

HAWAII MEDICAL JOURNAL

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Leo M. Maher, MD

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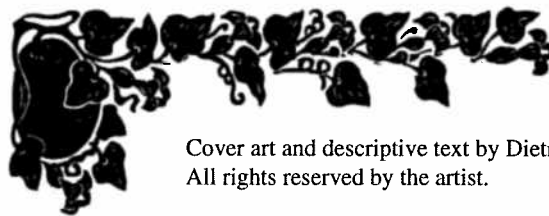
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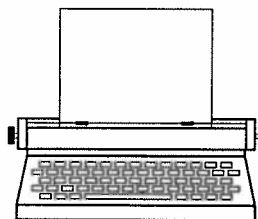
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Hawaiian Runners

Makoa was the most famous of all Hawaiian runners. But another was actually so fleet he could run short distances on top of water and once chased down a notorious canoe thief.



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Editorial

Patient Groups Call on Congress to Fully Fund the Food and Drug Administration

Norman Goldstein MD, F.A.C.P.
Clinical Professor, Medicine (Dermatology)
John A. Burns School of Medicine
University of Hawaii

Twenty leading, national patient organizations have called on key members of the House Senate Appropriations Committee to provide, at a minimum, level funding for the Food and Drug Administration for Fiscal Year 1998.

"The Food and Drug Administration helps patients gain access to important new lifesaving therapies. It is critical that the Agency receive adequate funding so it may sustain and build upon recent achievements," said Don Riggin, President and CEO of the Arthritis Foundation and Chairman of the Board of Directors, National Health Council.

"Equally important, level funding to the Agency is necessary to reauthorize the Prescription Drug User Fee Act for five more years," continued Mr. Riggin. One of the fundamental principles of the Prescription Drug User Fee Act is that the fees are additive and do not supplant the annual Congressional appropriation. Failure to provide at least level funding will automatically trigger an end to user fee payments, which will limit patient access to new therapies in a timely manner.

The Washington based National Health Council does not support the creation of new user fees, on industries not covered by current law, to make up for a reduction in funding to the Agency as called for in the President's budget request. Therefore, it is critical that Congress provide at least level funding to the Food and Drug Administration so it can continue to carry out its many critical public health responsibilities.

The National Health Council is a private, nonprofit umbrella organization of more than 100 health-related organizations nationwide. Its core membership includes over 40 of the nation's leading patient organizations, such as the Arthritis Foundation, American

Cancer Society, Juvenile Diabetes Foundation International and the Alzheimer's Association, Inc.—all groups representing people with chronic diseases and disabilities. Other Council members include the American Medical Association, Biotechnology Industry Organization and private businesses such as Pfizer, Amgen and Cigna.

Thanks to Stephanie Marshall of the National Health Council for this info/editorial.

Commentary

Robert A. Nordyke MD

By George Chaplin
Editor at Large, The Honolulu Advertiser



Robert A. Nordyke MD of Straub Clinic and Hospital

Voltaire said, "Men who are occupied in the restoration of health to other men, by the joint exertion of skill and humanity, are above all the great of the earth. They even partake of divinity, since to preserve and renew is almost as noble as to create."

Many of Hawaii's physicians merit such an encomium, but none more than Dr. Robert Nordyke, now seriously ill.

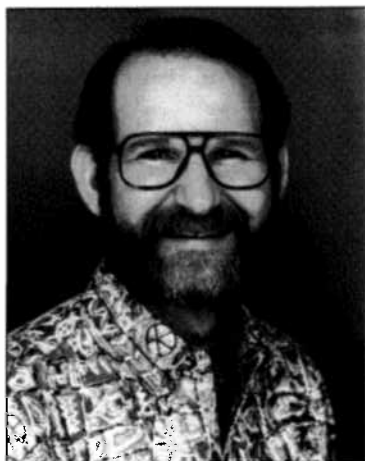
He is well recognized as a pioneer in nuclear medicine, but how many know his background, his formative years that made him into the multi-faceted person that he is?

He arrived 78 years ago in a California farming town, Woodland, in the Sacramento Valley, a town so small the kids could walk to either the elementary or the high school. They had one of each.

It was a time of screened porches and rocking chairs, a time of basic American values. His was a family with little money, but with seven children and lots of love - as well as a tree house that could be reached by climbing out of a second story window and jumping from the roof.

In due course Bob had a broken arm, poison oak and scarlet fever, with a big quarantine sign on the front door and half the family living elsewhere.

A lad with standard gustatory priorities, he used to sneak chocolate powder from a large can high on a kitchen shelf. Ever since, he sneezes every time he eats chocolate—either an allergy or an ongoing sense of guilt.



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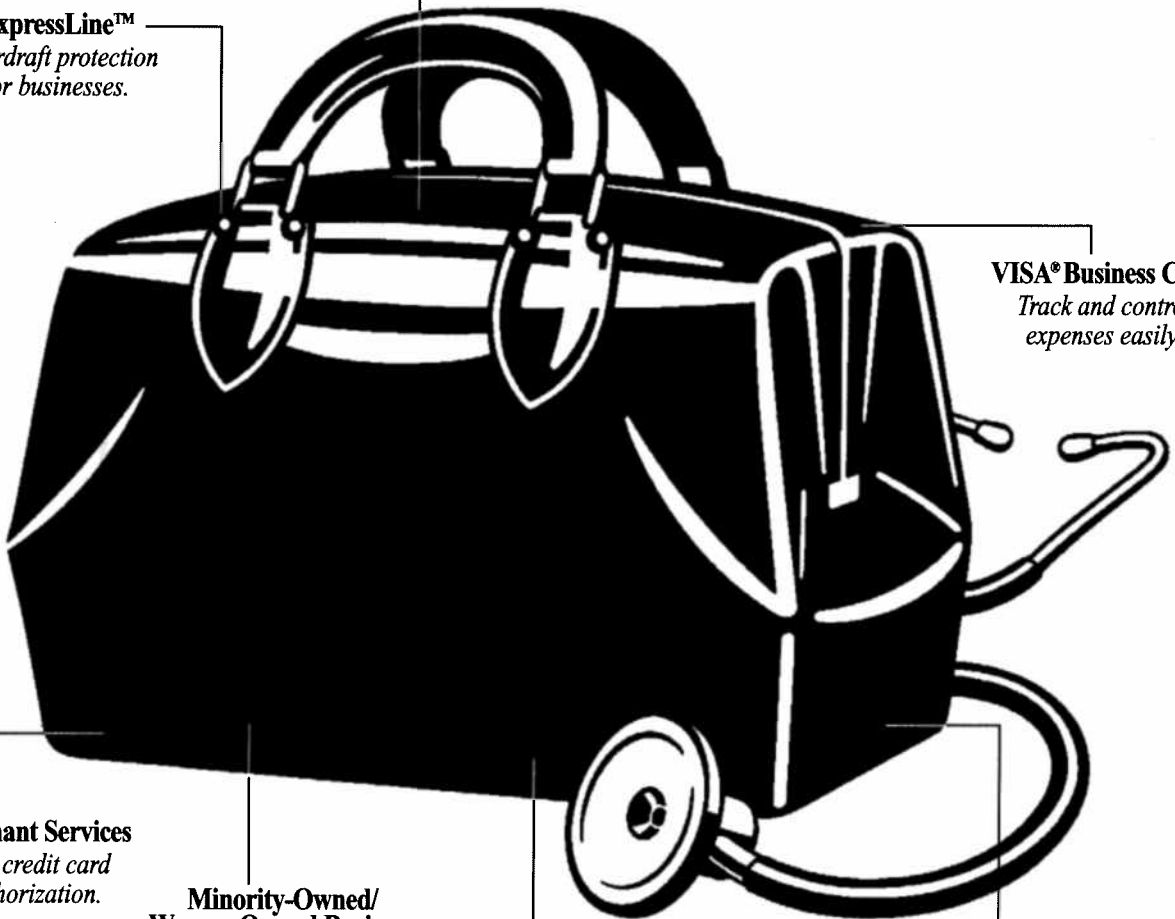
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Once, when his parents were away for a day, he was sent to stay with his maternal grandmother. He decided to run away - who among us hasn't? - with pajamas, toothbrush and favorite spinning top in a paper sack. It began to get dark, he was hungry and when a passing policeman told him his mother and dad were looking for him, his resolve melted and he let himself be taken home. Shades of Horatio Alger, Tom Swift and the Rover Boys!

A good, healthy, active American boy, he had his share of problems - from a BB gun that had a habit of shattering windows or targeting a well-padded lady's rump, to a ride on a horse he boldly mounted when he was five years old. The horse stopped on the tracks of the Sacramento Northern Railway and, despite Bob's frantic pleas, refused to budge. Fortunately, the oncoming electric

train screeched to a halt just feet away. Meanwhile, his mother was trying to find who had stolen her husband's favorite horse.

While Bob was still young, his dad taught him how to drive the family car. But instead of low gear he put it into reverse and promptly took out a nearby fence.

One summer during the Depression, he picked apricots on a ranch just out of town. He worked 10 hours a day, at 10 cents an hour, with 10 cents deducted for a sandwich and flavored water. Lunch! Incidentally, 10 cents is what it took in those days for a Saturday matinee featuring Tom Mix or Hoot Gibson.

As the Depression wore on, his mother, a Mills College alumna, had to take a job teaching. But it was in a nearly abandoned goldmine town in the Sierra foothills. There were only five children living there and since nine youngsters were required to qualify for an elementary school, Bob and three of his six brothers and sisters had to move there into a broken-down, unpainted shambles of a house, complete with well and outhouse. But winter snow and some old skis they found made up for the hardships.

Let's move to 1939, when at 19 Bob finished his junior year at Berkeley. His four-hour-a-day job in the university library didn't really enable him to save any money, so he got a summer job as a logger, felling timber in the Sierras. He and 17 others were signed up by a persuasive union representative. The next morning they were summarily fired. The National Labor Relations Board reinstated them, but a day later they were fired again - for "not working hard enough." No one since ever accused Bob of that!

A co-worker and friend of Bob's suggested they go to his family's farm in Idaho and pitch hay. Sounded good, but no money for travel, and a thousand miles to go. So, they hopped freight cars, sometimes clambering on top and stretching out, sometimes climbing into empty cars, scrounging food when they could, and most importantly, dodging unfriendly hoboes and railroad police, the notorious "bulls" eager to use their heavy clubs.

They finally got there and made the hay fly. But, always eager for new experiences, Bob during part of that summer worked as a Forest Service firefighter battling wild fires, which are always treacherous, often quick to reverse direction.

He survived, hitchhiked home and was graduated from Berkeley in 1940, having majored in English literature, political science and public speaking.

He signed up with his draft board, and followed with a two-month course in San Francisco in radio repair and radio telegraphy. He then thumbed his way to San Diego and got a job as radio operator on a large tuna fishing boat manned by Portuguese, only three of whom spoke any English.

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Off they sailed to the waters of Costa Rica and the Galapagos Islands. He sent Morse Code, up to 30 words a minute!

Came the war and Captain Robert Allan Nordyke put in four years in radar countermeasures. Next, med school at the University of California, San Francisco on the GI Bill. But there was no money to pay for the mortgage on a house he and brother Jim, a Navy lieutenant fresh from service, bought for their mother and themselves in Berkeley.

So he and Jim bought a 1928 - repeat, 1928 - Chevy with a flat bed for \$75 and went into the trash-hauling business in between classes. They did well and soon graduated to a one-and-a-half-ton surplus army truck bought at an auction.

Five years later, when interning at the Kaiser Permanente Hospital in Oakland, Bob Nordyke delivered, under supervision, 80 babies in a single month. Near the end of that rotation, at one delivery, he took off his mask and looked up at the new mother from between her draped legs and told her that all was well and that she had a beautiful baby.

She looked him straight in the eye and then, puzzled and upset, she said, "Aren't you my trash man?"

A few words about Bob's wife, Ellie, who lived in Hawaii as a child and went to Punahou. Came Pearl Harbor and she was evacuated to San Jose, where she finished high school. Her family and Bob's went to the same church and Bob's mother and brother decided that Bob was just right for her.

Once Bob was out of med school and Ellie completed a five-year nursing course at Stanford, they walked down the aisle on June 18, 1950, which adds up to 47 years ago.

Once Bob finished his grueling internship, Ellie quietly asked, "Why don't we take a year off and travel?" Great idea, but no money.

So ... he began working three eight-hour shifts - a regular daytime one at Kaiser's drop-in clinic, a 4 p.m. to midnight shift at Kaiser Hospital, and then on-call for emergencies from midnight to 8 a.m. Ellie worked two shifts, one as a public health nurse in San Francisco, and as a nurse in Kaiser's pediatric section. Six weeks later they had \$2,000 and were off - by plane to New York, third class on the Queen Mary across the Atlantic, a cheap Left Bank hotel in Paris, where they bought a car from two Stanford boys at summer's end, and headed for Belgium.

Their budget: \$2 a day, carefully nurtured, sleeping in a makeshift car bed on river banks, in hay fields, and splurging now and then in a



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campground in Holland, Germany, Denmark, Sweden, Norway, south to France and Spain. The cupboard was almost bare, when they heard about possible jobs at a U.S. air base near Casablanca, and ferried across the Straits of Gibraltar, to Morocco. Bob got a just-opened medic's job at the base and Ellie, with no nurse vacancies, found work in the accounting department, with the snowcovered Atlas Mountains as a backdrop.

In three months they had enough money to continue traveling. A French ship out of Marseilles took them across the Mediterranean, through the Suez, down the Red Sea, past French Somaliland in Africa to Ceylon, then to Saigon, on to Singapore and Hong Kong. Next an American freighter to Japan and then L.A., where Bob began his residency in medicine. Hard to beat or even match folks like that.

Ellie, as many know, spent 23 years at the East-West Center, a power in the population field, with several books and innumerable professional articles to her credit. She's made her own contribution to the population explosion, since she and Bob have five children, of whom they can well be proud.

Their son, who lives next door to them just above Punahou, is a physician, in charge of the Queen's Clinic in Hawaii Kai. Their four daughters include a registered nurse in Colorado, a teacher-writer living in Tokyo, an engineer-lawyer working at Hawaiian Electric Company and a registered dietitian here in Honolulu. Add to that number 11 grandchildren and you've got a good-sized voting bloc.

Bob has had a distinguished career in nuclear medicine, an impressive list of academic and hospital appointments, leadership posts in local and national organizations, and a half-dozen excellence-in-research awards. On publications, I stopped counting at 90.

Bob Nordyke lives and loves medicine, but his interests go beyond. He is a talented writer, an avid reader of such authors as Melville and Conrad, such poets as Wordsworth, T.S. Eliot, and Robert Frost, such playwrights as Eugene O'Neill, to cite but a few. He is a precise man, but a warm and compassionate and caring one who has earned widespread respect, admiration, and affection.

Dr. Robert A. Nordyke Summarized Biography

Pioneer in nuclear medicine, computerized medicine, and what is now known as medical informatics; superb clinician, widely published medical researcher, medical educator, innovative administrator. Straub Clinic and Hospital, Pacific Health Research Institute and Straub Pacific Health Foundation. Professor of Medicine at John A. Burns School of Medicine, 1991-95; Governor of the American College of Physicians, Hawaii Chapter, 1981-85. Named as one of Hawaii's top doctors in *The Best Doctors in America: Pacific Region, 1996-1997* (Woodward/White Inc. of Aiken, S.C.) as reported in *Honolulu* magazine, June 1996, doctors chosen by other doctors.

Born: July 14, 1919 Woodland, California

Military Service: U.S. Air Force, Captain, Radar Countermeasures, 1942-46

Education: B.A., U. of California, Berkeley, in English, Public Speaking, and Political Science, 1940 M.D., U. of California, San Francisco, 1951
Rotating Internship, Kaiser Permanente Hospital, Oakland, CA, 1951-52
Residency, Internal Medicine, Wadsworth V.A. Hospital, Los Angeles, CA, 1953-56

Married: Stanford University Chapel, Stanford, 6/18/1950
To Eleanor Cole:

Daughter of Louise and Ralph G. Cole (executive director of the Y.M.C.A. of the Territory of Hawaii, 1931-41)
Punahou School, 1933-45
B.S., Stanford University, 1950
M.P.H., U. of Hawaii, 1969
Research Fellow, East-West Center, 1969-92
Author of *The Peopling of Hawaii*

Certification: Diplomate, American Board of Medical Examiners, 1959
Diplomate, American Board of Internal Medicine, 1959 and recertified 1977
Diplomate, American Board of Nuclear Medicine, 1972
Medical Organization:

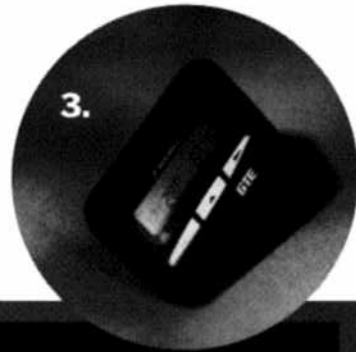
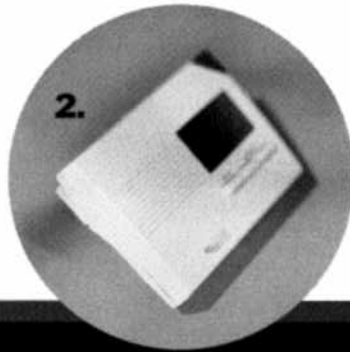
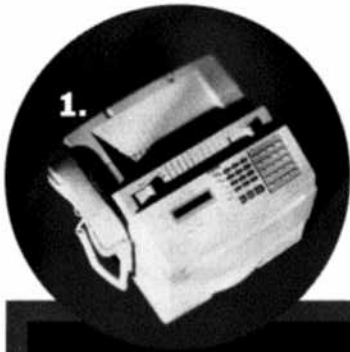
Member of the following medical organizations :
American College of Physicians, Governor of Hawaii Chapter, 1981-85
American Society of Internal Medicine President of Hawaii Chapter, 1980-81
Society of Nuclear Medicine, President of Hawaii Chapter, 1962-63
American College of Nuclear Medicine
American College of Nuclear Physicians, Delegate from Hawaii, 1971-84
Hawaii Medical Association
Continuing Medical Education Program Committee, 1965-68
Continuing Medical Education Committee, 1969-72 vice chairman, 1962
Bureau of Research & Planning, 1971-75
Joint Manpower Commission (physicians, nurses), 1972-75
Chair, Health Manpower/Health Costs Committee, 1976-78
Community Health Care Committee, 1978-79
Representative to State Board of Medical Examiners, 1978
Editor of special edition of *The Journal of the HMA* in honor of his colleague, Dr. Fred I. Gilbert
Honolulu County Medical Society
Delegate to HMA, 1969-74
Board of Governors, 1979-81
American Thyroid Association
Western Society of Clinical Research
American Federation of Clinical Research
Hawaii Academy of Science, Council, 1967
Pacific Health Research Institute
Board of Directors, 1960-91 and 1993-present
Associate Director and Secretary, 1965-91
President, 1985-91
Medical Director, 1991-95
Senior Investigator, 1995-present
Adviser to 24 summer scholars, 1960-present
Straub Pacific Health Foundation, Vice-President, 1991-93
American Board of Nuclear Medicine, Hawaii representative, 1977
National Academies of Practice, Distinguished Practitioner, Academy of Medicine, elected, 1993-present

Community Service:

University of Hawaii, Health and Social Welfare
Manpower Education Council, School of Medicine representative, 1972-74
Rutgers University Research Resource in Computers in Medicine
Hawaii Community Foundation Medical Advisory Committee
Pacific Radiopharmacy
Professional Board of Directors 1979-95
Magnetic Resonance Imaging Advisory Board
Honolulu YMCA
Chairman, Camp Branch, 1964-73, Camp Erdman:
instrumental in bringing about building of new cabins, other structures
Central Union Church
Outrigger Canoe Club

Awards:

First annual Professional Activities Award, Straub Clinic and Hospital, 1984
Excellence in Research Award, Straub Pacific Health Foundation, 1989-91
Laureate Award, American College of Physicians, Hawaii Chapter, 1990
Annual Koa Bowl Award, American Society of Internal Medicine, Hawaii Chapter, 1991



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Excellence in Research Award, Straub Clinic and Hospital, 1991 and 1993
Excellence in Research, Arnold Award, Straub Clinic and Hospital, 1995
Special Recognition Award, Society of Nuclear Medicine, Hawaii Chapter, 1997



Medical School Hotline

Publications: More than 100 professional publications

His Family

- includes:**
- Wife:** Eleanor Cole Nordyke
 - Children:** Mary Ellen Nordyke-Grace, Honolulu; Carolyn Cozzette, Highlands Ranch, Colorado; Dr. Thomas A. Nordyke, Honolulu; Gretchen (Nini) Worthington, Honolulu; Susan (Nunu) Nordyke, Tokyo
 - 11 Grandchildren:**
Aimee M. Grace, Nalani L. Grace, Cameron N. Grace, Trevor R. Grace, Noelle W. Grace, Andrew N. Cozzette, Jennifer M. Cozzette, Larissa H. Nordyke, Veronica A. Nordyke, Thomas J. Nordyke II, and Kaylin E. Worthington.
 - Three sisters:**
Betty Scher, Claremont, CA
Helen Krug, Atascadero, CA
Mary Louise Hardison, Santa Paula, CA
 - Brother:** James P. Nordyke, Honolulu

Description of Research Work Done by Dr. Robert A. Nordyke

Dr. Robert A. Nordyke is an internationally recognized specialist in nuclear medicine and a pioneer in the field of medical informatics, recognized for his development of computerbased medical records, databases, and clinical studies of thyroid disease. Since establishing the Department of Nuclear Medicine at Straub Clinic and Hospital in 1960, Dr. Nordyke has built a uniquely large and complete thyroid disease database, which has helped uncover many new facts about these frequently underdiagnosed diseases and about their treatments. He has demonstrated the correlation between size of a goiter (thyroid gland enlargement) and increased thyroid function (hyperthyroidism), has shown how the cure rate for hypothyroidism is affected by various drug combinations and dosages, and, most recently, determined what is the most cost effective sequence of thyroid function testing for general hospital laboratory use. Dr. Nordyke developed, in collaboration with Casimir A. Kulikowski, Ph.D., one of the earliest pattern recognition methods for computer decision support employing a combination of advanced statistical and logical reasoning techniques. Dr. Nordyke's research, in collaboration with Dr. Fred Gilbert, led the research efforts on information systems for multi-specialty clinics, chronic disease clinics, and screening for breast cancer at the Pacific Health Research Institute (PHRI).

(At a time when doctors kept patient records on 3x5 index cards and were viewing the computerization of medical records with suspicion, Dr. Nordyke recognized the power of computers as tools not just for keeping tidy notes, but for gathering and analyzing medical data in a way that would help direct doctors' diagnoses and treatments for patients. A visionary always bent on improving treatment for his patients, he was 30 years ahead of his time in realizing that the kinds of patients a doctor sees vary from practice to practice and that databases collected specifically for each practice improve the quality of patient care dramatically.)

Editor's Note:

Bob Nordyke MD is a very special man, as indicated by George Chaplin, himself a very special man.

Dr. Nordyke served as guest editor for the June 1995 Festschrift honoring Fred Gilbert MD - a testimonial to Fred and to his longtime associate and friend as well as to Bob. It was our largest and best Festschrift.

Bob has received many accolades, accomplishments and awards - as indicated in his biography. Most recently he received a special recognition award from the Society of Nuclear Medicine, Hawaii Chapter.

Mahalo Nui Loa, Bob for the Fred Gilbert Festschrift, for your efforts to construct cabins at the YMCA Camp Erdman on Oahu's North Shore, for your years of research and administrative guidance at the Pacific Health Research Institute, for the many many patients you have helped over the years, and for your friendship.

Public Health in Medical Education

by **Kenton J. Kramer, Ph.D., Assistant Professor,**
Department of Tropical Medicine
and Medical Microbiology

Kay A. Bauman, M.D., Associate Professor,
Department of Family Practice
and Community Health

A 1993 survey commissioned by the Assistant Secretary of Health Philip R. Lee stated that the United States had significant shortages of public health professionals including physicians (Am. J. Prev. Med., 1996). The goal of the U.S. Public Health Service, therefore, was to increase the number of physicians interested in the public health aspects of medicine. However, almost universally, medical education focuses on individual patients. It may be many years before the student realizes that his/her patient's health is directly related to the patient's family and the community in which the patient lives. The community medicine component of the M.D. Program at the John A. Burns School of Medicine (JABSOM) aspires to instill in our first year medical students an understanding of the principles of public health and the utilization of those principles to promote and preserve health.

Public health education emphasizes ways to promote and preserve health as well as to anticipate and/or correct factors adversely affecting the well-being and functioning of the community. This expansive view of health requires many types of health care professionals acting together as the physician for the community. In Hawaii, there is the added aspect of ethnic diversity and cultural beliefs which may at times come into conflict with western medical practices. The Problem-Based Learning (PBL) curriculum adopted by JABSOM in 1989 emphasizes the role of the family and the community in health issues by promoting community medicine as an important concept in medical care. One of our goals is to produce students with community awareness and cultural sensitivity and whose philosophy includes the maintenance and improvement of health not only for their patients but for all members of the community in which they serve.

JABSOM's curriculum gives our students a wide range of community experiences in order to promote cultural awareness and to examine ways of putting public health concepts into practice. To accomplish this goal, JABSOM has a dual tract community medicine curriculum. Entering first year students are required to select either the Primary Care and Community Medicine Program (PCCM) or the Ke Ola O Hawaii (Health of Hawaii) Program to fulfill their community medicine requirement. The student's total commitment in either program is 15 months.

In PCCM, the students participate in two of the following organizations: Queen Emma Clinics, Hina Mauka Drug and Alcohol Treatment Center, HUGS (Help Understanding & Group Support) for seriously ill children, Diamond Head Mental Health Clinic, Halawa Correctional Facilities, Leahi Hospital's Adult Day Care

Facility, Health Care for the Homeless, and the Tuberculosis Branch of the Department of Health. The time commitment at each site is 4 hours per week for 3 months. Students develop an appreciation for the medical needs of the individuals seeking care at each of these facilities and to interact with patients from various cultural backgrounds. They also learn the physician's role in meeting those needs and begin to gain an appreciation for the role other health care professionals play in caring for the patient. Finally, each student undergoes hospice training at either Hospice Hawaii or St. Francis Hospice where the focus is on comfort and community care for the dying and support for their family.

Working with community organizations is just one aspect of the PCCM curriculum. In their weekly health care problems, students are asked to integrate their PCCM learning with simulated patients and to explore other community agencies which may help in treating their "patient's" health problem. PCCM continues during the summer between the student's first and second year. The students must shadow a primary care physician and complete a community medicine research project. Shadowing a physician for 9 weeks is an integral part of the education of physicians. Students apply what they have learned during the year on "real" patients and examine how their preceptors interact with the community and contribute to solving public health issues through community and political involvement. At the same time, students are asked to identify and research a community health problem. This research project is a chance for the student to apply public health concepts and to explore ways epidemiology and biostatistics are used to investigate a health problem and as tools for developing possible solutions. Through these projects, students gain important research skills by investigating a community health care problem and at the same time gain practical experience in designing and executing a project with public health implications. Students have examined such diverse areas as cigatera poisoning on Oahu, bicycle safety practices, impediments to childhood immunization programs, development of anti-smoking campaigns which target specific groups, health care issues at Halawa Prison and the effects of delivery room temperature on newborn distress.

The second tract of the Community Medicine curriculum involves a multi-disciplinary approach to community medicine. Under the auspices of Ke Ola O Hawaii, students from the Schools of Medicine, Social Work, Nursing and Public Health come together to address health care issues of their community. There are four Ke Ola sites located at Queen Emma Clinics, Kalihi Palama Health Center, Kokua Kalihi Valley Comprehensive Family Services, and Waianae Coast Comprehensive Health Center. These sites bring students from the four disciplines together with grass-roots community organizations to identify and develop health projects, such as increasing participation in childhood immunization programs, improving ac-

cess to medical care by native Hawaiians, and school-based educational programs on health. The students meet once a week for 4 hours to learn the skills needed to work in a multicultural/multilingual community. Other practical areas addressed are factors which influence group dynamics, ways to facilitate the functioning of small groups of individuals from different backgrounds, community needs assessment, and program planning and implementation. Active community involvement is a hallmark of the Ke Ola Program. Students leave the program with the background and skills needed to tackle the health care needs in the under served areas of our State.

The partnership between JABSOM and the community organizations involved in PCCM and Ke Ola is providing valuable learning opportunities for our students to study and practice the principles of public health. This unique arrangement expands the learning environment away from the physical structures of the Manoa Campus and allows our students to quickly integrate into the community. The JABSOM administration is grateful to the participating organizations for volunteering their staff and facilities to help train the future physicians of Hawaii. With their help, JABSOM will continue to promote primary care specialties as career choices for our students. Studies are in progress to evaluate the effect these efforts are having on the career choices of our medical graduates.

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Diphyllobothriasis after Eating Raw Salmon

Jeffrey W. Hutchinson, MD¹; James W. Bass, MD¹; Denise M. Demers, MD¹; Gerald B. Myers, MD²
Departments of Pediatrics¹ and Pathology², Tripler Army Medical Center, Honolulu HI

An 11-year-old boy in Hawaii passed mucus and a moving object in his stool. The object was identified as a segment of the fish tapeworm *Diphyllobothrium* species which is not indigenous to Hawaii. *Diphyllobothrium* ova were also found in the stool. The only raw fish he recalled eating in previous months were tuna sushi and lomi-lomi salmon which usually contains raw but previously frozen salmon. Of these two fish, only salmon which is not native to Hawaiian waters, has been incriminated as a significant source of *diphyllobothrium* fish tapeworm infection. Freezing kills this parasite, however, we speculate that the raw fish in the lomi-lomi salmon that our patient had eaten had not been pre-frozen or was not adequately pre-frozen. Eating raw salmon without certainty that it has been adequately pre-frozen carries the risk of diphyllobothriasis or fish tapeworm infection.

Introduction

The custom of eating raw seafood has become increasingly popular in the United States over the past two decades largely due to Asian influences. Sashimi (sliced bite-size pieces of raw fish and other seafood delicacies), sushi (small portions of seafood pressed onto rice patties) and lomi-lomi salmon (chopped raw salmon, tomatoes, onions, green peppers and soy sauce) are popular foods in Hawaii that are currently consumed in increasing quantities at trendy Japanese restaurants across the United States. Many of these seafood delicacies harbor parasites that may be harmful to humans and raw salmon is foremost among them. We report a child with diphyllobothriasis who had previously eaten foods containing raw salmon and tuna. Of these two fish, only salmon which is not native to Hawaiian waters, has been incriminated as a source of *diphyllobothrium* fish tapeworm infection.

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Key Words: diphyllobothriasis, *diphyllobothrium*, salmon, sushi, sashimi, fish tapeworm

The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or as reflecting the views of the Department of the Army or the Department of Defense.

Illustrative Case

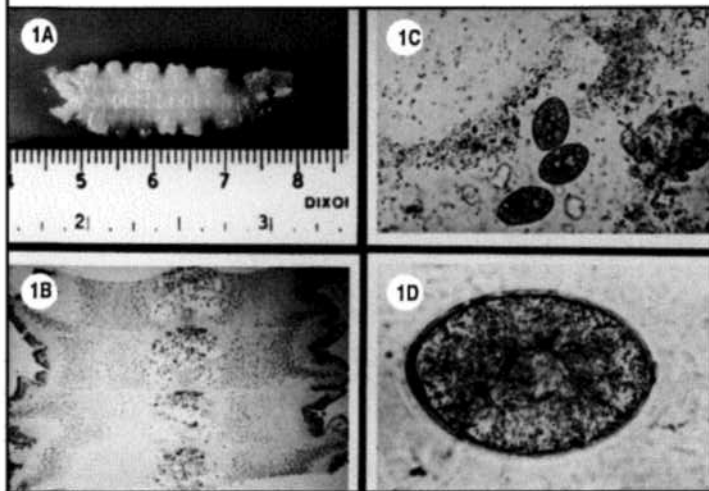
An 11-year-old boy presented to our Pediatric Clinic with the chief complaint of passage of mucus and a moving object in his stool. He denied other symptoms and physical examination was within normal limits except for moderate obesity. The stool specimen he brought with him contained a three by one centimeter tapeworm segment consisting of 17 proglottids (Figure 1A) of the fish tapeworm *Diphyllobothrium* species. A smaller segment of four proglottids was fixed, sectioned and stained and the segmental nature of the proglottids which are characteristically wider than they are long is evident. Centrally positioned rosette shaped uteri containing numerous ova are seen in each proglottid (Figure 1B). Numerous identical ova were seen in stool wet-mount preparations (Figure 1C). These ova, on higher magnifications, exhibit opercula on one end with abopercular knobs characteristic of *Diphyllobothrium* species (Figure 1D). On questioning the child recalled having eaten raw tuna sushi and lomi-lomi salmon, which usually contains raw but previously frozen salmon, within the previous three months. He was treated with a single dose of praziquantel; 600 mg orally. He was asked to bring in any further suspected worm parts in his stool for identification but none were seen and his stools returned to normal the following day. Repeated stool examinations from the patient and all members of his family were negative for proglottids or ova.

Discussion

Diphyllobothriasis in North America has been most commonly associated with *D. latum* acquired from eating uncooked or inadequately cooked fresh water fish from the waters of Alaska, Canada and the Great Lakes regions of the United States.¹ Salmon have been the most common cause of infection with this parasite in Japan.² The custom of eating raw fish has become increasingly popular in western cultures over the past two decades and eating raw salmon may now be the major source of diphyllobothriasis in the United States.^{3,4} Cooking infected fish for at least 56° C for five minutes or freezing at -18° C for 24 hours or -10° C for 72 hours kills *Diphyllobothrium* species rendering infected fish safe to eat.³

Species identification of the genus *Diphyllobothrium* requires examination of the intact worm including the scolex, strobila and individual proglottids which was not recovered from our patient.^{1,4,5} Of the 12 species of *Diphyllobothrium* only a few have been found to infect man: *D. latum*, *D. dendriticum*, *D. pacificum*, *D. ursi*, and *D. klebanovskii*.⁶ *Diphyllobothrium dendriticum*, *D. uri* and *D. klebanovskii* have most often been incriminated in Alaskan salmon infections and one of these species was probably the cause

Fig. 1A - 1D.—Diphyllobothriasis After Eating Raw Salmon
Hutchinson JW, Bass JW, Demers DM, Myers GB



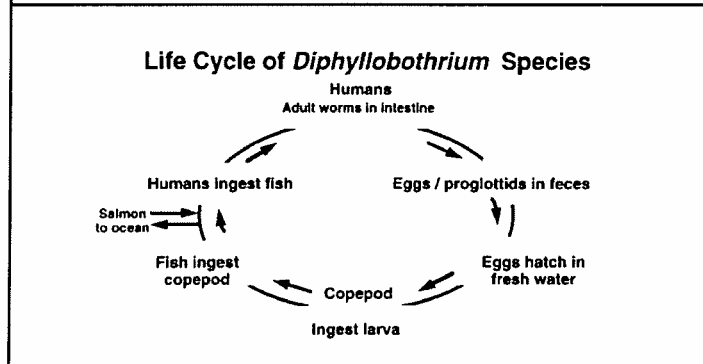
1A.—The strobila or chain of proglottids of the tapeworm *Diphyllobothrium* species that was passed in the patient's stool. 1B.—Fixed, sectioned and stained segment of four proglottids each showing central rosette shaped uteri with small dot-like ova within (X 10). 1C.—Operculated ova of *Diphyllobothrium* species in a wet-mount preparation of the patient's stool (X 200). 1D.—Same ova under higher magnification (X 1000).

of infection in our patient.⁷ Of the two types of raw fish he had eaten, tuna, which are pelagic fish, do not harbor this parasite while salmon, which are anadromous fish which must leave the ocean to spawn in fresh water rivers and lakes, have zoologic studies documenting a high rate of *Diphyllobothrium* infection.³ We speculate that the raw fish in the lomi-lomi salmon that our patient had eaten had not been pre-frozen or was not adequately pre-frozen.

Most commercial salmon in the United States come from Alaska where the fish are shipped to markets frozen. In recent years there has been a trend to ship fresh unprocessed Alaskan salmon to markets when processors are overwhelmed by large salmon runs. In 1980 such a bumper catch of salmon occurred in Alaska and a large number were flown fresh chilled but unfrozen to market in other states primarily those along the west coast.^{3,4} Prior to 1982 the Parasitic Disease Drug Service at the Centers for Disease Control was the only source of niclosamide in the United States and in 1980 there was a deluge of requests for this drug from physicians to treat patients with diphyllobothrium tapeworm infection. There were 17 requests in 1979 while there were 59 in 1980. Of 39 of these patients interviewed all recalled eating raw salmon and all denied eating any other fish known to transmit fish tapeworm infection.⁴ The following year niclosamide was licensed for general use in the United States so there is no record of how often this drug has been used to treat diphyllobothriasis since 1982.

In addition to being a source of diphyllobothrium infection salmon may harbor anisakis parasites.⁸⁻¹⁰ In a survey of 50 wild caught salmon taken off the Washington coast all were infected with *Anisakis simplex*.⁸ Eating raw fish infected with this parasite has been associated with severe gastrointestinal symptoms and complications including intestinal perforation. The only treatment for anisakiasis is surgical or endoscopic removal of the parasite.¹¹ A patient in Hawaii has been reported who developed severe gastrointestinal symptoms after eating raw lomi-lomi salmon.¹² During endoscopic examination an *Anisakis simplex* worm embedded in the

Fig. 2.—Diphyllobothriasis After Eating Raw Salmon
Hutchinson JW, Bass JW, Demers DM, Myers GB



Life cycle of *Diphyllobothrium* species. Salmon become infected during the fresh water phase of their life-cycle. Young fingerlings may eat many types of fresh water crustaceans including copepods in route to the ocean. Mature salmon return from the ocean to spawn and die. Infection can occur when salmon taken from either the ocean or from fresh water are eaten raw by mammals.

gastric mucosa, was removed. When lomi-lomi salmon purchased at a commercial market in Hawaii was examined numerous worm fragments and whole viable *Anisakis simplex* worms were found. In their review the authors concluded that in nearly all known human cases of anisakiasis with tissue involvement in the United States, salmon were the source of infection. Cooking to at least 60° C for five minutes or freezing at -20° C for 60 hours prevents this infection.³

Several studies have shown that parasitic infection from eating raw fish occurs most commonly when the food is prepared at home and that it rarely occurs from consuming raw fish at sushi bars in Japanese restaurants.¹³ However, as recently as 1989 a survey of 23 sushi bars in New York City revealed that all served raw salmon.¹⁴ It has been shown that cold smoking and most methods of marinating and brining cannot be relied on to kill anisakid worms and visual inspection can not be counted on to reveal all larvae.¹³ Unless the raw salmon served in these and other sushi bars or raw salmon purchased for home consumption has been pre-frozen, there is risk of infection with anisakid roundworms, as well as diphyllobothrium tapeworms, when this fish is eaten raw.

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The videotape provides viewers with information on organ and tissue donation from the perspectives of four key individuals. These individuals are: 1) a Filipino kidney recipient; 2) a donor family

member; 3) a professional educator of ODCH; and 4) a Filipino priest of the Catholic Diocese of Honolulu. Barriers that hinder Filipinos from becoming organ and tissue donors are addressed and information on why it is important for more Filipinos to become organ donors is provided.

ODCH's hopes to effectively reach more people in the community through the use of the videotape to increase their awareness on the need for more organ and tissue donors within the Filipino community as well as within other ethnic groups. In Hawaii, despite the high need for organ transplants, the Filipinos have the lowest donation rate in comparison to other ethnic groups.

In Hawaii, kidney failure hits Filipinos and Hawaiians harder than any other ethnic group. Filipinos and Hawaiians account for almost half of Hawaii's dialysis population, but only make up 28 percent of the Island's total residents. As of May 1997, 31 Filipinos (of a total of 152) are waiting for a lifesaving organ transplant in Hawaii statewide. All forty-one are waiting for a kidney transplant. In comparing the waitlist as of September 1995 to May 1997, the percentage of Filipinos waiting almost doubled from 15.7% to 27% as they continue to be the largest waitlist group in need of an organ transplant.

The production of the videotape was made possible through a \$5000 grant received by ODCH from the Atherton Family Foundation. Interested individuals and organizations wanting a free copy (while supplies last) of the videotape may call Angie Iaea at (808) 599-7630. Neighbor islands may call 1-800-695-6554.

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After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to drug discontinuation alone. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation and treatment with an antibacterial drug clinically effective against *C. difficile* colitis.

PRECAUTIONS

General: For topical use only; not for ophthalmic use. Concomitant topical acne therapy should be used with caution because a possible cumulative irritancy effect may occur, especially with the use of peeling, desquamating or abrasive agents. If severe irritation develops, discontinue use and institute appropriate therapy.

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Avoid contact with eyes and all mucous membranes.

Information for Patients: Patients using BENZAMYCIN® Topical Gel should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes, nose, mouth, and all mucous membranes.
2. This medication should not be used for any disorder other than that for which it was prescribed.
3. Patients should not use any other topical acne preparation unless otherwise directed by physician.
4. Patients should report to their physician any signs of local adverse reactions.
5. BENZAMYCIN® Topical Gel may bleach hair or colored fabric.
6. Keep product refrigerated and discard after 3 months.

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Data from a study using mice known to be highly susceptible to cancer suggests that benzoyl peroxide acts as a tumor promoter. The clinical significance of this is unknown.

No animal studies have been performed to evaluate the carcinogenic and mutagenic potential or effects on fertility of topical erythromycin. However, long-term (2-year) oral studies in rats with erythromycin ethylsuccinate and erythromycin base did not provide evidence of tumorigenicity. There was no apparent effect on male or female fertility in rats fed erythromycin (base) at levels up to 0.25% of diet.

Pregnancy: Teratogenic Effects: Pregnancy CATEGORY C: Animal reproduction studies have not been conducted with BENZAMYCIN® Topical Gel or benzoyl peroxide.

There was no evidence of teratogenicity or any other adverse effect on reproduction in female rats fed erythromycin base (up to 0.25% diet) prior to and during mating, during gestation and through weaning of two successive litters.

There are no well-controlled trials in pregnant women with BENZAMYCIN® Topical Gel. It also is not known whether BENZAMYCIN® Topical Gel can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. BENZAMYCIN® Topical Gel should be given to a pregnant woman only if clearly needed.

Nursing Women: It is not known whether BENZAMYCIN® Topical Gel is excreted in human milk after topical application. However, erythromycin is excreted in human milk following oral and parenteral erythromycin administration. Therefore, caution should be exercised when erythromycin is administered to a nursing woman.

Pediatric Use: Safety and effectiveness of this product in pediatric patients below the age of 12 have not been established.

ADVERSE REACTIONS

In controlled clinical trials, the total incidence of adverse reactions associated with the use of BENZAMYCIN® Topical Gel was approximately 3%. These were dryness and urticarial reaction.

The following additional local adverse reactions have been reported occasionally: irritation of the skin including peeling, itching, burning sensation, erythema, inflammation of the face, eyes and nose, and irritation of the eyes. Skin discoloration, oiliness and tenderness of the skin have also been reported.

DOSAGE AND ADMINISTRATION

BENZAMYCIN® Topical Gel should be applied twice daily, morning and evening, or as directed by a physician, to affected areas after the skin is thoroughly washed, rinsed with warm water and gently patted dry.

Important to the Pharmacist

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Project Caring for Life— Long-Term Care Funding Alternative

Leonard G. Katsarsky
Vice-Chairman of the Hawaii Long-Term Care Reform Task Force

Introduction

The Eighteenth Legislature, 1995, State of Hawaii sanctioned the establishment of the Hawaii Long-Term Care Reform Task Force as a matter of compelling State interest to design a system of long-term care services for Hawaii's citizens requiring long-term care that is affordable, available, and of high quality. The system would meet current and growing LTC needs; identify and plan new services and delivery systems, and determine how to pay for these services using both public and private funding.

Unfortunately, our society has not made adequate provisions for financing the cost of long-term care. Individuals and families are going broke, the Federal and State Medicaid program is stretched to the breaking point, and the need for long-term care is growing to epidemic proportions. Only society acting in concert will solve this problem.

We are faced with a difficult situation which must be addressed. Solutions will be complex, multifaceted, and demand much creativity. There are no quick fix solutions. One size will not fit all. Hard choices must be made. Difficult decisions will be required from both the Hawaii State Government and the individual citizens which they represent.

The bottom line is, in order for any LTC financing program to work in the State of Hawaii, it must be understandable and acceptable to the constituency. They must have choices and be made aware of them. Once this is achieved and a course of action is determined, legislation to activate the system should take place.

The purpose of the following funding concept is to provide the task force with a sample framework for a long-term care system which could be used as a yardstick for other alternatives as they are considered. It is by no means complete and in order to be effective will require modification and expansion as additional thoughts and information become available. It does however, provide us with much of the LTC situation as it is now; discusses many of the shortfalls and concerns within the system as it now exists; puts in writing the criteria we have committed to in our design of an improved LTC system; and provides us with a LTC financing concept that

will serve as a basis of comparison for all other funding alternatives presented.

Background

Definition

Long-term care includes subacute, rehabilitative, medical, and nursing care for people who have functional limitations or chronic health conditions and who need ongoing health care or assistance with activities of daily living. Long-term care services are provided in a variety of settings, including nursing facilities, assisted care living facilities, adult day care, home, and community based settings.

Examples of activities of daily living include bathing, dressing, eating, toileting, maintaining continence and transferring from bed

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to chair. Inability to perform activities of daily living (ADL'S) could be due to either physical or cognitive impairment.

Objectives

Senate Concurrent Resolution No. 121, H.D.1, dated May 12, 1995 sanctioned and expressed support for the Hawaii Long-Term Care Reform Task Force. The following long-term care objectives were requested by SCR121, and subsequently adopted by the task force:

1. Study and understand what Hawaii's long-term care needs are and what costs are associated with those needs.
2. Study and understand what resources are available for long-term care for today's elderly and disabled and those who will become the elderly and disabled in about twenty years.
3. Study and evaluate barriers to the provisions of community based services, and the construction of new facilities.
4. Educate the general public about the issue.
5. Establish the framework for implementation of a long-term care system.

Criteria

SCR121 and the Task Force Vision Statement provide the criteria necessary for the design of such a LTC system. They describe a LTC system that should:

1. be affordable.
2. cover as broad a segment of the population as is feasible.
3. significantly offset Medicaid LTC costs.
4. be financially stable over time.
5. offer a comprehensive and cost-effective benefit package with both institutional and home and community based care options.
6. be financed primarily through private funding and secondarily through a public safety net.
7. meet the needs of the Hawaii consumer, providers, and payors.
8. offer a full continuum of care between the nursing home and the home in the least intensive, most appropriate, and affordable settings.

Present Situation

LTC Statistics

The following statistics provide a snapshot of the LTC situation as we know it today and portray the magnitude of the problems that face us from both a national and local perspective.

1. Risk of needing nursing home / home health care

According to The Health Insurance Association of America, 46.8% of people over the age of 65 will spend some time in a nursing home. The odds increase to 71.8% for those who will receive long-term care in the home environment. This statistic becomes even more alarming when we realize that Hawaii has one of the fastest growing percentage of citizens living over the age of 85 in the nation.

2. Available nursing home bed space

National - 56.7 Beds/1000 Population (Age 65+).

Hawaii - 25.8 Beds/1000 Population (Age 65+).

3. Average stay in a nursing home:

National - Less than 4 Years.

Hawaii - 2 Years.

This statistic should not lead to the conclusion that people in Hawaii are healthier on average than the rest of the nation. The fact

of the matter is we lack sufficient bedspace to accommodate our needs. In most cases there are waitlists and therefore, many of the patients are entering nursing homes during their latter stages. Also, the culture of Hawaii favors caring for family members in a home environment for as long as possible.

4. Estimated annual nursing home cost:

National - \$20,000 - \$100,000/Year.

Hawaii - \$42,000 - \$80,000/Year.

These costs appear to increase at an approximate 5% annual rate.

5. Estimated daily home health care cost:

Hawaii - \$15 - \$25/Hour

(2-4 hour minimum for ADL assistance)

These figures represent the typical cost on Oahu for licensed custodial personnel to provide ADL assistance in the home environment. A registered nurse charges around \$35/hour for a home visit.

Levels of Long-Term Care:

Before addressing the present options available and future alternatives contemplated to pay for LTC we should first have a clear understanding of the levels of LTC and how they impact on the problem.

1. **Skilled nursing care** is defined as daily nursing and rehabilitative care, ordered by a doctor, that can be performed only by, or under the supervision of skilled medical personnel.
2. **Intermediate nursing care** requires occasional nursing and rehabilitative care, ordered by a doctor, that can only be performed by, or under the supervision of skilled medical personnel.
3. **Custodial Care** is care of a nonmedical nature provided for persons who cannot perform such basic living activities as eating, bathing, and dressing without assistance.

A LTC survey conducted by Harvard University for the U.S. House of Representatives included a study of these levels of care and determined, based on actual confinements to nursing homes, how each of these levels impacted on the problem of LTC. They concluded that .5% of the patients required Skilled Care, 4.5% required Intermediate Care, and 95.0% required Custodial Care. These statistics were reconfirmed by the Health Care Financing Administration in 1996.

Present Pay Alternatives

Medicare

Medicare is and always has been aimed at paying for acute and post-acute restorative care, not LTC. Medicare only addresses LTC at the skilled level. To qualify for covered skilled nursing facility benefits, the patient must:

1. Require daily skilled care which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis.
2. Be in the hospital for at least three consecutive days before entering a skilled nursing facility that is certified by Medicare.
3. Be admitted to the skilled nursing facility for the same condition for which patient was treated in the hospital.
4. Generally be admitted to the facility within 30 days of discharge from the hospital.
5. Be certified by a medical professional as needing skilled nursing or skilled rehabilitation services on a daily basis.

If the patient qualifies, Medicare will pay 100% of the approved

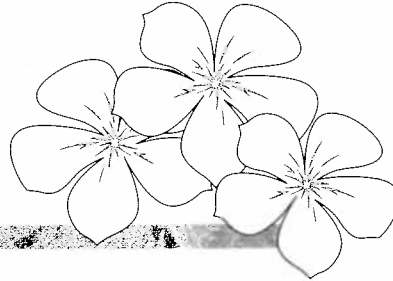
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Worker's Compensation
HMSA - 65C Plus
StraubCare Quantum
Queen's Hawaii Care
Aloha Care Quest
Kaiser Quest
HMSA Quest
PGMA
HMAA
Queen's HMSA Premier Health Plan
Physicians Health Hawai'i Inc.
University Health Alliance/HDS
Kapiolani Health Hawaii
Hawaii Laborers Health & Welfare Trust Fund



amount for the first 20 days. Medicare provides no coverage after 100 days. Neither Medicare nor Medigap insurance will pay for most nursing home care. Source, National Association of Insurance Commissioners and the U.S. Department of Health and Human Services.

Medicaid

Medicaid is assistance available to help people who are considered indigent or poor pay for health care. The program was never intended to carry the entire financial burden for the LTC costs of our elderly population. To qualify a family must first spend down their assets to poverty level.

Hawaii's Medicaid program has served as a public safety net to assist families that are impoverished to pay medical and LTC expenses. Under current law, with regard to LTC, the Medicaid safety net is only extended to institutional care. Medicaid coverage for the continuum of care provided between the home and nursing home does not presently exist.

Rules governing Medicaid LTC eligibility changed dramatically in August 1993 with the passage of Omnibus Budget Reconciliation Act of 1993 (OBRA). OBRA increased the look-back rules with regard to trusts and significantly changed the way the penalty is calculated and assessed for transfers or gifts within the lookback period. OBRA also requires states to institute recovery programs for all Medicaid services and expenses that are rendered.

Self-Insure (Private Pay)

According to the Health Care Financing Administration, 51% of the LTC costs in the nation are paid by individuals who are self-insured. Unfortunately, the odds are that most individuals who self-insure and require LTC over an extended period of time become impoverished and end up on Medicaid.

Long-Term Care Insurance

Private LTC insurance has been available in Hawaii since 1986 and is a relatively new product in the insurance marketplace. The quality of the product has greatly improved over the past several years. Today, LTC insurance policies include a wide range of benefits, features, and options that cover all levels of care. Many carriers provide coverage for the entire continuum of care stretching from the home to the nursing home. Cost of insurance is generally determined by the level of benefits selected and age at time of issue.

The purpose of LTC insurance is to help people protect themselves and their families from the escalating costs related to LTC. The circumstances for each person or family are generally different. They should therefore be provided with sufficient information to make an informed LTC decision based on their situation. If a LTC insurance program is appropriate it should reflect their situation as best they can afford it.

LTC insurance is not necessarily the answer for everyone. Different situations dictate different solutions. For example, an individual with limited assets and low income may better be served by spending down their assets and then going on Medicaid. Individuals with certain health problems or disabilities may not be able to qualify for coverage and other solutions would be required.

Product Overview

Level of Participation: LTC and how we prepare for it is a major

problem that faces all generations. It is a problem that society must solve. The criteria established for the design of Hawaii's LTC system dictates a system that is responsive to the LTC needs of the people it serves. In order for a LTC system of the magnitude envisioned for the entire State of Hawaii to work it must require the participation of all tax paying citizens. If all citizens are expected to participate they should be given choices that result in a course of action that best reflects their situation.

Continuum of Care

Hawaii's nursing homes are overcrowded and costs are escalating. According to a national study conducted by Harvard University, 95% of the patients in nursing homes require care at the custodial level. Whether or not these statistics are accurate, when applied to Hawaii, it is considered acceptable to assume that when examining the entire spectrum of care from home to nursing home a preponderance of the care required is at the custodial level.

It makes sense for Hawaii to take the necessary steps to create an environment that would fill the continuum between the home and nursing home with services and delivery systems that adequately support LTC at the custodial level. This would not eliminate the requirement for nursing homes but it should take pressure off them and provide our citizens with alternatives that may better fit their situation. Filling the continuum may also help control and reduce the overall cost of care to patients and their families.

Public Safety Net

Medicaid has served as Hawaii's public safety net to assist those who are impoverished pay for LTC. When we consider the overall lack of bedspace that presently exists in Hawaii's nursing homes it becomes evident that our safety net has a hole in it. Medicaid only pays for LTC at the institutional level. If the continuum of care were expanded and Medicaid assistance were extended to include the continuum of care, it would appear, more people could be taken care of in a more cost effective environment.

Funding Choices

Hawaii has one of the fastest growing populations of citizens living over the age of 85 in the nation. The odds are overwhelming that most of them will require LTC sometime in their life. Neither the state nor the nation has adequate financial resources to cope with the problem. Statistics reflect society has not made adequate provisions and that 92% of today's LTC bills are paid either by Medicaid or individuals who have chosen to self-insure. Unfortunately, most of those who self-insure and require LTC over an extended period of time become bankrupt and go on Medicaid.

When it comes down to who should be held accountable to pay for the system, the choices are limited. Every taxpayer above the level of poverty would be required to contribute to the funding of the system by electing to either to pay an annual LTC assessment based on their income or purchase a LTC insurance policy and transfer the risk to the insurance company. Individuals, at their own discretion, would be allowed to change their funding options to better reflect any changes in their personal situation. Those who elect to pay the assessment would still be required to spend down their assets prior to qualifying for Medicaid. The revenue generated through the collection of assessments would be utilized to offset Medicaid costs incurred at service and support levels below the nursing home. For

purposes of this concept paper it is assumed the annual assessment would not exceed 1% of gross income.

It is anticipated there would be an immediate influx of funds which could be used initially by the State to support the creation of a LTC environment of care between the home and the nursing home that is affordable, available, and of high quality.

Incentives

Appropriate incentives/disincentives should be created for both options to reflect the potential impact of each decision on the system. For example, those that would elect to pay the annual assessment would still be required to spend down their assets prior to qualifying for Medicaid assistance. However, if they do qualify and receive Medicaid, the entire sum of their assessed fees paid into the system would first be deducted from Medicaid's costs before any cost recovery measures are taken as required by OBRA93. Conversely, if the assessment option were elected and Medicaid assistance is not required, the entire sum of fees paid would be credited as a deduction from the participant's final estate taxes.

The obvious incentive for those who purchase LTC insurance would be an income tax deduction for the paid premium. On 21 August 1996, President Clinton signed into law "The Kennedy/Kassebaum Bill, Health Insurance Portability and Accountability Act." The law provides the following federal tax incentives for those who purchase tax qualified LTC insurance.

1. Individual Participants: A deduction up to certain age-related limits of their LTC insurance premiums, plus all LTC out of pocket expenditures, as part of the medical expense deduction over 7.5% of adjusted gross income on the federal tax form.
2. Employer Deductibility: All employer LTC premium contributions for employees are deductible to the employer as a business expense and non-taxable to the employee. Premiums paid on behalf of their employee's spouses are in fact also tax deductible as a business expense.
3. Self-Employed: 40% of the LTC premium is deductible as a business expense.

Product Examination

The purpose of the following product examination is to contrast the LTC funding alternative, as proposed, with the product design criteria established by SCR121 and Project Hawaii Cares' Vision Statement.

Criteria: LTC System should be affordable.

Discussion: In concept, the LTC Funding Alternative should be affordable. For the sake of this concept paper, it is assumed that the cost for the assessment option would not exceed 1% of annual gross income. The cost of LTC insurance is generally determined by the level of benefits selected and age at time of issue. By expanding the continuum of care and extending Medicaid to include the continuum of care below institutional level, it would appear, more people could be taken care of in a more cost-effective environment.

Criteria: LTC System should cover as broad a segment of the population as is feasible.

Discussion: Definitely. This system is designed to cover every citizen that requires LTC.

Criteria: LTC System should significantly offset Medicaid costs.

Discussion: Yes. By design, the Medicaid safety net has been

extended to include the continuum of care below the nursing home. Much of this cost should be absorbed through funds obtained from participants that elect the assessment option.

Criteria: LTC System should be financially stable over time.

Discussion: As people become better informed about LTC and are made aware of their alternatives, it is anticipated a great percent of them will elect to purchase their own coverage through a LTC insurance policy. Also, at their own discretion, individuals would be allowed to change their funding option to better reflect their personal situations.

Criteria: LTC System should offer a comprehensive and cost-effective benefit package with both institutional and home and community based care options.

Discussion: Yes. By design.

Criteria: LTC system should be financed primarily through private funding and secondarily through a public safety net.

Discussion: Yes. By design.

Criteria: LTC System should meet the needs of the Hawaii consumer, providers, and payors.

Discussion: Yes. The Medicaid safety net has been extended. The continuum of care has been expanded to include more services and delivery systems.

Criteria: LTC System should offer a full continuum of care between the nursing home and the home in the least intensive, most appropriate, and affordable settings.

Discussion: Yes. By design.

Summary

The synopsis of The Hawaii Long-Term Care Task Force describes the product of project "Caring ... For Life" as "the framework for implementation of a long-term care system. Framework will encompass promotion, programs, education, legislation and other initiatives necessary for an effective system. The product will be a combined effort of the private sector and government to bring about changes which will provide a continuum of services to all residents in need of long-term care in the least intensive, most appropriate and affordable setting."

The purpose of this concept paper has been to paint the big picture of LTC as it now is and provide, in concept, an alternative picture of what it could be. It is by no means complete but hopefully will serve as an initial effort to be addressed and, if appropriate, be expanded upon or modified. It could also serve as a basis of comparison for other alternatives as they are considered.

Long-term care is a complex problem, there are no quick fixes. The solution will require great imagination and the ultimate of our creativity. The product should be flexible and above all, should be able to stand the test of time.

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2. Synopsis, Hawaii Long-Term Care Reform Task Force, Project: "Caring ... For Life".
3. Long-Term Care, Knowing The Risk, Paying the Price, 1997.
4. AARP Public Policy Institute, 1996.
5. National Council On The Aging - John Hancock Long-Term Care Study, 1997.
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7. "Don't Wind Up Short On Long-Term Care," Jane Bryant Quinn, Chicago Tribune, 1997.
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9. Hawaii HealthCare Professionals, Inc., 1997 rate table.
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Council Highlights

Friday, June 6, 1997
Roger Kimura MD, Secretary

The meeting was called to order by Dr Spanger, President at 5:32 p.m.

Those present were Drs L. Howard, President-elect; C. Lehman, Immediate Past President; R. Kimura, Secretary, C. Kelley, Treasurer; AMA Delegates: C. Kam, A. Kunimoto; Speaker: H.K.W. Chinn; County Presidents: L. Sonoda-Fogel - Hawaii, W. Dang Jr. - Honolulu, G. McKenna - Kauai, A. Bairos - W. Hawaii; Councilors: T. Au, M. Shirasu, B. LeeLoy; Past Presidents: W. Chang, W. Dang, G. Goto, J. Lumeng, J. McDonnell; Young Physician Delegate: G. Caputy.

HMA Staff: J. Won, B. Kendro, N. Jones, P. Kawamoto, J. Asato, A. Rogness - recording secretary.

- Distinguished Medical Reporting Awards (DMRA): Dr Roger Kimura, Chair of the Public Relations Committee noted that the DMRA started 33 years ago. He presented certificates of recognition and prizes for the following categories: Not-for-profit Newsletter, Magazine or Newspaper Reporting - Michael Tsai (Article - "They Don't Inhale," HMSA's Island Scene Magazine); Radio Reporting - Dr Mark Schlacter (Women's Health Issues on the show Country Doctor, KGU radio); Commercial Newspaper or Magazine Reporting - Beverly Creamer (Article - "Stroke Therapy Works Miracles - Quick Action Crucial Doctors Say," Honolulu Advertiser); Television Reporting - Sandra Sagisi (Women on Ice) KGMB.

- Dr Spangler reported: 1) that the HMA is still working on the rabies issue and has met with Calvin Lum and veterinarians. HMA does not agree with the statistics on the risk assessment and will be obtaining more information for reconsideration; 2) Drs. Howard and Spangler will meet with the Chiropractors to go over their final order petition and give medical input; 3) The AMA meeting in Chicago will be from June 22-26; 4) The next Council meeting will be on July 11 instead of July 4. The agenda will be to review the Governance Section of the Restructuring Task Force. A summary of the May 3 Special House of Delegates will be distributed at the meeting.

- Alliance President, Cherlita Gutteling submitted a written report of the Alliance activities.

Mrs. Yuen on behalf of the Alliance to the HCMS and Eli Lilly and Co. made a presentation of their gift to the Hawaii Delegation to the AMA of white coats with an HMA emblem in celebration of 150 years of medicine. There was concern raised by an HMA officer that there is a problem with two conflicting groups within the HMAA of which neither possess the necessary legal documents to represent the Hawaii Medical Association at the AMA meeting in Chicago. There was concern that there may be two delegations from the Alliance attending the AMA meeting claiming to be the HMAA. It was noted that HMA can only endorse or not endorse an Alliance to represent the HMA. Due to turmoil within the Alliance, HMA offered to hire an attorney at HMA's expense to mediate concerns between the parties, however the Alliance declined.

For Action

- A motion was passed by Council that HMA withdraw approval of any organization representing HMA as the Alliance at this time and that the HMA request that the AMAA be informed of this action and that anyone claiming to be an HMA Alliance representative at the meeting in Chicago be given guest credentials. A registered letter would be sent from the HMA President with a copy to the AMAA.

- Council approved the nomination of Dr Scott Hundahl as the University of Hawaii's representative to the HMA Cancer Commission.

- A motion was passed by Council that any physicians who want to join HMA because of the PGMA lawsuit must be in good standing and will be assessed the prevailing dues rate at the time they join.

- A motion was passed by Council to send out letters from HMA requesting historical data on the 1996 worker's compensation rates.

Component Society Reports

Honolulu.—Dr Dang, Jr. reported that there will be an HCMS membership meeting on June 18 on the topic of "Safety in the Office," particularly on preventing and treating needle sticks.

Maui.—No report

Kauai.—Dr McKenna reported that their county has not met. He recently represented Kauai from the Physicians' Health Committee at an international conference on physicians health in Norway. There was a lot of concern about changes in ethical standards within medicine and whether medicine would be able to withstand the changes. He did a paper on The Impact of Managed Care on Physician' Health. It was noted that Europeans are unionized and therefore have a union representative negotiate with insurance carriers, etc. The physicians in Europe have the same problems with stress, overworking, substance abuse and disruptive physicians.

West Hawaii and Hawaii.—Both counties have not met but will have a meeting in June.

For Information

Fruit Irradiation Facility, Hilo.—Dr Fogel noted that money has been allocated by the Hawaii County Council for the facility. Waimea and Kohala seem to be the favored areas because of little seismic activity and little threat of volcanic flow. The problem is the potential health hazard to the community due to radiation leakage if an earthquake should occur. HMA sent letter to all the Hawaii County Council members expressing this concern and is presenting a resolution to the AMA.

Hawaii Health Information Corporation.—Dr W. Dang, Jr. who sits on the HHIC board as a representative for the HMA reported that HHIC does not release information on individual physicians, (such as in the case of economic credentialing), unless the individual physician is requesting the information or gives permission to release the information.

Meeting was adjourned at 7:55 p.m.

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Life in These Parts

KHVH News: Prison escapee recaptured. He was not hard to spot running down Dillingham Blvd. without his pants and leaving a trail of blood. He had lost his pants climbing the razor wire fence and had cut himself as well.

Paul Harvey reports: "This was a bad season for flu. 20,000 deaths were attributed to flu."

"Prevention of Alzheimers: First Advil and now 3 to 4 glasses of Bordeaux."

What you don't want to hear if you wake up during an operation. Surgeon saying, "If that's the spleen, what is that?"

Our Hawaii Medical Association was concerned about the Hawaii county fruit irradiation facility which would use radioactive Cobalt-60. **John Spangler**, HMA President; **Steve Moser**, HMA Environmental Health Committee chairman; and **Fred Holschuh**, Hilo Medical Center ER physician, past HMA president signed the HMA letter to the Hawaii County which expressed concern about the safety of a nuclear facility in a geologically active area like Hilo and suggested seismic studies before construction.

Bad Writing Contest

An academics' "Bad Writing Contest" was held at Canterbury University in Christchurch,

New Zealand. All entries in the contest were gleaned from published academic works and the top three offenders were all English professors, **Rob Wilson**, a tenured English professor at University of Hawaii won 2nd place with a sentence which read in part: "If such a sublime cyborg would insinuate the future of post-Fordist subject, his palpably masochistic locations as ecstatic agent of the sublime superstate need to be decoded as the "now-all-but-unreadable DNA" of the fast deindustrializing Detroit." Contest judge Denis Dutton, senior lecturer in the philosophy of art at Canterbury University said, "The contest showed that academics and major publishing houses have been so busy using the "magical incantations of jargon, they've forgotten what real thinking is. There is an endless ocean of pretentious turgid academic prose being added to daily, and we'll continue to celebrate it." (Submitted by our editor, *Norman Goldstein*)

Beware the PDR

Physicians and pharmacists, who answer emergency calls at the San Francisco Poison Control Center, say that the Physicians' Desk Reference, gives faulty and possibly fatal, advice on treating overdoses. The group surveyed 8 doctors who had called in for help and found that in the past year, half had turned to the seven pound, 3,000

page tome, listing information from manufacturers. Six drugs often used in deadly overdoses were reviewed in the 1994 edition and in each case, the PDR recommended treatments were dangerous, ineffective or simply outdated. Medical Economics, the PDR's publisher states that several flaws have been fixed in the 1997 edition.

(From *Scientific American May 1997*)

Physician Moves

Retiring

Honolulu physician **Bruce Chrisman** announced his retirement effective May 31.

And more Retirements

Honolulu physician **Cesar B. deJesus** retired effective June 1 after 40 years of practice.

HMA Officers Elected

A special HMA House of Delegates meeting on April elected **Leonard Howard President-elect** for the balance of 1997. Leonard had served as HMA treasurer for the last 17 months. Leonard practiced OB Gyn for 35 years, 10 years with the military, 6 years private and 19 years with Kaiser.

Charles Kelley, Straub occupational medicine specialist was nominated and elected by the HMA Council at their meeting on May 2 to serve as treasurer for the balance of 1997. Charles had completed his first term as a HMA councilor and served on the Finance Committee of the HMA Reorganization Task Force.

Oncology Conference

An 84-year-old homeless man was found unconscious in Aala Park and ended up in Kuakini ER. Surgeon **Andrew Oishi** (being second or third generation Japanese-American) had a language barrier because the man spoke only first generation Japanese. The alcohol level was over 0.14 (anything over 0.10 being legal intoxication). The patient had a successful CABG in 1996 and was in a nursing home from whence he had departed without permission. Admission Hb was 12.0 and occult blood positive. BE showed a constricting lesion near the splenic flexure. The patient had a successful colectomy, but the liver was cirrhotic and of 16 harvested nodes, 1 was positive. The pros and cons of further therapy were aired by attending radiotherapists, chemotherapists and pathologists. **Ken Sumida**, moderator, aptly summarized the situation: "It is recommended that no adjuvant therapy be started because of his cirrhosis, his poor performance status and the social circumstances." (Wot? Can't a guy have just a lil' drink?)


Conference Notes

Managing Hyperlipidemia in Your Office

S.Y. Tan MD, JD, Professor of Medicine, John A. Burns School of Medicine

re Serum Cholesterol & CHD

- Total cholesterol is obsolete. Think 'LDL'
- "The lower the cholesterol below 200, the lower the death rate"

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Six CHD Risk Factors

- Age: male over 45; post menopausal female over 55
- Family history of premature CHD
- Smoking
- Hypertension
- HDL below 35
- Diabetes

LDL Treatment Guidelines: (Treat more aggressively when pt has 2 or more factors)

Risk Factors	DIET	DRUG Rx	LDL Goal
Less than 2	160-190	190	160
More than 2	130-160	160	130
Established CHD	--	--	100

Key Points:

1. Think LDL rather than Total Cholesterol
2. Diet rarely lowers LDL. Use "statins"
3. Treat risk factors, eg diabetes, hypertension
4. For CHD patients, get LDL below 100

Conference Notes

Endoscopic Ultrasound by Donn Marutani, QMC staff gastroenterologist, QMC Friday am 4/18/97

Indications for EUS

- to determine resectability of upper GI tumors ie. esophagus; stomach; pancreas; ampulla
- to locate rectal tumors
- to locate submucosal tumors
- to assess a "questionable" pancreatic mass found by CT or ERCP
- to assess tumor recurrences at anastomotic sites
- to assess choledocholithiasis in "low suspicion" patients
- to assess chronic pancreatitis when studies are negative
- to determine pancreatic involvement in endocrine tumors

Miscellany

We Have Our Ways

A mother and her two young children made several visits to the office. She often mentioned her husband and hoped he would someday come for a general checkup. I'd never met her husband, but I was aware of his place of employment and I'd noticed a man fitting his description, leaving his workplace on several occasions, always smoking a pipe.

One day she came for an exam to see if she was pregnant, having missed two periods. While I was conducting a pelvic exam with vaginal speculum in position, I asked, "Does your husband smoke a pipe?"

She jumped off the examining table, speculum still inserted, and replied, "Yes, he does, Doctor. How can you tell?"

(Condensed version of a story by John Williston MD in Stitches)

A social worker recounted that he'd spent some time one day talking with a pleasantly demented lady in a senior's facility. The next day he returned to see her and greeted her with, "Hello, do you remember my name?"

Without missing a beat, she pointed at the

Classified Notices

To place a classified notice:

HMA members.—Please send a signed and typewritten ad to the HMA office. As a benefit of membership, HMA members may place a complimentary one-time classified ad in HMJ as space is available.

Nonmembers.—Please call 536-7702 for a nonmember form. Rates are \$1.50 a word with a minimum of 20 words or \$30. Not commissionable. Payment must accompany written order.

For Sale

Misc for sale.—Canon copier model 4050 \$1,950; desk 60" x 30" \$50.; Credenza 71" x 18" \$100. Ask for Nelson 536-7702.

4 in-line X-ray Viewer.—Like new. \$385. Call 537-1155

For Sale.—Exam table, drawers. Excellent condition. 536-9888.

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nursing station and replied, "No, I don't, but if you go over to that desk they might be able to help you."

(Story by Romyne Gallagher MD in Stitches, May '97)

Anecdotes

Close Call

(Condensed version) Michael Silver MD, From Stitches, Jan '97 issue

A family doctor sent me an ultrasound report on my OB patient. "The baby was fine and bladder was normal, but the kidneys weren't properly visualized." I noted my advise to him at the bottom of the report. "Suggest you repeat the ultrasound in 2 weeks (for CYA reasons)" and faxed back a copy to him.

His secretary called to inquire about the meaning of 'CYA.' With great difficulty she pried 'Cover Your Ass' out of my secretary. Twenty minutes later the patient called, very concerned, and wanting to know the meaning of 'CYA.'

As I desperately tried to think of a solution, the lights came on in my head. My secretary repeated my explanation to the patient, word for word: "The ultrasound CANNOT YET ASSESS the kidneys." The patient immediately and graciously said good-bye.

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We live in a world with too many moving parts.

A small study (five patients) of air bag injuries treated at UCLA School of Medicine trauma service revealed that slow speed car crashes carry potential for severe eye injuries. A 20 mph crash caused deployment of the air bag with force sufficient to rupture an eyeball. The driver became legally blind as a result while the passenger (no air bag) was not injured. In another low-speed crash, the patient was wearing rigid contact lenses when the air bag deployed causing bilateral retinal tears with detachment and a macular hole. An interesting side light is that four of the five patients were Asian-Americans, provoking speculation that perhaps shorter stature or shallower orbital rims may have been a factor.

In any given set of circumstances, the proper course of action is determined by subsequent events.

Here are some basic statistics regarding liability lawsuits and malpractice, compiled by a Harvard Medical School study of 30,000 plus New York patients:

—98% of patients given sub-standard care did not sue. Many suffered no harm, or only trivial harm.

—97% of patients who received sub-standard care, and who suffered a significant injury from medical treatment, didn't sue either.

—More than 80% of those who did sue had not received sub-standard care.

—Almost 20% of suits filed didn't even involve any adverse event, but these claims were nevertheless settled for an average payout of almost \$29,000.

—Neither the presence or absence of negligence nor of an adverse event, was associated with the outcome of the litigation.

—The single factor which correlated strongly with how much the litigant collected, was how severely the patient was disabled. In cases of permanent disability, the mean payment was more than \$200,000.

Hot cornbread and black-eyed peas, you can eat as much as you please.

The team from PHY-COR (pronounced fah-coah - southerners, you know) appeared on Maui to convince one and all interested physicians, that they plan to come to town and take over the Maui Medical Group, the largest single group of physicians on the island. They already have Straub in their pocket and want to integrate the neighbor islands into their warm and loving arms. Their term is *vertical integration*, and for the uninitiated, that means straight lines from primary care doctor, through specialist and to hospital. More simply, stay within the system; that's how you write a tight medical care contract. While the pitch is for a quality management team to take 17% and run the group efficiently for the benefit of doctors and patients, what it also means is a large, mainland, profit-making organization wants to buy a significant piece of the medical care and contracting in the islands. Somehow one has to wonder if the genesis is truly quality medical care at the fairest cost, or is there perhaps a serious profit motive among all the oratorical meadow muffs?

If the French were really intelligent, they would speak English.

France and Germany are running unemployment rates of 12 to 14%. Both nations have largely socialized health care systems, and rely upon taxation of the work force for funding. The elderly populations are increasing, and the coffers are being depleted. Spending reductions in the realm of 20% are in order, which in France will bring cataracts from \$350 down to about \$280 per procedure. With a direct income tax of 56% and a value added tax of 20%, French surgeons pay taxes of 70 to 80% annually. The German government has reduced its health care spending by 20%. The level of reimbursement for cataracts which was reduced 33% to \$378 in 1996, is expected to decrease further. Both countries anticipate that the budget reductions will result in long waiting lists for elective surgery.

Small business has enjoyed as much of Hawaii as it can stand.

On the economic scene right here in downtown paradise, we find many Hawaii businesses groping and struggling for survival. *Forbes* magazine rated Hawaii last in the nation for job growth. *Dun and Bradstreet* rated Hawaii as the worst in the nation for business and job migration. The March 1997

Expansion Management magazine listed Hawaii as the worst state in the nation for doing business. *Financial World* ranked our beloved island state dead last for locating a business. Meanwhile our legislators took bows and posed for photographers as they congratulated each other for the excellent work of the recent session. Tax relief - no way; reduce government - forget it; dance to the music of unions, insurance industry, and banking - you bet!

Forget the health nut stories. Tell me your grosser reminiscences.

T.E. Eckstein & Associates, a Minneapolis research firm, conducted a study analyzing 17 components that measure disease, access to care, lifestyle, occupational safety, disability, violent crime and mortality to produce a so-called number one health state. Minnesota captured the title for 1996, replacing New Hampshire, which dropped to number four due to an increase in the prevalence of smoking. Hawaii ranked third just behind Utah. A sad finding was that the national proportion for smoking has risen 0.4% to 22.6%, reversing previous trends. The "sickest" state was found to be Louisiana, while Nevada has the highest rate of adult smokers at 29.1%. In Hawaii, 20.4% of adults puff on the poisonous, addictive weed.

The certainty of misery is better than the misery of uncertainty.

On the subject of weeds, the present Washington administration, made up largely of the generation of flower children (but he never inhaled!), has backed away from the initial threat to prosecute physicians for discussing marijuana with their patients. The Justice Department and and HHS now have "clarified" their position, and stated that physicians have a right to discuss cannabis use as they would with any other treatment. The real problem, however, is that marijuana doesn't fit into any treatment regimens. The dosage is inexact, the quality and strength are variable, and each inhalation contains more than 400 chemicals, not a predictable, active therapeutic agent. Moreover, patients dose themselves. No drug company is willing to undertake research because there is no patent potential, which means that government grants are needed. Meanwhile 40% of oncologists have recommended marijuana for use in association with chemotherapy. Some ophthalmologists admit their glaucoma patients use cannabis, and some physicians treating AIDS patients, encourage marijuana as an appetite stimulant.

He who steals my purse steals trash. My wheels—that's something else.

If you drive a Honda Accord, keep it carefully protected. Thieves favor cars a few years old, because there is a great demand for parts. Honda parts are interchangeable from year to year, so they are frequently stripped and parts easily disposed. The 1994 Honda Accord EX was the number one stolen vehicle in 1996, closely followed by the Accord LX 1994 and 1996. For the three previous years the Oldsmobile Cutlass was the "winner." The vehicle least likely to be stolen was the 1993 Ford Probe. Honda Accord was the number two best seller in the U.S. in 1996, following number one, the Ford Taurus.

Look for the ridiculous in everything and you will find it.

A man walked into a Burger King in Ypsilanti, Michigan, at 7:50 am, brandished a gun and demanded cash. The clerk said he could not open the cash register without a food order. The man ordered onion rings, but the clerk said they were not available on the breakfast menu. Frustrated, the man walked away.

Addenda—

- ❖ Multi-focal lens implants appear to be beneficial except for night driving where they cause greater limitation due to glare.
- ❖ Al Gore is Gerald Ford without the pizzazz.
- ❖ Leaving sex to the feminists is like letting your dog vacation at the taxidermist.

Aloha, and keep the faith—rts ■

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