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Contents

Editorial
Norman Goldstein MD .................................................. 144

Special Commentary: Salvaging a Community Treasure at UH
Max G. Botticelli MD .................................................. 144

Special Contribution: Maine May OK Assisted Suicide
A.A. "Bud" Smyser .................................................. 145

Medical School Hotline
Richard Kasuya MD and Gwen S. Naguwa MD ..................... 146

MCCP Annual Report to the 1999 Legislature
Kathryn S. Matayoshi, Director,
Hawaii State Department of Commerce and Consumer Affairs .......... 149

Natural Rubber Latex Allergy, An Epidemic in the Health Field
Carl W. Lehman MD .................................................. 152

Natural Rubber Latex
John T. McDonnell MD .................................................. 158

The Legal Aspects of the Latex Protein Allergy Epidemic
Gary O. Galler JD and L. Richard DeRobertis JD .................. 160

News and Notes
Henry N. Yokoyama MD .................................................. 165

Classified Notices .................................................. 168

Weathervane
Russell T. Stodd MD .................................................. 170

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Kamehameha

The statue of King Kamehameha was unveiled by King Kalakaua in 1883.
Editorial

Norman Goldstein MD
Editor, Hawaii Medical Journal

Latex Issue

This month we have two excellent manuscripts by authorities on the natural rubber allergy problem, Carl Lehman MD and John McDonnell MD. Attorneys Gary Galiher and Richard DeRobertis review some of the legal aspects of this growing medical problem. This is an issue that should be of interest to all physicians and other health providers.

Hand Eczema in a Nurse

I recently received this Letter to the Editor:

Dear Dr. Goldstein:

I have had a great deal of problems with hand eczema over the years. As an OR night nurse (and wife of a physician), I have used many different types of creams, ointments, and gloves, and I still have problems. I understand this is a very common problem in physicians’ wives - too many samples available?

Because you are one of the senior dermatologists in Hawaii, I know you must have many patients with similar problems. I write to you so you might offer advice, not just to me but the other nurses, physicians’ wives, and others afflicted with hand eczema.

Sincerely yours,

X, R.N. (Name withheld upon request)

Dear Nurse X:

The Journal usually does not print anonymous letters, but in your case we will, and are happy to do so.

Yes, hand eczema is a very common problem in my practice. In fact, when I was doing the “Doctor Is In” TV news program with George “Granny Goose” Groves, hand eczema was the second most frequent complaint, after acne, that viewers called in to cure.

Hand eczema is a multi-faceted problem. Primary irritants include soaps and detergents, especially for individuals with atopic personal and family histories.

Allergic contact dermatitis may be caused by many creams and lotions that contain preservatives, perfumes and other inert substances that can produce a true allergic reaction. Allergy patch tests with the TRUE Test or similar kits can elicit the cause of this type of dermatitis.

Dyshidrosis or pompholyx is a sweat-retention, blistering condition of the hands and, in some people, the feet as well. Since heat, humidity, and stress make this disorder worse, gloves are usually not very helpful.

Gloves can actually contribute to hand dermatitis, not just by occluding the sweat glands but also by causing a true allergy, frequently to latex (see the manuscript in this Special Issue on Latex Sensitivity).

Superpotent topical steroids, while very helpful for short periods, can cause atrophy if used for prolonged treatment.

What else can be done? I usually do not patch test all of my hand eczema cases; only the ones that do not respond to treatment. Protective barrier creams may be useful.

There are many products such as SBR Lipocream, Proteque, Armadillo, Pro-Q or Preen that are especially beneficial for nurses, dishwashers, cooks, bartenders, and some housewives. I direct the patient to apply the SBR (Skin Barrier Repair) Lipocream or other protectant three or four times daily. Short courses of Class I (the superpotent steroids) are okay for a week or two. Then reduce the potency to a mid-potency strength, and subsequently to a lower, weaker topical steroid.

Short courses of oral steroids are also excellent in difficult cases. But, watch out for all those samples your husband brings home. Over-treatment can make your condition worse!

Norman Goldstein MD, Editor

Special Commentary

Salvaging a community treasure at UH
by Max G. Botticelli MD

The John A Burns School of Medicine is a casualty of the war of words that so often replaces rational decision-making in the political process.

While actively recruiting a dean for the school of Medicine, University of Hawaii President Kenneth Mortimer, decrying a lack of support for the school, suggested a plan to the UH Board of Regents that no new students be admitted. He later insisted that he would not stop admissions.

Gov. Ben Cayetano, recognizing the need for a medical school if the state is to have a viable health care industry, suggested that the school be privatized and that the funding for this new institution be obtained from a Mainland institution. The reiterative message from UH regent Ah Quon McElrath ignores the value of this institution to our community while overstating the relative value of the School of Public Health.

Is it any wonder that two candidates for dean have turned down substantial offers to leave their posts at Yale and University of California at San Francisco? Whether calculated or not, the effect of these words was to damage the reputation of the School of Medicine and jeopardize its existence as a part of the University of Hawaii.

If we are to salvage this community treasure, the public statements intended to manipulate the political process must stop and be replaced by rational planning. Part of that planning should be to consider a medical school outside the University of Hawaii.

The John A. Burns School of Medicine exists today because its namesake, the late Gov. John A. Burns, realized the importance of educational institutions to the well being of this community. He
visualized the medical school both as a provider of educational opportunities and as part of Hawaii’s economical infrastructure. The school has fulfilled this vision well:

• It has educated physicians, most of whom were born and raised in these Islands and a number of whom are Native Hawaiians.
• It has provided residency training for many of Hawaii’s practicing physicians.
• It has improved the quality of care delivered in Hawaii through its partnerships with hospitals.
• It brings medical research projects to Hawaii that would not otherwise be possible.
• It supports the good works of charitable institutions such as the Queen Emma Clinics, the Kalihi Palama Health Clinic, and the Waianae Coast Comprehensive Health Clinic.

These accomplishments alone should call for preservation of the medical school. But the school is also needed if Hawaii is to compete effectively in a competitive global health care market. Our competitors in this market include the University of California at San Francisco, Stanford University, the University of California at Los Angeles, the University of Oregon, and the University of Washington.

The faculties of each of these heavily endowed institutions are more expert at providing state-of-the-art medical care than any existing health care institution in Hawaii is, or likely to be in the foreseeable future. Furthermore, they are accessible and they provide care at a much lower cost.

If we are serious about the development of a health care industry, we must, as the Governor suggests, either partner with one or more of these institutions or build that expertise using existing Hawaii institutions as a base. In either instance a healthy and prosperous John A. Burns School of Medicine would be essential to provide the required academic, scientific and research base for such an industry.

Make no mistake, however, the school would have to be better than it is right now to provide this base effectively. To repair the damage this political babble has wrought and to set this venerable institution back on course, an aggressive and well thought-out plan is required. Such a plan is unlikely to come from the University of Hawaii.

A John A. Burns School of Medicine unencumbered by politics, a bureaucratic administrative structure, and an anachronistic tenure system would be better suited to help Hawaii develop a thriving healthcare industry. So privatizing the school makes sense.

Hawaii Pacific University has shown how a well-managed educational institution can effectively chart a course even in troubled economic times. A plan for the UH School of Medicine should consider and emulate its success.

What the Governor and the Legislature should do is continue the funding of the medical school at the present level, declare an end to any speculation about the future of the school, and begin a planning process that would include its privatization. Cayetano should set the context of the planning process by outlining its basic principles. He should insist that this new John A. Burns School of Medicine have:

• An understanding of the economics of higher education and the capability of responding to the vicissitudes of the marketplace.
• A commitment of academic freedom, the pursuit of quality and its educational mission.
• Steady and reliable funding including generous contributions from each of the institutions that stand to gain from a global healthcare market.
• A mechanism for faculty practice to generate additional funding.
• Fiscal responsibility without micromanagement or manipulation by the funding sources.
• Subsidization by the state for the cost of training students from Hawaii, but no state subsidization for out of state and foreign students who are solely responsible for the cost of their education.
• A business plan that includes the marketing of the medical school as an educational institution for Asian students, which has proven to be successful at Hawaii Pacific University.

Health care and health care education traditionally has been considered a function of tax exempt, not-for-profit institutions. Present day economic realities have changed health care providers, for better and for worse, into bottom-line oriented businesses.

The John A. Burns School of Medicine is a valuable resource that should continue to do what it does so well: train our young men and women to be physicians. If this requires that it become bottom-line business oriented, so be it.

Let’s stop the talk and start the planning.

Max G. Botticelli is Emeritus Professor of Medicine University of Hawaii John A. Burns School of Medicine

Editor’s Note:

Mahalo to The Honolulu Advertiser and Dr. Max Botticelli for permission to reprint the above article. In 1964, I recall speaking with the late Dr. Harry I. Arnold, Jr. about a new medical school. We both felt that a medical school in Hawaii was not a luxury, but a necessity. There were some physicians who, for various reasons, felt the Medical School was not a good idea.

As a Clinical Professor of Medicine of Dermatology at the UH, dozens of students and residents have taken electives through my offices and many other HMA members. Those interactions benefit both student and teacher.

The Hawaii Medical Association just conducted a survey of its members about the medical school. Twelve percent were opposed, but 88 percent wanted the Hawaii Medical Association to aggressively lobby to preserve our Medical School. Max Botticelli makes an excellent case for privatization of the medical school. Hawaii and the Pacific need the John A. Burns School of Medicine with or without its connection to the University of Hawaii.

Special Contribution

Maine May OK Assisted Suicide
From the Honolulu Star-Bulletin 4/15/99, HAWAII’S WORLD
By A.A. Smyser

The second state to approve physician-assisted suicide probably won’t be Hawaii. More likely, it will be Maine. Hemlock U.S.A., which founded the national right-to-die movement in 1980, thinks chances are bright there for voter petitions to put it on Maine’s November ballot next year and win.
Hemlock U.S.A. is committing a minimum of $250,000, its largest one-year contribution so far, to help Maine organize its fund-raising and get ballot signatures. Faye Girsh, national president, says Maine polls and population breakdowns are even more favorable than were those in Oregon, the first state to ratify.

She sees little danger of repeating the 2 to 1 licking administered to a Michigan proposition last year. That fight, she says, was pushed locally without adequate organization or funding.

Available money was pretty well used up getting ballot signatures. In the final weeks before the vote there were insufficient funds to counter the millions spent on media saturation bought by Right to Life forces.

Girsh spoke here at a Hemlock Hawaii meeting last month along with Derek Humphry, founder of Hemlock. Humphry traced the growing success of the movement from a California defeat in 1988 up to the 60-40 Oregon victory in 1997. He believes more than half of all states will legalize physician-assisted suicide and/or euthanasia on request by the year 2020.

Girsh and Humphry believe assisted-death forces can win in Maine even while being outspent by Right-to-Life and the Catholic Church foes, just as happened in two Oregon votes in 1994 and a re-ratification by a far bigger margin in 1997. Humphry reported continuing rear guard actions in Oregon. Twelve bills in its 1999 legislature would further restrict assisted suicide - even though only 15 of Oregon's 29,000 deaths were under the law last year.

In Congress, Rep. Henry Hyde, of impeachment fame, is a leading advocate for a bill forbidding the Food and Drug Administration to approve medications for assisted death, an unconscionable override of the U.S. Supreme Court's unanimous 1997 decision to leave choice in dying "to the laboratory of the states."

Girsh has an idea that conceivably could be used in Hawaii. This would be to reduce enabling legislation to a single sentence or paragraph. It would allow right-to-die help if carried out under accepted rules.

The Legislature would leave these rules to the Department of Health to adopt subject to approval by the Governor. This would transfer the long haggles over details from the limited 60-day legislative session to a forum able to operate without time limits.

Our 1999 Legislature, perhaps bloodyed by the 1997-98 fights over same-sex marriage, had no wish to even look at the details of the assisted-death law proposed by Governor Cayetano's Blue Ribbon Panel on Living and Dying With Dignity, on which I served. Neither the Senate nor the House invited testimony from the chairman of the panel!

Committees in each house ran through the charade of listening for a few hours to anyone who wanted to speak, then shelved the bills at least until next year. Only a single senator listened most of the time.

Hawaii polls consistently show strong support for legalizing doctor-assisted death under strict controls. National polls show similar support.

Girsh speaks of the right to die as "the ultimate civil right."

A.A. Smyser is the Star-Bulletin's contributing editor. His column runs Tuesday and Thursday.

Editor's Note:
Mahalo to A.A. "Bud" Smyser and the Honolulu Star-Bulletin for permission to reprint the 4/15/99 Hawaii's World. Whatever your opinion, this article will keep you up to date on the right to die issue.

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Medical School Hotline

JABSOM Celebration of Medical Education 1999

Richard Kasuya, MD
Associate Professor, Department of Medicine
Office of Medical Education

Gwen S. Naguwa, MD
Associate Dean for Student Affairs
Associate Professor, Department of Pediatrics

The University of Hawaii John A. Burns School of Medicine (JABSOM) has always maintained a strong commitment to research, service and education. In another demonstration of the latter, the School of Medicine recently completed a week of activities emphasizing various aspects of teaching/learning titled "JABSOM Celebration of Medical Education." Co-sponsored by the Hawaii Chapter of the Alpha Omega Alpha Honor Medical Society, the University of Hawaii Department of Medicine, and the Office of Medical Education, the week's activities included lectures, workshops, informal discussion and a first-ever medical education poster session.

The week was organized around the visiting professorships of two nationally and internationally-acclaimed medical educators: Dr. David Irby (Vice Dean of Education at the University of California at San Francisco School of Medicine) and Dr. LuAnn Wilkerson (Senior Associate Dean of Education at the University of California at Los Angeles School of Medicine). Together, they represented over 50 years of experience and accomplishment in the areas of faculty development, clinical teaching, problem-based learning and medical education research. Throughout the week, Drs. Irby and Wilkerson provided a series of workshops and plenary sessions on a spectrum of topics with titles ranging from "Ambulatory Teaching Lite: Less Time but More Fulfilling," "The One Minute Clinical Preceptor," "Exploring the Relationship Between PBL Tutor Behavior and Student Performance," "What Makes Small Group Learning Powerful," and "Preparation and Delivery of Dynamic Presentations." Dr. Irby also presented the 1999 Alpha Omega Alpha Lecture on "Distinguished Clinical Teachers of Medicine: What They Know, How They Reason, and What They Do." In addition to these sessions, Drs. Irby and Wilkerson met informally with interested faculty throughout the week to discuss areas of common interest.

---
One of the highlights of the week was JABSOM’s first Medical Education Poster Session. Over 30 posters on medical education, patient education, and community programs were presented by faculty, fellows, residents and medical students, with representation from over twelve departments and offices within the medical school, several associated community programs, and three medical school classes. In addition to providing another opportunity for faculty, students and community partners of the medical school to write abstracts and design posters, participants as well as attendees learned of the wide variety of programs, studies and community service activities which are conducted by and take place within the medical school. Many of them are presented at national or local meetings but are not well publicized within the school.

One of the primary objectives of the week was to reach out and involve as many of our faculty, residents and students as possible. With this purpose in mind, sessions were held at various sites within the community. It is estimated that over 250 different faculty and over 100 fellows or resident physicians attended at least one of the sessions, and many attended multiple sessions throughout the week. Participants also included community physicians, medical students, social scientists, educational specialists, and others. While the focus was primarily for our local medical education community, the symposium also attracted visiting faculty from Sung Kyun Kwan University Medical School (Korea) and Tokyo Women’s Medical College (Japan). Like JABSOM, both of these schools utilize problem-based learning as their primary educational paradigm which provided some exciting and engaging discussion and cross-fertilization of ideas throughout the week.

Feedback regarding the week’s activities from the visiting professors, faculty, and students was extremely positive. Drs. Wilkerson and Irby were especially impressed by the enthusiasm and commitment of all the participants, and planning already is underway for the next “Celebration.”

The energy, commitment and participation of the faculty, learners and community partners in events such as the “JABSOM Celebration of Medical Education” are the ingredients which enhance the educational opportunities and experience provided at the University of Hawaii John A. Burns School of Medicine. This never-ending dedication to improve as teachers and learners will continue in fulfilling the mission of the School of Medicine.
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Sponsored by Hawaii Medical Association
Introduction

The Medical Claims Conciliation Panel ("MCCP"), is a program of the Department of Commerce and Consumer Affairs ("DCCA"), State of Hawaii. The MCCP was established twenty years ago by Act 219, 1976 Session Laws of Hawaii, Hawaii Revised Statutes ("HRS") §671-11.

The MCCP program is responsible for conducting informal conciliation hearings on claims against health care providers before such claims can be filed as lawsuits. The decisions of the MCCP panels are advisory in nature and are not binding on the parties, in the event that any party still wishes to pursue the matter via the courts.

The real value of the MCCP program is demonstrated if the parties make conscientious and thorough presentations to the MCCP. In such cases, the decisions rendered by the panels provide the parties with fairly accurate advisory determinations of the relative merits of the claims, which should assist the parties in evaluating whether the claims should be pursued through the judicial system.

The MCCP program also provides opportunities for the parties to exchange information in a relatively expedited and inexpensive manner, which in turn provides for opportunities for the parties to explore the conciliation of meritorious claims prior to such claims being brought before the courts.

Lastly, the requirements of exchanging information between the parties, and making conscientious and thorough presentations to the panels, discourage the pursuit of frivolous or fraudulent claims, prior to further legal proceedings being taken by the parties.

In order to provide the Legislature with a comprehensive review of the MCCP program, the MCCP Annual Report to the 1998 Legislature covers the period of January 1, 1998, through December 31, 1998.

(See Flowchart of the MCCP Process on next page)

The Medical Claims Conciliation Program

In 1998, we continued to improve the processing and hearing of MCCP claims, as well as streamlining the MCCP procedures to minimize unnecessary costs and procedural requirements.

We also made significant strides in making MCCP informational materials and forms available to more people in more formats and media.

Expedited Claims Filing Process

The Expedited Claims Filing Process continues to be utilized by a growing number of parties, and in 1998 there were 25 claims filed utilizing the expedited claims process.

The Expedited Claims are ensured of faster processing through the entire MCCP process, sometimes as quickly as four months from the date of filing to the completion of the MCCP hearing. Additionally, because these expedited cases utilize other facilities to host the hearings, we have been able to schedule more hearings for claims brought under the regular MCCP filing process, because of the increased availability of the MCCP hearings room.

Streamlining of the Process for the Production of Records

Another area of improvement to the MCCP process that was undertaken in 1998, was to change how subpoenas for the production of medical records were issued, and the means by which the subpoenas had to be fulfilled.

Because the MCCP hearing process does not follow the formal rules of evidence, requests for the production of medical records can be made without the need and expense of formal discovery procedures. However, some of the parties to MCCP claims continued to utilize the more formal means of requiring the production of records. This formal discovery process required the custodian of records to appear at a court reporter's office and swear under oath that the documents produced were true and accurate copies of the documents requested, or to answer written interrogatories attesting to the authenticity of the documents produced. This level of formality increases both the cost and the logistical difficulties in producing medical records for MCCP proceedings.

Consequently, we initiated a new procedure that allows the individual or entity subpoenaed to deliver or send copies of the subpoenaed records to the person requesting the documents or a designated representative, along with a statement regarding the accuracy of the copies submitted. The new procedures greatly simplify both the preparation and the transmission of medical records to a requesting party.

Request to Appoint Specific Panel Chairpersons

In order to allow the parties themselves to become involved in the selection of a panel chairperson for a particular case, in 1998, we implemented a new procedure whereby the parties can submit a written request to the director of the Department of Commerce and Consumer Affairs, to have a specific eligible Panel chairperson appointed to serve as the Panel Chairperson for a particular case.

If the parties express a desire to use this process, a list of eligible panel chairpersons is provided to the parties. The parties can then
Flowchart of the MCCP Process

Claimant files claim with MCCP with filing fees

Medical Claims Conciliation Panel

Claim logged and set for hearing

If waiver granted

Director reviews request for waiver

or

Claimant applies for waiver of filing fees

Respondent(s) notified of claim; Parties notified of date and time of hearing

Respondents file responses; fee paid or waived

Panel selected; Parties file their pre-hearing Statements

Panel Conducts Hearing and issues Decision

Decision transmitted to Insurance Commissioner

Decision transmitted to Claimant

or

Respondent applies for waiver of filing fees

or

Director reviews request for waiver

If waiver granted

Decision transmitted to Respondent(s)
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  - HMSA's Plan 4
  - HMSA's Federal Plan 87
  - HMSA's State Plan
  - HMSA's Quest Plan
  - HMSA's Individual Plans
  - Federal Employees Plan (FEP)
  - HMSA's 65C & 65C Plus Plans
Kaiser - continuous since 1971
  - Kaiser of Southern California
DHS
CHAMPUS

Queen's Health Care Plans:
  - The Queen's Health Systems Health Care Plan
  - Queen's Hawaii Care
  - Aetna Health Plans
  - CIGNA Healthcare
  - Connecticut General-Northwest Airlines
  - Deseret Healthcare

Longs Drug Stores
National Elevator Industry Health Benefit Plans
Nippon Life Insurance
NYL Care Health Plans
Principal Financial Group
Queen's Preferred Plan
UNICARE Life & Health Insurance
United HealthCare
Medicare
University Health Alliance/HDS
Other Blue Cross Plans (through HMSA)
Hawaii Electricians Health Fund (UHA)
Hawaii Laborers Health & Welfare Trust Fund
Aloha Care Quest
Kaiser Quest
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Natural Rubber Latex Allergy, An Epidemic in the Health Field

Carl W. Lehman MD

Abstract:
The object of this paper is to educate health care providers of the markedly increased incidence of natural rubber latex (NRL) allergy to epidemic proportions during the past 10 to 12 years. A review of latex allergy problems in health care providers as well as patients is presented. Also reported is a questionnaire survey of institutions listed with the Health Care Association of Hawaii.

Introduction:
Natural rubber latex proteins are products derived from the milky fluid (latex) commercially produced from the rubber tree, Hevea brasiliensis. Synthetic latex, as used in latex paints, does not cause allergic reactions in patients with natural rubber latex allergy. For easier reading, “latex,” unless otherwise indicated, will refer only to natural rubber latex in this article.

The incidence of latex allergy has markedly and progressively increased by an estimated 64 fold during the past 10 years. The seriousness of an anaphylactic reaction to latex is compounded by the fact that many items commonly used to treat anaphylaxis may contain latex which if used, violates the primary principal of avoiding further exposure to the allergen inducing the reaction.

This article addresses significant latex allergy problems that affect both patients and health care providers who are affected with latex allergy when they, themselves, need health care. Also reported is a study of a survey of 18 Hawaii hospitals and 4 nursing homes.

Methods:
A cursory review of the literature concentrating on review articles, was done to provide basic information about latex allergy in this article. Questionnaires with a letter of explanation were sent to the Chief Executive Officer or comparable person of 41 member institutions of the Health Care Association of Hawaii. The recipient was asked to answer question #1 and refer the other questions to the most appropriate individual in that institution for a response. Twenty-two completed questionnaires were returned. The questions were condensed to the subject addressed in each question and the results are tabulated in table 1.

Results:
The yes/no answers are self explanatory with a few exceptions as noted under other “see text”.

The one “no” answer on question #1 was from a hospital that is properly addressing latex allergy problems. The “no” response was due to being unaware of the “epidemic” aspect.

Questions #5 & #6: The total number of employees listed by the various hospitals and other facilities responding was 14,238. The number of supportive workers that have direct contact with patients is listed in table 1: Sixty-seven known latex sensitive employees reported in the study is 0.52% of the total number of workers employed. Of this number, 9 were contact allergic dermatitis only.

Question #7: One hospital that is latex-free had no cases. No one was terminated from employment due to latex allergy. One was assigned to another job. Thirteen changed to wearing non-latex

Table 1

<table>
<thead>
<tr>
<th>Subject of Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Aware of latex allergy epidemic</td>
<td>20</td>
<td>1</td>
<td></td>
<td>see text</td>
</tr>
<tr>
<td>2. Facility has a latex allergy committee</td>
<td>15</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3. Has operating room(s) entirely latex free</td>
<td>4</td>
<td>2</td>
<td>9</td>
<td>5 alternatives</td>
</tr>
<tr>
<td>4. Latex free patient rooms</td>
<td>15</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Number of employees at risk of latex allergies 8,301</td>
<td>5,486</td>
<td></td>
<td></td>
<td>see text</td>
</tr>
<tr>
<td>6. Known employees with latex allergies</td>
<td>67</td>
<td></td>
<td></td>
<td>see text</td>
</tr>
<tr>
<td>7. How do you address latex sensitive employees</td>
<td></td>
<td></td>
<td></td>
<td>see text</td>
</tr>
<tr>
<td>8. Use latex powdered gloves:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. in hospital rooms only</td>
<td>4</td>
<td></td>
<td>1</td>
<td>options</td>
</tr>
<tr>
<td>b. only with direct contact with patient</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. in all departments</td>
<td>7</td>
<td>6</td>
<td>1</td>
<td>options</td>
</tr>
<tr>
<td>9. Factors considered in purchasing latex gloves:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. least concentration of latex protein</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. least processing chemicals in gloves</td>
<td>13</td>
<td>9</td>
<td>1</td>
<td>see text</td>
</tr>
<tr>
<td>c. hypoallergenic gloves</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. list other factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Understanding of hypoallergenic gloves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. less latex in gloves</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. less processing chemicals in gloves</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. both of the above</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Would you like an education session (latex allergy problems)</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
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Natural Rubber Latex Allergy, An Epidemic in the Health Field

Carl W. Lehman MD

Abstract: The object of this paper is to educate health care providers of the markedly increased incidence of natural rubber latex (NRL) allergy to epidemic proportions during the past 10 to 12 years. A review of latex allergy problems in health care providers as well as patients is presented. Also reported is a questionnaire survey of institutions listed with the Health Care Association of Hawaii.

Introduction: Natural rubber latex proteins are products derived from the milky latex (fluid) commercially produced from the rubber tree, Hevea brasiliensis. Synthetic rubbers, as used in latex pants, does not cause allergic reactions in patients with natural rubber latex allergy. For easier reading, “latex,” unless otherwise indicated, will refer only to natural rubber latex in this article.

The incidence of latex allergy has markedly and progressively increased by an estimated 64 fold during the past 10 years. The seriousness of an anaphylactic reaction to latex is compounded by the fact that latex is commonly used to treat anaphylaxis may contain latex which if used, violates the primary principal of avoiding further exposure to the allergen inducing the reaction. This article addresses significant latex allergy problems that affect both patients and health care providers whose contact with latex allergy when they, themselves, need health care. Also reported is a study of a survey of 18 Hawaii hospitals and 4 nursing homes.

Methods: A cursory review of the literature concentrating on review articles, was done to provide basic information about latex allergy in this article. Questionnaires with a letter of explanation were sent to the Chief Executive Officer or comparable person of 41 membe; members of the Health Care Association of Hawaii. The recipient was asked to answer question #1 and refer the other questions to the most appropriate individual for an answer.

Twenty-two completed questionnaires were returned. The questions were condensed to the subject addressed in each question and the results are tabulated in table 1.

Results: The yes/no answers are self explanatory with a few exceptions as noted under other “see text.” The one “no” answer on question #1 was from a hospital that is properly addressing latex allergy problems. The “no” response was due to being unaware of the “epidemic” aspect.

Questions #5 & #6: The total number of employees listed by the various hospitals and other facilities responding was 14,338. The number of supportive workers that have direct contact with patients is listed in table 1: Sixty-seven known latex sensitive employees reported in the study is 0.52% of the total number of workers employed. Of this number, 9 were contract allergenic dermatitis only.

Question #7: One hospital that is latex-free had no cases. No one was terminated from employment due to latex allergy. One was assigned to another job. Thirteen changed to wearing non-latex gloves. Two of these were also assigned to another job.

Question #9: Other factors listed as significant in determining purchase of latex gloves were availability, various details of contracts, user need, elongation properties, specific objective RAST and LEAP data, powder-free, and characteristics that provide protection for required infection control.

Questions #11 & #12: The author participated in providing a 1 hour education session, using a video tape and slides to discuss latex allergy problems at each of 3 hospitals. Information was sent to all of those requesting additional information in question #12.

Summary: This study reveals that key personnel from each organization are well aware of the problem of latex allergy being on the increase. While 2/3 of the institutions in this study are appropriately addressing problems with latex allergy, 1/3 need to take significant action. Most of these requested assistance to address their problems. In this survey, the incidence of known latex allergic individuals reported is below that expected for the general population and about 20 times less than expected in health care workers. If cases of sensitive latex workers are missed or not addressed, those sensitized health care workers with continued exposure to latex are likely to become progressively more sensitive and develop a more severe illness. Severe allergic reactions may cause devastating health problems for the sensitized employee including rare cases of inability to perform duties, sometimes in highly specialized jobs, and lead to very costly workers’ compensation payments.

Discussion: Type I, IgE mediated latex allergic reactions may be severe, causing deformation or even death. Sensitization results from exposure of susceptible individuals to latex rubber proteins possibly enhanced by presence of endotoxin which may act as an immunologic adjuvant. Presence of these potential allergens varies tremendously among manufacturers and even from batch to batch1. Allergic reactions to a wide range of medical products that contain latex have been reported including latex surgical gloves, adhesive bandages, intravenous equipment, and anesthesia equipment. Latex gloves are the largest single source of exposure to potential allergens2. Exposure to a latex allergen may be direct contact with an offending device3 or by inhalation of allergens carried by the contaminated powder with which most powdered gloves are coated4.

The clinical manifestations of latex allergy range from classic contact urticaria (Type IV reactions) to contact urticarial syndrome and systemic allergic reactions culminating in anaphylaxis (Type I reactions). Continued exposure to latex in sensitized persons may progress to generalized IgE-dependent allergic responses including generalized urticaria or pruritis, rhinoconjunctivitis, asthma, or anaphylaxis which may present as hypotension, shock, respiratory failure, and may be fatal5. Treatment of an anaphylactic reaction may be with items that contain latex materials and further worsen the anaphylactic reaction (see table 2).

Latex occupational exposure from powdered gloves, especially in anesthetics, may lead to persistent impairment and, although rarely, prevent a worker from remaining in that environment. The American Academy of Asthma, Allergy and Immunology and the American College of Asthma, Allergy and Immunology boards of directors issued a position statement concerning concerns regarding latex and non-powdered natural rubber latex gloves. The following steps should be taken to lessen risk of exposure to latex proteins. Latex gloves should be used only as mandated by accepted Universal Precaution Standards. The routine use of latex gloves by food handlers, housekeeping, and medical personnel in low risk situations (e.g., food handling, bed transport, routine physical examination) should be discouraged. Only low allergen latex gloves should be purchased and used. This may reduce the occurrence of reactions among sensitized personnel and should reduce the rate of sensitization6. Only powde; free latex gloves should be purchased and used. This will nearly eliminate latex aerosol levels and exposure7.

As of September 30, 1995, the Food and Drug Administration (FDA) issued a final rule requiring that all products containing natural rubber latex that contacts humans, state: “Caution, This...
Patients who have immediate hypersensitivity to latex must be treated by latex control. Inadequate latex control can result in two types of reactions: sensitization and immediate reactions. Sensitization of latex is a chronic condition that can last for many years and is not associated with immediate reactions. Immediate reactions to latex are highly correlated with a history of atopy and are mediated by IgE antibodies. Patients with immediate reactions can be categorized into non-reactors, low responders, and high responders based on their skin test response to latex.

Latex allergy is a complex immunological reaction that involves both IgE-mediated and non-IgE-mediated mechanisms. The diagnosis of latex allergy involves a combination of history taking, skin testing, and in some cases, specific IgE antibody measurements. Treatment options for latex allergy include avoiding latex exposure, using alternative materials, and desensitization therapy. Prevention strategies include the use of powder-free gloves and the development of latex-free environments.
Fifty-four percent of the participants attributed symptoms to latex exposure. The most common symptom was a rash on the hands, itchiness, and scaling. Eleven of 17 (64.7%) of the nurses testing positive to latex had two or more symptoms referable to either skin with rash or blistering, eyes with ocular swelling, burning or itching, or respiratory with symptoms of cough or wheeze.

Thirty-nine of the 135 (28.8%) reported reactions to latex products other than gloves. A history of atopy was strongly associated with the latex skin prick test positivity. Thirty-five of 230 (15.2%) non-reactors, have a history of atopy compared with 9 out of 17 or 52.9% reactors with a history of atopy. A large number of nurses wearing latex gloves noted irritation of their skin. It should be noted that both delayed hypersensitivity to latex and irritant dermatitis would explain many of these individuals problems.

To date there is no standardized latex solution available for assessing these patients. Testing done in Canada with natural rubber latex allergen provided a positive response in 94% of subjects who also reacted to 1 or more of the glove extracts.

This suggested that prick skin testing with a battery of glove extracts of known protein content may be used for accurate evaluation of natural rubber latex allergies.

The clinical history in patients with type 1 IgE mediated latex reactions is often both convincing and compelling. However, it alone is not sufficient to definitively establish a diagnosis of latex allergy.

Hamilton, et al, reports a multicenter latex testing efficacy study using non-ammoniated latex. The extract, processed by Greer Laboratories which was prepared from sap taken directly from the Hevea brasiliensis tree and serially tested at doses of 1,100, and 1,000 mcg/ml per ml using a prick puncture technique with bifurcated needles.

The clinical history combined with 1 or 2 stage latex rubber glove provocation assay was used to determine the definitive allergic latex status of 324 subjects enrolled in the study. The diagnostic specificity of the agent was demonstrated to be 100% and the sensitivity was 95% at the 100 mcg/ml per ml concentration with none of the patients in the non-latex allergic group developing a positive skin test response. At the 1,000 mcg/ml per ml concentration, the diagnostic sensitivity and specificity were 99% and 96% respectively.

The report of this study is promising and hopefully latex skin testing material will soon become available to assist in a definitive diagnosis. A definitive diagnosis is particularly important as it relates to social, occupational, and other legal ramifications of the condition.

**Conclusion:**

In conclusion, natural rubber latex allergy has increased tremendously during the last 10 to 12 years. The most common exposure in health care workers is to latex gloves. Powdered latex gloves creates a significant environmental problem in acting as a vehicle to allow the latex proteins to be airborne. The use of powdered latex gloves should be discontinued in all health care facilities including physicians offices, hospitals, and other health care facilities. Anaphylactic reactions to latex proteins are especially serious and compounded if an anaphylactic reaction is inadvertently treated with devices containing latex. Latex contact to mucosal or serosal surfaces may produce anaphylaxis in sensitive persons who only develop dermatitis with skin contact.

Latex allergy diagnosis is made by taking an appropriate history to establish atopy in the patient and/or allergic type reactions when the person is exposed to latex products. RAST or similar tests may be of value, but are not definitive to establish the diagnosis. Hopefully, standardized skin test materials will be available soon. Prevention is to minimize exposure and to decrease the risk of sensitization by purchasing non-latex products or latex products with a low content of latex and minimal endotoxin contaminant. Treatment of the sensitized patient is by avoidance of exposure and symptomatically if exposed. Labeling latex products and appropriately excluding the misleading term "hypoallergenic" from labels on latex products dispensed after September 30, 1998 will assist in more appropriate purchase of products and implement improvement of manufacturers standards. The study reported in this article indicates that continued education of health care workers in Hawaii regarding the subject of latex allergy must be pursued.

**References:**

21. Slater J. Latex allergy. Grand Rounds in Allergy, Asthma and Immunology, University of California Irvine, College of Medicine.
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or

BenzacW10%Washwere

used b.i.d. for a 20 second

lather phase followed by a

rinse. Significant differences

in reduction of P. acnes favored

TRIAZ at days 5 and 10.

Bacteriologic cultures were obtained using the

Williamson & Kilman technique.

No adverse reactions were experienced during

this study.

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Natural Rubber Latex
A short history of its production, use and sensitizing features in the development of latex allergy in adults and children

John T. McDonnell MD

The naturally occurring substance, latex, is a milky white substance which, when the bark is cut, drips from the Brazilian rubber tree, *Hevea brasiliensis*, which is in the family, Euphorbiaceae. Recently, the guayule bush, *Parthenium argentatum*, has been a minor source of latex. (ref.1) Latex is also produced by the cells of various seed plants (as of the milkweed, spurge, and poppy families) but these have not been used commercially to any large extent.2

Historical evidence exists that South and Central American Indians used latex to make waterproof shoes and bouncing balls. European explorers brought this compound back to Europe. In 1790, Joseph Priestly, the British Chemist best remembered as one of the discoverers of the element, Oxygen, coined the term, "rubber," when he first noticed that this compound "rubbed" out pencil marks. The milky rubber tree sap, usually a white fluid, is crude latex. After harvesting, it is filtered to remove particulate debris; then it is preserved by adding either ammonia or sodium sulfite.

Rubber made from latex is called “Natural Rubber Latex” or “NRL”. Depending on how the latex is manufactured, two kinds of Natural Rubber Latex (NRL) can be produced. Latex can be coagulated by the addition of acetic or formic acid to make crepe rubber which is used in hard products such as tires, rubber balls, and crepe rubber shoes. Liquid latex can also be processed by vulcanization to make thin, stretchy products such as rubber bands, balloons, condoms, rubber adhesive, and surgical gloves. Vulcanization is the process of heating latex with accelerators to speed up the procedure, anti-oxidants to make the product heat and chemical stable, and sulfur containing products to induce cross-linking between isoprene chains to produce a three-dimensional lattice. Compounds commonly used in the processing of latex include thiurams, dithiocarbamates, tetramethylthiuram monosulfide (TMTM), mercaptobenzothiazole (MBT), and isophenylamine.

Natural Rubber Latex is very popular because of its strength, flexibility, tear resistance, elasticity, and impermeability to bacteria and viruses. Thousands of common household items contain NRL, from shoes to pacifiers to rubber pants to kitchen cooking and storage materials.

Latex allergy is the result of the exposure of susceptible individuals to latex rubber proteins. The vast majority of latex sensitive people are only allergic to products made from liquid latex. Estimations of latex allergy range from 10-17% of all health care workers in the United States today.1 The allergic response in these situations can be mediated by either Type I (IgE-mediated, i.e. Allergic Rhinitis, Urticaria, Asthma or Anaphylaxis) or Type IV (Cell-mediated, delayed hypersensitivity) mechanisms of the Gell and Coombs classification of allergic responses.

In Contact Dermatitis situations, the response can be merely irritant reactions to the occlusive physical properties of the mere act of wearing a glove, which is not an allergic reaction at all. Alternatively, the reaction can be cell-mediated atopic eczema, an allergic response not only to the latex itself, but also to contaminants in the production process of the latex.3-4 As demand for more gloves increased geometrically after the Center for Disease Control issued its recommendation for universal precautions in 1987, a rush to meet demand led to latex processing plants moving closer to latex harvesting sites, giving rise to fresher and possibly more potent antigens.5 Other contaminants, including endotoxins, lipopolysacharides unique to the outermost wall of Gram Negative Bacteria, have risen in their content in latex gloves, particularly the less expensive, non-sterile gloves, and these, too, have been implicated in the allergic response in latex-allergic patients.6 These endotoxins were found mostly in the inside of gloves and were released as very small respirable particles that were not physically associated with the powder.

Type I, IgE-mediated allergic responses to airborne particulate latex particles are potentially far more severe reactions. Exposure is usually by inhalation of allergen carried by cornstarch powder with which most powdered gloves are coated to facilitate donning and removal.6 The clinical manifestations of Type I, IgE-mediated latex allergy range from mild urticaria to fatal anaphylaxis.

Health care workers, patients with genitourinary tract anomalies requiring daily bladder catheterization, atopic patients, and patients with tropical fruit (avocado, banana, and chestnut) allergy have had life-threatening anaphylactic reactions.7,8 Sensitive individuals may experience wheezing or flushing angioedema caused by contact of mucous membranes with latex products, such as with condoms, or dermatitis caused by household latex products, which may
progress to anaphylaxis. Thus the clinical history is essential, and questions regarding latex hypersensitivity should be asked of all patients preparing to undergo surgery, hospital procedures or internal pelvic exams because these procedures may produce life-threatening allergic reactions.  

Occupational latex allergy in health care workers occurs almost exclusively as a result of exposure to latex rubber gloves.  

Asthma caused by occupational exposure may persist even after the employee leaves the workplace. According to the Joint Position Statement of the American Academy of Allergy, Asthma & Immunology and the American College of Allergy, Asthma & Immunology concerning the use of powdered and non-powdered natural rubber latex gloves, such occupationally acquired asthma may lead to persistent impairment, and, rarely, to disability.  

Despite the majority of adult latex allergy being occupationally related in health care workers, children can and do develop sensitization to latex. Although multiple operations at an early age or urinary anomalies requiring daily catheterizations are well known risk factors for latex allergy in children, in a large study in Finland of children being evaluated for inhalant or food allergy, the prevalence of latex allergy was 1%. It is important to note that these children had already been identified as allergic individuals. The majority of children with latex allergy identified at screening or admitted because of suspicion of latex allergy belonged to the group of children who had not undergone previous surgery. Balloons, followed by gloves were the most common latex products causing allergic problems.

References:
2. Owbrty, DR. (Then) Director Allergy Research Laboratory, Henry Ford Hospital, Detroit Michigan. In Lecture at Latex Allergy Conference at Ala Moana Hotel, Honolulu, HI. Sponsored by The Queen's Medical Center, May 10, 1997.
The Legal Aspects of the Latex Protein Allergy Epidemic

Gary O. Galiher JD and L. Richard DeRobertis JD

The epidemic of Type I allergies to latex proteins appears to be limited to healthcare workers and others who have used or been exposed to powdered latex gloves. This phenomenon apparently began with the advent of universal precautions in the late 1980s and the consequent ten-fold increase in the demand for latex gloves.

Lawsuits against the manufacturers of powdered latex gloves commenced in the 1990s. They are filed in both state courts and federal courts. Cases filed in Hawaii State Circuit Court have been designated “complex litigation” and assigned to the Hon. Gail C. Nakatani. Cases filed in federal courts have all been temporarily transferred by the Multi-District Litigation panel to Philadelphia and assigned to the Hon. Edmund Ludwig. One recent jury trial in Wisconsin resulted in a verdict of $1,000,000. Documents produced by the manufacturers have been subjected to court protective orders which prohibit even alluding to their contents. Yet, published articles on this topic contend that the manufacturers shortened or eliminated the post-oven leaching time of their latex gloves and thus produced gloves with high extractable protein content. Some members of the industry appear to concede that changes in the manufacturing process, such as the shift from alcohol coagulants to water and decreasing the use of zinc-bearing components may be one of the factors in the increase in Type I reactions to latex. Leaching has long been described in the manufacture of “rubber gloves” as “probably reducing the risk of dermatitis to the wearer.”

Persons with Type I allergies have at least two parallel legal recourses: (1) filing worker’s compensation claims for occupational disease (which provided limited benefits) and (2) filing product liability actions against latex glove manufacturers (which provide full compensation for losses). Occupational diseases, including disabling allergies, have long been compensable under state workers’ compensation laws. A causal connection between work and the disease is sufficient. Product liability is more complex. Under Hawaii law, a manufacturer is liable to end-users for personal injury and disease caused by its defective products. A product is defective if rendered dangerous by a flaw in the manufacturing process, or it is defectively designed, or if the manufacturer fails to warn of dangers in the expected uses of the product by the public. A product is deemed defectively designed if (i) it is not as safe as an ordinary consumer or user would expect when used in a reasonably foreseeable manner; or (ii) the benefits of the product as designed are outweighed by the dangers imposed by the product.

To the extent that latex glove manufacturers decreased the total leach time to below the industry standard and this resulted in a higher level of latex proteins in the finished product, this would establish liability under both the manufacturing defect (i.e., flaw in the manufacturing process) and the balancing test for defectively designed products. That is, a product designed to have more latex proteins in the finished product than is otherwise necessary produces no added benefit to the end-user compared to the protective benefits already present in a properly leached latex glove.

A parallel theory of liability of the latex glove manufacturers is their failure to warn. Under well-established Hawaii law, a manufacturer is negligent if it fails to warn of the reasonably foreseeable dangers in its products. It is established in the published literature that the latex glove industry knew since the 1930’s that certain individuals can become sensitized to the naturally occurring proteins in latex gloves. Therefore, the manufacturers had both a duty to eliminate the dangerous levels of latex proteins from the finished product and to warn end-users of the risks inherent in high protein powdered latex gloves. Failure to warn liability can also be established if the warnings were inadequate or misleading. Thus, latex glove manufacturers which promoted their products as “hypoallergenic” when in fact they had high levels of protein allergens could be found negligent and consequently liable for sensitizing healthcare workers who develop Type I systemic allergies. Numerous documents in the public domain indicate that the latex manufacturers, through the trade association, Health Industry Manufacturers Association, actively resisted discontinuing the claims of “hypoallergenic” for latex gloves. On June 24, 1996, the FDA proposed that the term “hypoallergenic” be eliminated because it is false and misleading in that it incorrectly implies that the product labelled as “hypoallergenic” may be used safely by latex sensitive persons.

It is vital for anyone with a Type I allergy to understand that their claims against the manufacturers and for worker’s compensation benefits are subject to statutes of limitations. That is, a claim for being exposed and sensitized to latex proteins through powdered gloves will be barred if a legal action is not promptly filed. The exact knowledge which triggers the running of the statute of limitations is a technical legal issue and depends upon the particular facts of each individual case. Indeed, the elements triggering the running of the statute of limitations have been the subject of numerous appellate court opinions. No healthcare worker should assume his/her claim is already barred; nor should he/she assume that it is safe to delay seeking legal advice.

continued on page 167
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Continued from p. 150

select an eligible panel chairperson that is agreeable to all parties. Once the parties agree, then they submit their written request to the Director of the Department of Commerce and Consumer Affairs.

In most cases, the Panel chairperson requested by the parties will be appointed by the Director; however it is made clear to the parties that their request to the Director is a request and that the appointment of the chairperson continues to be a function of the Director.

Migration of MCCP Database

At the close of the calendar year 1998, we moved the entire MCCP database to a more capable and functional database program. Although the process did take a substantial amount of effort, we are now capable of analyzing MCCP statistical data in a more comprehensive manner, and on a real-time basis.

MCCP Forms and Informational Materials

The final area of improvement in the MCCP program that occurred in 1998, was regarding the availability of MCCP information and forms.

Thanks to a project undertaken by the Information and Communication Services Division of the Department of Accounting and General Services, we were able to place MCCP forms and informational materials on the State of Hawaii web page on the World Wide Web. As a result of the forms being posted on the State’s internet site, parties and interested persons, now have unlimited access to these forms and informational materials, 24 hours a day from any Internet access point anywhere in the world. The internet address for the MCCP informational materials and forms is: www.state.hi.us/forms/, and the forms are under the section for the Department of Commerce and Consumer Affairs, and the Medical Claims Conciliation Panel.

We are currently in the process of adding more MCCP forms and informational materials to the State’s website, as well as making the forms available by way of automatic faxing upon request through the DCCA Consumer Dial system.

Number of Claims Filed in 1998

In 1998, there were 154 cases filed with the MCCP program, involving 318 claimants, and 436 respondents. It should be noted that although there were 318 different claimants, there were not 436 different health care professionals and facilities named as Respondents. However, each case requires the same individualized processing effort, even if some of the cases involve some or all of the same respondents.

In regards to parties who are unable to pay the required filing fees, in 1998, 31 individuals requested filing fee waivers, and of the 31 requests, 27 waiver requests were granted by the Director. 1

Disposition of Claims Heard in 1998

In 1998, the MCCP panels heard 130 cases that involved a total of 267 claimants and 364 respondents. Once again, it should be pointed out that although these statistics indicate that 267 different claimants were involved in the claims heard by MCCP panels, there were not 364 different health care professionals or facilities involved.

1 The requests to waive the filings were denied because the claimants had the financial ability to pay the required filing fees. The MCCP utilizes the same financial guidelines to determine a party’s eligibility to waive the MCCP filing fees, as the courts use in determining whether a party can proceed in forma pauperis in a judicial proceeding.

1 In six of the cases in which the Panels found actionable negligence on the part of all or some of the respondents, the Panels were not able to make determinations of damages.

It is also significant that of the cases heard by the MCCP in 1998: 1) there were 28 cases in which the claimants were not represented by attorneys (pro se claimants); 2) of the 130 claims heard, the MCCP found only two underlying claims to be frivolous (palpably without merit); and 3) in 2 cases, claimants who did not have attorneys to represent them obtained findings of actionable negligence against some or all of the respondents involved in those cases.

In 21 of the cases where the panels found actionable negligence on the part of all or some of the respondents, the panels rendered advisory determinations of damages ranging from $10,000.00 to $3,000,000.00.

The following table provides a statistical overview of the disposition of cases heard by MCCP panels in 1998.

| Total number of parties in cases heard: | 631 |
| Total number of Claimants | 267 |
| Total number of Respondents | 364 |
| Total number of hearings conducted: | 130 |
| Actionable negligence found: | 11 |
| Some Respondents negligent: | 10 |
| No negligence found: | 105 |
| Dismissed at hearing: | 3 |
| Settled or withdrawn at hearing: | 1 |
| Total Damages Recommended by Panels: $11,020,000.00 |

Figure 1: Number of Claims Filed in 1994 Through 1998

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Figure 2: Disposition of Claims Heard in 1998
Conclusion

We greatly appreciate the support that we have received from everyone during the past several years, while we developed systems and processes for carrying out our additional responsibilities for the MCCP program. We have listened to the concerns and suggestions of the parties and participants, and whenever possible, we have made the required modifications to the procedures involved, or incorporated the proposed solutions into the MCCP program itself.

Special thanks to Rod Maile, Senior Hearings Officer, and his staff at our Office of Administrative Hearings. Rod's commitment to continuous improvement is the driving force behind the innovation in the MCCP process.

We will continue to work with the parties and participants of the MCCP program to find new ways to allow the program to fulfill statutory and philosophical obligations.
At the Mauna Kea Resort, we recommend a daily round of golf on two championship courses. We also advise world-class dining, two of Hawaii’s best beaches, and the shared amenities of a timeless resort. When it comes time for your meeting, we offer spectacular indoor and outdoor settings, state-of-the-art facilities, and a professional staff to assist you with your special needs. To find out how we can make your next meeting unforgettable, call 1-800-735-1111.

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Life in These Parts...

Charlie Judd, So Fondly Remembered...

(From Bob Krauss's, "Our Honolulu, Sept. 30, 1958)

"I am pleased to announce that Dr. Charlie Judd won't have to climb up and paint the roof of his new health center in Kalihi the way he did on the first one...It's too bad he isn't here to enjoy it."

"People of our country call him a saint," said Malaia Patu, registered nurse at Kokua Kalihi Valley Comprehensive Family Services Center. "They see him, they say, here come Jesus."

"This is one reason: It is the Samoan custom to circumcise boys when they enter school, but the $300 that clinics charge can be too much for a poor family especially if there are a lot of children. Kokua Kalihi Valley director Jory Wateland remembers when Charlie said, 'I'll do it at the center for $35.'"

"Other physicians said crazy. One of them called him a missionary eccentric. His wife Mary called him "Doctor No Charge."

When he died in 1987, a tribute to him from the people of Western Samoa included a ceremony at Central Union Church. Only one other foreigner — Robert Louis Stevenson — received such tribute.

Church and community leaders started Kokua Kalihi Valley in 1972 to provide services most needed in the community. One of them was medical care. The Rev. Lalomilo Kamu of the Kalihi Samoan Baptist Church recommended Charlie.

A volunteer plumber fixed up an examining room in an empty studio apartment. Charlie brought his black bag and they were in business. He shared the space with a sewing class and a public health nurse.

Then the board scraped together $850 to buy two Army surplus personnel trailers. Charlie helped on weekends to convert them into a service center on a vacant parking lot. It filled such a need that foundations and other contributors put up money for a proper building.

Malala cooked hamburgers for the volunteer carpenters.

The center on Gulick Street provides the services useful in Kalihi: dental and medical care, behavioral counseling, perinatal education, family planning, after school programs. Charlie would see 30 patients in 3 hours after being up most of the night in surgery.

"Our budget the first year was $33,000," said Watland. "But Charlie insisted that everyone receive the finest care. That's the imprint he left."

In 1979 Charlie became medical director when the budget expanded to permit hiring doctors. Other services have expanded, too.

"The doctors and nurses at the center could make more at other places," said Mary. "They stay because they want to."

But the center is bursting its seams — five people in what used to be one office. So Charlie's friends are chipping in for a new building in his honor, two and a half times bigger. The goal is $5.4 million; $3.3 million has been raised.

"It will be on School Street closer to those who need it and on a bus line," said Mary. Send donations to Kokua Kalihi Valley, 1486 Gulick Ave., Honolulu, HI 96819.

Potpourri ...

(Stitches Mar '99, Patricia Merle MD, Lantzville, B.C.)

A young Chinese woman presented to her doctor concern that she hadn't become pregnant after two years of marriage. With a waiting room full of patients, the doctor wasted no time.

"Just take off your clothes and hop on the examining table," he instructed, "and I'll be right back!"

The young woman gazed at him horrified. "No, no, doctor!" She shook her head. "You don't understand! I want a Chinese baby!"

Life in These Parts...

"For Doctors, Honesty is A Good Policy" by Beverly Creamer (medical reporter extraordinaire)

Scott Hundahl, surgical oncoscopist: "The delicate dance of what to tell a patient whose illness is threatening: to kill them is actually a very simple one-step...Patients deserve the truth...patients will often ask real specific questions about prognosis and they deserve the best answer that you can provide. Particularly in oncology, there are sensitive ways to share the information. It would not be the best for a physician to tell a patient he or she has a certain number of months to live. Instead it's preferable to offer a patient the statistical odds on survivability of their particular stage of disease. Even when doctors do their best, patients sometimes aren't able to listen. Psychologically, patients tend to repress information they're not able to handle. In the world of cancer treatment, there is no real certainty. We've all seen people with extensive disease who, as the result of a new drug or a new treatment, are suddenly brought back from the brink. In the early 1970's there were young men with testicular cancer throughout their bodies, and there wasn't much that could be done. Then came Cisplatinum and suddenly even the patients with extensive disease were being cured. And now testicular cancer, even in the disseminated stage is curable about 70 percent of the time."

"Childhood cancers have a higher cure rate than adult cancers simply because over the last two or more decades parents have been willing to try anything to save their children's lives. And that meant willingness to put their children in clinical trials testing new drugs. Most children with cancer are now being cured...That's one of the real triumphs of oncology."

Kenneth Kipnis, medical ethicist and UH professor of philosophy: "It can be put gently by saying something like 50% of the patients like you will live for this amount of time, 25% will die sooner and 25% will live longer...The first mistake is giving anyone a deadline for his life. That's not medically accurate and patients sometimes are very angry at physicians who give them a deadline."

"The second mistake is to say 'I don't know.' Again that's not true. Physicians are familiar with the course of a disease and do have fairly good judgment in this area."

Willow Morton, VP of Kapiolani Medical Center and former chairman of its bioethics committee: "The need for honesty. 'When the patient is terminally ill and treatment is palliative rather than curative, knowledge can give the patient and family time to handle the issues they need to before death. They can make their good-byes, resolve old hurts, say all the things they have always wanted to say.'"

Potpourri II...

A doctor, a dentist and an attorney were in a boat together when a wave came along and washed them overboard. Unable to get back into the boat, they decided two would hold on and the third would swim to shore for help. The doctor volunteered.

The dentist said, "There are hundreds of sharks between here and the land. You'll get killed."

Without further discussion, the attorney took off. As he swam toward the shore, the sharks moved aside. The dentist said, "That's a miracle!"

The doctor said, "That's professional courtesy!"

A wall between Heaven and Hell fell down. St. Peter called over to the Devil, "Send over an engineer to get this wall back up."

Satan answered, "My men don't have time for that."

"If you don't, I'll sue you."

Satan asked, "Where are you going to get a lawyer?"

Life in These Parts...

"It's All About Balance" (Excerpts from a MidWeek Cover story by Mark Doyle, May 20 '98, interviewed in Honolulu Club Restaurant)

"For a guy who might be the next national light weight body building champ, Dr. Peter Fong talks and acts more like a priest or philosopher than a world class fitness fanatic" (In 1997, Peter placed 4th in the US National Body Building Championships in Dallas and also won the "Most Improved Award") "This is a quiet, reflective guy who orders fried calamari and moves as easily in conversation from physical anatomy and medical science to philosophy."

"When Fong, 38, talks about training his body, it is inseparable from how it affects his mind and his spirit as well."

Peter Fong is a board certified anesthesiologist at Kaiser permanente who gets up at 4 am five days a week to train, starting with a cardio session and then moving to intense weight training before going to work. In the afternoon, he does a second cardio session. These are the light days. Sixteen weeks before a competition, the schedule is even more intense, seven days a week instead of five.
Fong says, "I've always enjoyed challenges. I like to live life to the fullest and take it as far as I can. I kind of view it as an adventure."

"It's the day-in, day-out performance in the operating room that helps him achieve the most important thing in his life — balance." 

"Fong says his body building and medicine give him the opportunity to strike a balance...It's a matter of understanding yourself, and continuing to improve yourself — on all levels — intellectual, physical and spiritual."

"To do what I want to do requires a great deal of focus. And to maintain that focus, I have to have that balance. It's what life is all about."

**Potpourri III...**

*"20 Things you Don't Want to Hear During Surgery" (Contributed by our editor Norman Goldstein, who got the list from a Richard Clark MD, who in turn got it from a Jerry Levy MD; Jerry got it off the Web and has no idea of the source)*

1. Better save that. We'll need it for the autopsy.
2. Someone call the janitor — we're going to need a mop.
3. Wait a minute, if this is his spleen, then what's that?
4. Hand me that...uh...that uh...thingie.
5. Oh my! Hey, has anyone ever survived 500ml of this stuff?
6. Rats, there goes the light again...
7. Ya, know, there's big money in kidneys. Heck, the guy's got two of 'em.
8. Everyone stand back! I lost my contact lens.
9. Could you stop that thing from beating? It's throwing my concentration off.
10. What's this doing here?
11. That's cool. Now can you make that leg twitch?
12. I wish I hadn't forgotten my glasses.
13. Well, folks, this will be an experiment for all of us.
14. Anyone see where I left the scalpel?  
15. OK, now take a picture from this angle. This is truly a freak of nature.
16. Nurse, did this patient sign the organ donor card?
17. Don't worry. I think it's sharp enough.
18. She's gonna blow. Everyone take cover!!!
19. Rats! Page 47 of the manual is missing!
20. Anything that follows the word "oops".

**Medical Tid Bits I...**

In February, the National Cancer Institute recommended (for the 4th time in 10 years) that moderately advanced cervical cancer be treated with chemotherapy and radiation rather than radiation alone. Five studies involving 1,500 women with cervical cancer treated simultaneously with chemotherapy and radiation showed a reduced risk of dying by 30 to 50%. All five studies had best results with platinum based drug like cisplatin. (Time 3/8/99)

The FDA has okayed an all natural progesterone derived from Mexican yams for use with estrogen in hormone replacement therapy. Called Premarin, it is identical with the progesterone in a woman's body and raises HDL more effectively than synthetic progesterones. (Time 1/11/99)

Researchers think casual drinking is a big cause of absenteesim, tardiness and poor productivity. Some 23% of managers sometimes have a drink during the work day and 25% of workers occasionally come in with hangovers. (NEJM)

Watch your water softener if you have HTN or kidney disease. A recent study suggests that calcium based softeners may lead to dangerously high build-up of K... (Time: 12/21/98)

A study of 2,647 patients treated for mild to moderate heart failure with beta-blockers lowered their risk of death by 34% over a 15 month period. Beta-blockers counter the body's "fight or flight reaction" to stress (ie the beta adrenergic receptors in muscle which respond to surges of adrenaline).

Milton Packer, professor of medicine at Columbia Presbyterian Medical Center reports that "fewer than 5% of congestive heart failure patients are on beta-blockers. If we can get 75 to 90% of these patients on beta-blockers, we'd be saving tens of thousands of lives." (Lancet, 1/2/99)

**Conference Notes...**

*"Screening for Thyroid Disease", QMC 5/7/99, VP Peter Singer, Prof of Medicine, Chief Endocrinology USC*

A. Introduction: Prevalence of Thyroid disease in US:

- Hyperthyroidism: 0.5%
- Nodular Goiter: 5%
- Hypothyroidism: Age 40 1-2%
- 50 3%
- 60 5-7%
- 70 10-12%
- 80+ 15-20%

Hypothyroidism: sustained TSH.

a. Chronic: Hashimoto's
b. Subclinical: Free T4 = Normal
c. I & age. (Graves' & age)
d. Sy's: apathy, depression, lack of interest

**Be aware of the prevalence of hypothyroidism...Early screening can prevent morbidity...**

B. Case Presentation: (68 yr. woman with elevated cholesterol)

T.C. = 278

Syx: Fatigue, vague chest pain, loss of appetite with 10 lb wtg loss, depression

Exam: P = 68, BP150/96, Placid appearance; interested in surroundings

Lab: Hb:12, TC = 278, LDL = 161

Dx: a. Hyperlipidemia, b. Depression, c. RO Heart Disease

Cardiologist: EKG = Abnormal; bradycardia, non-specific ST: low voltage...

Stress ECHO: normal

Dx: a. Hyperlipidemia, b. Depression

Rx: Low fat diet; psychiatric referral

Psychiatrist: Lab: TSH = 19.2 (0.4 - 4)

Free T4 = 5.2 (5 - 12)

Dx: Mild Thyroid Failure

Rx: L-T4 0.05 microgram po/d

3 mos later: Appetite pt happy

Lab: TSH = 1.2, TC = 231mg%, LDL = 138

(Some patients lose wtg, but this pt gained wtg)

C. Reasons for Screening for Thyroid Disease:

- Relatively prevalent
- Adverse clinical consequences preventable
- Clinical dx unreliable
- Treatable

D. Prevalence: Thyroid Deficiency in Framingham Cohort:

13.5% women over 60 = hypothyroid (TSH>5)

10% men over 60 = hypothyroid

Hypothyroid Screening Survey:

New dx: 5.4%

Previous dx inadequate Rx: 7.5%

Previous dx inadequate Rx: 4.3%

Total hypothyroid cases in women over 40 = 17.2%

*** LDL-C c hypothyroidism

Draw TSH in hypercholesteremia

E. Clinical Symptoms a/c hypothyroidism:

- Fatigue
- Lethargy
- Sleepiness
- Mental impairment
- Cold intolerance
- Hoarseness
- Dry Skin
- Loss perspiration
- Loss of Memory

***Hypothyroidism increases with age... Do TSH at age 35 and q 5 years...

G. Treatment:

- Treat overt hypothyroidism

Goal: Normalize TSH

Start healthy pt< 50 yrs old I. 6 microgram qId

Healthy pt > 50 yrs: 10 microgram/d

Coronary patient with hypothyroidism: treat coronary disease first.

H. Metabolic consequences of Hypothyroidism:

- Cardiac
- Respiratory
- GI
- Neurologic
- Hematologic

Medical Tid Bits II...

A panel of 150 experts recommended last January that CHF patients should be on digitalis, diuretics, ACE's and Beta Blockers (Presently under prescribed) (Time 2/1/99)

When non-smokers suffer from emphysema, chronic bronchitis or asthma, their lung cancer risk rises to 94% — which may be genetic or due to chronic inflammation. (Time 2/1/99)

A study of 89,000 women found that high fiber diets (fruits, vegetables, and grain) makes no difference in incidence of colon cancer... (NEJM Jan '99)

The diet pill Orlistat which awaits FDA approval, is being sold in Europe. Obese dieters lost 19 lbs in the first year compared to 13 lbs on placebo. Side effects include cramps and fecal incontinence. (Time 2/1/99)

(Ed: Orlistat was approved by FDA in April and is marketed as Xenical...)
Scientists report that half of all cases of dog and cat bites carry Pasteurella which can cause septicemia, bursitis and even meningitis. (JAMA & NEJM)

A recent study says calcium supplements (1,200mg/d) reduce the growth of colon adenomas. Researchers theorize that calcium binds with compounds that irritate the colon lining. (Time 1/25/99)

MayoClinic reports that 639 women with moderate to high risk of developing breast cancer underwent prophylactic mastectomies from 1960 to 1993, thus reducing their risk of dying from breast cancer by 90% (a figure which is debatable). Researchers have identified two major genes BRAC 1 and BRAC 2 whose mutations increase breast and ovarian cancers. Tests for these genetic mutations cost $2,400 for the first test per family and $400 for subsequent tests... (Time 1/25/99)

**Medical Tid Bits III...**
FDA has approved a hand-held imaging device called T Scan 2000 which sends tiny jolts of electricity into mammogram detected breast tumors. Malignant cells apparently conduct electricity differently from normal cells. The scan may prevent 200,000 unnecessary biopsies per year.

Root Canal specialists say that when a tooth gets knocked out, put it in a glass of milk. Milk keeps the tooth alive by nourishing the root cells for at least an hour.

The Wall Street Journal reports 10 deaths and 11 cases of GI hemorrhage attributed to Cefzorax. Monsanto says there is no proof that the drug caused the deaths. Since January, 2.5 million prescriptions have been written for the drug. (Time 5/3/99)

Eating an egg a day won't keep the doctor away, but probably won't hurt your heart either or cause a stroke per JAMA. Researchers from Harvard and Brigham and Women's Hospital in Boston studied egg consumption by 120,000 nurses and other healthy professionals with normal cholesterol levels and found no link between eggs and heart disease or stroke (except in diabetics)

Dietary fat may be unhealthy for the heart, but will not cause breast cancer according to a study involving 90,000 women.

Viagra may not work for women according to preliminary data. Thirty post menopausal women took the drug and only 21% reported improved sexual function viz enhanced desire and easily achieved orgasms... (Time 3/22/99)
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You are invited to attend...

- **Patient Care Conference – Herbal Psychotropics**
  Enrico G. Camara, MD, FAPM
  May 4, 1999  4:30 – 5:30 p.m.
  Doctors Dining Room
  **LEARNING OBJECTIVES**
  At the conclusion, participants should be able to:
  - Understand the basic biochemistry of valerian, kava, and St. John’s wort as it relates to their psychoactive properties.
  - Identify those patients for whom these agents may have a therapeutic role in clinical management.
  - Describe risks, side effects and possible interactions with each other and with prescription drugs.

- **Ophthalmology Conference – Unusual Retinal Vein Occlusions**
  Sherman Valero, MD
  May 20, 1999  5:00 – 6:00 p.m.
  Queen’s Medical Center Imaging Classroom
  **LEARNING OBJECTIVES**
  At the conclusion, participants should be able to:
  - Describe branch and central vein occlusions.
  - Evaluate and measure unusual causes for these disease processes.
  - Manage vein occlusions medically and surgically.

- **Friday Noon Conference – Latex Allergy As It Affects Health Care Providers**
  Carl W. Lehman, MD
  May 21, 1999  12:30 – 1:30 p.m.
  Doctors Dining Room
  **LEARNING OBJECTIVES**
  At the conclusion, participants should be able to:
  - Describe the epidemic increase of natural rubber latex allergy during the past 12 years and how to reverse the trend.
  - Manage a hospital to be safe for personnel and patients with latex allergy.
  - Recognize the seriousness of natural rubber latex allergy to personnel and patients.

- **Patient Care Conference – An Update on Medicine in Hawaii**
  Jared Acoba; Rudy de Alday, MD; Dan Canete, MD; Fort Eizaga, MD; Reuben Guerrero, MD; Keith Kamita; Robert Pang, & Vince Wong
  May 29-30, 1999  1:30 – 5:00 p.m.
  Turtle Bay Hilton
  **LEARNING OBJECTIVES**
  At the conclusion, participants should be able to:
  - Understand practice guidelines for routine health maintenance screening.
  - Summarize the regulatory issues surrounding the proper and legitimate prescribing of opioids for the management of pain.
  - Recognize the role of cosmetic pharmaceuticals in improving the appearance of aging skin.
  - Review the clinical uses or indications of low molecular weight heparin.

Please call Fran Smith at 522-4471 for more information.
Our Legislators Don't Know the Meaning of the Word Fear — But Then, There are Many Words They Don't Know the Meaning of.

Laser pointers and hazardous toys have been given priority attention with warnings from the American Academy of Ophthalmology, raising the issue to national prominence. But none of that approaches the hazards to people in Hawaii with our unlimited fireworks holidays. There can be no doubt that the year 2000 will be greeted with a display of noise, fire, rockets and sulfurous fumes such as never before seen here. While the Legislature dawdles and diddles with temporizing measures, and postures about religious practices, it is apparent that there will be no change in the law unless Washington Place is ignited by a stray rocket. It's a cruel world out there.

Charity was Once a Virtue; Now It's an Industry.

Historically, for all of Y1.9K (this century in current jargon) many hospitals have enjoyed nonprofit status and have been exempt from taxes on property, income and gifts. In the current climate, questions are arising about how much and how deserved such tax advantages are. In 1995 alone, the aggregate value of exemptions (reserves) to nonprofit hospitals was $4.5 billion in income taxes and $1.7 billion in property taxes. In order to show that the tax advantage is appropriate and properly administered they should demonstrate that they are turning any surplus funds back into community actions that are not profitable, such as teaching or charity programs.

1200 Drop in Membership in 1999 - What's Ahead, Jack?

While we fuss and struggle to trim expenses in order to keep the HMA budget intact, consider the troubles of the California Medical Association. Jack Lewin, M.D., CMA CEO (we all remember him) is trying to make up for the loss of 1,200 members this past year. Efforts were made to reduce the CMA House of Delegates which number 439 (slightly more than the AMA House!) by about one-third, and reduce the board of trustees from 45 to 23 (the AMA makes do with 16). Both measures were resoundingly defeated at the meeting of the House of Delegates. Nothing is so painful as change when it doesn't happen.

In Law, Nothing is Certain but the Expense.

In California, the MICRA law, passed in 1975, which limits jury awards for pain and suffering to $250,000, has long been the gold standard for those seeking reform in medical liability. Without doubt the statute has been a great success in limiting the cost of malpractice insurance in California. Previous attempts to dump MICRA have failed, but now the law is under determined attack from trial attorneys and some health care leaders. Trial attorneys claim the Legislature and the governor are much more sympathetic to some change in the law. At least, they say, the cap should be expanded to reflect inflation, and are looking for $800,000 with built-in regular adjustments. And if MICRA fails in California, can our Hawaii law be far behind?

You Can Fool Some of the People ----

Merck makes two compounds with the same active ingredient, Finasteride. Proscar is a 5 mg. dose for prostatic hypertrophy, while Propecia is 1 mg. for baldness. The two tablets are similarly priced although Proscar has 5 times the effective dose. Also, Proscar is covered by health insurance plans, but Propecia is considered to be used for a cosmetic condition, and not covered. Now, baldness patients are getting prescriptions for Proscar and cutting the tablet into four or five pieces with a razor blade or a plastic pill splitter. Insurers are calling it insurance fraud. Merck claims that Propecia is priced fairly, and strongly opposed Proscar misuse. The underlying reality is that pharmaceuticals are very expensive, and that patients feel no dishonesty in some creative dosage manipulation.

Choose your Airline and your Toilet Paper Through a Process of Elimination.

With turn around time sometimes as short as twenty minutes, airplanes are getting dirtier than ever. A decent cleaning job only occurs when the aircraft is shut down over night. Frequently as planes stay on the go during the day, they become garbage pits with newspapers, plastic cups, scattered napkins, food particles, even disposable diapers stuffed between seats or in pockets. Flight attendants collect pillows, fold blankets, and pick up magazines and papers between flights, but do not do "major cleaning." Airlines flew about 70% full last year, the highest in 20 years, and increased passenger loads means longer loading and unloading times, especially with multiple carry-ons. It all accrues to less time for cleaning. Airlines are criticized for not having clean air, but only recently have passengers begun to complain about wallowing for hours in someone else’s trash. In fact, a thorough cleaning of carpets, seats, and cushion repair only occur once a month. America is very much in need of an airline with panache — clean cabins, sufficient space, fresh air, enough flight attendants, and palatable meals.

Losses of $880 Million in Two Years

Kaiser Permanente had some bright spots in 1998, such as Hawaii, Portland, Oregon, and Washington D.C. It's a good thing they had some sunshine, because for the year Kaiser had net losses of $434 million. This makes two consecutive terrible years for Kaiser, because 1997 produced net operating losses of $447 million. The huge deficits were attributed to high pharmacy and hospital costs, as well as out of network services. Still, Kaiser anticipates a return to profitability by delaying capital expenditures and improving hospital operations. Kaiser has long been the poster ad for politicians citing the efficiency, quality, and cost effectiveness of HMO care, so when the yardstick bends, what then?

Just Exactly What is Diddley Squat?

We already have the washeteria expanded with a cocktail bar, and now we have the telephone soda machine. In Australia, the Telstra Corp. is combining a soda-vending machine with a pay telephone. Soft drinks can be purchased using a prepaid calling card while you punch up your stockbroker. The gimmick is still in trials, but the phone people expect the machine to appeal to younger public telephone users.

Eat What you Want - Stay Fit - Die Anyway.

Chow down, egg-lovers. A Harvard School of Public Health study published in JAMA tells us that a diet which includes eggs does not in fact engender cardiovascular disease. The report is based upon a 12 year study of 120,000 people, and found that patients who average an egg a day face no higher risk of heart attack or stroke than those people who rarely eat eggs. Researchers analyzed data according to five rates of egg consumption, ranging from less than one egg a week to more than one a day. Surprise! They found no evidence that increased ingestion was associated with higher incidence of cardiac disease or stroke. Because of cholesterol content, eggs have long been believed to cause cardiovascular disease, although no one to this time had attempted to prove that presumption. Frank Hu M.D., lead author of the study, suggests that people should pay more attention to broader aspects of their diet – avoiding saturated fats, animal fats, and hydrogenated vegetable oil while increasing fruits, vegetables, whole grains, and olive and soybean oils.

Addenda

美国人消费超过20lb的糖果每人每年。

在伦敦，它支持法律让在公园骑摩托车。

(And if it’s moving?)

Aloha and keep the faith — rts ■
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