responsible for the selection of doctors. Physicians and families are more likely to select a specialist who has been here for some time and is well known.

*Report of Budget Request for the 1963-64 Fiscal Year:* The Governor has recommended a budget of $371,228 for the Crippled Children Section for the 1963-64 fiscal year. This is only to maintain the current level of services. The amount recommended includes increase in surgical fees estimated at 60 per cent; medical fees, about 12 per cent; radiology, 34 per cent; and hospitalization, 17 per cent. These estimates refer only to procedures frequently used by CCS.

Dr. Edgar added that the Governor's budget recommendation also included State funds to take over the Conservation of Hearing treatment program which is now supported by Federal funds and will terminate June 30, 1963. A hearing testing program without available services for children of families who cannot afford to pay would be ineffective. The Chairman told of the problems that develop when children's hearing handicaps are not picked up. He noted that since the institution of this program more mothers have been asking for an examination of their children's hearing and treatment.

*Services for Guam Crippled Children:* Dr. Edgar advised that there are a number of children in Guam with very severe defects, some of which are rare in Hawaii. They have a considerable backlog because of the lack of services (particularly those of specialists). Hawaii has been asked to take some of these children for treatment. Guam has paid all the bills. However, there has been an

overload on the Hawaii social and clerical workers. These cases have taken time that CCS could ill afford to spend. Guam has written that they have many more cases and were advised that CCS cannot take more than one a month (because of staff time entailed). A plan was developed whereby a certain amount of Federal funds, which would ordinarily go to Guam for crippled children, will be deposited to the CCS account here. These funds will permit the Section to employ a part-time social worker and a clerk. This plan has been accepted by Guam, and so in the next few months it will be implemented, and cases will start coming in at the rate the part-time people will be able to handle. They cannot be taken in big quantity; it will be gradual. The proposed amount of money is $25,000. The plan will be submitted to Governor Burns for approval. These Guam cases will be done at the same fee schedule accepted here for Hawaii CCS cases.

JOHN P. FRAZER, M.D.

*Advisory Committee to the Bureau of Crippled Children*

The Committee recommends approval of the report with the following comment: The hospitals should not be in the practice of medicine, and should not be expected to negotiate fees for any physician. Therefore we recommend that the Hospital Liaison Committee of the HMA meet with the Hospital Association to solve this problem.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## MATERNAL AND INFANT MORTALITY STUDY COMMITTEE

This committee also serves as the Advisory Committee to the Maternal & Child Health Section of the State Department of Health, formerly the Bureau of Maternal and Child Health.

Its objectives and purposes are:

(1) To study all maternal deaths and a selected number of infant deaths by full scientific analysis and unrestricted discussion on all factors involved with rigid adherence to ethical and legal principles so that anonymity of all parties involved may be maintained; (2) To determine existence and nature of avoidable factors so that these may be reduced or eliminated; (3) Objective and impersonal report and dissemination of knowledge gained so that better maternal and infant health care may be assured through improvement in teaching and practice; and (4) To serve as an advisory committee to the Department of Health on programs relating to maternal and child health.

Major activities of the Committee for 1962 were as follows:

(1) The Committee studied in detail eight maternal deaths. Two were considered nonobstetrical, one of which was due to intracranial hemorrhage due to ruptured aneurysm and the other was trauma due to an aircraft crash. Of the remaining, one was considered indirectly obstetrical and nonpreventable, and five cases were classified as being directly obstetrical deaths. Two of these obstetrical deaths were due to septic abortion and considered preventable; one was due to spontaneous rupture of a pregnant uterus, amniotic fluid embolism and air embolism to the lungs and considered nonpreventable; one death was due to acute blood loss following rupture of the uterus and subsequent sub-total hysterectomy in a patient who was in prolonged ineffectual labor, and the case was classified as being preventable; one death was due to acute blood loss due to abruptio placenta and possibly ruptured uterus resulting from version and extraction, and the case was classified as being preventable.

(2) A sub-committee of this committee called the "Steering Committee" met at monthly intervals to select infant deaths for presentation to the Committee as a whole. This Committee is now being chaired by Dr. Donald Char. Twenty-two infant deaths were studied by the Steering Committee and of these six cases were considered noncontroversial and nonpreventable and studies were terminated in the Steering Committee. Of the fourteen infant deaths that were presented to the Committee as a whole, three cases were considered directly obstetrical deaths and considered preventable; five cases were classified as being directly pediatric deaths, and out of these, three were considered preventable deaths, one nonpreventable and one death nonclassifiable because of insufficient information; three cases were classified as being combined obstetrical and pediatric deaths, and, of these two were found to be preventable deaths and one nonpreventable.

(3) Several members of the Committee were invited and attended a meeting of the Hawaii County Medical Society on March 16, 1962. Acute toxemia of pregnancy and problems concerning premature infants were presented and discussed. Dr. S. Z. Levine, Professor Emeritus of Pediatrics, Cornell Medical Center, was a guest participant at the meeting.

(4) In cooperation with the Hawaii Section of District 8, American College of Obstetricians and Gynecologists, this Committee took an active part in urging the administrators of 11 neighbor island hospitals having obstetrical services, to send nurses to a three-day nursing conference in Seattle, Washington, in September 1962.

(5) The members of this Committee have seen the need for early and adequate consultations and referrals in the management of many of the maternal and infant death cases which were studied. Many of the cases classified as being preventable might have been salvaged had the attending physicians sought help before the critical stage of the diseases was reached.

(6) The members of this committee are taking an active part in trying to get a law passed by the Legislature which would provide that the findings and conclusions of investigative committees whose main objective is to reduce mortality and morbidity by education and dissemination of knowledge be rendered confidential and that the members of these committees and those furnishing information be protected from unjustified legal action.

Another area of concern of this committee is the medical examiner system in this State. As of now, the medical examiner system is regulated by each county. For this reason investigations of violent deaths or those that occur under questionable circumstances are inadequately carried out. It is hoped that legislation will be introduced in this present session to make the medical examiner's system statewide and set the qualifications of a chief medical examiner. Whether such a bill will pass during this present session is uncertain. However, the legislators should be exposed to this idea so that possibly in the next session such a bill can be passed.

Because many maternal and infant deaths occur in poorly equipped and staffed small rural hospitals, this committee respectfully recommends to the House of Delegates that the Public Administration Services Survey of the State of Hawaii covering this particular area, be endorsed and that the Governor, Speaker of the House of Representatives, and President of the Senate be so informed.

GEORGE GOTO, M.D.

*Maternal and Infant Mortality Study Committee*

Committee approves the report, without comment.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## DIABETES COMMITTEE

The Diabetes Detection Drive was well publicized and well attended in 1962 when the Department of Health's Clinitron was again used in Honolulu. In general there was no change in the format except, at the suggestion of Dr. Giles, most of the clerical work previously carried out by Department of Health personnel was done in the Association offices.

No reports have been received from the neighbor islands and it is not known what activities were carried out in any county other than Honolulu. In Honolulu the Clinitron was used for six consecutive days, two days each in three locations.

A total of 2,565 individuals were screened and of these 141 were referred to their physicians, including 16 previously known diabetics. The known diabetics were discouraged from participating in the screening program but the Clinitron services were not denied them.

Broken down by age groups the results of the Honolulu screening program were as follows:

| Age Group | Total Tested | Positives Previously Unknown | Total Diagnosed New Diabetics |
|---|---|---|---|
| 0-4 | 17 | – | – |
| 5-24 | 205 | – | – |
| 25-44 | 785 | 23 | 5 |
| 45-65 | 1,088 | 69 | 21 |
| 65 and over | 464 | 33 | 10 |
| Not known | 6 | – | – |
| All ages | 2,565 | 125 | 36 |

The Clinitron program is attracting more attention each year and serves as a worthwhile health education project. We feel it should be included in the over-all public relations program again next year under the direction of this Committee and thank the Council for the allocation of funds which will make this feasible.

LOUIS G. STUHLER, M.D.

*Diabetes Committee*

Committee approves the report, without comment.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## MENTAL HEALTH COMMITTEE

The year 1962-1963 has been a significant one for the cause of mental health in the United States and in Hawaii. The most important single factor was the first Presidential message to Congress to deal exclusively with mental health. President Kennedy proposed in February 1963, a plan to combat mental illness and mental retardation which would require approval of more than $31 million, including: (1) grants to states to cover the major cost of setting up comprehensive community mental health centers, plus staffing costs for the first four years; (2) project grants to stimulate development of comprehensive maternity and child health care service programs, which it is believed would reduce mental retardation by one half; (3) project grants to promote action on mental retardation and pay much of the cost of centers for research in mental retardation; and (4) extension—up to eighteen months—of vocational rehabilitation for mentally retarded and others whose rehabilitation potential is difficult to determine. Even before this message, the 87th Congress had appropriated $4.2 million in its 1962-1963 budget for the National Institute of Mental Health for distribution to the states to help them formulate plans for comprehensive mental health programs. Hawaii's share of this has been set at $50,000 in matching funds should the Public Health Service approve the "plan for planning" developed in Hawaii. These funds are to be administered by the State Department of Health. A similar sum is anticipated in the following year, so that the planning activity is expected to proceed over a period of two years.

The 1962-1963 HMA Mental Health Committee came into existence with three pre-existing matters for action. The House of Delegates on Maui had mandated the Committee to form a subcommittee to study drug addiction, though the previous Mental Health Committee had made such a study and reported no need for such action. Another matter was a request from the AMA Council on Mental Health requesting the HMA Committee to form a committee of physician and lay leaders active in mental health activities to attend a AMA National Congress on Mental Illness and Health. The third matter was an invitation to attend a conference on "Planning for Mental Health" sponsored by the Mental Health Division and co-sponsored by the Mental Health Association and The Conference Center of the University of Hawaii. Dr. Schnack represented the Committee and HMA at this conference which was held on June 21-23, 1962, and preceded the first Committee meeting.

Four meetings of the full Mental Health Committee were held: July 13, September 20, December 17, and March 25. The first meeting the Committee considered the matter of drug addiction. The consensus was that a subcommittee was not necessary. However, to follow the House of Delegates mandate it was agreed to form one. Dr. Spencer is Chairman and Dr. Stevenson is Consultant. Dr. Dorothy Natsui was named to succeed herself as our representative on the Advisory Committee to the Director of Health. Dr. Schnack was appointed by Dr. Giles to be the HMA member on the Steering Committee for the Governor's Conference on Rehabilitation of the Mentally Ill Adult.

Also at the first meeting Dr. Giles directed to the Committee the question of education in mental health principles. It was pointed out that in each of the past two years a 20-hour course on psychiatry in office practice had been offered under the auspices of the Western Interstate Commission for Higher Education, sponsored by the HCMS and the HAGP. The Hawaii Psychiatric Society has obtained a NIMH grant to continue this type of course, with Dr. Schnack as Training Director. On February 16-17, 1963, Dr. Schnack attended an American Psychiatric Association "Colloquium for Postgraduate Teaching of Psychiatry" in Los Angeles. Curricula, teaching methods, evaluation, and particularly how to attract and reach nonpsychiatrist physicians were the major concerns of this colloquium.

The relationship of psychiatrists and psychologists and the related question of a certification or licensure law for psychologists were given much consideration in the first two meetings. Most of the members were persuaded by Dr. Giles's arguments in favor of a licensing act, but the difficulty of defining the practice of psychology was underscored. When it appeared later that the psychologists themselves were not preparing a bill for the Legislature, further consideration of this matter was dropped. This Committee and a subcommittee of the Legislative Committee participated in meetings to which psychologists were invited to consider this issue. It was brought up in our committee that the AMA had answered an inquiry from the HCMS about psychologists practicing in physicians' offices. The AMA legal counsel believed a psychologist in this situation is similar to other ancillary personnel, such as nurses. The implication is that the physician would be responsible for the acts of the psychologist. Part of the discussion suggested that the psychiatrist or physician who refers a patient to a psychologist remains responsible for the patient's total physical and mental health.

In each of the three first committee meetings there was some discussion of drug addiction and related subjects. It was felt that the problem of drug addiction is not acute in Hawaii, and that it is well under control by the Health Department and the Federal Government. In general, the Committee members agreed with the stand of the AMA and the Federal Bureau of Narcotics against ambulatory treatment of addiction. New York City's plan to try this and every other possible approach on an experimental basis was noted. The AMA subsequently clarified its stand as not being opposed to experimental programs which might mean giving narcotics in ambulatory treatment of the addict.

The increasing problem of "glue sniffing" was taken cognizance of, and the plans of the Honolulu Police Department to ask for a change in city laws and of the Health Department to alter regulations pertaining to sell-

ing glue were both noted. The Oahu Health Council has become interested in the problem. and wishes to become a central storing point for information pertaining to "glue sniffing."

Wearing two hats. one of them HMA's, Dr. Schnack participated in over a half dozen planning sessions of the Steering Committee for the Governor's Conference on Rehabilitation of the Mentally Ill Adult, and another session in the spring (1963) at which the originally proposed follow-up conference was discussed in relation to possibilities for contributing to the formulation of the State Plan under the NIMH grant, as well as planning for the conference itself. Three of our committee members attended the Governor's Conference on October 1, 1962: Dr. Druecker, as representative of the HMA, and Drs. Pauling and Schnack as representatives of the Hawaii Psychiatric Society.

At the first Committee meeting a subcommittee was formed with Dr. Lum as Chairman to prepare for participation in the AMA Congress on Mental Illness and Health. It was decided that the scope of this subcommittee should probably be the accumulation of information on all the on-going mental health activities of the various agencies active in the field and on conferences, meetings, etc. It was further implied that this subcommittee should continue in existence indefinitely. This subcommittee invited participation by the Mental Health Association, the Hawaii Psychiatric Society. and the Mental Health Division. Four meetings preceded the Chicago Congress held October 4-6, 1962. The subcommittee came to the conclusion that more than had yet been proposed in Hawaii should be done actively to try to carry out recommendations of the Congressional Joint Committee on Mental Illness and Health incorporated in its report *Action for Mental Health,* and that it therefore would not limit its activity to collecting information. A letter was written to the AMA obtaining regrouping in the regional discussion sessions for our delegation to the Congress to meet with California, rather than Arizona and Nevada. Letters requesting travel funds and per diem for the subcommittee members were written to the local foundations. Four days' per diem and one round trip fare were donated from these sources, an insurance company donated one day's per diem unsolicited, a drug company gave another round trip fare to the Mental Health Association, and the Governor approved four days' per diem for one member who was going to be in the Chicago area on government business. Thus Mrs. Levy, and Drs. Lum and Schnack were able to be present at the First Annual AMA Congress on Mental Health and Illness, which was co-sponsored by the National Association for Mental Health, and the American Psychiatric Association. Three days and evenings were spent in plenary sessions and discussion groups on topics and by geographic regions, and for Dr. Schnack in meetings of the State Mental Health Committee Chairmen. The final evening the Hawaii delegates drafted a report of eleven specific proposals for action.

The December 17, 1962, meeting of the Committee spent most of its time debating these proposals and action to be taken on them, and the further function of the subcommittee. As result of the third Committee meeting the Chairman has prepared an amended Report of the Steering Committee delegation to Chicago which has been distributed to the entire membership of HMA; letters signed by the HMA president have been sent to all hospitals with training programs urging the inclusion of at least two sessions each year on psychiatric subjects; and letters requesting that a physician be included on the Board of Directors and the key committees are to be sent to a long list of agencies dealing with problems in which mental health is a significant aspect.

Discussion again led to the decision to continue the subcommittee, called The Steering Committee on Mental Health. While it was generally thought that the over-all picture of mental health activity was more appropriately the concern of the parent committee and that the subcommittee should involve itself with specific, limited, or short-term projects. the considerations that the HMA Committee should deal with all mental health subjects that involve the HMA as an association and that it is more feasible for a subcommittee to invite resource persons from lay organizations (a committee of the HMA may not include nonphysician, nonmembers) were persuasive.

Following this decision, the Steering Committee immediately embarked on planning for an HMA statewide conference to carry out the first recommendation made in Chicago, to inform the membership of the AMA Principles on Mental Health and the program of the AMA Council on Mental Health, and other recommendations aimed at increasing the mental health skills of nonpsychiatrist physicians and lay persons such as public health nurses, school personnel, clergy, and social workers, and broadening the participation of physicians in the treatment in the community of the mentally ill and retarded. The Chairman of the Mental Health Committee requested of the HMA Council approval of this conference proposed for June 25-26, 1963, and an allotment of $200.00 for expenses. Approval was voted by the Council at its February 13 meeting. The Steering Committee then began inviting physicians of national importance on an informal basis. at the time of this report having assurance of the presence of Dr. Edward Greenwood, President, American Orthopsychiatric Association; Dr. William Sheeley, Director, Postgraduate Education Project of the American Psychiatric Association; and Dr. Howard Kern, Jr., Director. Community Psychiatry Training Program, Johns Hopkins University School of Medicine. The AMA is planning to send a Past Chairman of the Board of Trustees. Arrangements are guaranteed, and the program is almost perfected.

March 1-2, 1963, the Ninth Annual Meeting of State Mental Health Representatives met in Chicago. The AMA invited at its expense the Directors of State Health Departments. Directors of State Mental Health Authorities, Chairmen of State Medical Associations' Mental Health Committees, and the Executive Secretaries of the State Medical Associations. Hawaii was represented by Drs. Edward Colby and Yan Tim Wong, representing Drs. Leo Bernstein and Robert Spencer, respectively for the first two invitations, and Dr. George Schnack and Miss Lee McCaslin.

In addition to plenary sessions, in which many of the talks related to President Kennedy's Health Message and many more with problems and illustrative state programs for carrying out the Program of the AMA Council on Mental Health, there were again regional and state discussion periods. Dr. Schnack was selected to be Recorder for both the Western Region and Hawaii. The topic for consideration in each of the state meetings was coordination of plans for mental health and cooperation of the medical societies and the state agency. The Hawaii representatives wrote an optimistic report, as policies of both agencies have been to obtain advice from each other, and physicians members in most cases belong to both.

For next year's program in mental health we recommend continuation of the present program and an expansion of efforts to integrate mental health concepts into the daily practice of physicians and to increase the participation of physicians in community activities and organizations in which mental health aspects are a significant part.

First will be the on-going activity of two projects already started: the June 25-26 Conference, and the Planning for a State Plan in Mental Health. The Mental Health Committee should continue to have a representative on the Steering Committee of the Governor's Conference for Rehabilitation of the Mentally Ill Adult, and a representative on the Advisory Committee to the Director of Health, as well as on the Planning Committee of the State Plan project.

The subcommittee known as the Steering Committee on Mental Health should continue as a body to collect information on all mental health activities in Hawaii, and to serve as liaison with community agencies, as well as carry out the local activities of the HMA intended to promote the Program of the AMA Council on Mental Health. The HMA should have delegates to the projected

AMA Congresses on Mental Health for future years, as well as 1963, and should send the Chairman (or his representative) to the Annual Meeting of State Mental Health Representatives.

Finally, the HMA should do what it can to forward the recommendations of the Steering Committee delegates to the AMA National Congress on Mental Illness and Health which have not yet been completed, particularly: (a) support the improvement and expansion of existing programs in mental health services with special emphasis on programs for children and adolescents and mental health consultations, (b) support the development of new facilities such as day- and night-care centers, emergency home visiting service, sheltered workshops and rehabilitation centers to the extent that recruitment of adequately trained personnel seems reasonable to expect, (c) assist in the preparation and passage through the Legislature of a modern Mental Health Act, and (d) stimulate, participate in, and help finance research in medicine, psychiatry, anthropology, psychology, and sociology which may advance knowledge of emotional illness and health at Hawaii State Hospital, the University of Hawaii, and elsewhere. In order to properly carry out these objectives, a wider representation of non-psychiatrist physicians on the Mental Health Committee is greatly to be desired.

Of presently unknown, but tremendous, value to the entire population of Hawaii, would be inclusion of protection against mental illness in all HMSA and accident and health insurance policies written in this State. The 1963-1964 Mental Health Committee might undertake a project to work with the insurance underwriters and the HCMS Insurance Committee to accomplish this end, and/or to investigate the possibility of getting such a requirement enacted into law, working cooperatively with the Legislative Committee.

George F. Schnack, M.D.

*Mental Health Committee*

The Committee wishes to recommend acceptance of the report with the correction to the report in regard to the statement "Honolulu County Medical Society Insurance Committee" which is nonexistent. In its place we recommend that in 1963 and 1964, the Mental Health Committee should undertake a project to work with the Insurance Underwriters and the Medical Care Plans and Fees Committee to accomplish this end, namely the broadening of health coverage to include mental illness. The Committee would like to comment also that HMSA *does* have some insurance coverage available for mental illness and has had for some years. (Delete remainder of last sentence.)

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## POLIO COMMITTEE

From time to time invited nonmembers met with us to aid in specific areas or to facilitate better liaison. The Committee met eight times from July 11, 1962, to February 6, 1963. A subcommittee met on numerous occasions. Our chief responsibility was setting policies and coordinating the counties in the oral vaccine program.

Honolulu County was well along with its plans for "Operation Swallow" and the other counties were in various stages of planning at the time I assumed chairmanship of the Polio Committee.

Our principal efforts were directed towards information and publicity for the neighbor counties and to set up a surveillance committee with the Public Health Department to check any suspected polio that might occur before, during, or after the Swallow Program, for it was recognized that any wild virus infection in the State might cast serious suspicion on the attenuated vaccine. Fortunately, we had no polio during this period.

Swallow I was begun October 14 and completed October 20, 1962; the results were excellent. The population, from three months of age up, immunized, numbered 484,323, and this was out of a total estimated population of 627,718, or 77.2%. The rate for the school-age group, from 5 to 18 years, was 91.4%.

Swallow II conducted December 2, 1962, was also a success with 76.4% of the total population and 92.6% of the school-age group immunized.

The State of Hawaii was well on the way to establishing a historic record of a simultaneous statewide immunization program designed to completely eliminate the spread of wild polio virus. It was, therefore, disappointing when Type III was not given an unconditional clearance by the Surgeon General of the United States Public Health Service. Our committee had access to the records upon which this recommendation was made and disagreed with the decision; however, when the American Academy of Pediatrics concurred, it was decided that we must wait for further study. During this waiting period the organization of 5,000 volunteers disintegrated, the allocated State funds were turned back to the State Treasury, and plans were made for disposal of the excess monies acquired by the counties from Swallows I and II. Finally, when the Surgeon General again approved Type III for mass immunization our committee concurred and recommended that this be done if practical.

The President of this Society and the State Director of Health did not feel at this point that it was practical and Swallow III was "postponed indefinitely." Any further administration of oral polio vaccine is to be given at the discretion of the private physician.

We would like to recommend that the State Polio Committee be permanently dissolved and that a new committee be formed, this to deal with all communicable diseases and questions of immunizations and further, we strongly recommend that the Association not enter into any further mass immunization programs unless it be to forestall or interrupt a serious epidemic.

John H. Peyton, M.D.

*Polio Committee*

The Committee recommends approval of the report, except we recommend the last paragraph be as follows: "We would like to recommend that the State Polio Committee be permanently dissolved and that a new committee be formed; this to deal with all communicable diseases and questions of immunization. We recommend deletion of the recommendation that the association not enter into any further mass immunization programs, etc.

**ACTION:**

**The Chairman moved adoption of this portion of the report. The President ruled that that portion recommending a change in the name of the committee could not be acted on at the present session since it would necessitate a change in the bylaws. The Chairman amended his motion to state that action be taken at the next session of the House of Delegates. The motion was adopted as amended.**

## RADIUM COMMITTEE REPORT

This committee met once, on September 11, 1962. Present were Drs. G. Goto, G. Henry, R. Nordyke, R. Rigler, and J. Wang. Change in the name of the Committee was first considered. Historically, its interest centered around the use of radium, then it expanded to x-ray safety, both therapeutic and diagnostic, and most recently to include radioactive isotopes in addition to radium. It was, therefore, decided to recommend that the name be changed to one more appropriate to its function, "Radiation Committee."

Radium application charges to patients were found to be insufficient to pay for its cost, the deficits being taken up by the State. It was generally felt that the charge to

patients, all having cancer, should not be increased at this time.

Considerable interest was shown towards implementing a program for investigation of safety of x-ray and isotope installations. This is a major undertaking if it is to be properly done since there are over 500 such units in Hawaii. Recently the U. S. Public Health Service has given a large grant to the Hawaii State Department of Health to aid in such a survey and a full-time person will start such a survey on about July 1, 1963. It therefore seems reasonable that the Department of Health should carry on the monitoring and that this Committee should cooperate in whatever way is feasible.

The U. S. Atomic Energy Commission is now in the process of turning over licensing and control of most medically useful radioisotopes to the states. This should be anticipated by us and a reasonable, coordinated method for administering this function be developed in the next year or two.

ROBERT A. NORDYKE, M.D.

*Radium Committee Report*

Recommend approval of the Report without comment.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## VENEREAL DISEASE, ADVISORY COMMITTEE TO THE BUREAU OF

This Committee met on October 22, 1962, at the request of the Department of Health to review that section of the public health regulations which refers to "Prevention of Blindness at Childbirth," and which reads:

> Any physician, midwife, or any other person in attendance at childbirth shall instill a 1% solution of silver nitrate into the eyes of every child immediately after birth. Solutions other than 1% silver nitrate may be used only on approval by the Board of Health and subject to such conditions and restrictions as the Board may impose.

The Health Department was advised that it was the belief of the Committee that 100,000 units/gm may be substituted with the approval of the Director of Health. The use of penicillin ointment, however, should be authorized only with the specific written approval of the Director of Health.

The Committee feels that in view of the paucity of information available and the lack of adequate studies, the substitute use of other agents, such as bacitracin and the sulfa drugs, should be disapproved for combating ophthalmia neonatorum.

The Committee notes that there has been an increase in venereal disease cases reported to the Health Department, although not in the same proportions as has been the case in many large mainland cities. Your Committee again repeats the request for utilization of adequate diagnostic procedures, particularly in cases where there is urethral discharge. Patients should not be treated without examining smears. In addition, adequate follow-up in the case of serologic examinations is often overlooked. Many cases of venereal disease may thus go undetected and consequently unreported to the Health Department. Inadequate reporting makes for inadequate epidemiological follow-up and obvious inability to stem the increase of venereal disease.

JOHN F. CHALMERS, M.D.

*Venereal Disease, Advisory Committee to the Bureau of*

Committee approves the report, without comment.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## SCHOOL HEALTH COMMITTEE

This committee has had several monthly meetings during the past year and has focused its attention in many areas of school health.

The first task the Committee launched into was the establishment of the 7th grade physical examinations. The House of Delegates in 1962 had mandated this committee to set up a program for medical examinations for all 7th graders, particularly those in the low-income groups which would require public assistance and aid through the State Departments of Education, Health, and Social Services. A coordinated program was established during the summer and early fall establishing the number of children who came from families that could not pay for the recommended physical examination. On Oahu it was established that 189 children were eligible for physical examinations provided by the Health Department; on Kauai, 16; and on Hawaii, 19. Maui, unfortunately, did not participate in this initial screening program. This committee then, with the strong support of the Maternal and Child Health Services Branch of the Department of Health established the policies for the physical examination of these children and participated actively in this. It was of interest to note that the two leading defects needing attention in these children were obesity and dental caries. The over-all community interest and support of the 7th grade physical examination has been good. Dr. Edgar noted that 1,040 children were examined at the Hickam dispensary just before school started and the large number necessitated a second examination of about 600 children. The committee feels that the Hawaii Medical Association should continue to strongly support this program. The committee also recommend, that for future planning, the 10th grade physical examination should also be considered.

The second concern of this committee was in the realm of the school health coordinators' program of the Department of Education. An entire meeting was devoted to discussion with Mrs. Bialko, the supervisor of health coordinators. It is of major concern to the Committee that there is a limited number of health coordinators on the island. There is a total of 34 in the Islands: 29 on Oahu, two each on Maui and Hawaii, and one on Kauai. At present each health coordinator is assigned to three to five schools to work with. This makes it almost impossible for one person to develop any effective program in the respective schools since considerable time is spent traveling from one school to the other. The ratio of health coordinators to pupils is approximately 1 to 3,900. One cannot hope to establish an effective health education or health appraisal program with such limited resources. In spite of an increasing number of new schools the next year, the Department of Education budget and legislative budget will not permit the addition of even one new health coordinator per year to meet the coming needs. It is the recommendation of the Committee that the Hawaii Medical Association strongly support the additional need of more health coordinators in the Department of Education.

Physical Education and the Physical Fitness program were the third area of concern to the committee. A session was held with Kay Fossom, department head of the Physical Education branch of the Department of Education, discussing various problems in the school. An attempt to classify the "medically handicapped" in the study, a more definite classification will be forthcoming. The societies should consider the possibility of presenting a panel on the Physical Fitness and the Physical Education programs as now conducted in our school system.

A final meeting was held on March 15, 1963, in which Dr. Ira Hirschy, epidemiologist of the Department of Health, presented the problems of communicable disease control in the schools. An attempt at arriving at some decision on the exclusion of patient from classes of the various communicable diseases was made. Specific problems of salmonella and strep throat were discussed.

In summary, the School Health Committee has attempted to pursue the objectives of maintaining, improv-

ing, and promoting the health of the school-age child. It is hoped that the total future program will include adequate supervision of the physical, mental, emotional, and social aspects of school life.

Calvin C. J. Sia, M.D.

*School Health Committee*

Committee recommends approval of the report. Recommend that this Committee meet with school authorities and discuss the school physical examination and its limits in eliminating the risks involved in Physical Education programs and Competitive Sports.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## ADVISORY COMMITTEE TO THE BUREAU OF TUBERCULOSIS

This committee held one meeting in October, and two in March. The purpose of the meetings was to discuss the proposal of the National Tuberculosis Association to attempt a tuberculosis eradication program in Hawaii on a demonstration or experimental type basis. This was proposed by a joint committee consisting of the U. S. Public Health Service and National Tuberculosis Association.

If this project goes through, Hawaii might be the area for a trial program. The funds for such a project would have to come from Federal, State, and N.T.A. appropriations. The many problems of funds, liaisons, as well as programming and education, were discussed.

The second meeting on March 4, 1963, was held with Mr. Donald Trauger, Director of Research and Statistics of the National Tuberculosis Association. Mr. Trauger discussed his feelings on the possibilities of eradication of tuberculosis in Hawaii. Included in his discussion was the sponsoring of this program by the U. S. Public Health Service, National Tuberculosis Association, and the Hawaii Department of Health. Elaboration was made upon a draft of his report entitled "Current Status of Tuberculosis Control in Hawaii." It was Mr. Trauger's opinion that the State of Hawaii was paying the largest amount per capita per year, or 3.5 million per year. Mr. Trauger also stated the ATS and USPHS endorse the use of isoniazid as prophylaxis for converters to positive tuberculosis skin tests. Most of all, greater administrative control throughout the organizations would be required. The eradication program in Hawaii, if instituted, would take no less than ten years, this being an optimistic figure.

The actions of the Committee were: (1) approval of the idea of utilizing more INH as a prophylactic measure; (2) interest in the tuberculosis eradication program, although it was generally agreed that it would require greater coordination and liaison between Hawaii, Washington, D. C., and New York.

The last meeting of the Committee held on March 18, 1963, was devoted mainly to discussion of the tuberculosis eradication program, and most members felt that if an all-out program were instituted in Hawaii, a tremendous saving of funds would eventually occur after an initial outlay of a large sum.

It was the consensus of the Advisory Committee that lack of definite information on the eradication program makes it difficult to present to the House of Delegates at the present time.

Suggestions for next year's Advisory Committee for Tuberculosis were (1) to continue to work out the project of a possible eradication program for tuberculosis in Hawaii; (2) to consider a tuberculin test as a requirement for each school entrant.

The Committee would like to have the House of Delegates' endorsement on continuing the actions of the Advisory Committee of Tuberculosis, i.e., (1) tuberculosis eradication program in Hawaii; (2) tuberculosis skin test for each school entrant; (3) isoniazid prophylaxis to all converters.

Wallace W. S. Loui, M.D.

*Advisory Committee to the Bureau of Tuberculosis*

Recommend acceptance of the report with the following modification, except in the next to the last paragraph, item 2, "to consider a tuberculin test as a regular part of a physical examination for each school entrant." Eliminate the use of the word "requirement."

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## RESOLUTION NO. 1

Re: Fluoridation

Whereas, The prevention of preventable disease has been a primary goal of conscientious physicians from time immemorial; and

Whereas, The prevention of tooth decay by improvement of general nutrition and education in dental hygiene has been, as shown by numerous published reports, an almost complete failure; and

Whereas, Tooth decay is shockingly prevalent in children in Hawaii, more so than in almost any community in the world; and

Whereas, Tooth decay is largely preventable by correction of deficiency of intake of a mineral nutrient, fluoride, in the public water supply; and

Whereas, Fluoridation of public water supplies has never been shown to have produced any harmful effect in any of the many millions of persons drinking such water over the past twenty years, except for mild mottling of enamel in a small percentage of children; now therefore be it

*Resolved,* That the House of Delegates of the Hawaii Medical Association hereby reaffirms its confidence in the effectiveness, the safety, the economic soundness, and the propriety of fluoridation of the public water supply for the prevention of tooth decay; and be it further

*Resolved,* That the public be reminded that every year this public health project is postponed results in depriving about 20,000 children, for life, of the maximum benefit of protection against tooth decay.

Respectfully submitted,

Harry L. Arnold, Jr., M.D.
Robert A. Nordyke, M.D.
Fred I. Gilbert, Jr., M.D.
W. Harold Civin, M.D.
Frederick A. Dodge, M.D.
Thomas K. Oshiro, M.D.
Norman R. Sloan, M.D.
Thomas S. Min, M.D.
T. K. Lim, M.D.
Dean M. Walker, M.D.

*Resolution No. 1*

Regarding fluoridation of the public water supply. Committee recommends no further action by the Hawaii Medical Association and refers to the action of the Association in 1959.

**ACTION:**

**The President noted that the Reference Committee report failed to recommend that the resolution be adopted, not be adopted, or adopted with recommended revisions. The Chairman read the resolution on fluoridation which was passed in 1959 and which reaffirmed for the third time the Association's stand in favor of fluoridation of the public drinking water. He advised that the Reference Committee had heard from a large number of people. Most of the testimony from doctors in private practice opposed fluoridation from a socialogic standpoint, but because this matter had been acted upon by the HMA in 1959, the Reference Committee thought it was superfluous for the Association to again adopt a reso-**

**lution. Dr. Burden noted that the resolution before the House now and the one passed in 1959 were essentially the same.**

**It was moved that the House of Delegates reaffirm the position of the Hawaii Medical Association in accordance with Resolution #7 passed in 1959. There was no second to the motion.**

**It was moved that the House of Delegates confirm as its policy of action what the House of Delegates in 1959 passed regarding fluoridation. The motion was seconded and passed.**

### RESOLUTION NO. 4

Re: Relationship between cigarette smoking, lung, cancer, and coronary artery disease

WHEREAS, The Hawaii Medical Association represents the medical profession of the State of Hawaii: and

WHEREAS, This association is aware of its responsibility to the citizens of the State of Hawaii; and

WHEREAS, There is mounting evidence of a direct causal relationship between cigarette smoking and lung cancer; and

WHEREAS, There is a strong statistical association between cigarette smoking and illness and death from coronary artery disease; and

WHEREAS, There has been an alarming increase in the incidence and mortality of lung cancer in men of over 100 per cent during the past ten years; and

WHEREAS, Death rates from coronary artery disease in middle aged men are from 50 to 150 per cent higher among heavy cigarette smokers than among those who do not smoke; now therefore be it

*Resolved,* That the Hawaii Medical Association, aware as it is of its duty to alert the citizens of Hawaii to public health hazards, wishes to acknowledge the causal relationship between cigarette smoking and lung cancer, and the strong statistical association between heavy cigarette smoking and coronary artery disease; and be it further

*Resolved,* That this association wishes to encourage dissemination of information to the public regarding the relationship of cigarette smoking to these two serious health hazards.

*Resolution No. 4*

Committee recommends acceptance and approval of Resolution #4 on the Relationship between Cigarette Smoking, Lung Cancer, and Coronary Artery Disease.

**ACTION:**

**The Chairman noted that the resolution was not signed. The President ruled that the resolution was not in order because it was submitted on the floor by someone not legally constituted to do so and it was therefore to be considered not introduced. Thereupon Dr. Hartwell introduced the resolution and moved that it be adopted with the change of the word "casual" to "causal" in the first resolved. The possible conflict with the statement made by Dr. Macdonald at the scientific session was noted. The Chairman of the Reference Committee said his committee felt there was a tremendous amount of evidence produced throughout the nation.**

**The President asked if the members of the House had any objections to introducing the resolution at this time. There being none, the resolution was put to a vote and was adopted.**

The Chairman stated that he would like to acknowledge the effort put in by the committees and the fact that the Reference Committee had accepted the reports without comment did not mean they did not appreciate the fine work that had been done.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## BYLAWS AND PARLIAMENTARY REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your reference committee on Bylaws and Parliamentary Affairs gave careful consideration to the matters referred to it and makes the following report:

### ARRANGEMENTS COMMITTEE

This committee met early in the year and also had other meetings. One meeting with representatives of the exhibitors group was extremely fruitful in satisfying their needs and desires in planning the exhibits.

The Banquet Subcommittee has chosen the Oahu Country Club for the dinner and dance. The price will include music, entertainment, and refreshments. The Golf Subcommittee has again arranged to play at both Oahu and Waialae Country Clubs and is pleased to note the cooperation of these clubs. Also we are happy to announce the deficit from previous years has been wiped out. The golf fees will include breakfast, green fees, and a contribution to the Fund. Because of the increased costs, the fee had to be increased to $12.50.

The exhibit area has been oversubscribed and the committee wishes to thank all those involved in this endeavor.

The Committee recommends that in the future we do not solicit golf prizes from the various donors, but will accept them if they are offered.

Finally, the chairman wishes to thank the members of this committee and the Executive Secretary who have given so much of their time in helping arrange the meeting.

R. VARIAN SLOAN, M.D.

*Arrangements Committee*

The Committee recommends that any speciality society which is planning a meeting that may conflict with the annual meeting of the HMA clear this date with the Arrangements Committee in advance. The Committee feels that a conflict of meeting dates involving doctors is bad for both programs when the meetings are concurrent.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

### AWARDS COMMITTEE

This committee met on one occasion and at that time selected a member to receive the annual Robins Community Service Award. It noted that the Robins Company does not wish to be associated with the presentation of this award and suggested that the Association might want to consider having the Governor make the presentation. The committee voted to present a special award to the Association's senior member. The selection of an appreciation plaque for the President was considered by this committee. The committee felt that it would be appropriate to give special commendation to the physicians who have participated in the Kokua Samoa project. No nomination was made for the President's annual award for contributions in the field of employment of the handicapped.

After departure of the committee's chairman, Dr. A. V. Molyneux, a request was received from the Oahu Health Council to make a nomination for their annual service award. As acting chairman I requested that the committee members be circulated and asked to submit names for this award. No names were submitted and no nominations were made.

I believe that the House of Delegates should set forth criteria for the selection of recipients for awards that are given regularly to the members of this Association and instruct the Awards Committee when it is called upon to make nominations for awards not confined to physicians, whether or not lay nominees should be considered.

ROBERT Y. KATSUKI, M.D.

*Awards Committee*

It is recommended that the Awards Committee set forth the criteria for the selection of respective awards that are given regularly by the members of this Association and that these awards be confined strictly to physicians.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## HAWAII MEDICAL PRACTICE ACT REVIEW COMMITTEE

At the present time no changes in the present Medical Practice Act are being planned by this ad hoc committee. However, as the present Legislative Session continues, we are certain that problems relating to our Medical Practice Act will come up. We will handle these problems as they occur.

B. ALLEN RICHARDSON, M.D.

*Hawaii Medical Practice Act Review Committee*

The Committee recommends that this Committee be disbanded and its function be assumed by the Legislative Committee.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## PERSONNEL COMMITTEE

The Personnel Committee met on September 25, 1962, to set staff salaries and policies for 1962 and 1963. These recommendations were subsequently approved by the Council.

A. V. MOLYNEUX, M.D. (in absentia)

*Personnel Committee*

The Committee recommends that the Personnel Committee be abolished and its functions be assumed by the Council and Treasurer.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## BYLAWS AND PARLIAMENTARY COMMITTEE

This committee met once during the year and completed the business at hand.

The committee recommends:

1. The Maternal and Infant Mortality Study Committee be permitted to change its name to "The Maternal and Perinatal Mortality Study Committee."
2. The Radium Committee be renamed the "Committee on Radiation" as per its request.
3. The functions of the Federal Medical Services Committee be assumed by the Medical Care Plans and Fees Committee, the latter to become a regular standing committee.
4. That no delegate be seated as a delegate *pro tem;* that such seating is contrary to the bylaws; that if the provisions in the bylaws with respect to delegates are followed carefully by component county societies, the need for such "last minute" procedure would be obviated.
5. That the fiscal year be changed to the first of a month immediately or soon to follow the Annual Meeting, the exact date to be recommended by the Treasurer.
6. That the right of component societies to waive county society dues does not bind either the HMA or the AMA to do the same. The Committee has gone on record to point out that membership in the AMA, and in its constituent state associations, is possible only by way of joining a county medical society. Conversely, one who joins a county medical society is automatically a member of his state medical association, and the AMA. The dues he pays as a county society member includes a portion assigned to HMA and a portion assigned to AMA. Once he has accepted membership in HCMS, and has been accepted upon the payment of the fees, he has no further personal right to determine how the dues money is spent; he has only one vote, although he is free to influence other voters toward a decision of the majority.
7. That all permanent committees of HMA be given the status of "Standing Committees, which are to serve in an advisory capacity to the State Health Department or other agency or person, when called upon to do so by the President or House of Delegates;" that the bylaws be amended to reflect this recommendation.
8. A letter from the Secretary relative to the Chapter on assessments was received after the committee met.

J. I. FREDERICK REPPUN, M.D.

*Bylaws and Parliamentary Committee*

The Committee concurs with the first two recommendations of the Bylaws and Parliamentary Committee and recommends that they be adopted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

The Committee does not concur with the third recommendation in this report and recommends that the Federal Medical Service Committee be maintained as a separate independent committee and not be placed under the Medical Care Plans and Fees Committee.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

This Committee recommends that the fiscal year be changed to begin on July 1 and end June 30 of the next year. We also suggest that the officers elected at the Annual Meeting take office at the beginning of the fiscal year. In this regard, however, as it is a major change in policy, we would like to refer this matter to the Bylaws and Parliamentary Committee for consideration during this next year.

The Chairman explained that the Reference Committee felt that if a man was elected at the annual meeting, he would have about six weeks to get his feet wet and this would include a trip to the AMA. When he took office he would be completely ready to move. This would give the incoming president time to form his committees. The Reference Committee meant to imply that this be voted on at the next House of Delegates Meeting.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

The Committee wishes to add to point number 7 of the Report that an amendment to Chapter 8, Section 3 of the Bylaws be passed as follows: The President shall appoint all committees of the Association and designate the chairman, except the Nominating Committee. The Nominating Committee shall consist of five members elected annually by the House of Delegates. The Nominating Committee shall select its own chairman. A list of all committees shall be circulated to the membership.

The Chairman explained that the Reference Committee meant by the "House of Delegates" that at least three members be members of the House of Delegates. Dr. West asked if this were a recommendation to the Bylaws and Parliamentary Committee that this change be made. Dr. Mason said that this was an amendment to an

amendment and was for action at this session. Dr. West asked for a point of order.

A recess was called to discuss the point of order.

The meeting was again called to order. The question arose when the proposed change would become effective if adopted. Dr. West noted that there was no provision that the neighbor islands be represented. He noted that this usurps one of the few prerogatives left to the president and suggested that three members be elected and two be appointed by the president.

Dr. Hartwell said this change was originally proposed after referral to Roberts Rules of Order which states that the President should not have this power.

**ACTION:**

**The Chairman moved adoption of this portion of the report. The motion was amended to read that "The President shall appoint all committees of the Association and designate the chairman, except the Nominating Committee. The Nominating Committee shall consist of eight members elected annually by the House of Delegates; five members to be from Honolulu County, and one member from each of the other counties."**

**The motion as amended was passed.**

The Committee would like to comment on point number 8, and suggest that the matter of assessments, the age of life members, etc., be referred back to the Bylaws and Parliamentary Committee.

The Chairman read the letter from the Secretary to the Bylaws Committee.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

This Committee recommends a point number 9; that the House of Delegates direct the Council to meet at least quarterly during each year and that the President, at his discretion, may cancel not more than two of these meetings after consultation with the Council, and that this matter be referred to the Bylaws and Parliamentary Committee to incorporate this in the Bylaws.

**ACTION:**

**The Chairman moved adoption of this portion of the report. Dr. Burden spoke to this point. A motion to amend the report by changing the words "not more than two" to "not more than one" was not seconded.**

**This portion of the report was adopted.**

## LEGISLATIVE COMMITTEE

The Legislative Committee has been meeting weekly for the past several months, preceding and during the legislative session. The Committee augmented the regular Hawaii Medical Association staff by engaging an attorney, Edwin H. Honda, and a clerk.

Coincident with engagement of a staff, legislation to be proposed or supported was collected, discussed, and sorted out. Highest priority went to legislation aimed at encouraging and supporting study committees by making their findings immune to subpoena. This was spearheaded by Dr. George Goto.

The third phase consisted of activity directly relating to the Legislature, such as collection and analysis of bills, discussion of attitude toward these bills, and subsequent instructions to Mr. Honda as to whether to push, ignore, or oppose. There were many appearances before committees by various physicians and by Mr. Honda. Mr. Honda spent much time, often twelve hours a day, attending hearings, being in and about activities, and talking with legislators personally. A party for legislators was held at Queen's Surf early in the session.

Despite the excellent work of many doctors as individuals during the election, the Medical Association as a whole did an outstandingly bad job of establishing relations with legislators during the the election campaign. In spite of this, relations with legislators have been better during this session than ever before. We have found the legislators on the whole to be astute. There have inevitably been some fundamental disagreements but they were kept within the bounds of reasonable discussion.

It is impossible to convey to the general membership an understanding arising from hundreds of hours of discussion. Nevertheless, the Committee strove to keep the membership informed by means of a weekly bulletin during the session.

Comments and suggestions were invited weekly, and some of the members responded. Those who showed unusual interest and willingness were encouraged to more fully explore some issues, with the result that some members did yeoman service in developing legislative projects and actively supporting them in appearances before committees. Dr. John Chalmers, for instance, spent a great deal of time and effort working on bills relating to pharmacies. Dr. George Goto likewise shepherded and spearheaded the study committee records protection bill. Dr. Scott Brainard followed the professional incorporation legislation, and Dr. Mary Glover took an interest in industrial accident compensation. Drs. Theodore Tomita, George H. Mills, and Fred Shepard spent many hours in discussing the University's health services budget with various legislators. Dr. Shoyei Yamauchi worked diligently in an effort to get the Commission on Aging put on a permanent basis. These individuals are mentioned only to emphasize the importance of individual interest and activity in conjunction with the Committee.

*HAMPAC:* The attitude of the members toward the Political Action Committee is characterized by apathy and lethargy. We conclude that it is not possible to get more than a small percentage of doctors (ten per cent so far) to join, even though Congress and the local Legislature repeatedly come close to passing bills which will have a major effect on every member of the Association. Hawaii's doctors have contributed to AMPAC an average of 23 cents each. (In some states each doctor contributed over 40 times as much.) HAMPAC is just as poorly supported. Since these political committees are our only means of developing credit and good relations with candidates before election, the delegates are requested to recommend a means to cure this severe defect.

*Fluoridation:* The Committee would like to suggest that the House of Delegates reexamine the 1959 resolution which gives blanket approval of fluoridation of water supplies. Extensive discussion within the Committee has brought out the fact that there is some opposition to fluoridation within the membership of the Association. Therefore, it is suggested that the House of Delegates reexamine its stand.

*Suggestions for next year's program:*

1. Mr. Edwin Honda has done much to improve our relations with the Legislature. He is quiet and uses a soft sell. His presentations have been with dignity.We feel that the result has been even more than we could expect considering the atmosphere during the election. The intricacies of medical practice and the interrelationships of committees of the Association, the county societies, the hospitals, and the government are such that it takes someone outside the medical field considerable time to begin to feel at home in understanding these relationships. Mr. Honda has amassed much information, but is only just now beginning to understand some of the relationships and problems. Therefore, it is suggested that arrangements with Mr. Honda be renewed for 1964.

2. Unless physicians are to surrender completely, it is inevitable that the present legislative program must be continued and perhaps enlarged. In the present political climate, which will not change in the foreseeable future, legislative activity must be put on a permanent continuing basis. Therefore, it is recommended that funds for this Committee be incorporated into the regular Association

dues, even if such dues must be increased by the amount of the present legislative assessment. There may be some doubt concerning the tax deductibility of special assessments. Also, the very nature of an assessment implies that it is temporary. Incorporation into the dues would resolve these problems.

3. The party for the legislators served a useful purpose. It gave an opportunity for personal acquaintance and individual discussion. It is suggested that the party be repeated in 1964, and in that connection there are two recommendations: A. Set the date very early in the session. We thought we were having it early this year, but even so, many of the legislators were already too busy to attend. Also, it was somewhat of an anticlimax, coming right after the Governor's formal party. B. Start months in advance to prepare a program. Perhaps various doctors could be persuaded to prepare in advance a little show consisting of singing by various doctors, a doctors' orchestra, and perhaps some politically oriented skits.

An alternate suggestion is to discontinue the party and institute instead a continuing program of informal entertainment, such as luncheons.

4. During the 1963 session, we found that we had common interests with the hospitals on a number of issues. Correlation between physicians and hospitals was fairly good because of innumerable telephone calls between the Chairman and Mr. Honda and Mr. Kiefer of the Hospital Association. Actually, it would have been easier and smoother if Mr. Kiefer had been an unofficial member of our Legislative Committee. This might be considered for 1964.

5. Vitalize the Hawaii Medical Political Action Committee so as to establish relations with legislators before election. It has been repeatedly called to our attention that it is those who help with elections who get attention. This Association, as such, however, cannot enter into election activity. It has to be left up to HAMPAC or to individual doctors. Both are good, but they have proven entirely inadequate for our purpose. A way must be found to make every physician become a member of HAMPAC. In spite of every attempt before and during the 1962 campaign on a voluntary basis, support of HAMPAC was so weak as to leave it almost totally functionless.

*Recommendations which require action by the House of Delegates:*

1. Incorporate the former special assessment into the dues, and raise them accordingly, so as to make legislative funds permanent.
2. Require compulsory membership in HAMPAC for the reasons outlined above. HAMPAC is well set up at present. It simply needs money and the strength and interest wide membership would give it, in order to forestall unfavorable outside control.
3. Recommend to all hospitals that they immediately appoint a physicians' committee to control drug purchase and distribution.
4. A number of times advice from an attorney concerning matters not within Mr. Honda's responsibilities has been needed. The HMA is probably the only state medical society that does not have an attorney on retainer and it is suggested that a provision be made in the budget to cover the cost of engaging legal counsel.
5. Recommend to all hospitals that they review their procedures for granting staff privileges and offer to work with them on this project.

P. H. Liljestrand, M.D.

*Legislative Committee*

The Committee approves of suggestion No. 1 that arrangements with Mr. Edwin Honda be renewed for 1964.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

Regarding the recommendations of the Legislative Committee, the Committee approves Recommendation No. 1 and suggests that the dues collected for this purpose be earmarked and labeled "Funds for Public Relations and Education."

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

Regarding Recommendation No. 2, the Committee is not in favor of compulsory membership in HAMPAC.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

We approve Recommendations 3 and 5.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

No. 4. The Committee has some hesitation in recommending employing an attorney on a retainer basis because of the exorbitant cost, but suggests that we obtain an attorney's services, when needed.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## SCIENTIFIC PROGRAM COMMITTEE

The Scientific Program Committee met on six occasions to develop a program on Cancer for the 1963 meeting of HMA. The subject was covered in categories of epidemiology, etiology, pathology, detection, and therapy. Guest speakers included Drs. Emerson Day, James P. Cooney, Robert W. Miller, Ian MacDonald, and Maurice Tainter. Seven panels were developed drawing freely upon local talent. Much of the hard work was shouldered by coordinators, Drs. Doris Jasinski, Grant N. Stemmermann, and Fred I. Gilbert.

We are grateful to the Hawaii Division of the American Cancer Society for their generous assistance in many areas, the most substantial of which is bringing three of the above named guest speakers to Hawaii. A monetary gift of $250 from the Roche Laboratories was also received.

It is not possible to acknowledge individually, all who helped to make the program a success. Some 35 local physicians were involved. To them we extend our heartfelt thanks.

We have not discussed as a committee, suggestions for next year's program, but several are listed:

(1) Viral diseases—Rapid advances in this area have occurred since the development of the roller tube tissue culture method of Weller. This is the area where the agents are being discovered even before their relationship to disease is established.
(2) Orthopedic diseases in Hawaii—If one includes congenital, traumatic, neoplastic, and metabolic diseases, the arthritides (especially gout), prosthesis and rehabilitation, an interesting seminar can be formulated.
(3) Diseases caused by physical agents—In this modern era of accelerated motion, with exploration of outer space and depths of oceans, diseases resulting may assume increased importance. Radiation diseases, electrical, gas, poisons, and perhaps most important, trauma, can be included in the discussions.

Paul Y. Tamura, M.D.

*Scientific Program Report*

The Committee recommends the report and wishes to compliment the scientific program for their excellent work.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## AMA-ERF COMMITTEE

The Hawaii AMA Research and Education Foundation committee has had no meeting during the past six months because this committee consists of only one member, myself.

The committee responsibility was wished on me in September, 1962, when Dr. Tilden, the past committee chairman was about to go on an extended mainland trip for his vacation.

Since then, the national headquarters of the AMA Research and Education Foundation has sent through Dr. Tilden lists of contributors to the Fund. According to these lists, during 1962 (from January 1 to December 31), 195 members of the Hawaii Medical Association have contributed $5,828.98 and the Woman's Auxiliary has added $372.50.

Early in December, 1962, I suggested to Miss McCaslin that a letter to each member may stimulate interest in the Fund. Miss McCaslin informed me that in all probability the AMA would be sending such a letter and her prediction was correct. The response was, however, far from encouraging.

KIYOSHI INOUYE, M.D.

*The AMA-ERF Committee Report*

The Committee wishes to thank Dr. Inouye for his work and would urge all members to financially support the Research and Education Foundation of the American Medical Association.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## HAWAII MEDICAL JOURNAL

The average size of each issue of your HAWAII MEDICAL JOURNAL has dropped for the third year in succession, this time to 92 pages—48 of advertisements, 44 of text. This ratio of advertising to text pages is a little misleading, because of the very large (and subsidized) special issue on Graduate Medical Education in Honolulu (the Michael-Uhl Report). Following is a tabulation of the average distribution of pages per issue for the past four years:

| | 1959-60 | 1960-61 | 1961-62 | 1962-63 |
|---|---|---|---|---|
| Scientific | 17 | 19 | 17 | 19 |
| Features | 24 | 17 | 24 | 23 |
| Technologists | 2 | 2 | 2 | 2 |
| Advertisements | 80 | 60 | 53 | 48 |
| Total | 130 | 104 | 100 | 92 |

The JOURNAL now goes to 824 paying subscribers: 591 member physicians, 77 medical technologists, and 156 miscellaneous. Advertisers receive 118 free copies, publishers 28, and miscellaneous persons 42; 186 copies go out for exchange with journals the Hawaii Medical Library wants. The fact that we do not charge the Library (at cost) for these exchange copies represents a substantial subsidy to the Library, even more than does our gift to them of 180 review copies of new medical books during the past year. The House of Delegates should at least be aware that this subsidy is being made, and it should be charged against the Association, not against the cost of publishing the JOURNAL, as it now is. So should the cost of the 30+ pages required for the annual meeting transactions.

The new feature, "Reports on Poisoning," has been published rather irregularly, because material has not been submitted. "Reports & Snorts" has been continued. So has "In Memoriam"—now having reached 43 installments and still going strong.

A two-page section for which copy is supplied by the Hawaii Society of Medical Technologists has been continued during the past year. One page in each of the last three issues has been allotted to the Hawaii Academy of General Practice, the copy being supplied by their Secretary, Dr. J. I. F. Reppun. No holds are barred.

Reviews of 49 new medical books, and capsule comments on 131, were published during the year, a more economical ratio than the 79/68 of the previous year.

The average space allotment for original scientific articles in the past six issues remained at 17 pages, except for the special report already mentioned, which raised the average for the year to 19.

The JOURNAL's actual income has been $4,550 from subscriptions and sales, and $22,000 from advertisements, nearly $3,000 less than the year before. The JOURNAL's "real" expenses—those we would be relieved of if we didn't publish it—totalled $22,880: a net "real" profit of $3,670. Subtracting prorated expenses of the Association's operations from this, as shown in the Treasurer's Report, leaves the JOURNAL with a net *paper* loss of $3,990.

We recommend the continued publication of the HAWAII MEDICAL JOURNAL. It is further recommended that (1) The cost of exchange subscriptions be charged to the Association, as a Library subsidy. (2) The value of books received for review be credited to the JOURNAL. (3) The cost of JOURNAL pages used to report Association affairs be charged to the Association and not to the cost of publishing the JOURNAL.

HARRY L. ARNOLD, JR., M.D.

*Hawaii Medical Journal*

The Committee accepts this report but recommends omitting the last sentence of the second paragraph and the last sentence of the report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## TREASURER'S REPORT

The figures presented in this report have been approved by the Council but have not been audited. The auditors are in the process of reviewing the books at the time this report is being written, but in order for the report to be in the hands of the delegates before the annual meeting, the written report will have to be submitted before the audited figures become available. The difficulties over the past years in getting the auditors to go over the books early in the year have not improved. Mr. Hough has faithfully performed the audit for many years and the Association is indebted to his personal concern for its well-being and the many extra duties he has performed on our behalf. However, it is my recommendation that since his staff is unable to perform the audit at the appropriate time, that a new firm be engaged for the next audit.

The recommendation of the Bylaws & Parliamentary Committee that there be a change in the fiscal year is concurred in. It is my recommendation that the fiscal year be changed to from July 1 to June 30, and that this be effective in 1963. Further it is recommended that the dues year remain unchanged. Inasmuch as a change in the fiscal year will have to receive approval of government agencies, it is recommended that the action of the delegates take this into consideration. A fiscal year that begins after the annual meeting will permit the House of Delegates to determine which requests for funds can be granted within the budget they set. It also gives the new officers responsibility for the greatest portion of the year's financial activities.

For the past several years the bookkeeping has been handled by an outside firm. Mr. Ajifu is a public accountant and his services have been excellent. The delay in his getting the monthly accounts in order has not been in the best interests of the Association. This delay has been due to a late audit and not the fault of the accountant. Since the auditors have not gone over the 1962 figures, Mr. Ajifu has been unable to make reports on this year's finan-

cial transactions. This is a highly unsatisfactory arrangement. I recommend that the Association confer with the Honolulu County Medical Society to see if some arrangement can be worked out whereby their full-time bookkeeper can also take over the Association books. The County has recently taken over the Hawaii Medical Library bookkeeping. In recommending the County arrangement, I feel that this should include the accounts payable and accounts receivable, which are not now done by Mr. Ajifu. They need not take over the posting of dues and assessments to the individual ledger. It is advantageous to have one person in charge of all phases of the accounting and that this person be a full-time bookkeeper. It has not been practical to try to employ someone who has other duties and devotes only part of his time to the books. The salary of a competent bookkeeper would make it impossible for the Association to employ a bookkeeper under present budget restrictions, even though the services might be divided.

If the budget proposed for the full calendar year is adopted for a six-month period and a new budget is proposed for the new fiscal year beginning July 1, the Association's funds will be depleted before 1964 dues are collected and no expansion of programs can be considered. There will be no money for an active legislative program. I do not feel that money to be used in legislative work should be raised by assessment, but rather should be a part of the dues.

The Council authorized an appropriation of $8,000 to conduct the fee survey. In order to retain the funds already committed for the expansion of the Mabel Smyth Building, an assessment of $15.00 a member is hereby recommended to make up this deficit.

The budget has not included any appropriation for the contemplated move of the executive offices. Upon completion of the Hawaii Medical Library building, additional space will be made available to the Association at an increase in the monthly rent and maintenance fee. There will have to be additional capital outlay for furniture and fixtures in the larger offices. The Mabel Smyth has under consideration a plan to offer telephone services to its occupants. Even if this plan does not materialize, a more satisfactory telephone system will have to be worked out for both the County and State offices and this will increase the monthly telephone bills.

In order to give consideration to the Association's future, I recommend that in place of the usual Council meeting an interim session of the House of Delegates be called in August, and at that time the dues for the next budget period be set in accordance with the fiscal appropriations the House of Delegates decides to make. If the House agrees with this recommendation, I recommend that the enclosed budget not be acted upon except that expenses against this should be ordered not to exceed 8/12ths of the suggested allotment, except in the instance of funds allotted by assessment (Legislative and Medical Care Plans & Fees Committees).

The work and cost factors in running state medical associations vary with the degree of activity and goals that they set for themselves. These do not vary too much with the size of the society.

The only sources of revenue outside of dues for the Hawaii Medical Association come from the annual meeting and the JOURNAL. Annual meeting income this year should exceed the estimate made in the accompanying budget. At the time this was prepared, there was a lack of interest among the exhibitors and it was thought that we would not have our full quota. Since that time it appears that we will now have at least 42 exhibitors.

The JOURNAL can no longer be expected to reimburse the Association to the extent it has in the past and we are fortunate that it is not running a deficit. It is understood that the Indiana journal ran $17,000 in the red this past year and the Washington (D.C.) annals had to be subsidized to the extent of $20,000. Similar circumstances surround other medical journals.

The JOURNAL's expenses in publishing Association proceedings have increased considerably.

The General Fund as of December 31, 1962, subject to possible change by the auditor, was $34,783.02, which included cash on hand, cash in the bank, inventory, liabilities, furniture, etc. This represents a net decrease of $1,845.34 over the amount reported December 31, 1961. There were several transfers in the savings and loan accounts to avoid carrying in any one account more than the amount that can be Federally insured. A portion of the money received for dues early in the year was transferred from the checking account to savings and loan accounts in order to accrue interest during the first part of the year when it was not needed for operating expenses.

Mr. Ajifu adopted a new system in reporting salaries charged to miscellaneous committees. These have been charged to both the committee and the salary accounts and debited as a reimbursable item ($636.71), which makes it appear that the salary account was far in excess of the budget.

The Physicians' Benevolent Fund continues to grow. Two new savings and loan accounts have been opened for this fund, one on Maui. I recommend that we continue to transfer money to this fund as collected and that it be distributed in the various savings and loan accounts undisturbed throughout 1963.

A change in prorating the salary of the casual help chargeable to the JOURNAL was approved by the Council, from one-half to one-sixth.

The following budget was approved by the Council at its February 13, 1963, meeting:

BUDGET FOR 1963

| | 1962 BUDGET | 1962 TOTALS | 1963 BUDGET |
|---|---|---|---|
| INCOME: | | | |
| Dues | $34,260.00 | $33,847.50 | $34,820.00 |
| JOURNAL (See Schedule I) | 30.00 | (3,206.28) | (3,220.00) |
| Annual Meeting (See Schedule II) | 4,460.00 | 2.967.48 | 4.980.00 |
| Interest | 1,500.00 | 1,622.72 | 1,600.00 |
| Miscellaneous | 600.00 | 713.38 | 700.00 |
| Legislative assessment | — | — | 12,760.00 |
| Total Income | $40,850.00 | $35,944.80 | $51,640.00 |
| EXPENSES: | | | |
| AMA Convention | $ 3.120.00 | $ 2.708.75 | $ 3,260.00 |
| Audit and accounting | 1,280.00 | 1,235.00 | 1,580.00 |
| Auto allowances | 600.00 | 600.00 | 600.00 |
| Committees (Schedules indicated) | | | |
| Legislative committee (IV) | 3,500.00 | 3,423.77 | 12.800.00 |
| Mental Health committee (V) | — | — | 200.00 |
| Health Education committee (VI) | 650.00 | 496.13 | 1,950.00 |
| Careers committee (VII) | — | — | 370.00 |
| Diabetes committee (VIII) | — | — | 340.00 |
| Public Relations committee (III) | 10,000.00 | 9,498.01 | 7,270.00 |
| Medical Care Plans and Fees (IX) | — | — | — |
| Council expenses | | | |
| Travel | 500.00 | 237.00 | 500.00 |
| Meals and room | 200.00 | 147.48 | 250.00 |
| Per diem | 320.00 | 140.00 | 320.00 |
| Donations | 330.00 | 325.00 | 150.00 |
| Entertainment | 300.00 | 107.41 | 400.00 |
| Insurance | 150.00 | 153.15 | 200.00 |
| Library | 100.00 | 100.00 | 100.00 |
| Miscellaneous | 600.00 | 163.03 | 600.00 |
| Postage | 800.00 | 805.32 | 900.00 |
| President's contingency fund | 1,500.00 | 145.75 | 750.00 |
| Rent | 1,850.00 | 1,848.00 | 1,850.00 |
| Repairs and maintenance | 150.00 | 8.28 | 150.00 |
| Salaries | 14,770.00 | 16,269.25 | 16,680.00 |
| Stationery, printing and supplies | 1,400.00 | 1,191.06 | 1,400.00 |
| Subscriptions and dues | 360.00 | 505.00 | 520.00 |
| Taxes (S.S. and U.C.) | 350.00 | 340.09 | 380.00 |
| Telephone and cable | 1,000.00 | 1,155.15 | 1,250.00 |
| Travel | 350.00 | 598.24 | 150.00 |
| Woman's Auxiliary expense | 2,850.00 | 2,796.25 | 2,900.00 |
| Special authorized expenses | — | 367,65 | — |
| Furniture and fixtures | 1,000.00 | 1,105.33 | 750.00 |
| Total Expenses | $48,030.00 | $46,471.00 | $58,570.00 |
| LESS: reimbursed JOURNAL expenses | $ 7,180.00 | $ 6,938.82 | $ 6,890.00 |
| Less reimbursed salaries from other activities | — | 636.71 | — |
| EXCESS OF EXPENSES OVER INCOME | — | ($ 2,950.00) | ($ 40.00) |

## Budget Report on Hawaii Medical Journal
### Schedule I

| | 1962 Budget | 1962 Actual | 1963 Budget |
|---|---|---|---|
| **Income:** | | | |
| Advertising—National | $23,730.00 | $22,483.23 | $17,000.00 |
| Local | | | 5,000.00 |
| Sales and subscriptions— | | | |
| Members | 4,300.00 | 4,538.25 | 3,540.00 |
| Nonmembers | | | 1,010.00 |
| Total Income | $28,030.00 | $27,021.48 | $26,550.00 |
| **Expenses:** | | | |
| Automobile allowances | $ 300.00 | $ 300.00 | $ 300.00 |
| Commissions paid | 860.00 | 875.42 | 900.00 |
| Discounts allowed | 2,530.00 | 2,834.95 | 2,800.00 |
| Miscellaneous | 100.00 | 44.77 | 100.00 |
| Postage | 170.00 | 292.77 | 400.00 |
| Printing | 17,000.00 | 18,812.27 | 18,500.00 |
| Rent | 930.00 | 924.00 | 930.00 |
| Salaries | 5,300.00 | 5,357.11 | 5,250.00 |
| Stationery and supplies | 150.00 | 402.10 | 150.00 |
| Telephone and cables | 480.00 | 242.66 | 260.00 |
| Taxes | 150.00 | 117.71 | 150.00 |
| Copyrights | 30.00 | 24.00 | 30.00 |
| Total Expenses | $28,000.00 | $30,227.76 | $29,770.00 |
| **Excess of Income (or Expenses) Over** | $ 30.00 | ($ 3,206.28) | ($ 3,220.00) |

## Budget Report on Annual Meeting
### Schedule II

| | 1962 Budget | 1962 Actual | 1963 Budget |
|---|---|---|---|
| *Registration* | | | |
| Income | | $2,280.00 | $3,750.00 |
| Expenses: | | | |
| Telephone | | | $ 30.00 |
| Badges | | | 50.00 |
| Hotel, room, meals, and entertainment | | $ 219.32 | 100.00 |
| Printing | | 450.89 | 450.00 |
| Stationery and supplies | | 28.39 | 150.00 |
| Travel | | 100.74 | — |
| Wages | | 143.26 | 170.00 |
| Miscellaneous | | 80.74 | 50.00 |
| Total Expenses | | $1,023.34 | $1,000.00 |
| Excess of Income Over Expenses | $1,340.00 | $1,256.66 | $2,750.00 |
| *Banquet* | | | |
| Income | | $1,162.50 | $1,200.00 |
| Expenses: | | | |
| Miscellaneous | | | $ 100.00 |
| Music | | | 200.00 |
| Liquor | | | 100.00 |
| Dinner | | $1,185.00 | 750.00 |
| Leis | | 52.00 | 50.00 |
| Total Expenses | | $1,237.00 | $1,200.00 |
| Excess of Expenses Over Income | | $ 74.50 | — |
| *Breakfasts* | | | |
| Income | | $ 406.00 | $ 450.00 |
| Expenses: | | | |
| Catering | | $ 325.50 | $ 450.00 |
| Excess of Income Over Expenses | | $ 80.50 | — |
| *Dinner* | | | |
| Income | | $ 581.00 | — |
| Expenses: | | | |
| Dinner for 178 hosts | | $ 489.50 | — |
| Excess of Income Over Expenses | | $ 91.50 | |
| *Picnic* | | | |
| Income | | $ 336.00 | $ 350.00 |
| Expenses: | | | |
| Miscellaneous | | | $ 50.00 |
| Lunches for 95 members | | $ 285.00 | 270.00 |
| Beer | | 29.25 | 30.00 |
| Total Expenses | | $ 314.25 | $ 350.00 |
| Excess of Income Over Expenses | | $ 21.75 | — |
| *Exhibitors* | | | |
| Income | | $3,000.00 | $3,500.00 |
| Expenses: | | | |
| Signs | | | $ 100.00 |
| Rental of booths (Sheraton-Hawaii) | | $ 350.00 | 1,115.00 |
| Hauling booths and hiring trucks | | 325.25 | — |
| Electrical wiring of booths | | 325.00 | — |
| Rental of meeting hall | | 303.78 | — |
| Miscellaneous | | 104.40 | 55.00 |
| Total Expenses | | $1,408.43 | $1,270.00 |
| Excess of Income Over Expenses | $3,120.00 | $1,591.57 | $2,230.00 |
| Net Income | $4,460.00 | $2,967.48 | $4,980.00 |

## Public Relations Budget
### Schedule III

| | 1962 Budget | 1962 Actual | 1963 Budget |
|---|---|---|---|
| **Income:** | | | |
| Assessment | — | $ 115.00 | — |
| **Expenses:** | | | |
| Advertising—radio program | $ 1,200.00 | $2,008.94 | $ — |
| Advertising—newspaper, etc. | — | 562.49 | 500.00 |
| Conference expense | 560.00 | 522.50 | 480.00 |
| Counsel fee—Hugh Lytle | 6,000.00 | 6,000.00 | 4,800.00 |
| Dues to MSEA | 10.00 | 10.00 | 10.00 |
| Miscellaneous | 2,130.00 | 293.84 | 150.00 |
| Postage | — | 36.00 | — |
| Stationery, printing and supplies | — | 55.98 | — |
| Travel | 100.00 | 123.26 | 150.00 |
| Television time for special events | | | 1,200.00 |
| Medical message of the month | | | 360.00 |
| Photo section costs | | | 90.00 |
| Total Expenses | $10,000.00 | $9,613.01 | $7,740.00 |
| **Excess of Expenses Over Income** | $10,000.00 | $9,498.01 | $7,740.00 |

## Legislative Budget
### Schedule IV

| | 1962 Budget | 1962 Actual | 1963 Budget |
|---|---|---|---|
| **Income:** | | | |
| Assessment—580 members at $22 | — | — | $12,760.00 |
| **Expenses:** | | | |
| Legislative Counsel | | | $ 6,000.00 |
| Extended session | | | 1,000.00 |
| Public Relations Counsel | | | 1,200.00 |
| Dinner | | | 750.00 |
| Mailings | | | 650.00 |
| Miscellaneous entertainment | | | 1,000.00 |
| Miscellaneous expenditures | | | 750.00 |
| TODAY'S HEALTH subscriptions | | | 150.00 |
| Clerical help | | | 1,200.00 |
| Unassigned | | | 100.00 |
| Total Expenses | $3,500.00 | $3,423.77 | $12,800.00 |
| **Excess of Expenses Over Income** | $3,500.00 | $3,423.77 | ($ 40.00) |

## Mental Health Budget
### Schedule V

| | 1962 Budget | 1962 Actual | 1963 Budget |
|---|---|---|---|
| **Income:** | | | |
| Registrations | — | — | $ 100.00 |
| **Expenses:** | | | |
| Stationery, supplies and postage | | | $ 100.00 |
| Meals and leis for guests | | | 100.00 |
| Printing | | | 100.00 |
| Total Expenses | — | — | $ 300.00 |
| **Excess of Expenses Over Income** | — | — | $ 200.00 |

## Health Education Budget
### Schedule VI

| | 1962 Budget | 1962 Actual | 1963 Budget |
|---|---|---|---|
| **Income** | — | — | — |
| **Expenses:** | | | |
| Moderator | | | $1,040.00 |
| Taxes | | | 40.00 |
| Sunday ads | | | 570.00 |
| Daily ads | | | 200.00 |
| Miscellaneous | | | 100.00 |
| **Excess of Expenses Over Income** | $650.00 | $496.13 | $1,950.00 |

## Careers Committee Budget
### Schedule VII

| | 1963 Budget |
|---|---|
| **Income** | — |
| **Expenses:** | |
| Printing | $370.00 |
| Miscellaneous | $270.00 |
| **Excess of Expenses Over Income** | 100.00 |

Diabetes Budget
Schedule VIII

| | 1963 Budget |
|---|---|
| Income | — |
| Expenses: | |
| Medical technicians | $240.00 |
| Miscellaneous | 100.00 |
| Excess of Expenses Over Income | $340.00 |

Medical Care Plans and Fees Survey Budget
Schedule IX

| | | 1963 Budget |
|---|---|---|
| Income | | — |
| Expenses: | | |
| Travel | | $ 150.00 |
| Bulk mailings (4 at $30) | $ 120.00 | |
| Mailing postcards (375 at 4¢) | 15.00 | |
| Postage on returns (500 at 25¢) | 125.00 | |
| Envelopes | 40.00 | |
| Cost of questionnaires (700 at $1) | 700.00 | 1,000.00 |
| Editing questionnaires (500 at 50¢) | $ 250.00 | |
| Consultation services | 450.00 | |
| Preparation of material for data processing | 350.00 | |
| Interpretation of data | 250.00 | |
| Random sampling in doctors' offices (100 at $10) | 1,000.00 | 2,300.00 |
| Data Processing (500 x 500 at ½¢ for 1st run (1,250)) | $1,250.00 | |
| 500 x 500 at ¼¢ for additional runs (625) | 2,500.00 | 3,750.00 |
| Cost of printing finished RVS (1,000) | | 800.00 |
| Excess of Expenses Over Income | | $8,000.00 |

*Treasurer's Report*

The Committee considered this report at length. We recommend a change in the Auditor.

The Committee has already considered the change of the fiscal year in our report of the Bylaws and Parliamentary Committee.

The Committee recommends that one competent bookkeeper be employed for the HMA and the Honolulu County Medical Society. It is our thought that the Nurses' Association, Library, and Mabel Smyth Building may also employ the same individual.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

Regarding the incorporation of the legislative assessment as part of dues, this has been covered in our report of the Legislative Committee.

**ACTION:**

**The Chairman moved adoption of this portion of the report. Dr. Burden advised that the Legislative Committee wanted to set the assessment at $20, whereas the Committee's chairman felt it should be $22. The Council set the assessment at $22.**

The Committee considered the expenditure for the Fee Survey and approved the assessment.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

The Committee recommends that the telephone service for the Society be improved as follows: either the Physicians Exchange act as a central switchboard, or that we have a separate switchboard with each organization using it contributing to its support.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

Our comments in regard to the Interim Session of the House of Delegates: This has been considered in the report of the Bylaws and Parliamentary Committee and would be taken care of by more frequent meetings of the Council, and it is recommended that this paragraph be deleted from the Treasurer's Report.

**ACTION:**

**The Chairman moved this portion of the report. The purpose of the proposed interim meeting was discussed. The motion was changed to retain the recommendation that there be an interim meeting of the House of Delegates.**

**This portion of the report was adopted as amended.**

## PRESIDENT'S REPORT

The Hawaii Medical Association, with other businesses and organizations, has in recent years reached the period where a change in outlook and a change in philosophy appears to be in keeping with the advancements in our social scheme of things. As these advancements and changes are amounting to a revolution in our way of life, so may the organization and structure of our Association be developed to meet the requirements of these changes as they are taking place.

There is one concept, however, we must keep in mind from the start to the finish—we must have increased concepts of the idea of service to our fellow man so that all steps necessary can be taken to protect the health of our patients. The progress in our capacity to serve depends on our ability to develop new ideas to meet the challenges as they appear. This is an age of ideas. The ideas which catch the public's fancy will be the ideas which lead either to the right or left, or to the center. It is a necessity to develop ideas which will meet the challenges and satisfy these needs. We must adopt the attitude of forceful aggressiveness to develop these activities, not the attitude of crawling in a hole and hoping no one sees us.

There are a number of potentials for the development of programs and plans for community development of medical care. To develop these plans, an efficient, effective business organization is necessary. We are at the present time analyzing the effectiveness of the executive offices so that reorganization may be done to develop this effectiveness to its greatest extent. This, I feel, is one of the first steps to developing the powerful thrust which is needed in our organization. Our committees during the year have been a tremendous success. It is the work of these committees which forms the basis strength of our organization. I want to mention particularly the grand foundation the Mental Health Committee has laid for attack in our State on the mental health problem. The plan has been outlined by the American Medical Association, recommended to Congress by the President of the United States and is being developed here as a cooperative enterprise by the Hawaii Medical Association and the State Board of Health. By developing these as cooperative enterprises, repetitions and conflicts will be avoided.

The Careers Committee has developed a program which is a tremendous success and has received the response and wholehearted enthusiasm of the Association and public. I wish to commend them and hope they will carry on for the future here in Honolulu, as well as help to develop the program for the neighbor islands as well.

The Emergency Medical Service Committee and The Public Relations Committee have also been very effective.

A new committee has been developed which will give assistance to professional organizations who desire to come here to hold conventions of a scientific nature. This committee will also be of assistance to groups of professional organizations here who wish to hold conventions

abroad. This may develop additional income for our Association as it grows. This points up one of the weakest factors in our organization and that is the need for funds. The requirements for consultants and executives are such that increased income is required to pay these consultants and executives. The larger states with their numerous members are able to develop an income which will take care of them. Here, our needs are almost the same but our income is smaller. Every avenue, other than dues, should be explored.

The School Health Committee and Polio Committee have given invaluable service in improving the health of the children and particularly the Polio Committee in its cooperative functioning with the Department of Health, coordinating the polio immunization campaign which was done during the past year.

I hope that the succeeding president will take into consideration the need the unions and businesses have for help in interpreting the medical care plans produced for them by insurance companies. We would be perfoming a service to offer to these organizations, free of charge, the service of consultants so that these organizations would be aware of the basic factors of the plans they are buying. This, I feel, would save considerable misunderstanding of the aims and services of the professional, on the part of insurance companies, unions, and businesses, and would satisfy a need where a vacuum now exists. This could be implemented by a committee to perform such duties.

A sustained effort is necessary to bring a better understanding between the various county medical societies and improve communication by increasing the number of visits by the officers and executive secretaries to various county societies. Joint discussion groups should be developed so that the problems of social and economic interest to all the societies may be explored. I have found a lack of understanding in some of the societies of the basic problems of the Association. This, I feel, is a lack of communication more than anything else. The development of legislative and political activity by the neighbor island societies should continue. They will be playing a more important part in this phase of our Association in years to come.

In discussing and studying the organization of the Association as it is at this time, the problem of officers, particularly that of president, being elected periodically from neighbor islands should be studied. A president who is distant from the executive offices is somewhat remote from the problems that are continually developing. As a result, there is some loss of effectiveness in the administration of the offices of the Association. This weakness can be taken care of in time with the reorganization of the business offices of the Association and with the development of discussion groups to acquaint our members with the broad issues and problems of the Association. At any rate, this requires some discussion and exploration.

In conclusion, my impression is that this has been a successful year for the Hawaii Medical Association. A broad foundation has been laid for all phases of its activities. The work which has gone before by the officers and members in years prior to this have contributed tremendously to what has been done this year. I wish to thank the chairmen of the various committees and the members who have devoted many hours of sincere, conscientious effort and have been repaid by so little except the satisfaction of a job well done. To them I give my sincere aloha.

FREDERICK L. GILES, M.D.

*President's Report*

The Committee approves the report and commends the President, and wishes to call your attention to the first paragraph and to the next to the last paragraph as especially excellent and deserving of your study.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## SECRETARY'S REPORT

The total active membership of the Association, as of December 31, 1962, was 623, an increase of 28 over December 31, 1961. The inactive members, reported through only one county, numbered 25, exclusive of the two members whose status has not yet been clarified, Drs. Donald Brown and Raymond Dusendschon. The inability to clarify the status of these two members is caused by a difference between the HMA and Honolulu County Medical Association bylaws. Letters have been directed to that Society and it is hoped that this matter will be clarified before the end of 1963. Honolulu County is evaluating the status of their inactive members and it is expected that the number will decrease materially.

Of the 623 active members, 41 were granted dues waiver. This is an increase of almost 50 per cent over the previous year.

The total number of physicians licensed to practice in Hawaii, as of December 31, 1962, was approximately 997 or 75 more than last year. Of these 731 reside in Hawaii.

By counties the active membership is made up as follows:

| | Active Dues Paying | Active Dues Waived | Total |
|---|---|---|---|
| Hawaii | 46 | 8 | 54 |
| Honolulu | 496 | 27 | 523 |
| Kauai | 9 | 2 | 11 |
| Maui | 31 | 4 | 35 |
| | 582 | 41 | 623 |

There has been a decided improvement in the membership reporting since last year.

The Council met only twice since the last meeting of the House of Delegates, September 26, 1962, and February 13, 1963, with the result that there was a financial savings to the Association in this budget category. This also resulted in lengthy meetings. The following is a summary of some of the more important actions it has taken since the last annual meeting:

At the earlier meeting a letter from Dr. George Ewing relative to the use of pictures in the HMSA advertisements which appear in the JOURNAL was read and filed. A letter from the Honolulu County Medical Society relative to the House's 1962 action to implement a fee survey was read and filed inasmuch as action on this request had already been taken. The Secretary and Treasurer were requested to look into the matter of dues waiver and report to the Bylaws and Parliamentary Committee. The Treasurer's request of an increase of $300 in the auditor's fee was granted. A new savings and loan account was authorized to be opened on Maui. The Personnel Committee's report was accepted, and it was voted to sponsor the AAPS Essay Contest on a State level, although the latter decision was subsequently reversed by action of the Public Relations Committee. Hawaii County's annual report, which was omitted at the last annual meeting, was accepted. New memberships and subscriptions were approved; i.e. *Challenge to Socialism* and the Hawaii Hall of Health.

At the last meeting, it was voted to urge each county society to develop within its organization utilization committees in the hospitals in its jurisdiction. The Treasurer's report and proposed budget was approved with a few minor changes. The amount of the Legislative Assessment was set at $22.00 and the manner of payment was decided upon. Reports from nine committees were reviewed, and acted upon. The following were approved: Mental Health Conference for June, 1963; standing orders for Public Health Nurses; transfer of a portion of the public relations counsel allotment to the Legislative Committee. The Polio Committee's recommendation to schedule Operation Swallow using Type III vaccine, if practical, was accepted. The decision to defer action on the House of Delegate's mandate to draw up a contract for the Public Relations Counsel was made after the Council was advised that a new investigating committee had been appointed by the President. A mail ballot approved of the

proposed Cancer Study. Another mail ballot approved the scheduling of a special membership meeting for the purpose of presenting the annual press awards. An official seal was adopted. The publication of a roster of members was approved but no funds were appropriated. It was voted to disapprove the inclusion of physicians in the *Biographical Record of Americans of Japanese Ancestry*. It was voted to allow the application for a FCC license to be made in the Association's name. The Council confirmed the Public Relations committee's decision not to sponsor the AAPS Essay contest in view of the inability to get approval from the Department of Education.

A ballot giving the Council members a choice of seven dates for the 1964 meeting resulted in such a close vote (five each for May 14-17 and April 30-May 3, and one divided vote) that I should like to propose that the House of Delegates vote to determine which of these two dates it wishes to select. I further recommend that the meeting be held in Honolulu at a location to be chosen by the Arrangements Committee. In addition, I recommend that since the Bylaws are silent on the matter of how assessments are to be collected and are in error when they refer to a class of member that does not exist in the Association, that the House of Delegates vote to clarify this section in order that it will be clearly stated who will be exempt from assessment, who will collect the assessment, if assessments may be prorated, and when assessments become delinquent.

Samuel D. Allison, M.D.

*Secretary's Report*

The Committee approves the report and proposes the next annual meeting be from April 30 to May 3, 1964. We approve that the meeting be held in Honolulu and that the location be chosen by the Arrangements Committee.

In regard to the last recommendation, the Committee has already considered this question in our report of the Bylaws and Parliamentary Committee.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MABEL SMYTH MEMORIAL BUILDING, BOARD OF MANAGEMENT

Most of this past year's meetings have centered around two problems—the excavation and remodeling of the basement and the inclusion of radio-call service through the Physicians' Exchange.

The remodeling of the building project has cleared all but one of the many hurdles that were presented. The Honolulu County Medical Society's Board of Governors has approved the project and guaranteed to remain in the building for at least twenty years. Their attorney has asked for a clarification of one portion of the lease. The Queen's Hospital has petitioned the court on this matter. As soon as this is set forth and loan negotiations are completed, leases will be drawn up and the construction will begin. The Hawaii Medical Association has committed itself to partially finance the cost of improving the basement. This will be in the form of an amortized loan to be paid back with interest.

The cost of remodeling of the second floor after the library moves out will be the responsibility of the Building.

A petition for a license from FCC has been forwarded to Washington in the name of the Hawaii Medical Association. As soon as proper licensing requirements have been fulfilled, the Physicians' Exchange will embark on a new system which will include selective receiver broadcasts to its subscribers, which will be offered at a nominal sum.

I should like to again call to the attention of the House of Delegates the importance of supporting the Physicians' Exchange. The solvency of the building is the responsibility of the Hawaii Medical Association, along with the Hawaii Nurses Association, and the Exchange plays a major role in maintaining that solvency.

Toru Nishigaya, M.D.

*Mabel Smyth Memorial Building, Board of Management*

The Committee has considered this report and believes that the Minutes of the Board of Governors of the Honolulu Medical Society do not include the term "guarantee" to remain for at least twenty years, but the term "agreed" was used, for a period of ten years.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was noted that the document transmitted to Mabel Smyth relating to the County's offer to remain a tenant in the Mabel Smyth Bldg. stipulated a period of 20 years. The Chairman recommended adoption of the report. It was adopted.**

## INVESTIGATION COMMITTEE

The committee appointed by President Giles to study the executive set-up of the HMA met Wednesday evening, March 20, at the Tahitian Lanai at 7:00 P.M.

Various aspects of the problem were thoroughly discussed and it was the conclusion of the Committee that professional help was needed in order to make an adequate study and reach logical decisions as to the necessary steps to be taken.

Dr. West, who had been requested by the chairman to look into the availability of a suitable consultant, reported the results of his conversations with Mrs. Marjorie Peters. After discussing his report, it was voted to ask Mrs. Peters to come to the Tahitian Lanai to discuss the matter further with the Committee. Dr. Giles stated that if the Committee felt inclined to authorize the study he would be willing to finance it from his contingency fund. Mrs. Peters met with the committee and discussed the problems involved. After this discussion the committee voted to hire Mrs. Peters to make the necessary investigation and report back her findings to the committee together with special recommendations.

Members present were Drs. William Bergin, Hawaii; Webster Boyden, Kauai; Toru Nishigaya, Oahu; Rodney West, President-Elect; and F. L. Giles, President.

Due to the shortness of time, it was not possible to make this study in time to make recommendations for the annual meeting. The Committee recommends that as soon as the study is complete and a report available that active study and implementation of the recommendations be undertaken by the Council.

J. Alfred Burden, M.D.

*Investigation Committee Report*

Your Reference Committee recommends approval of this report and recommends continuation of this ad hoc committee until survey is completed.

The Chairman noted that Mrs. Marjorie Peters would begin survey in June and would be paid $500 a month.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## RESOLUTION NO. 2

Re: Appreciation.

Whereas, The 1963 Scientific Program of the HMA was enriched by the contributions of the guest speakers; and

Whereas, The Hawaii Division of the American Cancer Society made it possible to bring three outstanding guest speakers to participate in the meeting and further-

more contributed in other areas toward making the program a success; and

WHEREAS, Roche Laboratories made a generous monetary contribution toward the support of speakers; therefore be it.

*Resolved*, That the HMA express its appreciation to the Hawaii Division of the American Cancer Society and the Roche Laboratories for their generous contributions.

Introduced by
PAUL Y. TAMURA, M.D.

*Resolution No. 2*

The Committee approves the Resolution.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## KAUAI COUNTY MEDICAL SOCIETY

The Kauai Society held both scientific and business meetings. The former covered the following: *Pharmacy Bill in Hawaii State Legislature*. The Society met with their local senators and representative in an effort to develop recommendations to be presented to Governor Burns requesting that he not sign the Bill and recommending that the Pharmacy Board be placed under the jurisdiction of the Department of Health. *Cancer:* The Society approved the establishment of a Cancer Loan Closet whereby cancer patients and their families may obtain hospital beds and other supplies for home use. The Society also approved the showing of films to high school students as an educational means of enlightening the community, along with the support of an educational meeting at which time cytology of cancer will be demonstrated and discussed. *Polio:* The Society approved the administration of Polio Vaccine III to pregnant women and those persons below the age of 40 and children up to age 19. *Glaucoma:* Society members cooperated in the Glaucoma Clinic which was held in January, 1963, under the sponsorship of the Lions Clubs of Kauai.

The sessions of note included a dinner meeting on March 25, when we had a talk by Dr. Bob Wilkins, on "Hypertension and the Recent Advances in Cardiology."

The Society has made arrangements to hear Dr. Emerson Day speak on May 6, 1963, and Dr. William H. Beierwaltes, on May 24. 1963.

The Society plans to participate with The Queen's Hospital in postgraduate Education Conferences in Medicine and Surgery.

One member of the Society will attend the conference on Prematurity and Premature Infant Care to be held in Honolulu in May.

Additional speakers will be heard throughout the year either from the hospitals in Honolulu or as visiting physicians from the mainland.

PATRICK M. COCKETT, M.D.
*Secretary*

*Kauai Medical Society*

The Committee approves the report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## HONOLULU COUNTY MEDICAL SOCIETY

The Honolulu County Medical Society held regular monthly meetings throughout the year except for the months of May, July, and August. In addition to conducting the regular business of the Medical Society, many interesting speakers presented talks on socio-economic and medical subjects.

During the last year the Honolulu County Medical Society sponsored and operated the Operation Swallow Program for mass oral immunization against Type I and Type II polio. This program was most effective and resulted in the immunization of approximately 77% of the total population of Oahu.

The Continuing Education Committee of the Honolulu County Medical Society obtained funds for a thorough study of Hawaii's postgraduate educational facilities, and obtained the services of Dr. Henry Uhl of Delmar, New York, and Dr. Max Michael of Jacksonville, Florida, to conduct this survey. This survey report was published in the January-February 1963 issue of the HAWAII MEDICAL JOURNAL. The first governing Board, under the chairmanship of William F. Quinn, will meet on May 9 to establish a coordinated continuing education program for Hawaii.

The Medical Society is continuing its program of bringing top physicians to Hawaii for its annual postgraduate lecture series. During 1962 Dr. Victor Richards of Presbyterian Medical Center, San Francisco, California, was guest lecturer for the postgraduate series. Also during 1962 Dr. Rees B. Rees of the Dermatology Department of the University of California lectured to the Society through the courtesy of Merck Sharp & Dohme's postgraduate program. For the 1963 postgraduate series, Dr. William B. Beierwaltes of the University of Michigan Medical Center will be the guest lecturer speaking on the general theme of Nuclear Medicine.

THEODORE T. TOMITA
*President*

*Honolulu County Medical Society*

The Committee approves the report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MAUI

Under the leadership of Dr. Clifford F. Moran, President, the Maui County Medical Society held five meetings in 1962. Other officers were: Vice President, Dr. Wolfgang Pfaeltzer, and Secretary, Dr. William E. Iaconetti.

In February, Mr. William McAuliffe discussed the King-Anderson Bill. At the June meeting, Dr. George Ewing, consultant of the Bureau of Crippled Children Convulsive Disease Program, spoke on convulsive diseases, both as to etiology and type, and presented drugs used for the control of seizures and the changing thought of the treatment of convulsive seizures.

At the August meeting, Mr. Sanford J. Langa, Republican candidate for the office of Chairman & Executive Officer, County of Maui, and the Honorable Elmer F. Cravalho, Speaker of the House of Representatives, discussed campaigns and endorsement of candidates and parties.

A movie, "Your Health, Your Choice," featuring Dr. Edward Annis, President-elect of the American Medical Association, was shown in October. A combined Christmas party and meeting was held in December with members of the Auxiliary.

Two new members were accepted into the Society in 1962: Dr. J. Kendall Wallis, Psychiatrist, Mental Health Division, Department of Health, County of Maui, and Dr. Milton M. Howell, Resident Physician, Hana, Maui. Dr. Louis S. Rockett was reinstated to active status.

Officers elected to serve in 1963 are: President, William E. Iaconetti; Vice President, Kenneth A. Haling; Secretary-Treasurer, James F. Fleming; Councillor, Joseph E. Andrews; Delegates, Edward B. Underwood and Marion L. Hanlon; and Alternate, Ah Yet Wong.

WILLIAM E. IACONETTI, M.D.
*President*

*Maui Medical Society*

The Committee approves the report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

### HAWAII

The Hawaii County Medical Society enjoyed another fruitful year with Dr. Pete Okumoto as President from May to December, 1962, and Dr. R. P. Henderson from January to April, 1963. The highlights of the society's activities for the year were: (1) Operation Swallow—77.4% took Swallow I and 76.4% took Swallow II in Hawaii County; (2) Immunization program for the Peace Corp—Doctors volunteered their services for this program; (3) Annual Christmas Party—Entire Peace Corp group invited to Country Club for Christmas dinner and party.

Guest Speakers for our monthly meetings were: (1) Dr. V. Richards—*Recent trends in Cancer Surgery*. Movie: Cancer Cells; (2) Mr. Burl Yarberry—Director of University of Hawaii. *Report on Progress and Expansion of UHHC*; (3) Dr. Margaret Smith—*Parasitic Infection Transmitted from Animals*. Dr. Morris Shaffer—*Epidemiology of Salmonellosis*. Mr. Minett—*Leptosprimosis*. Dr. Margaret Smith—*Tuberculin Testing and Recommended Immunizations*; (4) Dr. Raimondo—*Clinical Use of Steroids*; (5) Dr. Thomas Durant—*Management of Congestive Heart Failure*; (6) Dr. Robert Aird—*Seizures*; (7) Dr. Rees B. Rees—*Common Dermatoses and Their Management*; (8) Dr. Claude Welch—*Surgical Aspects of Peptic Ulcer*; (9) Dr. George Ewing—*Convulsive Disorders, Current Philosophies, and Management*; (10) Dr. Ernest Jawetz—*Principles of Antibiotic Therapy*; (11) Dr. Robert Wilkens—*Recent Advances in Cardiac Therapy*; (12) Dr. Fred Giles—*Aims and Policies of HMA*, and Dr. Mills—*Fee Questionnaire*.

*Hawaii Medical Society*

The Committee approves the report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

The Chairman thanked the members of his committee and all the people who had appeared before the Reference Committee.

**ACTION:**

**The Chairman moved adoption of this report as a whole as amended. It was adopted.**

## INSURANCE AND MEDICAL REFERENCE COMMITTEE

In the absence of Dr. Steuermann, Dr. Richard D. Moore was appointed chairman pro tem and read the Reference Committee report.

Mr. President and Members of the House of Delegates:

Your Reference Committee on Insurance and Medical Service gave careful consideration to the matters referred to it and makes the following report:

### FEDERAL MEDICAL SERVICES COMMITTEE

The Committee met on call whenever sufficient Medicare claims needing adjudication were collected. Pending completion of the Fee Survey, no action has been taken to bring the Medicare fee schedule up to date. Discussion on whether this fee schedule should be published has taken place, but the Committee does not feel that this should be taken up with the Office for Dependents Medical Care prior to the time negotiations for a new HMSA schedule are completed.

Problems encountered with the Medicare contract have revolved around assigning fees for unlisted procedures and the determination of equitable fees for physicians whose bills include laboratory services done outside their offices. Further study is needed before recommendations can be made on these two matters.

The Committee previously approved the routine cutting by HMSA of Medicare fees claimed if they were in excess of the amount allowed. Only on one occasion has a physician objected to these cuts and the Committee recommended that his claim be paid in full. The Committee at that time asked that the practice of automatically cutting the amounts claimed down to the schedule allowed be abandoned and that these claims be referred to the Committee for adjudication.

The situation wtih the Veterans contract has improved somewhat. An agreement was signed last June which approved of a fee schedule submitted by the Acting Chief Medical Director of the local office. This agreement will terminate on June 30, 1963, at which time we have been assured that the schedule submitted to this agency last year will go into effect. The surgical section is now on the RVS (at $4.50), as are most of the radiology and pathology procedures ($5.00).

The former Medical Director for this area, Dr. Westover, has retired. His replacement is Dr. Rose. Dr. William Middleton, of the Washington office, has also retired.

It is recommended that this Committee be kept as a separate standing committee and not be made a subcommittee of the Medical Care Plans and Fees Committee. It is further recommend that next year's committee be instructed to work closely with the Medical Care Plans and Fees Committee, whose approval should be sought before any new contracts are negotiated. The Veterans Contract has already been negotiated, and the Medicare contract negotiations should be instituted as soon as the fee survey is completed and the HMSA schedule revised to reflect the present going rates.

GROVER H. BATTEN, M.D.

*Federal Medical Services Committee*

Your Reference Committee recommends the approval of the Federal Medical Services Committee report. It further approves the recommendation that this Committee be kept as a separate standing committee and not be made a subcommittee of the Medical Care Plans and Fees Committee.

However, the Reference Committee recommends that the relationship of the Federal Medical Services Committee to the Medical Care Plans and Fees Committee be studied by the Constitution and Bylaws Committee and that an appropriate recommendation be submitted to the 1964 House of Delegates for action.

The Committee also recommends the adoption of the recommendation that next year's committee be instructed to work closely with the Medical Care Plans and Fees Committee whose approval should be sought before any new contracts are negotiated.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

### MALPRACTICE INSURANCE STUDY COMMITTEE

The Treasurer and Dr. William S. Ito were appointed to study the feasibility of obtaining group professional liability insurance for the Hawaii Medical Association. This has not been as simple as it first appeared and there is nothing concrete to offer to the House of Delegates at this time.

We have been in contact with the casualty division of Theo. H. Davies' Insurance Department and the Liberty Mutual Insurance Company, which handles the coverage for several Honolulu groups. The former has to date been unable to locate a carrier that is willing to write a basic plan. Excess coverage is on a different rating basis and appears to be more negotiable. Liberty Mutual was re-

luctant to approach their mainland connection and advised that the groups with this coverage get it because some of their members are affiliated with the American College of Physicians and the American Society of Internal Medicine. However, they have asked for a list showing each member's specialty and will pursue this further after they receive this information.

There is apt to be some change in the malpractice set-up for Hawaii. A good deal of this coverage has been written by Royal Indemnity through First Insurance. Now that this firm has affiliated with Great American, there is some speculation about what will happen to their professional liability lines. Royal will continue to be sold through other outlets. It has been reported that a new method of rating has been set nationally but that locally there is reluctance to adopt this method as it would mean further rate increases.

Los Angeles County Medical Association has two approved programs. These programs are being checked for availability in Hawaii. They have warned their members that other companies are soliciting physicians and offering policies which do not provide that the physician policyholder must consent in writing to any settlement by the carrier. These policies provide, in essence, that if the doctor refuses to settle for, say, $3,000 and if the case is later lost for more than this amount, the doctor must pay all the amount over the $3,000 and all costs incurred after his refusal to consent to settle. No such policies are known to exist in Hawaii but the local physicians would do well to examine their policies and to carefully evaluate any plan they contemplate buying.

It is my recommendation that this committee continue to investigate the possibilities of getting group malpractice insurance. At the same time a program should be set up to attempt to reduce the number of legal actions.

THOMAS H. RICHERT, M.D.

*Malpractice Insurance Study Committee*

The Reference Committee approves the Malpractice Insurance Study Committee report and this Committee further recommends that the Hawaii Medical Association Malpractice Insurance Committee coordinate its efforts in making this study with the Honolulu County Medical Society's Malpractice Insurance Study Committee.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## HOSPITAL LIAISON COMMITTEE

Several areas of discussion were covered by this committee in the past year. The more important were as follows:

*Hospital Costs and Facilities:* At the present time there are no new hospital beds on the drawing boards for rapidly growing urban Honolulu county. Hospital costs continue to rise and at present the cost per patient day in urban Honolulu is approximately $48.00. Hospital utilization continues to be an important factor in hospital costs.

*Internship and Residency Training Program:* The Michael and Uhl report recently completed and published in the January-February, 1963, issue of the HAWAII MEDICAL JOURNAL recommends several changes in the existing internship and residency program and the consolidation of medicine, surgery, pediatrics, OB gyn, etc., in specific hospitals for more efficiency and better program. The AMA Council on Medical Education and Hospitals issued to all hospitals a memorandum asking for reconsideration of salaries for interns and residents and the standardization of salaries so this means would not be used as a lever to obtain house staff. This again will be costly to Hawaii's hospitals.

*The Health Facilities Planning Council of Hawaii was Incorporated:* The purpose of this Council is to make available to all interested parties facts and information pertaining to the efficient and sound development, construction and use of hospitals and related health facilities. Dr. T. Nishigaya and Dr. G. H. Mills represent medicine on the Council.

*Medical Care Program of the Department of Social Services:* Fifty per cent of a $2½ million budget was spent for hospitalization in 1961-1962. Seventy-two per cent of this was utilized in Honolulu county. Physicians in Honolulu hospitals render medical care without charge to all indigent and medical indigent patients. Rural Oahu doctors and doctors of Kauai, Hawaii, and Maui Counties receive only token payments for their services.

*Recommendations:*

1. That the communication and liaison between hospitals, county medical societies, and the Hawaii Medical Association be kept on the highest plane in matters pertaining to hospital utilization in order that the present hospital facilities will be used most efficiently, and an attempt be made to slow the rapidly rising cost of hospitalization.
2. That the Continuing Education Committee of the Honolulu County Medical Society keep the Council and officers of the HMA apprised of the medical education facilities (internship and residency) and programs in the hospitals in order that the Association can give assistance when needed and that the quality of medical care in Hawaii can continue to be maintained on a high level.
3. That the Hawaii Medical Association and its delegates give full support to the goals and programs of the Health Facilities Planning Council of Hawaii.
4. That all physicians in the State continue to support the medical program of the Department of Social Services so that only necessary dollars need be obtained to give adequate care to the indigent and medical indigent.

GEORGE H. MILLS, M.D.

*Hospital Liaison Committee*

The Reference Committee recommends approval of the report of the Hospital Liaison Committee with the deletion of the last sentence of the second paragraph of the report and the words "give full" in Recommendation No. 3.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MEDICAL CARE PLANS AND FEES COMMITTEE

This committee was originally formed in February, 1962, and has functioned without interruption since its inception. The original membership has been changed only slightly with changes in representation from Hawaii, Kauai, and Maui and the addition of two men from Honolulu county. Ensuing meetings have been held monthly and smaller meetings, as needed, at necessary times.

The Fee Survey mandated by the delegates got under way in December with the appointment of this committee and approval of the budget by the Council in January. The whole committee was divided into two subcommittees to expedite both the survey and the HMSA negotiations; Dr. C. M. Lum is chairman of the HMSA negotiation committee. The fee survey group is chaired by Dr. O. D. Pinkerton.

The HMSA committee has met frequently to debate possible changes in the HMSA fee schedule that are administrative in nature and which would not be automatically taken care of by a change to the 1960 relative value schedule. Further discussions pursuant to changes in contracts between HMSA and the county societies have continued and are outlined in the appended report of that subcommittee.

The fee survey is being mailed and its results will be used as the basis for the Hawaii Relative Value Study in its completed form and to determine the conversion factors for use with the schedule. A tremendous task is

still ahead in this compilation, its attendant hearings, and deliberations. It should be recognized that 100% satisfaction with the resultant schedule is utopian and cannot be totally fulfilled. Dr. Pinkerton's report is appended.

Attendance has been excellent by some of the members; Maui and Kauai have been represented at practically every meeting. The membership of the committee has been altered slightly by the addition of two more members from Honolulu and one more each from Hawaii and Maui. Substitutions should be made for those Honolulu members who are consistently unable to attend as the balance is seriously disturbed by their absence.

The recommendations to the delegates are as follows:

1. Continuation of the committee with as much continuity as possible.

2. It is recommended to the delegates that the committee be given the authority to use the information from the survey, the spot checks, and results of consultations with the specialty societies in the establishment of the final form of RVS as they best see fit.

3. It is recommended that the final form of RVS remain in effect unchanged for a period of two years.

4. It is recommended that a short-form survey be conducted every two years and the committee meet with the various specialty societies for possible revisions at appropriate intervals.

5. It is recommended that the committee continue to meet with HMSA to negotiate those portions of the schedule that will not be automatically taken care of by converting to the Relative Value Schedule.

6. It is recommended that continuing effort be made in assisting carriers to provide schedules that are "full service" in scope.

7. It is recommended that a review committee be formed on a state level, its membership and chairman to be appointed by the president, to be available to all carriers for the purpose of adjudicating claims and fees.

8. It is recommended that the delegates accept the recommendations as stated in the HMSA subcommittee report.

It has been a distinct and rare privilege to enjoy such unselfish, conscientious participation by my colleagues on the committee. I commend their efforts to you.

Robert G. Hunter, M.D.

**Fee Survey Subcommittee**

The meetings of this subcommittee have been held primarily for formulating information releases to the physicians regarding the current fee survey. These were released in the form of three letters to all physicians in the State of Hawaii. The members assigned to this division were Drs. Iaconetti, Mills, Mitchell, Moore, and Reppun.

The decision as to the employment of a research firm had to be made and the Pacific Research Corporation was designated for this work. The fee survey items on the questionnaire is in the process of being printed and will be in the mail shortly. The physicians are again advised that the fee survey forms will be coded, but only for the information of the Pacific Research Corporation. This coding is necessary in order that should any physician fail or overlook to send in his copy of the questionnaire, he could be notified so that it may be completed and mailed in.

It is the hope of our Committee that ALL physicians comply and cooperate in making Hawaii one of about twenty states who have done this survey activity.

O. D. Pinkerton, M.D.

**Report of the HMSA Subcommittee:**

Dr. Chew Mung Lum was asked to chair this subcommittee and his group consisting of Drs. Batten, Brennecke, Burden, Ito, and Crawford (who replaced Dr. Mizuire) submitted the following recommendations which have been approved by the committee as a whole. If a specific recommendation has not been made in an area, there is no change recommended.

Administrative Procedure Revisions

*Aftercare:* Listed values for all surgical procedures include the surgery and the follow-up care for the period indicated. Necessary follow-up care beyond this listed period is to be paid on an office call or hospital visit basis. Where the follow-up period is listed as zero (0) and the item is preceded by an asterisk (*), the following rules apply:

(a) The listed value is for the surgical procedure only.

(b) All postoperative care is to be paid on an office or hospital visit basis.

(c) When such a procedure requires hospitalization an additional two (2) units are to be added to the listed value to cover the additional services. (A charge for the initial hospital visit is not to be charged in addition.)

(d) When such a procedure is carried out at the time of the initial office visit, an additional one unit (1) is to be added to the listed value in lieu of the initial office visit charge.

*Assistance at Major Operations:* HMSA will not pay for assistance at operations at hospitals where there are residents or interns available. However, where special assistance is needed for specific technical reasons, a fee will be allowed with the approval of the Medical Director. The bill should be presented by the assisting physician. An allowance of $25.00 or 15% of listed value for the surgery, whichever is greater, will be allowed.

*Bilateral Procedures:* No change recommended except to eliminate the reference to "Eye, Ear, Nose & Throat."

*Endoscopic Services:* Endoscopic services are payable by HMSA. In cases where major surgery follows as a result of endoscopic findings, HMSA will allow the major fee for the surgery and one-half the endoscopic fee if both are performed on the same day. HMSA will pay the full combined fee if the two procedures are done on separate days.

*Infections and Trauma:* Where complications develop, special consideration will be given provided written requests for additional benefits, together with an explanation, are submitted to the Medical Director for necessary action. Where no actual cutting, debridement, or incision and drainage is involved, such case is considered medical (nonsurgical), and the difference between the physician's charges and HMSA's allowance shall be responsibility of the member.

*Multiple Procedures:* When multiple surgical procedures are performed through the same incision, the value will be that of the major procedure only, unless otherwise specified, except when additional values (as indicated below) are warranted; e.g., multiple procedures in a hand, foot, or other small part. Written report to be submitted upon request in the latter case.

When multiple surgical procedures are performed at the same operative session in separate operative fields and through separate incisions, full fees will be allowed.

*Consultations:* Consultation fees will be paid. Consultation should not be confused with referral. If a case is referred to you and surgery or treatment is performed by you, the HMSA allowance would be made to you and no consultation fee will be allowed. However, if you were called in by the physician for consultation and the case is continued by the physician requesting your opinion, your service would be a consultation and a fee of $10.00 would be paid directly to you. Only one consultation will be paid by the plan unless a written report is submitted and approved by the Medical Director or the Medical Committee.

Consultation Fees are not allowed for the following unless a written report is submitted and approved by the Medical Director or Medical Committee.

1. When the patient continues treatment with the consulting physician.
2. When consultation is between physicians in the same clinic or office.
3. When such consultation is required by the hospital.
4. Surgical consultation where Fee Schedule amount is less than $75.00.

*Medical Care Concurrent with Surgery:* Medical conditions treated concurrently with surgical conditions by

the same physician may command an additional fee by report.

*Payment:* Payments for services rendered HMSA members is made directly to participating physicians by HMSA. Payments are made twice monthly. All claims paid or payable are subject to review and verification including inspection of pertinent records of any physician or hospital upon authorization of the Medical Committee of HMSA. All payments made for services rendered by nonparticipating physicians will be made direct to the physician if an "assignment of benefits" is made.

Participating physicians are requested to bill HMSA within thirty (30) days after completion of services. Claims received more than ninety (90) days after completion of service will be subject to a service charge not to exceed 25% of the total allowance by HMSA.

*Surgical Fees:* The surgical fees listed in this booklet will constitute payment in full for members whose annual income does not exceed the following levels:

Subscriber and Family........................$7,500.00
Subscriber with no Eligible Dependents..........$6,000.00

If the member's income exceeds these levels, the physician may charge more than the HMSA allowance.

Surgical fees listed will constitute payment in full for members of the Federal Employees Medical Plan regardless of their income.

### Additional Administration Operating Procedures Not Included in Present HMSA Booklet

1. "Sv." items: "Sv." in the value column indicates that the value is to be calculated as the sum of the various services rendered (e.g., hospital visit, application of cast or splint, detention with patient, office visit, etc.) according to the ground rules and schedule of benefits covering those services.

2. "By Report": When the value of a procedure is to be determined "by report," a report including the size and location of the lesion (or procedure) where appropriate and the operating time will usually be considered adequate. Follow-up care for such procedures will be that of the nearest similar procedure.

3. Complications or other circumstances requiring additional or unusual services may warrant additional charges on a fee-for-service basis. Written report to be submitted upon request and payment to be made upon approval of the Medical Director or Medical Committee.

4. When a surgical procedure or procedures are carried out within the listed period of follow-up care for a previous surgery, the follow-up period will continue concurrently to their normal terminations.

5. Procedures not specifically listed will be given values comparable to those of the listed procedures of closest similarity. A written report to be submitted upon request. Values for these procedures to be determined by the Medical Director or the Medical Committee.

6. If a patient or his family has multiple coverage (by multiple coverage is meant other insurance policies which will indemnify the insured for professional services regardless of payment by HMSA) a participating physician has the right and privilege to charge the patient up to but not exceeding his or her usual fee providing there is prior agreement with the patient, and further providing that the patient in all instances makes known the existence of other possible additional insurance which may provide coverage.

### HMSA Contract

*Individual Contracts:* The Honolulu and Hawaii County Medical Societies are in favor of discontinuing individual contracts, while the Maui and Kauai County Medical Societies have voted to continue with individual contracts.

*Master Contract:* The master contract should be between the Hawaii Medical Association and the HMSA. The nominations to HMSA's Board and committees should be made by the individual counties as at present except that the counties will submit to the HMSA the exact number of names as required to fill the vacancies.

*HMSA Committees:* HMSA committees of physicians shall be appointed by the President of HMSA, with the approval of the Executive Committee of HMSA, from among HMSA participating physicians. Such committees shall be constituted on the basis of one committee member for each 100 (or fraction thereof) participating physicians who are members of each County Medical Society. If the foregoing provision for constituting committees shall provide for less than nine (9) members on a committee, the President of HMSA may appoint additional committeemen. Such additional appointments shall be made from members of the County Medical Society concerned, but the total number of members of a committee shall not exceed nine (9). The Society annually will furnish HMSA with names of members of the Society for each committeeman to be appointed from the Society. Nothing contained in this paragraph concerns the Medical Committee of HMSA, which shall continue to be composed only of physicians who are Directors of HMSA.

*Individual Contracts:* The following paragraphs of the present contract shall be eliminated:

> HMSA will enter into individual agreements with physicians on a standard contract form, a copy of which (marked Exhibit "C") is attached hereto, and will not offer to contract individual physicians on terms different than those contained in Exhibit "C", except as provided in paragraph (9), below. As used in this agreement, the term "participating physician" means any physician and surgeon licensed to practice in the State of Hawaii who has an individual contract with HMSA in the form hereto attached as Exhibit "C" or Exhibit "D" or in any other form permitted by the provisions of this agreement.
>
> Except as permitted by paragraph (9) below, HMSA will not offer a form of contract different than Exhibit "C" without the prior written approval of the Society. The current HMSA form of agreement with participating physicians concerning the Federal Employees' Medical Plan, a copy of which is attached as Exhibit "D", shall be used by HMSA through October 31, 1961. If thereafter HMSA shall continue to participate in the Federal Employees' Medical Plan and the form of agreement attached as Exhibit "C" shall be appropriate for physicians participating with HMSA, such Plan, the form of Exhibit "C" shall not be appropriate, the form of Exhibit "D" or any necessary modification thereof shall be used.

In their place the following shall be inserted: A physician who agrees to be a participating member in the regular HMSA plans does not automatically become a participating member in the Federal Employees' Medical Plan. In order to become a participating physician in the Federal Employees' Medical Plan, the physician must so agree in writing.

*New HMSA Plans:* Any new medical or surgical plan not being offered for sale at the time of this agreement must be approved by the Medical Association prior to being offered by HMSA. A plan is not considered new unless the fees or administrative procedures are chan°ed.

*Appointments:* The following portion of the HMSA contract shall be omitted:

> a. The Society may at any time place additional names on the panels and withdraw any names therefrom;
> b. HMSA shall notify the Society whenever either panel contains fewer than the minimum number of names specified, and the Society shall with reasonable promptness furnish HMSA with additional panel names; and
> c. The names of persons listed on the panels shall be kept in confidence.

*Compensation:* HMSA will continue its established policy of paying the same compensation to all physicians rendering similar services in similar circumstances, according to its schedules of compensation for professional services rendered and Administrative Operating Procedures without discrimination.

*New Plans and Contracts:* The following paragraphs shall be eliminated:

> If any third party with whom HMSA may negotiate to establish a new medical or surgical service plan shall insist that such plan contain any provision at variance with the provisions of the HMSA schedules of compensation for professional services rendered or the Administrative Operating Procedures, HMSA will not institute such new plan without first submitting such variances in writing to the Society. If the Society shall notify HMSA in writing of its disapproval of such variances or shall not within thirty (30) days notify HMSA of its approval of such variances, then HMSA shall be free to solicit physicians and surgeons to participate in such

proposed plan and to institute such plan, and the Society shall be free to exercise all right accorded it under the provisions of paragraph (9-A) of this agreement.

The Society shall actively encourage its members to enter into individual agreements with HMSA containing the terms in Exhibit "C" hereto or any modification thereof approved by the Society, but the Society need not encourage and may actively discourage its members from entering into or continuing to be parties to any individual agreements offered by HMSA which are not approved by the Society. If either HMSA or the Society has given notice of termination of this agreement, the Society may then also actively discourage its members with respect to such individual agreement.

The Federal Employees' Medical Plan, as it is now operated by HMSA or will be operated by HMSA under terms already negotiated with the U. S. Civil Service Commission for the new one-year contract period commencing November 1, 1961, is approved by the Society.

No participating physician's contract shall be terminated by HMSA unless termination (a) is affirmatively recommended by the Medical Committee of the Board of Directors of HMSA and approved by the executive committee of the Board of Directors of HMSA or (b) is approved by the Board of Directors of HMSA after prior consultation and approval by the medical committee of the HMSA.

CHEW MUNG LUM, M.D.

*Medical Care Plans and Fees Committee*

The Chairman called attention to the typographical errors contained in the original HMSA subcommittee report prior to submitting the Reference Committee's report. The paragraph on compensation should not have been included and the one on participating physicians contract should not have been deleted.

Under paragraph No. 3 it is recommended that the final form be unchanged for a minimum period of two years.

Under paragraphs No. 2 and No. 3, insert "of the relative value survey" after the words final form.

Under paragraph No. 9, it is recommended that an additional member from Honolulu County Medical Society be added to the Medical Care Plans and Fees Committee.

I move adoption of this portion of the report.

### FEE SURVEY COMMITTEE

The Reference Committee recommends the adoption of this report. I move adoption of this portion of the report.

### REPORT OF THE HMSA SUBCOMMITTEE

The Reference Committee approves the report of the HMSA Subcommittee with the following exceptions:

*Master Contract:* Your Reference Committee recommends that the present arrangement with HMSA concerning Master Contracts and County Societies be continued until such time a better solution to the problem can be found and that the contracts so drawn be for a period of one year.

On Page 21, paragraph 6 under "Additional Administration Operating Procedures Not Included in Present HMSA Booklet," delete "at the initial visit" on lines 8 and 9 and the deletion of the final sentence of paragraph 6.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

### RESOLUTION NO. 3

WHEREAS, The practice of radiology, pathology, anesthesiology, and physical medicine is an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine, or any other designated field of medicine; and

WHEREAS, It is an accepted policy of the American Medical Association adopted in 1951 that a physician should not dispose of his professional services to any hospital, corporation, or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee; and,

WHEREAS, The guides to "Relationships Between Physicians and Hospital" (JAMA 147:1684-1685, December 22, 1951) was reaffirmed by the House of Delegates of the American Medical Association in December, 1959, established guides based on the principles promulgated in 1951; therefore, be it

*Resolved,* That the House of Delegates of the Hawaii Medical Association instruct the Hawaii Medical Association's Delegate to the American Medical Association to introduce a resolution at the next annual meeting of the American Medical Association which would call for reaffirmation of the principles already set forth by that body or to support such resolution should it have been introduced.

Introduced by:

COL. L. HAMILTON
*President*
Hawaii Society of Radiologists

GRANT N. STEMMERMANN, M.D.
*President*
Hawaii Society of Pathologists

CARL JOHNSEN, M.D.
*President*
Hawaii Society of Anesthesiologists

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

Your Reference Committee commends the work of the chairmen and members of the committees mentioned in this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MISCELLANEOUS BUSINESS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee on Miscellaneous Business gave careful consideration to the matters referred to it and makes the following report:

### CAREERS COMMITTEE

The Careers Committee has become richer and wiser as a result of the experience of the past year. A Medical Careers Day was sponsored for high school juniors and seniors on February 22, 1963. Medical and laboratory exhibits were shown at Queen's, Children's, St. Francis, and Kuakini Hospitals and at Kinau Hale.

Sixty-four doctors were hosts to 124 high school students during the day, which lasted from 8:30 a.m. to 4:00 p.m. The doctors were divided into a morning shift and an afternoon shift. Each doctor was host to three or four students on each shift. Most of the students visited their host physician's office and had breakfast and lunch with their hosts at the respective hospitals. The participants considered the day a tremendous success.

Planning for a Medical Careers Day involved meeting with superintendents of the Department of Education, school vocational counselors, heads of 23-odd paramedical vocations, hospital administrators, and scientific exhibitors. The Woman's Auxiliary helped with the registration of students and doctors as well as by providing standby transportation.

The success of the day required the close cooperation of people in the paramedical fields, the hospitals, the Department of Education, the students, and the Woman's Auxiliary, as well as the doctors. The cordiality engendered among the involved groups was very enriching.

Another Medical Careers Day, tentatively set for November 11. 1963, is contemplated. The day will be made statewide. Doctors are asked to set aside that day to be hosts to the high school students.

An exhibit booth was staffed at the University of Hawaii, for their Careers Day on February 26, 1963. For 1964, plans are being made to include all health careers in a larger exhibit booth.

A tabulation of 26 vocations in health careers is being compiled giving training requirements, nature of work, job opportunities, training, and education facilities. Funds for the printing of such a chart are being sought.

The Committee feels that the work has been hard and time consuming, but that the over-all gains from good public relations, effective medical recruitment, and closer cooperation among doctors have made the work worthwhile.

The work of the committee could not have been done without the tireless help of Miss Lee McCaslin and the office staff.

Sau Ki Wong, M.D.

*Careers Committee*

The Reference Committee feels that the funds made available to the Careers Committee should be increased by the transfer of those spent for the AAPS ESSAY CONTEST. Otherwise, we suggest the report be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## NURSES LIAISON COMMITTEE

The Nurses Liaison Committee met for the first time in its existence on December 20, 1962. This meeting was devoted primarily to a discussion of general relationships. Both doctors and nurses present agreed that doctors made adequate contribution to nursing education; an area of concern to doctors appears to be the changing role of the nurse from bedside care to administration. Representatives of the nursing profession present felt that this change was not necessarily desired by nurses but was perhaps a response to need within the hospitals. The consensus of the Committee was that further discussion of this topic should ensue with representatives of hospital nursing administration present.

The Committee again met on January 17, 1963, for the purpose of recommending revised standing orders for Public Health Nurses to the association. These were revised and subsequently approved by the Council.

Recommendation: Inasmuch as a meeting to discuss nursing roles with hospital nursing administrators was not held, it is recommended that this be considered.

Linus Pauling, Jr., M.D.

*Nurses Liaison Committee*

The Reference Committee feels that there is lack of coordination and mutual understanding as to principles to the Nursing and Medical professions and to improve this, the Nurses' Liaison Committee should make greater efforts toward positive action and recommendations.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## HEALTH EDUCATION COMMITTEE

Throughout the year this Committee held monthly meetings on the first Friday. There were two changes in the TV program format. The last program to be taped at KONA-TV was "Hear This" with Drs. L. Q. Pang, Howard Honda. Donald Wright, and John Watson. This program is still on tape and has never been used.

On August 21, 1962, the Committee began a series of weekly programs on KTRG-TV called "Spotlight On Medicine." The difference in studio equipment pointed out the desirability in changing the panel format. The number of participants was reduced to three, and a moderator, Mr. Gordon Burke, was employed.

At the suggestion of the studio, the weekly program was changed to a telephone call-in format on November 13, 1962. The "Call Your Doctor" series has proved popular and we believe it has increased the appeal of the program. There have been two survey periods during the time we have been on KTRG-TV, but the results of the second survey are not yet available. The station does not cover a wide transmittal area and is the newest to be licensed in Hawaii. It has not yet developed a listening audience comparable to that of its competitors. The first survey did not indicate that there were sufficient listeners to record, even during some of their more popular programs. Therefore, there are no statistics to show how well the Association program is drawing. It has an unfortunate time slot when it competes with both "Untouchables" and "Jack Benny." However, it is shown at prime time and it was because suitable showing times were not available through KONA-TV that the change in stations was made.

Two of the Association's video tapes were sold for $200.00 each. The ones remaining have two programs still intact, one on psychiatry and one on poison. The money received from this sale has permitted the Committee to order posters with easels which advertise the program. These will be distributed to the doctors' offices. We are hopeful that this can be accomplished with the help of the Woman's Auxiliary.

The Committee recently devised a letter which has gone out to all the participants and which asks them for suggestions for future programs. In addition, the Committee also wrote to the Health Coordinators on Oahu and asked for their opinions. The Committee also wrote to each specialty society asking for a list of suitable subjects. Unfortunately, only one doctor, Dr. Gulledge, replied.

The Committee has for many years avoided putting on a program built around a controversial subject. This reluctance has been abandoned and we are pleased to advise that such potentially explosive subjects as "Abortions," "VD," and "Mercy Deaths" have been given without repercussion. We try to pick this type of subject for survey periods. The principal reason for being able to adopt the new call-in format and to program such controversial subjects is Mr. Gordon Burke's ability to handle the incoming calls and field the questions to the panelists, who are not always physicians. His services have been invaluable. The physicians in the last few programs have worn jackets purchased by the Committee for their use.

The Committee has authorized a weekly one-column, one-inch ad in the Sunday TV Supplement, which is now on contract, and on occasion has placed larger ads in the papers on the day of the program. It is the hope of the Committee that the House of Delegates will see fit to reinstate in the current budget a request for funds necessary to place advertisements in the daily papers, and provide an increased budget for the next fiscal year in order that the program may be properly publicized.

The Committee further recommends that the "Call Your Doctor" format be retained and that the HMA continue its association with KTRG-TV.

It has taken considerable leg-work to produce these programs and the Committee is indebted to Mr. Hugh Lytle for the services he has performed in lining up participants, attending each 7:00 A.M. Monday meeting with the moderator and panelists, and being on hand for the weekly broadcast. We also wish to thank the Executive Secretary for help in coordinating the Committee activities.

Herbert Y. H. Chinn, M.D.
Andrew C. Ivy, Jr., M.D.

*Health Education Committee*

Your Reference Committee recommends approval of this report and implementation of the recommendations outlined.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## PUBLIC RELATIONS COMMITTEE

The HMA PR program has grown steadily in scope and effectiveness during the past year. Meeting on 62 separate occasions, members of the PR Committee have originated and implemented a number of projects designed to enhance the professional image of Hawaii's physicians. In accord with the principle of "good works adequately communicated to the public," these projects were publicized through the following main channels of communication:

*Newspapers:* A steadily increasing flow of medical news and articles featuring some aspect of the human, scientific, or political side of medicine has appeared in the local press. As a result of the annual press medical awards, informal discussion groups with key news media people, and a new policy of buying advertising space, there has been a definite improvement in press-medical relations. A new and simplified press-medical code is presented with this report. "Medical Capsules" is now a weekly feature in the *Star-Bulletin*.

*Radio:* The weekly HMA radio program "Ask The Doctor" appeared regularly on KGU during 1962 and is being continued by the station without cost to the Association. The PR Committee has expressed appreciation to Hugh Lytle for excellent scripts and to Dr. Lyle Phillips and others for loyal assistance. A number of appearances on radio commentator shows were arranged for local physicians and two new series of daily medical news spots have recently been initiated as a public service: "Medical Milestones" on KGU, and "Doctor's House Call" on KGMB.

*Television:* During 1962 the HMA's Health Education Committee launched its weekly TV program "Call The Doctor." Steadily improving in format and viewer appeal, it is now well established and may eventually attract outside sponsorship. Under the able direction of Drs. Ivy and Chinn the Health Education Committee plans a continuing series of interesting and informative weekly programs. In addition, several special TV programs of medical and political interest were shown. More are planned for the coming year, including prime time exposure for AMA president-elect Annis.

*Mailings:* A ready-made channel of communication to the public exists in the monthly statement mailings of hundreds of physicians to many thousands of patients throughout the community. Plans are being formulated to provide doctors' offices with concise, informative "Medical Message of the Month" enclosures for inclusion in regular statement mailings. All physicians will be urged to give this material a "free ride" in their monthly mailings.

*Community Projects:* Of the several public service projects fostered by physicians in 1962, notable community appreciation and favorable publicity were accorded the statewide polio immunization project "Operation Swallow," the medical assistance program "Kokua Samoa," the first-time "Medical Careers Day," and training courses in "Disaster Planning." Continuing participation by Hawaii's physicians in such community projects will do much to enhance the local image of the medical profession.

*PR Counselor:* Mr. Hugh Lytle has served as PR consultant and press secretary to the HMA for the past 2½ years. He has faithfully attended all PR committee meetings as well as general membership and key medical committee meetings. He has formulated and issued hundreds of press releases, written and produced many radio programs, and assisted in the production of the weekly TV programs. His effective behind-the-scenes legwork has contributed greatly to the success of the HMA PR program.

*Recommendations for 1963-64:*

1. Further development and implementation of a medical "Message of the Month" program utilizing the monthly statement mailings of doctors' offices as an additional channel of communication to the public.
2. Additional funds should be allocated for newspaper advertising and publicity to increase community interest in HMA-sponsored TV and radio programs.
3. Medically-sponsored school essay contests accomplish little and are potentially inflammatory. They should be discontinued and replaced by such projects as "Medical Careers Day" and the provision of medical speakers at school assemblies.
4. The state PR Committee should provide correlative assistance to increase effectiveness of the Speakers' Bureaus now operated by the county societies.
5. Present newspaper, TV, radio, and community programs should be continued and expanded wherever possible.
6. The services of Mr. Hugh Lytle as PR Counsel should be continued for 1963-64.
7. Adoption of the following condensed medical–news media code:

*Proposal for a Condensed Medical–News Media Working Code:* The medical profession realizes that effective reporting of medical news and information to the community is in the best interests of the public, the news media, and the profession itself.

The Hawaii Medical Association recognizes the desire and the responsibility of the media to present news as promptly, completely, and accurately as possible, and agrees to make available, and to volunteer whenever possible, all medical and health information which is not precluded by its internal code of ethics.

By the same token, it is requested that representatives of the media of public information understand and accept the principle that there must be certain reasonable and necessary exceptions to the free and unrestricted reporting of medical news, as follows:

(1) *Information which may jeopardize the legal right of every patient and physician to privacy and confidentiality in the doctor-patient relationship.*

In matters of private practice and hospitalization the wishes of the attending physician shall be respected as to the use of his name, picture, or direct quotation, but all other medical information in which the public has a rightful interest, and which does not violate (1.) above, shall be freely provided.

(2) *Information deemed not in the public interest.*

The medical profession is probably the best judge of information in the health field which may be premature, misleading, false, dangerous, or otherwise inimical to the public interest, and competent medical opinion should be sought before such information is publicized by the news media.

(3) *Publicity which may directly or indirectly serve to promote or advertise the professional qualities of individual physicians.*

The propriety of such information is best decided within the medical association itself, and requests for news releases involving names or pictures of physicians in private practice in Hawaii should be cleared through its executive office. We will give approval of all medical releases, including names and pictures, unless contraindicated under this code.

In summary, the Hawaii Medical Association pledges to the news media ready and equal access to an increasing flow of medical and health information with the understanding that the news media will respect the provisions outlined above. With an increasing spirit of cooperation and good relationships between the two professions, it is believed that open communication and frank discussion can resolve areas of doubt or disagreement which may arise.

William H. Stevens, M.D.

*Public Relations Committee*

Your Reference Committee recommends approval of this report and implementation of the recommendations outlined.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## THE EMERGENCY MEDICAL SERVICE COMMITTEE

This committee held five meetings this year, plus several separate meetings of the Communications subcommittee under the chairmanship of Dr. Fred Lam, Jr. The subcommittee report is included below. Representatives of various participating paramedical and lay organizations attended most of these meetings. Dr. Frank F. Schade, representing the Council on National Security, AMA, attended one meeting and will assist us in establishing closer liaison with the AMA. Activities of this committee have assumed a broader scope, thanks mainly to the continued interest and cooperation of the State Department of Health. These activities are summarized as follows:

1. Participation in preparation of the *Report of the Health and Medical Resources Task groups, City and County of Honolulu, on Local Area Survival.* This is a monumental 91-page study productive of several recommendations which will help to guide the future activities of this committee.
2. Participation in an exhibit on survival techniques, Armed Forces Day, May, 1962.
3. Attendance by a delegate at the annual A.M.A. meeting on Disaster Medical Care.
4. Review of the disaster plans of most Hawaii hospitals. A manuscript is in preparation outlining essential basic principles for developing or improving hospital disaster plans wherever indicated.
5. Participation in the organization and guidance of the Medical Self-Help Training program which has already given survival instruction to over 3,000 persons in the State, with the assistance of more than 100 instructors. The volunteer organizations most deserving of praise in this achievement are the Hawaii Nurses Association, Public Health Nurses, the Red Cross, and the L.D.S. and Adventist churches. A program for more advanced training is currently being worked out with American Red Cross cooperation.
6. Disaster First Aid Training courses have been completed for 10 First Aid Stations, of a projected 40 on Oahu, involving approximately 300 trainees. Participation by members of the Medical Association has been minimal despite repeated efforts to stimulate interest in this program.
7. Three disaster drills with simulated casualties have been held, each involving one aid station and one hospital. Radio communications were employed in these drills.
8. Four training sessions utilizing Emergency Civil Defense Hospitals were held throughout the State.

Continuation of the programs noted in paragraphs 4, 5, 6, 7 and 8 is recommended. Again it is urged that each county medical society plan one annual program devoted to disaster medical care. Training material including a variety of 15- to 30-minute motion pictures is available on request.

An Emergency Medical Service Plan, now under preparation, attempts to correlate the functions of civil and military emergency agencies particularly in the realm of local and natural disasters. Such a plan is needed to define specific areas of authority and to provide for effective and orderly control of medical services. The state and county medical societies are currently lacking in specific authority whereby emergency medical action may be expedited. Towards this end the accompanying paragraphs are submitted for consideration and recommendations.

### Disaster Planning for State & County Societies: Source of Authority

1. Each county medical society should formulate its own plan to allocate emergency authority, providing sufficient flexibility to apply to any size or type of disaster problem. Such planning is essential wherever more casualties are present than doctors available to give individual care, thereby necessitating emergency field treatment, mass transportation of casualties, triage, and the employment of volunteer rescue workers. Liaison with official agencies, delegation of medical duties and personnel, and disbursement of emergency supplies should then be the responsibility of the persons having such authority.

2. The president of a county society may be designated for such emergency function, or a medical coordinator who is not an officer of the society may be so named. Likewise, a deputy coordinator should be selected to assume control in the absence of the first-named individual. Any person allocated such emergency authority should be reasonably acquainted with the basic principles of mass casualty care as well as with prescribed disaster planning, local rescue capabilities and the character and disbursement of emergency medical supplies.

3. In the event of State Civil Defense Agency intervention, appointed authority at the state level would perhaps best function through the chain of command of standing officers of the Hawaii Medical Association. Such authority will then be exercised in cooperation with the Director of the Department of Health who assumes emergency control of nonmilitary medical resources for Civil Defense, as prescribed by law. An advisory staff selected from the Emergency Medical Service Committee of the HMA may be necessary in the event of widespread or major disaster. Activation and administration of the Medical Service Plan will become the responsibility of the officer or medical coordinator having this appointed authority.

Edward W. Boone, M.D.

### Communications Subcommittee Report:

For the past several months this subcommittee has been meeting in an effort to work out a communications system for Civil Defense. It soon became obvious that in order for this to be successful, it would have to be tied in with the physicians' everyday facilities. There has long been a need for expanded services in Mabel Smyth's Physicians' Exchange and so the subcommittee set to work to devise a system which could be incorporated in the exchange and which would give the members the additional services they need at a reasonable cost. The following is an explanation of the proposed radio-call system:

Purpose: To provide more complete communication coverage to the physicians, the hospitals, the public, and the ambulance service.

Means: A radio-call service connected with the Nurses and Physicians Exchange.

Location: Base control station to be at the Physicians' Exchange at 510 So. Beretania St.

Transmitters: The main transmitter will be located on the ridge of Diamond Head in Huling tunnel and will be provided at no cost. In the case of an emergency, the base control station can be moved to Diamond Head. There will be auxiliary transmitter sites in order that complete island coverage can be offered. To begin with, there will be only one auxiliary transmitter, which will be located at Castle Memorial Hospital. Coverage will include almost all parts of Oahu—Kaneohe, Waimanalo, Kailua, Pearl City, Waipahu, Wahiawa, Ewa, etc., and all parts of Honolulu.

Equipment: The equipment will consist of the base station at Mabel Smyth; the transmitter, located at strategic positions; direct lines to all major hospitals in the city (which will permit physicians and hospitals to communicate through the Exchange); direct line to the Hawaii Ambulance service through the Physicians' Exchange); and physicians' pocket receivers (these will be selective receivers; that is the receiver would go on only when the message is for the individual carrying the receiver. He will hear a beep, like a telephone ring, emanating from the receiver). Ultimately it is planned to tie in the system with the hospitals' paging systems which are now in need of overhaul. Also being planned is a mobile service (which is an added benefit that may be purchased by the subscriber if he wishes it).

Service: This service will be provided to all subscribers wishing to add it to their present benefits. It is available in and out of the hospitals, doctors' offices, public places such as theatres, the stadium, etc. The physician gets a beep on his receiver and turns it on to listen to the mes-

sage. The message is repeated each 15 minutes for three times. The physician receiving the message will call the exchange and advise that he has the message. Physicians with two-way mobile sets will answer from their automobiles. It is planned that only urgent messages will be broadcast. Routine messages will be given by asking the subscriber to call the Exchange. If there is no answer to the beep after three 15-minute calls, it will be assumed that the doctor is either out of range or does not wish to be in communication.

There will be two operators on the Exchange during peak hours and service will, as it is now, be continuous 24 hours a day, 7 days a week.

COST: The physician may lease or buy his equipment. The equipment will cost a little more than that being used in Honolulu today because (1) it will have a wider reception range, (2) it will be better built, (3) it will be selective and there will be no interference with messages being transmitted for other people, (4) it does not have to be kept turned on all the time in order to receive messages.

The receiver itself costs $189 if bought outright. If this is the physician's choice, he has to maintain service and batteries. The alternate plan is to lease a receiver. The Physicians' Exchange will handle this for the physicians. The monthly cost for leasing a receiver is $5.28. This includes all servicing charges. However, through the joint cooperative arrangement of the Physicians' Exchange, the hospitals, and the Hawaii Ambulance Service, total charges for physician subscribers is estimated at $17 a month, including the lease of the receivers. The Physicians' Exchange will maintain a supply of loaners for use by its subscribers and pay all maintenance charges. There will be no limit on the number of incoming or outgoing calls. No additional charges will be made regardless of the number of calls that are made.

The reason for the reasonable cost is that the Exchange is willing to absorb some of the cost of getting the system installed. It will also be subsidized by the Hawaii Ambulance Service, and may get further subsidization from the hospitals if there is good participation by the physicians. The Exchange does not operate to make a profit; it operates a service for its members and to help with the maintenance of the Mabel Smyth Building.

BRAND: The equipment to be used is manufactured by General Electric. Base station and transmitter equipment will be leased through Ramsay and with an option to buy.

AVAILABILITY: A petition for license is now before the FCC in Washington and as soon as the license is granted, service will be made available to all physicians on Oahu.

The Board of Governors of the Honolulu County Medical Society has approved of this program and has voted to assist in encouraging members to join. This is not the final answer to the communications problem for Civil Defense. However, after the system is established, and the hospitals join in with their own transmitters and receivers located in each hospital, the Civil Defense system will be greatly enhanced. At the present time the Citizen Banders have been assigned to handle the communications for the hospitals and aid stations. They have approximately 200 mobile and fixed stations, but the service will have to be divided between the medical facilities and rescue and engineering.

I want to thank the people who have met with us to help work out this system—Drs. Robert Katsuki, William Dang, Robert Marks, and Casimer Jasinski plus Mrs. Storme, Mr. Pearce, Miss McCaslin, and Mr. Harvey Masuda of the Hawaii Ambulance Service.

FREDERICK M. K. LAM, JR., M.D.

*The Emergency Medical Service Committee*

It is recommended by the Reference Committee that the name be changed to Disaster Committee in order to emphasize the nature of their program.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## POSTCONVENTION COMMITTEE

A new committee was appointed by the President to provide liaison with the various medical societies who wish to hold meetings in Hawaii. In addition, the committee has been instructed to promote Hawaii as an ideal setting for scientific meetings.

There has been one meeting of this committee since it was formed, on March 22. Since that time the chairman has been in touch with the National Medical Association and the International Society for Research on the Reticuloendothelial System. The former will meet in Hawaii in August, and the latter in September, 1963. We have written both societies and offered assistance.

Subsequent to the committee meeting, I have personally met with Dr. Johnson of the National Medical Association and introduced him to other members of the Association as well as to the staff at Tripler. I have also met with the head of the Hawaii Visitors Bureau's convention division and feel that this connection should be mutually beneficial.

Postconvention tours are customarily managed by travel agents and it is the recommendation of the committee that we cooperate with the travel agents in putting on the scientific programs their clients are interested in. The committee also recommends that the Association contact the travel agents prior to their making firm plans and make arrangements with them to handle the scientific portion of their tours.

Although in time this activity may become self-supporting, there are no funds allocated for its activities in the present budget and it is recommended that the Treasurer be authorized to reimburse the committee for any expenses it might incur.

It is further recommended that this be a continuing committee and that the House of Delegates assign to this committee a suitable name. The title "Postconvention Committee" is not descriptive of the committee's activities and there was not time to take this matter up with the committee as a whole prior to the annual meeting.

JOHN M. FELIX, M.D.

*Postconvention Committee*

Your Reference Committee recommends approval of this report and implementation of the recommendations outlined.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## PUBLIC RELATIONS COUNSEL

Within the last two years Honolulu newspapers have quadrupled their production of constructive medical news and there is a better understanding, among editors, of the reasons for what they have considered the vagaries of medical ethics. Conferences with editors and staffs have been held; more are in prospect. A new, simplified press code has been prepared for approval.

A half-dozen writers have shown interest in medical reporting since institution of the Hawaii Medical Association prize for the best medical writing of the year. Several are training themselves in medical news writing. A sample was the coverage with pictures of the Medical Careers Day tours, by an *Advertiser* woman writer who wrote a comprehensive account. Her most recent production was a treatise on deafness. Typical also was a recent credit given by the *Star-Bulletin* to the HMA for offering the services of anonymous plastic surgeons who removed tattoos from girl juvenile delinquents in the interest of their rehabilitation. An *Advertiser* reporter, a newcomer to Hawaii, has several constructive medical news features backlogged. The editor prefers to space them out.

The weekly radio program over KGU now is in its 16th month. This is a time consuming effort, but the radio time now is given free by the station and it is a project worth any amount of effort. This program is keyed, on

occasion, to events in the news, such as the diabetes detection drive, Heart, Cancer, and Operation Swallow.

The weekly television program, even more time consuming, is extraordinarily successful, thanks to the cooperation of many physicians who meet for 7:00 A.M. breakfast before the program and then sacrifice several hours of the evening. This program, "Call the Doctor," presented weekly over Channel 13, is an open-telephone, question and answer feature. The telephone hardly ever stops ringing.

"Call the Doctor" puts the medical profession before the public in the best possible way. Time for this program also is given free by the station.

An enterprise that has lapsed but should be revived is the speaker's bureau. Time given to the radio program and the television series has prevented personal attention to this project during the first three months of this year. Also in a temporary lapse is the very important campaign to organize an Association of the Professions in Hawaii.

Production of constructive medical news by newspapers and the other media is important. No less important is that the editors should understand the reasons why medical ethics sometimes forbid the giving of information. Conferences with editors have cleared up some, but not all of the misconceptions of the press in this area. The American press is alert and intelligent. It is quite possible that the American medical profession, which has liberalized its attitude considerably in the last decade, will yield to further liberalization in the next ten years—with the encouragement of the press.

HUGH LYTLE

*Public Relations Counsel*

Your Reference Committee recommends approval of this report and implementation of the recommendations outlined.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

### WOMAN'S AUXILIARY TO THE HAWAII MEDICAL ASSOCIATION

The untimely death in March of our Auxiliary's first president, Mrs. Frank Spencer, is a great loss to our organization. It also serves to remind us of the great strides that have been made since a small group of farsighted and enthusiastic physicians' wives finally succeeded in organizing the Woman's Auxiliary to the Hawaii Medical Association 15 years ago. Today, it has more than 500 members. The enlarged scope of activities and frequent requests from community, church, and lay groups for cooperation and leadership in health-oriented programs are indications of its vital place in the community. Its primary objective, however, remains to assist the HMA.

At the request of the HMA's president, Auxiliary members this year:

1. Distributed more than 200 posters and manned three Clinitron registration desks during a Diabetes Detection Drive, November 12-17. 2. Handled the registration and stood by to provide transportation for the HMA's Careers Day Program on February 22. 3. The Honolulu Auxiliary contributed more than 800 hours recruiting volunteers and serving as clinic supervisors during both phases of Operation Swallow, a community-wide Sabin oral polio vaccine program. 4 Hand addressed invitations to state legislators for an HMA party, stuffed hundreds of envelopes and made thousands of telephone calls to remind HMA members of various functions.

From the programs suggested by the national headquarters, we chose those most pertinent to Hawaii and most interesting to our membership:

1. American Medical Association Educational & Research Foundation (AMAERF) has always been a favorite. The AMA considers it so vital that it paid the travel expenses of your president and AMAERF co-chairman, Mrs. R. Varian Sloan, to the Western Regional Workshop Conference in Salt Lake City, Utah, October 18-19. Our report stimulated great interest and several firsts, i.e. the sale of stationery, bridge cards, Christmas candies and cards. The use of sympathy and appreciation cards with donations to AMAERF is being promoted.

The Honolulu County Auxiliary waged a well-planned campaign to make every auxiliary member a contributor. The membership was divided into 50 teams. Each team captain sent members of her team a letter explaining the importance of the program with a contribution form. She then followed up by letter or telephone those from whom she had not received a reply.

For the first time the State Auxiliary contributed $100. Our two smaller county auxiliaries are also responding well by selling bridge cards. To date members have contributed nearly $1,500.

2. Safety programs rated second priority in Hawaii, as nationally. To bolster the seat belt campaign of the Mayor and local Junior Chamber of Commerce, the Auxiliary is providing every doctor in the State with 200 "PX for Safety" leaflets to enclose with his monthly bills.

On Oahu we are planning to co-sponsor with the Department of Health and PTA classes on mouth-to-mouth resuscitation programs in all schools next fall. Kauai's safety chairman accompanied Captain Alvis of Pearl Harbor Navy Yard when he spoke to schools on Kauai on safety in scuba diving.

Honolulu County's slide file on "Poison Goes Hawaiian" is being kept up to date and is used extensively by schools and other organizations.

3. A class on medical self-help under Civil Defense is being given to members and their friends in cooperation with the State Health Department. The goal is to train at least one member of each family to take care of his family's emergency health needs in case of an atomic attack, until professional help can be obtained. A few enthusiastic members as well as our Civil Defense chairman, Mrs. Robert Chung, have given generously of their time to teaching classes, helping to recruit teachers, and writing form letters publicizing the classes.

4. At the request of the National Auxiliary, we have added International Health Activities to our list of standing committees. Its purpose is to help peoples of other countries solve their health problems and thus carry our good will abroad. Our chairman, Mrs. B. Allen Richardson, recently saw first hand the dire needs in American Samoa. In a few short weeks, she collected, packed, and sent more than a ton of used clothing, bed sheets, wire clothes hangers, newspapers, medical journals, magazines, toys, and 100,000 vitamin pills. Efforts will be made to help medical schools and hospitals throughout the Pacific area.

5. Representatives from 13 lay women's organizations and wives of interns and residents were invited to attend a luncheon program sponsored by the Honolulu County Auxiliary's Mental Health Committee. "The Intricate Balance of a Happy Marriage" was discussed by four well-informed panelists.

To improve communication, five issues of *Rx for Doctors' Wives*, a statewide newsletter, were published during the year. This helped bridge the gap between the constituent auxiliaries and the 500 auxiliary members and wives of interns and residents.

Members of the small auxiliaries on Kauai, Maui and members-at-large on Hawaii have done outstanding work in the field of community service as well as on Auxiliary projects. Kauai members have been active in the Library Association, Mokihana Club, Civil Defense, Blood Bank Mobile, Cancer Survey, and Operation Swallow. On Maui, where the Auxiliary can boast of 100% membership, some enterprising members began a novel project of making comic puppets for hospital patients. Some are serving as officers and board members of religious groups, thus promoting closer relationship between the churches and the medical profession. On Hawaii, members assisted doctors with their blood bank team, Operation Swallow, tuberculin tests for school children, and distributing health literature. They also made toy bags for children in pediatric wards and did weekly shopping for TB patients.

Mrs. P. Howard Liljestrand, 1960-61 president, has received national recognition. She was asked to participate in the memorial service of the 1962 annual convention in Chicago, was appointed Western Regional Community Service Chairman, and was nominated for Constitutional secretary on the national slate.

The bylaws are being revised to (1) add International Health Activities to the list of standing committees, (2) to have the state Auxiliary pay national dues for all widowed members, (3) to add a corresponding secretary, and (4) to change the membership of the Nominating Committee for greater efficiency.

In conclusion I would like to thank the members for the honor and privilege of serving as their president. The responsibilities have been great but stimulating and satisfying because of the members' kokua and willingness to serve. My heartfelt gratitude goes especially to Dr. Giles, President of HMA, and the HMA Advisory Committee for their thoughtful advice; Miss Lee McCaslin for her invaluable assistance; our hardworking Board of Directors: the county presidents; committee chairmen; Mrs. Thomas Min's telephone committee; and Mrs. Robert

Katsuki's faithfulness in keeping the In Memoriam project up to date.

Let us continue to strive for a better informed and stronger auxiliary and closer relationships among medical families as well as to carry out our national theme "Aim for Excellence in Achievement."

MRS. FRED K. LAM

*Woman's Auxiliary to the Hawaii Medical Association*

Your Reference Committee recommends approval of this report and implementation of the recommendations outlined.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## ASSOCIATION OF THE PROFESSIONS

This ad hoc committee has not held any meetings since last May. The political controversy over medical care which surrounded the last election proved an insurmountable obstacle in furthering the formation of the proposed association. However, there is still interest in this project among the other professions and it is hoped that we will have something more concrete to offer in the near future, and recommend continuation of the committee.

A. L. VASCONCELLOS, M.D.

*Association of the Professions*

Your Reference Committee recommends approval of this report and implementation of the recommendations outlined.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## HAWAIIAN ACADEMY OF SCIENCE

Since the last annual meeting interest among the physicians in this activity has shown an increase. We sent out application forms with the last Newsletter and the returns are now being processed. At one of the Hawaii Academy of Science meetings Dr. Joseph E. Stokes III spoke on "Epidemiology of Heart Disease in Hawaii" and his presentation was well received by the predominantly lay audience.

W. HAROLD CIVIN, M.D.

*Hawaiian Academy of Science*

Your Reference Committee recommends approval of this report and implementation of the recommendations outlined.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

## ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

During the past year no meetings were called of the Advisory Committee. There were no major problems to be considered and the minor requests for advice or confirmation were negotiated by telephone with the concerned parties.

The Woman's Auxiliary is to be commended on their usual, very efficient aid and promotion of various functions of the Medical Association.

HOMER R. BENSON, M.D.

*Advisory Committee to the Woman's Auxiliary*

Your Reference Committee recommends approval of this report and implementation of the recommendations outlined.

**ACTION:**

**The chairman moved adoption of this portion of the report. It was adopted.**

**The chairman moved adoption of this report as a whole. It was adopted.**

## NOMINATING COMMITTEE

This committee met twice to select nominees for officers to be elected at the annual meeting.

The Committee reviewed, studied, and discussed the qualifications of many candidates and is now pleased to present the following slate of nominees for your consideration:

President-Elect........................................*Burt O. Wade*
Treasurer....................................*Herbert Y. H. Chinn*
Councilors from Honolulu............*Edward W. Boone*
(Two to be elected) *George Goto*
*O. D. Pinkerton*
*Shoyei Yamauchi*

In view of the time required to become familiar with the proceedings of the House of Delegates, it is felt that a delegate becomes useful only towards the end of his first term of office. The Committee feels that it would be to the interest of the Hawaii Medical Association that the same parties serve for another term and wish to submit the following names for reelection to these offices.

AMA Delegate....................*Richard D. Moore, M.D.*
AMA Alternate Delegate........*George H. Mills, M.D.*

All nominees have been contacted and have accepted the nominations.

J. ALFRED BURDEN, M.D.

*Nominating Report*

Dr. Burden read the Nominating Committee's report. He quoted from the Constitution and Bylaws and spoke in favor of the candidates selected. He noted the reasons for having annual meetings on the neighbor islands every three years and the difficulty that the neighbor island physicians have in coming to the meetings in Honolulu.

The President entertained nominations from the floor. He ruled that the election of the Nominating Committee became effective with this meeting. The Secretary resigned his office. After nomination had been made from the floor, the following ballot was submitted to 32 eligible voters and Drs. Henderson, Sloan, and Iaconetti were appointed tellers.

President-Election........................................*Burt O. Wade*
*Samuel D. Allison*
Treasurer.......................................*Herbert Y. H. Chinn*
Councilors from Honolulu............*Edward W. Boone*
*George Goto*
*O. D. Pinkerton*
*Shoyei Yamauchi*
*Bernard Fong*
*James Cherry*
Secretary.......................................*Randal A. Nishijima*
*Burt O. Wade*
*R. Frederick Shepard*
Nominating Committee..............................*F. L. Giles*
*Allan Leong*
*Carl Mason*
*Toru Nishigaya*
*T. T. Tomita*
*R. D. Moore*
*James A. Mitchel*—Hawaii
*P. M. Cockett*—Kauai
*J. A. Burden*—Maui
AMA Delegate................................*Richard D. Moore*
AMA Alternate Delegate..................*George H. Mills*

The Secretary was instructed to cast a unanimous ballot for the unopposed candidates and Drs. Chinn. Moore. and Mills were declared elected.

The tellers announced that four members had voted for four councilors although the ballot stated that only two were to be elected. The ballots were declared invalid. The failure of any candidate to secure a majority of the votes cast for Secretary necessitated a second balloting for this office. Upon completion of the count the following slate was announced elected.

President-Elect................................*Samuel D. Allison*
Treasurer....................................*Herbert Y. H. Chinn*
Secretary....................................*Randal A. Nishijima*
Councilors....................................*Bernard W. D. Fong*
*O. D. Pinkerton*
Nominating Committee............................*J. A. Burden*
*Allan Leong* *P. M. Cockett*
*Carl B. Mason* *J. A. Burden*
*R. D. Moore* *F. L. Giles*
*T. T. Tomita*

**RESOLUTION NO. 5**

Re: Dr. Edward R. Annis

Action on an attempt to formulate a resolution requesting the HMA delegate to the American Medical Association to introduce a resolution proposing that Dr. Edward R. Annis' term of office be extended was deferred in view of the difficulty in phrasing the resolution. The intent of the Body was made known to the Delegate.

**RESOLUTION NO. 6**

Re: Appreciation for Dr. Felix Marti-Ibanez

The Chairman of the Reference Committee on Miscellaneous Business advised that his report failed to carry the proposed resolution thanking Dr. Marti-Ibanez for his contribution of four books and a one-year subscription to MD Magazine as prizes in the Careers Day Essay Contest. The House voted to convey such thanks to Dr. Marti-Ibanez.

The meeting adjourned at 6:00 p.m.

SAMUEL D. ALLISON, M.D.
*Secretary*


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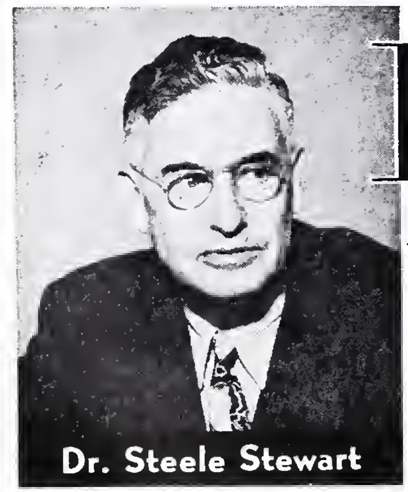


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## *Book Reviews* continued from 448

continued from 448

### A Primer of Cardiology, 3rd Ed.

*By George E. Burch, 366 pp., $6.00, Lea & Febiger, 1963.*

THIRD EDITION of a standard text for medical student and budding cardiologists. Depressingly dense typographic appearance, but an excellent work.

### Atherosclerosis: Mechanism as a Guide to Prevention

*By Campbell Moses, 239 pp., $8.00, Lea & Febiger, 1963.*

CHOLESTEROL diet and atherosclerosis through the eyes of a Pittsburgh specialist in this problem.

### The Surgical Clinics of North America, Vol. 43, No. 2

*Management of Trauma, William R. Waddell, M.D., Guest Editor, 574 pp., May, 1963.*

A COMPILATION of material presented during the 1962 Trauma Course given by the University of Colorado Medical Center.

### Forensic Medicine

*By Lewis J. Siegal, M.D., LL.B., 354 pp., $12.50, Grune & Stratton, 1963.*

A PRACTICAL and useful treatise, but written in "legalese" which would be far more intelligible to an attorney than to a physician.

### Living with Epileptic Seizures

*By Samuel Livingston, M.D., 348 pp., $6.50, Charles C. Thomas, 1963.*

INDISPENSABLE, practical, authoritative guidebook for the physician who must advise the parents of an epileptic child —or an epileptic adult—about "living with" the disease.

### ★Surgery in World War II

*Editor in Chief, Colonel John Boyd Coates, Jr., MC, USA, 394 pp., $4.25, Office of the Surgeon General, Department of the Army, Washington, D.C., 1963.*

THE INTERRELATIONSHIPS of traumatic and thoracic surgery are explored from the historical standpoint by Frank Berry and from the surgical standpoint by Lyman A. Brewer III, M.D., in this beautifully printed volume. Every surgeon who enters the chest should read it.

### The Year Book of Drug Therapy (1962-1963 Year Book Series)

*Edited by Harry Beckman, M.D., 648 pp., $8.50, Year Book Medical Publishers, Inc., 1963.*

EXCELLENT REVIEW, as usual, of clinical pharmacology in current literature, June, 1961, through September, 1962. We found no more recent reference.

### The Management of the Anxious Patient

*By Ainslie Meares, M.D., B.Agr.Sc., D.P.M., 493 pp., $9.00, W. B. Saunders Company, 1963.*

A PRACTICAL manual of office psychotherapy, simply written. ■

## *Notes and News* continued from 449

continued from 449

DR. GEORGE F. SCHNACK differed in his opinion with military doctors in a recent court case involving a marine.

DR. MARIE FAUS nominated Mrs. Hal Lewis (wife of Hilo's DR. HAL LEWIS) for Mother of the Year. Similarity in name to another personality caused quite a furor.

DR. WALTER LOO made the front page of the *Advertiser* because of his activities with the Hilo Lions.

DRS. HERBERT NAM and Y. KIM helped honor Korean graduates at a recent dinner dance.

DR. SIDNEY FUJITA, when called upon to say a few words after a movie on cancer, was found fast asleep.

Members of an advisory group to back Drag Race Course on Oahu include DRS. M. HASEGAWA and R. YOU.

Feature story on child beating in the *Star-Bulletin* helped get DR. R. K. B. HO a good press.

Also a feature series on the Kaneohe Hospital got DRS. WILLIAM J. T. CODY and GEORGE SCHNACK well-deserved publicity.

DR. M. MITSUDA is involved in a Hui which is contemplating a new hotel on Kalakaua Ave.—name, Alokalani.

DR. LEO BERNSTEIN was honored for 25 years in the health field.

## Congratulations To—

DRS. BERNARD W. D. FONG, PAUL KAUFMAN, and NOBORU OISHI—who were recently designated as Fellows and Associates of the American College of Physicians.

DR. ROWLIN LICHTER, who took the "long leap" and married Miss Barbara Foxworthy.

DRS. J. D. HUITT and PHILIP H. F. WATT, who are newly elected members, American Academy of Pediatrics.

DR. ICHITARO KATSUKI, active at 98 years, who was honored as the Dean of the Hawaii medical profession at the annual HMA meeting.

DR. R. VARIAN SLOAN, who was honored for heading Operation Swallow and was given the Robins' Award for public service.

DR. SAMUEL WALLIS for winning the coveted low net (President's trophy) at the annual golf tournament. His net score, 78—handicap, 12.

DR. R. TANOUE was low gross with a 77.

DR. WILBUR S. LUMMIS, JR., who was appointed Chief of Hospitals and Medical Facilities in the State Health Department, succeeding the late DR. S. PRICE.

DR. PATRICK T. LAI, who was named Father of the Year in Medicine. ■

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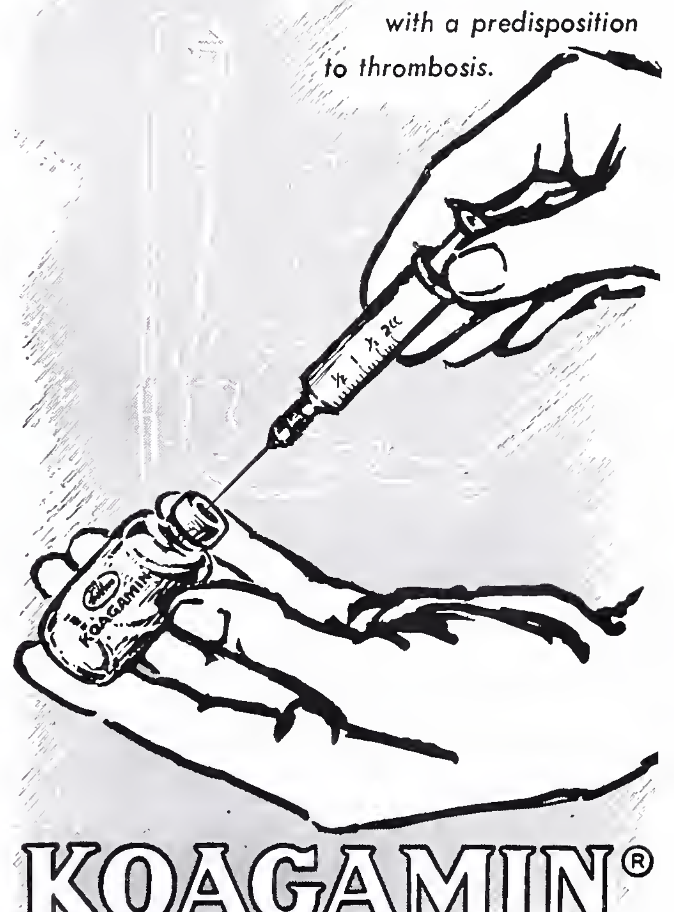


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# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

*Editor:* NELLIE CHEREVAS, St. Francis Hospital Laboratory

## *The Mounting of Pathological Anatomical Museum Specimens In Translucent Plastic*

About 1946, after much trial and error, Haviland and Kampmeier, from the Department of Anatomy at the University of Illinois, found a satisfactory resin compound and developed a procedure by which water-wet specimens, without complete clearing and resulting loss of contrast, could be embedded. This process with modifications has since been made commercially available and has found a wide and popular application in the biological sciences, mainly in teaching departments.

This commercial product represents in principle a partially polymerized syrupy water-white liquid, which upon addition of a catalyst turns into a friable gel. The same effect may be obtained by application of heat or light, particularly ultra-violet light. This process is accompanied by liberation of heat and contraction of volume. When gelation has been completed, the mass is subjected to a mild external heat treatment, so-called curing, by raising the temperature of the gel gradually to approximately 60°C. When hardened, the mass is gradually allowed to cool. The end result is a translucent, clear, hard plastic which can be sawed, drilled or polished with comparative ease.

We have adapted and used this method for the preparation of anatomical specimens and have found it relatively easy, allowing us to build up a pathological-anatomical museum. The embedding material, e.g. prepolymerized plastic, and the catalyst, as well as some molds, can be obtained commercially through the biological supply houses.[1, 2] The technic consists essentially of two major steps: the preparation of the anatomical specimen, and the actual embedding.

### PREPARATION OF THE ANATOMICAL SPECIMEN

1. Fix tissues, preferably in 10% formalin. If other methods of fixation have been used, it is advisable to wash them out with tap water. It will facilitate the final mounting if the specimen is immersed in the fixation fluid in such a way that the tissue hardens or "sets" in the shape desired. Cysts or other hollow structures will retain their shape if the fluid contents are replaced at least partially by formalin, using a needle and syringe.
2. Trim specimen to the desired shape if necessary.
3. Dehydrate in ascending concentrations of aqueous glycerine. This process empirically facilitates surface contact between the tissue and plastic and avoids the shrinkage and clearing effect resulting from alcohol or other dehydrants. Transfer the specimen directly from formalin or wash-water into 10% aqueous glycerine for 24 hours. Then transfer to 25, 50, 75, 90, and 100% glycerine, leaving it for 24 hours in each successive concentration. Add a "knife-tip" of thymol crystals to the three lowest glycerine concentrations to prevent the growth of fungi. The infiltration time in large-sized specimens may require up to one week or even more for each bath.
4. Transfer the specimen from 100% glycerine to absolute ethyl alcohol and leave in the alcohol until diffusing streamers of glycerine have stopped coming from the specimen. The time needed depends on the size of the specimen, varying from approximately 10 minutes to 1 hour. Slight intermittent agitation helps.
5. Dry the specimen in air. Light blotting of the surface and 10-minute exposure to warm room air is sufficient.
6. Transfer the specimen to uncatalysed plastic and let it soak for approximately 24 hours. It may be necessary, depending on the size of the specimen, to change the uncatalysed plastic two or three times. After each change let the used, glycerine-polluted plastic drip-drain from the specimen. For better results and in order to save working time, this can be done overnight. The specimen is now ready for embedding in the mold. The embedding is achieved by pouring several consecutive layers of the plastic material onto each other.

### EMBEDDING TECHNIC

1. Select a mold which will accommodate the specimen. Molds may be of any clean, smooth glass, metal, ceramic, or lacquered wood which is treated with a "mold releasing compound." The latter is available through a supply house.
2. Estimate the thickness of the finished mount.
3. Pour as much plastic into a clean, dry measuring cup as is needed to fill the selected mold with a layer approximately half an inch thick.
4. Add the catalyst to the plastic and stir well. The amount of the catalyst needed depends on the thickness of the desired cast. The following table may serve as a guide:

| THICKNESS OF EACH LAYER | % OF CATALYST |
|---|---|
| Under ½ inch | 0.3 |
| ½ to 1 inch | 0.2 |
| 1 to 2 inches | 0.1 |

It is of advantage to use less catalyst than specified, although the gelling time will be increased. Excessive amounts of catalyst may lead to the cracking of the

cast due to the increased liberation of internal heat produced during polymerization.

5. Place the catalyst mixture, while still in the measuring cup, under vacuum to eliminate air bubbles. An ordinary vacuum-type desiccator serves this purpose well. This step may be omitted if the catalyst added is kept on the low side, as the air bubbles will have sufficient time to rise to the surface. The use of a desiccator is recommended with porous tissues or specimens which harbor hidden air bubbles. Badly trapped air bubbles can be aspirated with a long thin needle through the still syrupy catalyst mixture.

6. Pour the base layer and set the mold aside, covered, until the plastic has gelled. This will need from four to eight hours.

7. When the base or supporting layer has gelled, measure sufficient catalyst and plastic for the specimen layer.

8. Pour the specimen layer over the base layer and then place the specimen in it, using care not to trap air bubbles. If air is trapped, remove by aspiration.

9. Let gel at room temperature.

10. When gelation is complete, cover the surface with cellophane or aluminum foil and let stand overnight at room temperature. Some specimens have a tendency to float; if this occurs, cover the specimen only barely with the second layer; when this layer has gelled, cover with a third layer to provide adequate depth above the specimen. In the case of thick specimens of one inch or more, do not attempt to complete the cast with two or three layers but make as many layers as necessary, each one not exceeding one-half inch in thickness.

11. Place the mold in a cold paraffin oven (or incubator) and heat gradually from one to three hours to a temperature between 50° and 60°C. Keep at this temperature for six to eight hours, then cool gradually from two to six hours at room temperature. During this curing time, the plastic will contract enough to allow the block to be lifted out of the mold.

12. The plastic specimen block is now ready for sanding and polishing. Rough trimming can be done if necessary with a crosscut saw. Sanding is accomplished on any belt or disc sander. Polishing or buffing is done with ordinary buffing wheels dressed with "Tripoicake" or any other fine-grain abrasive.

Another way to obtain a high-gloss surface is by dipping the rough sanded surface into catalysed plastic which is poured as a thin spreading layer on a scratch-free glass surface. Upon setting and curing, the glass is removed and an extremely smooth surface is obtained. This is excellent for front and back surfaces, while the sides, the less important surfaces, are left for sanding and buffing treatment.

13. The labelling of specimens may be done in many different ways, according to the purpose and taste of the technologist. We have used small cards ($1\frac{1}{2} \times 2\frac{1}{2}$ inches) with a typewritten text. They are supported on short plastic rods, cast in about 10 mm diameter test tubes and cut into $\frac{3}{4}$ inch long pieces. As cement, "Pliobond" universal cement may be used. Another attractive way is to mount the label in the plastic block together with the specimen, especially when the label is printed photostatically on transparent film.

It is obvious that the amount of work involved in the outlined procedure is initially greater than in the preparation of wet mounts, nevertheless the load falling on a single day is negligible. The work can be done during those unavoidable free spells inherent in laboratory routine. As for cost, the material used is cheaper than the glass containers needed in wet mounts. The results are rewarding enough to prefer the use of plastic embedding over the preservation in fluids, be it in glass or plastic jars or plastic bags.

REFERENCES

1. Embedding specimens in Carolina Embedding Plastic, Carolina Biological Supply Co., Elon College, N.C.
2. How to Embed in Ward's Bioplastic. Ward's Natural Science Establishment, Inc., P. O. Box 24, Beechwood Station, Rochester, N.Y.

Condensed from the *Canadian Journal of Medical Technology*, June 9, 1961.

## *Parasitology and Chinese Mythology*

In Chinese mythology, our world creation was brought about by the dissemination of the body of the first primordial being called PAN GU. At his death his body flesh created the land, his bones the hills and mountains, his blood the lakes and rivers, the hair of his head the tall forests, the hairs on his body the grasses, flowers and shrubs, while the living parasites which dwelt on his body became men and animals peopling the earth. So that you see the subject of parasitology goes back very far indeed. This may help to explain the nature of some people you have met. ■

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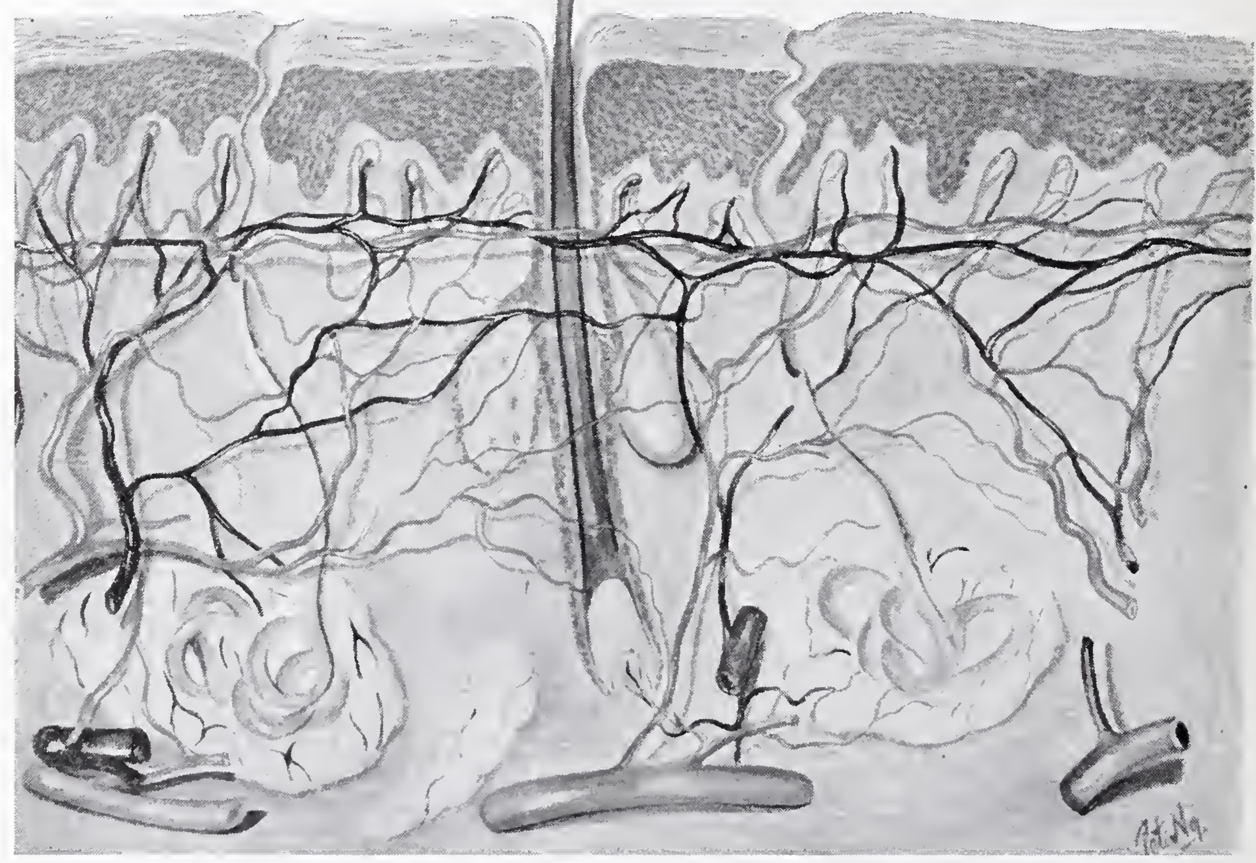

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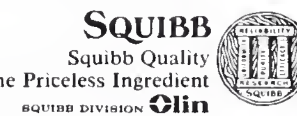
*References:* (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.



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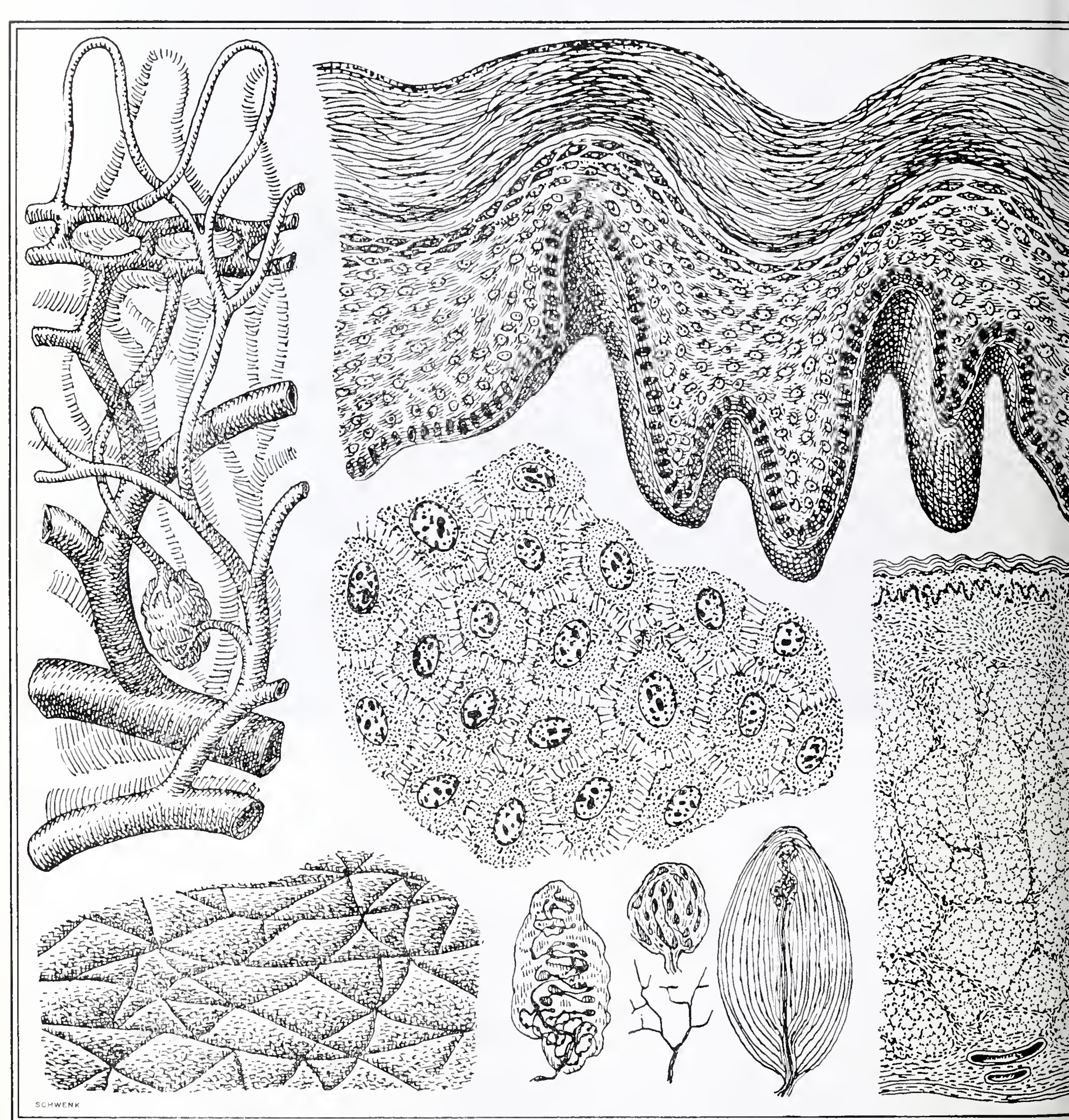
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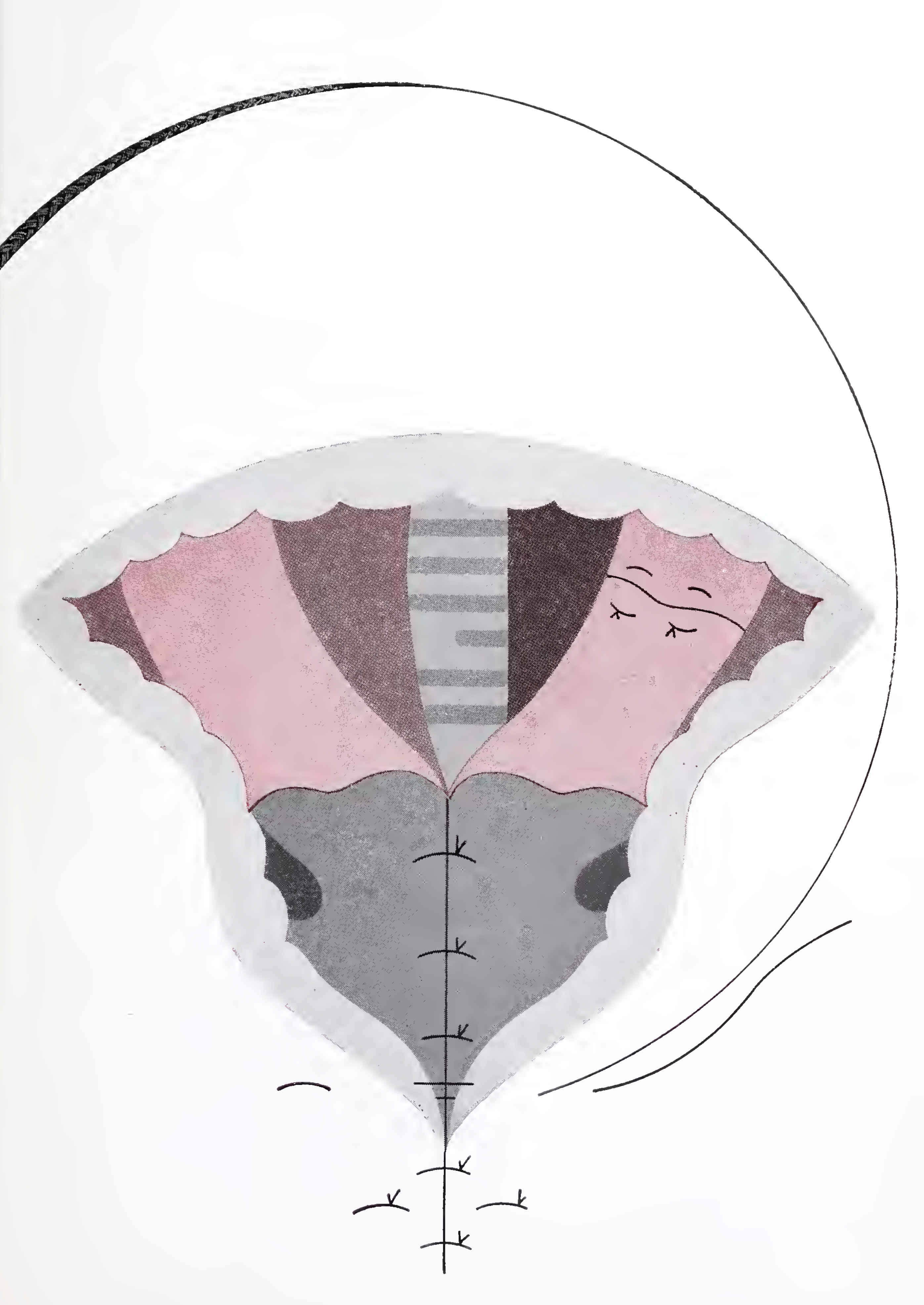

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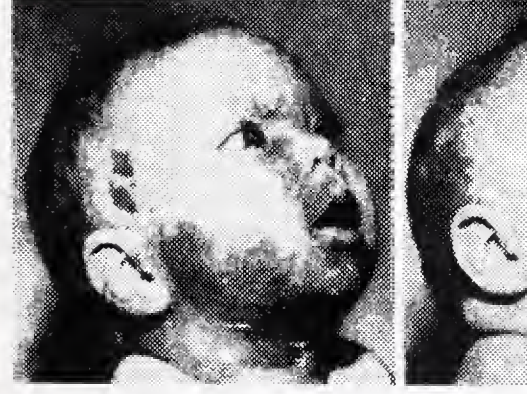

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**Matlin, E.: The Obvious in Obesity, Clin. Med. 8:1071 (June) 1961.*

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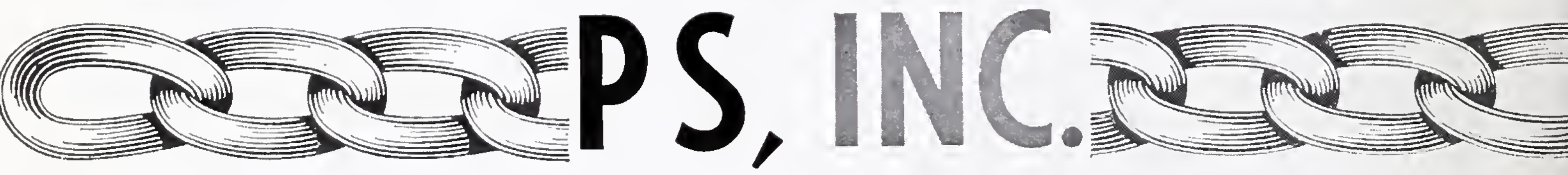


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