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CONTENTS

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Highlights of the HMA Council Meeting of June 4, 1993

Members present were: J Chang, President; A Don, F Holschuh, J Spangler, S Wallach, C Kam, R Stodd, C Lehman, M Cheng, R Goodale, P Chinn, W Dang Jr, P Hellreich, S Hundahl, K Thorburn, C Kadooka, H Percy, T Smith, J Lumeng, J McDonnell; Guests: Drs A Hawk, B Fong; Legal Counsel V Woo; F Reppun, Editor, *HMJ*; Auxiliary President, S Foo; HMA Staff: J Won, N Jones, L Tong, J Asato, J Estioko, and A Rogness, recording secretary.

The Secretary's Report and Treasurer's Report showed a marked decrease in HMA membership with dues down some 12% and about 100 dues-paying members to be dropped for non-payment of dues.

A letter was received from the president of the Hiroshima Prefectural Medical Association announcing the biennial visit of the Atomic Bomb Commission medical team to conduct examinations on A-bomb survivors, July 5 to 14, 1993. A luncheon will be hosted by HMA leadership to honor the team members and to rededicate the sister relationship established between the two medical associations many years ago.

The Membership Task Force is girding up for the next membership drive. Council approved a program in which senior HMA leaders will undertake a membership recruitment effort.

The Public Relations Committee chair, Steven Levine, reported that the committee has been successful in coordinating a health education television program. The Committee garnered KHON-TV2's support of the concept, and medical reporter Leslie Wilcox will moderate. The program is co-sponsored by HMSA and Longs Drug Stores. HMA will not be liable for costs but will provide medical consultants, staff expertise and a phone bank of HMA members. Council approved the project. Physician members will be alerted and asked to serve on the phone banks to answer viewer questions.

Bernard Fong, chair of the Hawaii Foundation for Medical Care (HFMC), an affiliate of HMA, presented to Council a video and material relating to the Connecticut State Medical Society (CSMS) IPA (Independent Practice Association), an HMO. Council agreed that such an approach by a new entity might be the way for physicians in Hawaii to meet the challenges of health care reform both locally and nationally. It approved the creation of a separate, for-profit, capital stock corporation, to be owned by physician members of the HMA, in which physicians could have the control over their own practices and the future of physician reimbursement. HMA members will be kept informed of developments.

HMA's Hawaii Health Quest (the State of Hawaii's new proposal) Coordinating ad hoc Committee recommended that a letter be sent to U.S. Health and Human Services Secretary Donna Shalala reiterating the fact that Hawaii's physicians have always sought to provide their patients with the best in medical care and that the Hawaii Health Quest program was not discussed with physicians prior to its promulgation and has not been endorsed by the HMA; any program of this type needs input from Hawaii's physicians.

Fred Holschuh
HMA Secretary

Review of SHPDA

Former president of HMA Russ Stodd had been discussing SHPDA and the CON with David Hoff, editor of the *Maui News*. Hoff asked Russ to submit a contribution to the column headed "Viewpoint" in the *Maui News*. Russ promptly complied. It appeared in the 28 April issue.

Having obtained permission to do so, we are pleased to reproduce it in the pages of this *Journal*.

What's particularly tickling to our funnybone is David Hoff's comment, printed in the same issue:

"Doctor has the right perscription."

The column stated:

"We've never thought much of the State's archaic Certificate of Need process, a gobbledygook of bureaucracy that gives thumbs up or thumbs down to proposals for new medical equipment or facilities...Maui eye surgeon Dr Russell T Stodd argues convincingly for the abolishment of CON. We second the motion."

The HMA Council, at its meeting on 7 May, unanimously voted to pass this message on to our readers.

The editor

■

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Salmonellosis in Hawaii: 1987 to 1990

Hans E vom Dorp MD, MPH*

After an overview of salmonellosis, its epidemiology is described and techniques are discussed by which the disease could be brought under control. A review is made of all salmonellosis cases reported to the Department of Health Epidemiology Branch for calendar years 1987 to 1990. This data is compared with national and state laboratory data. Reports received by the Epidemiology Branch often lack sufficient information; this accounts for the sizable "unknown" entries. This frustrates a person's understanding of a more accurate incidence of the disease.

Introduction

Salmonellosis in Hawaii was reviewed comprehensively in 1984[1]. The purpose of our report is to review the incidence and prevalence of salmonellosis in Hawaii from 1987 to 1990. The analysis is based on data from the reports of the Epidemiology Branch[2], the Department of Health annual *Statistical Report*[3] and information from the State Laboratory[4]. A case of salmonellosis was defined by the isolation of *Salmonella* subspecies (spp) by a diagnostic laboratory.

Salmonellae infect humans as well as many species of animals. Identical serotypes can be found in both populations. Several taxonomic systems have been used to classify salmonellae with the most common method recognizing 3 species: *S. typhi, S. cholera-suis*, and *S. enteriditis*. The prototype of enteric fevers, typhoid fever, is caused by *S. typhi,* found only in humans[5]. All other salmonellae infect both animals and humans with more than 2,000 species (serotypes) of *S. enteritidis. S. enteritidis* subspecies are usually referred to by their subspecies name only, eg *S. typhimurium, S. arizona*, etc. *S. cholera-suis* can be responsible for generalized Salmonella septicemia with focal lesions to be found anywhere in the body. Most large outbreaks of salmonellosis involve one of the *S. enteritidis* serotypes.

Epidemiological investigations show that outbreaks of the disease often are attributed to improper food processing, food handling or storage. At any point from food production to food consumption, contamination with salmonellae can take place with human infection as a result.

Salmonellae are killed readily by heat at 55°C (131°F) for one hour or in 15 to 20 minutes at 60°C (140°F)[6]. The length of time the food item is heated affects the degree of penetration of the heat. An unthawed piece of meat or packaged food will obviously heat unevenly with the cooler core likely to provide a nidus for possible later contamination. Animal salmonellosis can lead to human infection if meat, meat byproducts or eggs are cooked only partially, or if milk is not pasteurized. Salmonella contamination of meat and eggs can be deep-seated and good heat penetration is imperative.

Salmonellae can spill from animal viscera and feces during the preparation of carcasses in the slaughterhouse, during the milking of animals, or by fowl while they lay eggs. The bacteria can course through the blood of poultry and be present within the magma of eggs. With the introduction of antibiotics into animal feeds, the resistance to antibiotics by Salmonellae has increased. Domestic fowl probably constitute the largest single reservoir of salmonellae[6].

A recent investigation of an outbreak in Hawaii established that 9.43% of the eggs randomly sampled in Honolulu supermarkets were contaminated on the shell surface by salmonellae[7]. Further investigation pinpointed a producer's faulty egg-sanitizer's temperature-control mechanism as an etiological factor. In that report, the investigator correlated 16 cases of salmonellosis in 1989 with serotypes isolated from eggshells[7].

For the sake of expediency, foods often are prepared long before they are consumed. In order to avoid overcooking, these foods are often kept at low heat, thereby ensuring an ideal medium for bacterial growth and then quickly re-heated before serving. The USDA recommends that thorough reheating of previously prepared foods be done at 165°F or higher before being served[8].

In reported outbreaks of salmonellosis, the implicated food was frequently prepared early in the day before being consumed several hours later, either without adequate refrigeration or without proper re-heating. Both proper heating and refrigerating can effectively attenuate the presence of Salmonellae. Salmonella overgrowth is kept at a minimum at temperatures below 5°c (41°F).

For transient, uncomplicated enterocolitis caused by one of the *S. enteritide* spp, specific medication is generally unnecessary and treatment is supportive, consisting only of rehydration and electrolyte replacement. The use of antibiotics may help propagate resistant strains and increase the likelihood of a carrier state. Since the biliary tract is usually unaffected by gastric acidity, yet proximal enough to the GI tract, its higher pH can provide a refuge for Salmonellae, especially *S. typhi*. Cholecystectomy is generally curative for up to 80% of the population of carriers[9].

Although most human infections with *salmonella* spp are self-limited and often unreported, the cases presented to health services frequently involve very old or very young people. In such cases the morbidity may be significantly high.

Discussion

Incidence

When the rates for salmonellosis are compared by year for Hawaii and the nation, Hawaii has an incidence nearly 2 1/2 times that in the nation as a whole (Table 1). Hawaii's

(Continued on page 212) ➤

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Communicable Disease Division
P.O. Box 3378
Honolulu, Hawaii 96801

Received for publication June 6, 1991

Working Together Toward Better Health Care.

A lot of people are taking a wait and see attitude toward the new health-care reforms sweeping the nation. Not The Queen's Medical Center. We believe in order for health-care reform to work, everyone needs to work together—health-care providers, insurance companies, government agencies and physicians.

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(Continued from page 210)

Table 1:

Comparison of Incidence Rates
Hawaii and Nation: 1987 to 1989

State of Hawaii	Nation
1987 42.6/100,000 population	1987 42.6/100,000 population
1988 44.07/100,000 population	1988 17.809/100,000 population
1989 33.0/100,000 population	1989 16.8/100,000 population

*Source: Statistical Report, DoH and State Laboratory
**Source: Annual Summaries on Salmonella Surveillance, CDC, 1989

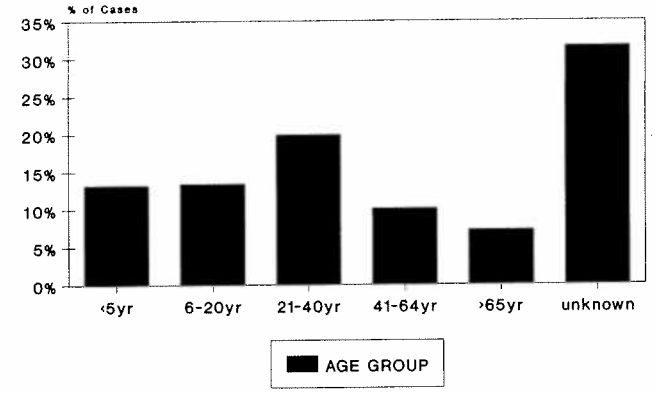
Table 2:

State of Hawaii, Incidence of Salmonellosis
Serotype* and Calendar Year
(reporting restricted to 10 or more cases per year)

Serotype	Year			
	1987	*1988*	*1989*	*1990*
Agona	15	14	13	16
Anatum		25		
Berta			12	
Enteriditis		13	12	
Hadar		19	21	15
Heidelberg	38	31	56	30
Infantis				16
Muenchen		13		16
Newport	15	19	10	16
Oslo		12		
Oranienberg		22		
Panama			11	
St Paul			13	13
Typhi, Phage Types A, M, E & E1				12
Thyphimurium	27	123	35	107
Thyphimurium var Cop			22	37
Weltevreden	29	70	66	40
Montivideo	10		10	
Unreported serotypes	261	23	4	9
Others (incidence of 9 or less cases reported)	67	138	102	120
Totals Cases	***462***	***522***	***387***	***447***

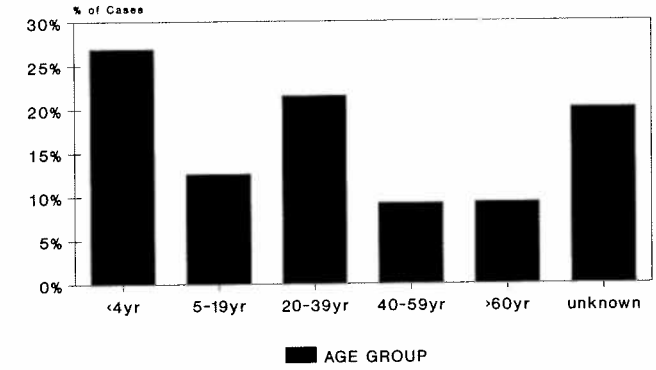
*Source: Statistical Report, DoH and State Laboratory
**Source: Annual Summaries on Salmonella Surveillance, CDC, 1989

Figure 1
Age Distribution (%) of Salmonella Cases
Hawaii, Calendar Year 1987



Source Epidemiology Branch

Figure 2
Age Distribution (%) of Salmonella Cases
Nation, Calendar Year 1987



Source: CDC

rate in 1990 was 39.3 per thousand persons. At the time of this writing, national figures for 1990 have not been published.

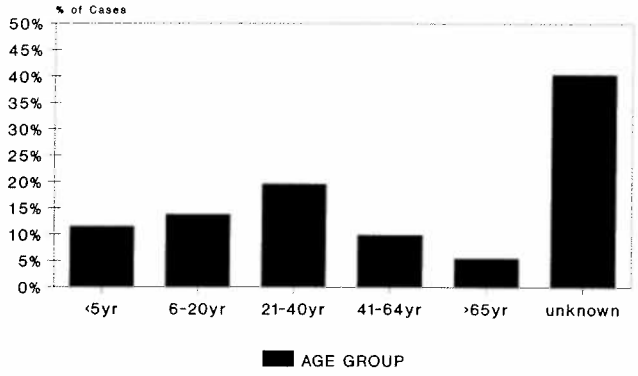
What accounts for this higher incidence of salmonellosis in Hawaii when compared with the rest of the U.S.? One suggestion is that our small population base and small geographic size results in better surveillance than in the rest of the United States. Cultural food preferences and sites of food consumption might be other factors contributing to the high incidence of the disease. Another contributing epidemiological factor is that salmonellosis reporting is mandatory in Hawaii.

Seasonal variation

The date of onset of the disease is usually not submitted to the Department of Health (DoH); hence, temporal analysis can be done only by the time and date of the report. A time lag of not more than one month between date of onset and date of report was usually observed when dates of onset and dates of report were both available.

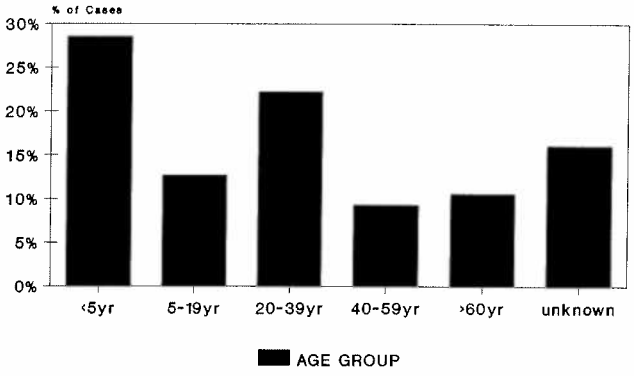
Dates of reporting by months of confirmed Salmonella cases to the DoH are shown in Figure 8. Note the consistently low level of incidence for a period of approximately 8 months, and an increase during the summer and autumn months. There has never been an explanation for this observation except that it might be attributed to increased recreational activity, an increase in tourism and the greater consumption of *picnic-type foods*, traditional among Hawaii residents during those months.

Figure 3
Age Distribution (%) of Salmonella Cases
Hawaii, Calendar Year 1988



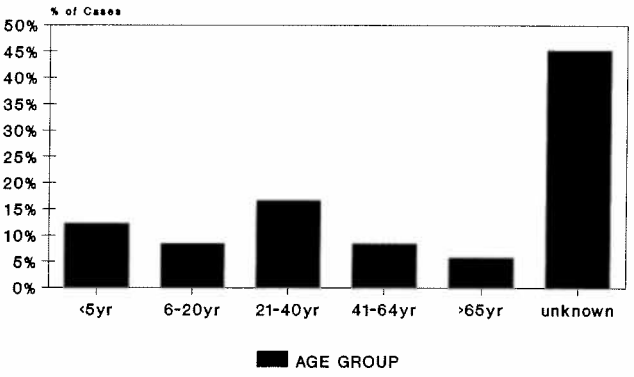
Source: Epidemiology Branch

Figure 4
Age Distribution (%) of Salmonella Cases
Nation Calendar Year 1988



Source: CDC

Figure 5
Age Distribution (%) of Salmonella Cases
Hawaii Calendar Year 1989



Source: Epidemiology Branch

Age

National data for 1990 are not available at this writing. It was possible to compare only state and national age distribution statistics for 1987 (Figure 1 and Figure 2), 1988 (Figure 3 and Figure 4) and 1989 (Figure 5). The <5-year-old group is a smaller percentage of the total reported cases in Hawaii accompanied with the cases in the U.S. in both 1987 and 1988. A smaller percentage of cases among the younger than 5-year-old group is unexplained but it may be accounted for by the rather large numbers in the category labeled "unknown age".

Serotypes and their relationship to etiology

The most frequently occurring serotypes for Hawaii are listed according to the number of human cases of salmonellosis reported (Table 2).

It has been difficult to correlate particular serotypes of *Salmonella* spp with particular foods, since laboratory and epidemiology reports generally do not indicate the source of the infection. However some serotypes are generally associated with particular animal reservoirs. For example, in the 1987 barbecued chicken outbreak[10], the 67 culture-confirmed cases were of the *S. agona* serotype, commonly found in poultry. Poultry flocks also may be heavily infected with *S. typhimurium*[11].

In preparation for the annual Honolulu Marathon in early December 1987, a high carbohydrate meal was prepared for the contestants several days before the event. This banquet meal resulted in 288 clinical cases of Salmonellosis with eventual laboratory-cultured confirmation of 25 cases. *S. weltevreden*, a common serotype in Hawaii, was cultured in all of the confirmed cases[12].

Apart from a few isolated incidents in which a particular serotype was responsible for a large outbreak of disease, it is difficult to associate specific serotypes with particular foodstuffs in Hawaii. Investigation into this area might help to reduce the disease outbreaks.

Reporting

A more accurate understanding of salmonellosis in Hawaii has been frustrated by incomplete communicable disease reports submitted to the Epidemiology Branch. These reports are required to be submitted by physicians, clinics and hospitals as soon as possible after the diagnosis of a reportable disease. The misleading or incomplete information provided in these reports is evidenced by the category of "unknown age" in the reports.

On the national level, the younger-than-5 age group accounts for more than 25% of the total cases of salmonellosis[13]. Available figures in our Epidemiology Branch account for less than 15% of all cases under age 3[2]. On the other hand, State Laboratory reporting shows high levels of incidence among the younger age groups during fiscal year (FY) 1987 to FY 1990[4]. The majority of these cases in the ≤age-3 group show a mean percentage of 38.02% of the total number of cases reported over the 4-year period (see Figure 6). These figures are higher than the reported national percentage totals for the respective age groupings. A comparison between these reported percentages is highlighted in Figure 7.

(Continued) ➤

Conclusion

Although surveillance data can provide a basis for policy, if the data are incomplete because of poor reporting practices, conclusions about the existing data can be misleading. In order to accomplish a more comprehensive survey of salmonellosis in Hawaii, it was necessary to compare the available data in the Epidemiology Branch[2] with that in the State Laboratory[4] and in the Centers for Disease Control (CDC) *Annual Summaries on Salmonella Surveillance*[13].

Better cooperation is needed between the Hawaii DoH and the medical community in the direction of better reporting procedures. These should be honest, complete and provide only pertinent information; they should be submitted on a timely basis.

Consistently good reports should receive accolades; poor reports should be singled out for follow-up with suggestions to the reporter for improvement.

It is usually the responsibility of public health workers to determine the causative factors of a disease outbreak and to initiate control measures to decrease morbidity and mortality. However, common sense dictates that greater attention to very simple and yet effective measures of food preparation and storage by the general public can decrease the incidence and prevalence of the disease in Hawaii. As has been pointed out in this discussion, meat, chicken, eggs and milk account for most of the outbreaks of infection by *Salmonella* spp. Often this is a function of the lengthy journey from field and farmyard to the eating table.

Although most people have little control over the production of food, there is a degree of control that people can exercise over the subsequent storage, handling and ultimate serving of food.

Because salmonellae are ubiquitous in our environment, the general public needs to be aware of the problem. Its role in preventing infection within the home and in dining establishments needs to be emphasized.

ACKNOWLEDGEMENTS

Suggestions about the subject and subsequent review of this material have been made by Eugene Pon MD, Henri Minette, DPH and David Sasaki DVM MPH of the State Epidemiology Branch and Al Katz MD, Professor of Epidemiology at the University of Hawaii, School of Public Health. Their recommendations are appreciated. Thanks also are extended to Mr. John Tawney for his assistance in putting the manuscript together.

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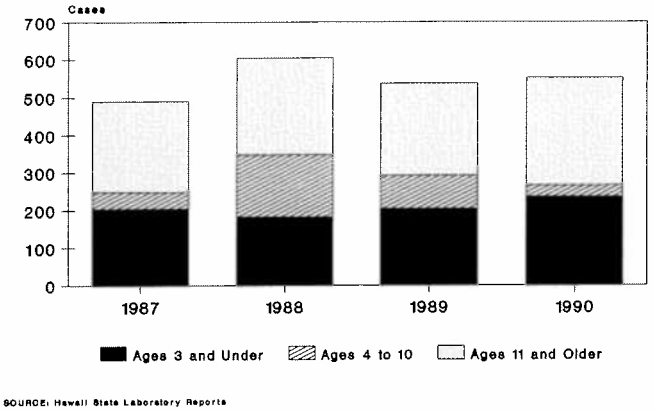
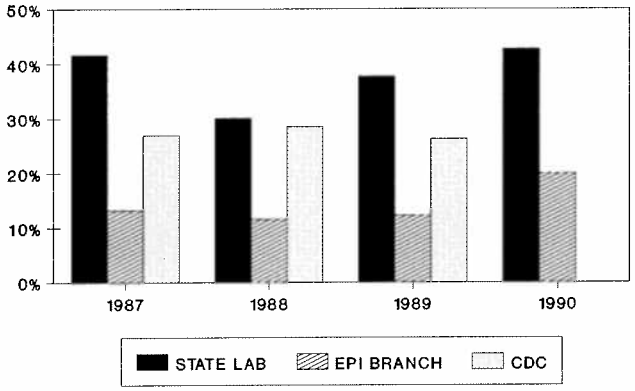
Figure 6
SALMONELLOSIS STATE LABORATORY REPORT
FY 1987 to FY 1990



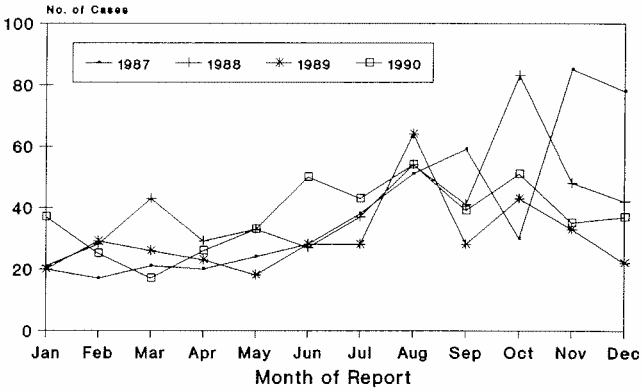
SOURCE: Hawaii State Laboratory Reports

Figure 7
Comparison of Salmonellae Reports
Incidence in Children: 5 years & younger



SOURCE: State Lab, Epi & CDC Reporting

Figure 8
Monthly Incidence of Salmonellosis
Hawaii, 1987-1990



SOURCE: Epidemiology Branch

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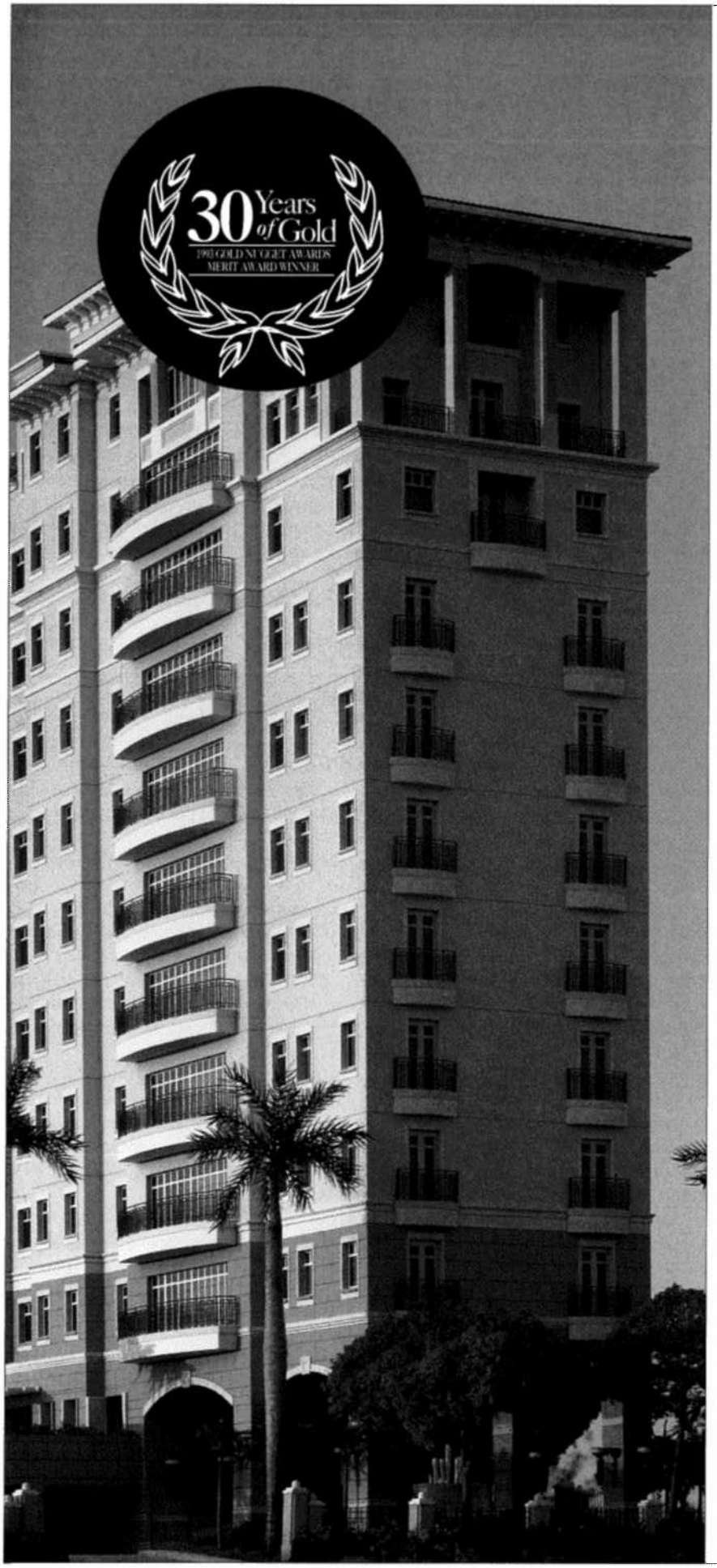

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One Rx for Solo Survival

Linda "Fritz" McKenzie JD*

The Clinton administration's prescription for the "health care crisis" that was a hot campaign topic will be forthcoming. Mrs. Clinton is not backing away from the 100-day deadline set by the President. Hillary has already begun to focus on some of her big hits, if one can believe the media reports about her comments related to drug companies. The months ahead will be crucial for solo and independent physicians and should be used by them to prepare for a change in how they practice medicine. The following article suggests one area to which they may choose to direct their energies.

Hardly a publication can be read without being confronted with "THE HEALTH-CARE CRISIS".

All national media; locally, our news items and editorials, even local CPA's newsletters seem to focus on health-care and its costs. Obviously an industry that commands almost 14% of the gross national product in an economy that is at best sagging and is at least sad will attract a plethora of specialists and consultants who have ideas and solutions.

The vast majority of physicians feel besieged and beleaguered by a new onslaught of would-be authorities telling them how best to care for their patients. It's not enough that insurance carriers, governmental state and federal agencies, and legislative bodies have all decided to have their input into what at one time was a very private matter between physician and patient. Now we also have consultants and politicians, and let's not forget the opportunists, who have jumped on the health-care bandwagon.

So where does all of this leave the MD who for years has been out there delivering or attempting to deliver health care in the same doctor-to-patient manner that doctors for centuries before have done? With the cry for managed care, better utilization and more scrutiny in all aspects of the delivery of health-care and the additional demands on physicians' time, perhaps the most urgent question is where does this leave the solo practitioner? Many will say: "Nowhere!" History tells us that this is probably not true. People will tolerate just about anything except "messing with their healt care" and most, in the final analysis, do not want it delivered like their supermarkets serve up packaged goods, nor to be served the same way they would receive a meal at a fast-food place. They want individualized, personal care.

So what is the lone soldier of medicine or the small group to do? I am not fond of framing references in terms of war, but it seems to be an analogy with which many physicians can relate, given the present day health-care climate in which many of them feel they are forced to function. Does the lone MD throw in the weapon, surrender and go to work for a hospital or HMO; or retreat to the ivory towers of academia and tell everyone else how it should be done; or become a high school or college biology teacher, pharmaceutical representative; or simply take early retirement and fish or golf every day instead of only on Wednesday?

For younger physicians, most of these options are not available, at least for the ones with visions of practicing solo. There are not a lot of alternatives for many physicians. MDs come from a school of focused learning that leaves them with very few job skills for the marketplace other than practicing medicine or teaching it. In fact, many are still attempting to repay their debt for the privilege of spending 20-plus years in the educational process and earning the right to place "MD" after their surname. For these brave souls attempting to wing it in the marketplace, what can or should they do?

My suggestions have not changed from the message I have attempted to deliver on every occasion the past decade when I have spoken to and with physicians and/or their spouses, particularly those responsible for managing their physician-spouse's practice.

One thing is certain: What medical school did not and does not do is prepare students to be business managers. Admittedly a few are gifted with a good business sense, but they are rare and often accused of neglecting the medical and personal part of their practice if and when they become overly involved in the business end of it.

Again, what can be done to allow that group of individuals who choose to practice in a solo environment to continue to do so? Throughout the history of this nation autonomy has been precious in all aspects of the American society and perhaps most in the areas of entrepreneurship and medicine. How can physicians maintain their independence and still survive financially in the new models that are being touted, perhaps dictated, by those in control and by the economy itself?

The very first step to be taken must be to make a clear and realistic assessment of how the practice, and particularly the office, is being managed and by whom. How are personnel being utilized; how is technology being utilized; what if anything can the physician do to manage time, deliver quality care and still be cost effective.

Historically, most physicians have not had to pay attention to the bottom line, as all other business people must do. Business acumen was never high on most physicians' priority lists. As a matter of fact, those in the profession who did pay attention to such matters weren't always terribly serious about focusing on a well-run and cost-efficient office. Mediocrity and make do were the watchwords in too many instances. Now a qualified and skilled coding expert on the staff has taken on new value. An organized and experienced office manager has become a highly sought individual; and, if either or both of these happen to be an interested spouse, the physician is sitting on a virtual gold mine. The inherent

(Continued on page 218) ➤

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Submitted for publication February 26, 1993

FINANCIAL SERVICES FOR ISLAND BUSINESSES

An Advertising Supplement to Pacific Business News, Hawaii Medical Journal, Hawaii Dental Journal and Hawaii CPA News

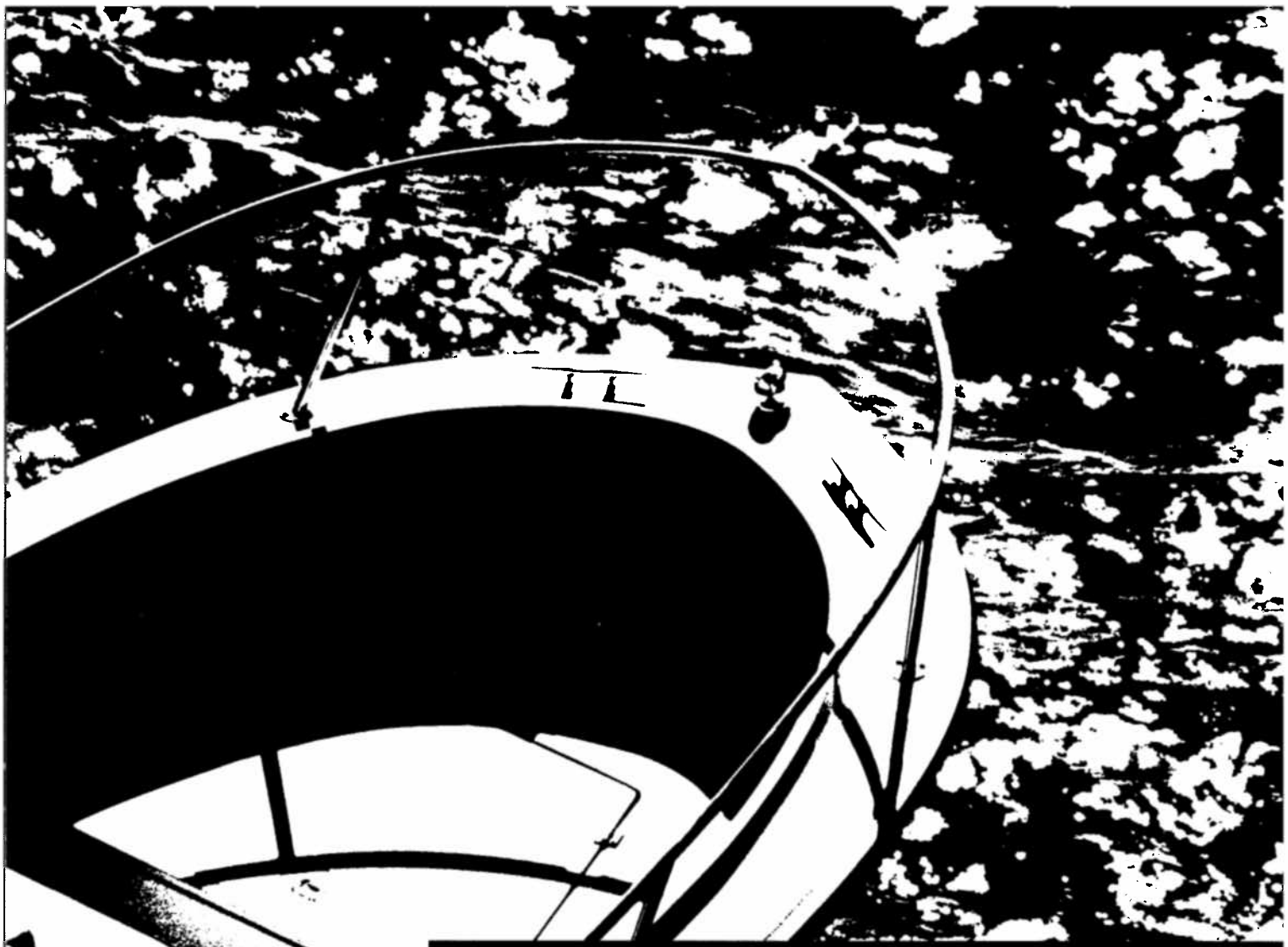
"These are good times to test a bank's financial services," said Ronald Migita, the man most directly responsible at Bank of Hawaii for delivering the goods. "When the economy slows down, everybody has to be a little more careful — a company of what it spends and a bank of what it lends."

Liberty Bank's Milton Zane is more direct: "Times like this separate the men from the boys." That goes for both businesses and bankers.

Hawaii's economy has been in a slow- or no-growth mode for the last two years. Bank economists expect more of the same this year. Against a backdrop of the kind of expansion the economy has experienced in the 34 years since Statehood, a three-year period of even slow growth can seem to many like a full-scale depression.

But it isn't, and the outlook is for improvement next year. In the meantime, Hawaii's small businesses, which make up the vast majority of all businesses in the state, are tightening their belts, rethinking their game plans and looking for all the help they can get — "as long as it doesn't cost anything," said Bank of Hawaii vice president and small business advocate Robert Fujii. "Everybody's hanging on to their cash."

Even so, bankers agree there's plenty for them to do. One expressed the opportunity this way: "We have the chance to get to know our clients, spend a little quality time with them," said Central Pacific Bank's Wayne Kirihara, a marketing man. "We may not be able to help them now with new services, but, in knowing them better, everybody benefits eventually."



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Raising Money

Even continuing low interest rates aren't coaxing many small business borrowers to take on more debt, but many companies have been taking advantage of conditions over the past year or more to restructure existing financing. Bank of Hawaii senior vice president Ron Migita says the bank's credit policies are unchanged despite the economic slowdown, but there's no rush to borrow. "We've got plenty of money to lend, but it's a cautious world out there," he said.

Even the pace of refinancing — substituting new, lower-interest loans for old, higher-rate paper — has slowed somewhat, according to Pioneer Federal Savings Bank executive vice president Al Yamada. Though referring primarily to the mortgage financing done by Pioneer, he says refinancing volume is down from a year ago, even six months ago.

But GECC Financial Corp. vice president Lester Shoda, who heads that finance company's Pearlridge branch, says some small business owners are rearranging their loans to take advantage of today's low rates. "We're seeing some refinancing," he said. In the beginning of the year, we noticed many homeowners were taking out building permits for construction and home additions. We also heard homeowners and general contractors mention that they were frustrated with their lenders because of the delay and amount of paper work that was required to obtain loan approval for home renovations.

GECC hopes to change that come late August, when it launches what it's calling its "Remodeling Equity Loan" program. Though aimed primarily at homeowner interested in expanding or renovating their residences, the program is a new wrinkle in the home equity credit line services originated by GECC some years ago.

Under the program, consumers can use the existing equity in their home to do any type of renovation- room and bathroom addition, repair and upgrade that kitchen, install a swimming pool. It will increase the value of the home and at the same time save the homeowner money. It is a simplified construction loan program up to $100,000 or more where no bond will be required as long as there is no major structural change to be done to the home. Besides this savings, our program does not charge you any points and if you qualify, no appraisal may be needed. In fact, we can even include bill consolidation without refinancing the homeowner's existing first mortgage. At the same time, our Remodeling Equity Loan offers flexible repayment plans which makes it easier for the homeowner to qualify. Our Remodeling Equity Loan program welcomes investors as well as owner occupants.

"One of the keys to operating in an economy like today's is flexibility," said Chow. "You have to be innovative in your approach to things, ready to seek out the things that work best under the circumstances."

Adjusting to the Times

"Whenever times get uncertain, most businesses instinctively pull in their horns," said Winston Chow, executive vice president at First Hawaiian Creditcorp, a unit of First Hawaiian Inc., parent of First Hawaiian Bank. "We're seeing mostly debt restructuring among the small businesses we deal with," added Chow.

Larger institutions like First Hawaiian Bank and its affiliates offer an array of business services. They extend far beyond business loans — to areas like credit card, payroll and other cash management services — but traditionally tend to cluster around lending. In that field there are a variety of loan types: credit lines, short-term corporate loans, commercial real estate loans, and more.

First Hawaiian Creditcorp has done a lot of "land loans" in recent years — loans on purchased property to finance home and other construction. These can be used simply to build on the property — often times at a lower cost and more suitable design than buying existing homes — or can be combined with permanent financing, a mortgage on the finished development. The credit company belongs to the Hawaii Community Reinvestment Corp., a local agency that helps fund affordable multi-family housing, and has done land loans through this program.

Executive vice president Chow says many business owners have used such real estate financing to restructure their companies' debt. "With today's low lending rates, especially on long-term real estate loans, people are paying off their short-term, higher-cost debt with the long-term loans," he said. "The savings to cash flow can be substantial."

"One of the keys to operating in an economy like today's is flexibility," said Chow. "You have to be innovative in your approach to things, ready to seek out the things that work best under the circumstances."

A Way to Keep Up

One such innovation might be avoiding the often high cost of buying capital equipment by leasing it. The rapid changes being forced on many industries by technological developments, coupled with keen competition in every marketplace, makes maintaining state-of-the art equipment a must in most businesses. Letting a competitor get the jump on you with the latest development in, say data processing or telecommunications, could be very costly. Yet, the expense of keeping up with technological change can be beyond the reach of a struggling business, what with all the normal operational demands on cash flow. Leasing the new equipment could be the answer.

First Hawaiian Leasing Inc., another subsidiary of First Hawaiian Inc., does a lot of its business with companies trying to keep up with the obsolescence built into today's high-tech equipment by manufacturers and caused by sudden breakthroughs in the market. Once, capital equipment would serve a business at least as long as its depreciation schedule. But, where much of the high-tech equipment is now concerned, this is no longer true, according to First Hawaiian Leasing executive vice president Steve Marcucilli.

As a result, companies have had to adjust their thinking. "They're learning that it isn't ownership of equipment as an asset that's important, it's the contribution the equipment makes to cash flow that counts."

"In today's marketplace, a computer system may last no more than five years, at the rate advances and new product development is taking place," said the executive. "Maybe not that long, if new software or peripheral equipment comes along that won't fit your system. You then have a choice. You can either trade your system in on a new one that uses the latest developments, or you can try to make do while your competition is taking advantage of the new developments. Sometimes, you can't afford to sit tight without losing business," said Marcucilli.

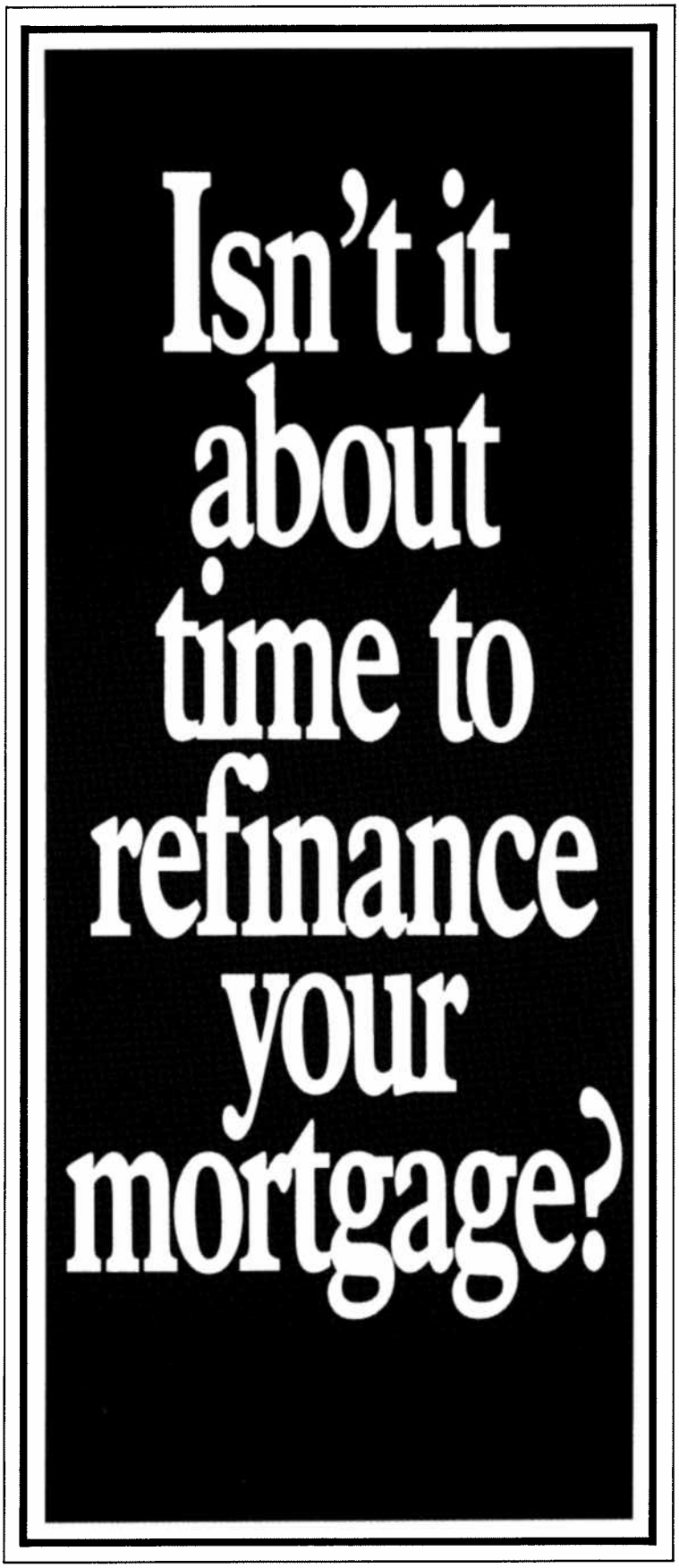
First Hawaiian Leasing handles a wide assortment of business equipment, from cars to computers. The savings it offers customers goes beyond the cash flow advantages of leasing over owning the equipment. The price and tax breaks the leasing company realizes by being the equipment owner and buying in quantity are savings that are passed on to customers in lease rates, an option that can save them cash and offer other advantages.

But even equipment cost savings are affected by business slowdowns.

When revenue declines, so does everything else on an income statement. Bankers say the current business slump has affected the need for new capital equipment, something leasing agents say has slowed consumption.

Good Time for Service

Robert Tsukada, a vice president at American Savings Bank, says the best



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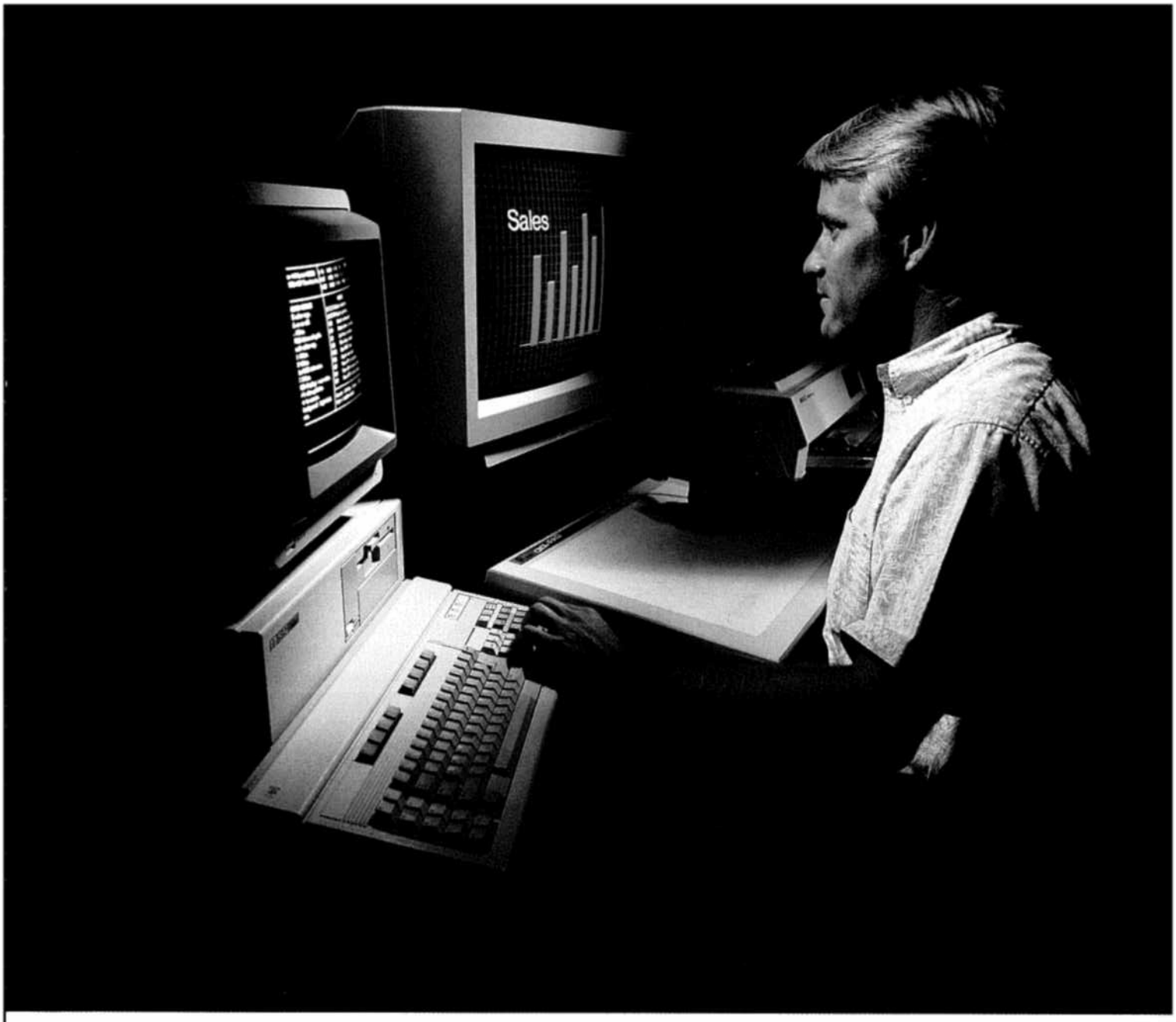

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"In today's marketplace, a computer system may last no more than five years, at the rate advances and new product development is taking place,"

way he can characterize the climate for bank services is "cautious." "There's across-the-board caution," he said. "It isn't that they don't want or need the services, it's that they don't want to do anything that might end up costing them more money."

This has created an opportunity for bank lending and branch officers to get to know their business clients, Tsukada and other bankers say. "We encourage our people to talk to their business customers," said Liberty Bank's Milton Zane.

One reason: "We want to know as soon as they start having problems," said Wayne Kirihara, of Central Pacific Bank. But the reason isn't just defensive. "Maybe there's something we can do to help them."

"We tailor our business to small business," said Zane. "Many business owners know the products and services they sell better than their business itself. Maybe they're great auto mechanics, but not very good business administrators. Helping them succeed is a challenge for a banker. You have to get a little involved. If you don't, and the client goes out of business, both you and the client lose."

"We're giving a lot of individual attention to our business customers," said CPB's Wayne Kirihara. "These are hard times for many small businesses. They're now catching a softness that's been rippling through the economy since 1991. First to be hit was tourism, then retailers, now small business people in general. They need all the attention we can give them."

The main focus of such help is cost containment, says Kirihara. "People aren't making any major moves in their business, no big commitments. They don't want to do anything that's going to mean a jump in costs. Most are hanging on, cutting costs where they can, waiting for the economy to improve."

The situation gives banks an opportunity to get to know their clients better, says the CPB executive. "We're telling our branch managers and loan people to spend time with their clients, even if there's no business to conduct with them. Get them to tell you about their business, discuss their problems. Maybe there's something we can do — cross-selling our services. Call it micro-marketing. Maybe the best thing we can do is listen."

American Savings' Bob Tsukada notes that the economy has led to a slowdown in loan demand, as well as some tightening in credit. "Basically, we're just being cautious like everybody else," he said. Since much of the bank's contact with business clients is through its 45 branches, he also says this is a good time for both sides to get to know the other better.

"Just filling out a loan application can be an enlightening experience," says

Tsukada. "The borrower can find out a lot about his own financial needs and so can his banker. Even if the loan isn't approved, it's an educational experience that will pay off later."

There's a science to filling out such applications, Tsukada and others say, that is helpful not only to the lender but the borrower as well. "Going through the discipline of filling out an application, including assembling the information you need, tells a borrower something about his own cash needs."

Tailoring the Service to the Business

Tsukada, who heads American's corporate banking department, says his operation deals with many professionals as well as business people. The association has made business loans for only about a decade, so he says it's still expanding in the field, although Tsukada says it never wants to grow to the point that it loses the personal touch that he feels is essential in business as well as consumer banking."

Serving professionals' financial service needs has become something of a specialty. "People tend to forget that their doctor, lawyer, or accountant are in business the same as they are," said Tsukada. "No matter how skilled and successful they are in their practices, if they ignore the business side they're in trouble sooner or later. A doctor needs financial services the same as a building contractor or a manufacturer, they're just a little different."

"We've spent time in the field familiarizing ourselves with those differences and I think as a result we've built a good business with professionals," he said. "Each is different and working with them helps us make a practice of tailoring our services to the business we're dealing with. That's important with all clients."

Cash Flow is What Counts

A number of institutions offer counseling services on top of specific services like payroll handling. Bank of Hawaii, the state's largest bank, probably offers the most extensive battery of small business services.

Bankoh organizes its business client relationships on levels. The levels are based on size of sales. "We care most about

"People tend to forget that their doctor, lawyer, or accountant are in business the same as they are,"

cash flow," said Ron Migita, who is in charge of the bank's business lending and related activities. "Some loans are based on assets, like real estate loans. We're interested in the cash the business generates."

Bankoh's 100 or more individual branches usually handle business clients that have up to $2 million in annual sales. Those with sales of $2 million to $10 million normally work through the bank's network of Business Banking Centers — one-stop financial service operations that offer all the bank's business services under one roof. There are three centers on Oahu, and one each on the islands of Maui, Hawaii and on Guam, where Bank of Hawaii has a large presence. Larger accounts are handled by the bank's corporate banking office in Honolulu.

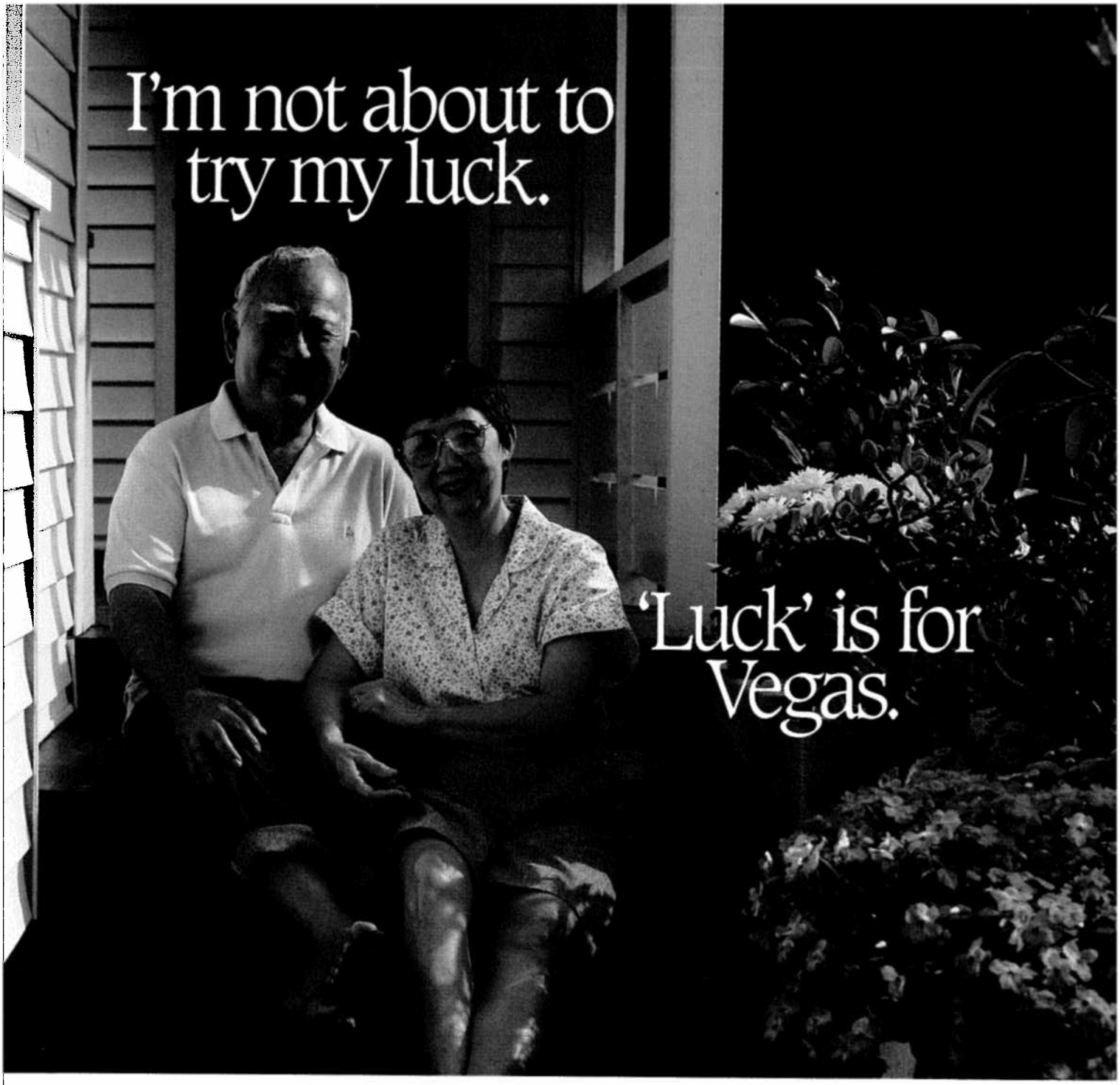
Bank of Hawaii has the most extensive international banking operations in Hawaii. It has branch or representative offices in the South Pacific and in most of the banking capitals of Asia. Bankoh's international division, based at its Honolulu headquarters, provides a full line of financing and other services for international clients.

But, according to Ron Migita and Bob Fujii, the bank's small business advocate, such diversity hasn't diminished the bank's attention to the business that is still its foundation, serving Hawaii customers. Creation of the systemwide business banking centers is an indication of this commitment.

The Bankoh business services run from business checking and savings accounts to usual loan and other credit services, credit cards, payroll and other cash management services, and access to the bank's large international department. The bank even has a factoring operation to help businesses with their cash flow.

The Bankoh family of institutions includes trust operations, led by Hawaiian Trust Co. These services are being expanded greatly with the acquisition of American Financial Services of Hawaii, parent of Bishop Trust Co. and American Trust Co. Bishop and Hawaiian Trust have long been the leading full-service trust operations in Hawaii and their combination will give Bancorp Hawaii, Bank of Hawaii's holding company, a dominant position in the Isle trust business.

The trust companies offer assistance in managing employee benefit accounts and other administrative and advisory functions to corporate as well as individual clients. Both have experienced research departments well qualified to manage all types of investments. American Trust specializes in depository trusts, such as employee profit-sharing and similar plans whose investments are managed by others.



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"Of course, you never know," cautioned Yamada. "If I knew for sure what interest rates were going to do I'd be sitting on the beach sipping a mai tai."

Decentralized Services

First Hawaiian Bank and its family of service companies puts more emphasis on the branches, with backup from the head office. Being Hawaii's second-largest bank, FHB provides the full gamut of small business services, augmented last year with the bank's acquisition of the former First Interstate Bank of Hawaii, an institution that specialized in working with small businesses. First Hawaiian is also in the process of acquiring Pioneer Federal Savings Bank, which will expand its already sizable mortgage loan activities.

Central Pacific Bank's Wayne Kirihara says niche marketing is what banking is all about these days. Small businesses are one of CPB's niches. "This is what business is in Hawaii,' he said. "Ninety-five percent of your corporate business is with small businesses. You have to tailor your services to their needs."

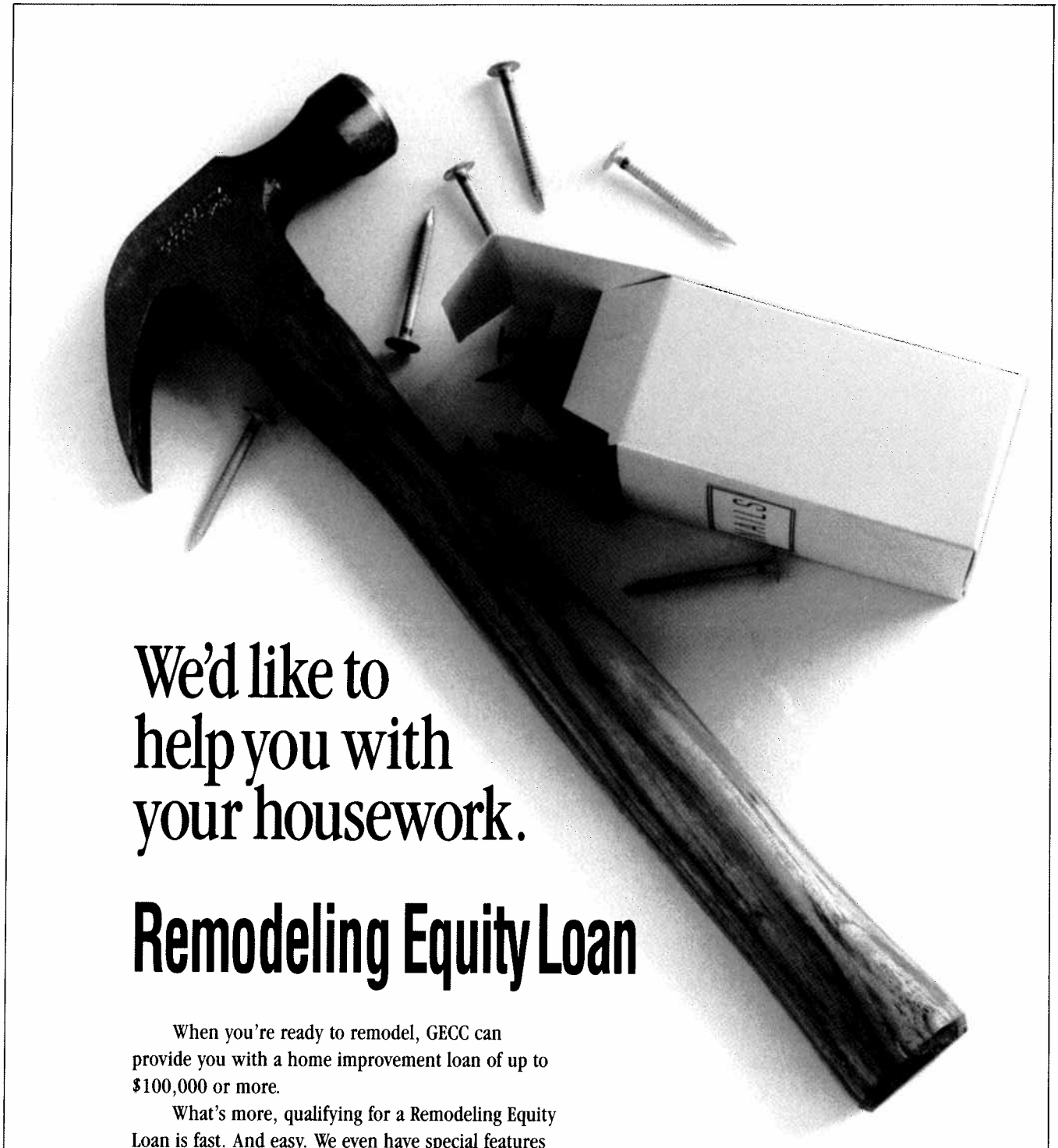
Most banks say they are positioning themselves for the economic upturn that they hope will happen next year. Loan volume is by and large flat, with occasional upticks — which, all hasten to say, are better than downticks.

"Slower loan volume doesn't mean slower business activity," said Pioneer Federal's Al Yamada. "We're still making a lot of loans and that may pick up when people decide interest rates are about to head up again."

But Yamada and others think rates will stay at present levels for the rest of this year. "Of course, you never know," cautioned Yamada. "If I knew for sure what interest rates were going to do I'd be sitting on the beach sipping a mai tai."

Bank of Hawaii says its volume in SBA loans — loans backed by the federal Small Business Administration — is actually up this year, but SBA loans are difficult to obtain because of their qualification restrictions.

A sign of the times: Bank of Hawaii says there's been some weakness in its payroll services to businesses, including automatic paycheck deposits. "When times are tough, people want to see their paycheck, not just get a deposit slip, " said Bob Fujii, who recently won the SBA's "Minority Small Business Advocate of the Year" national award.



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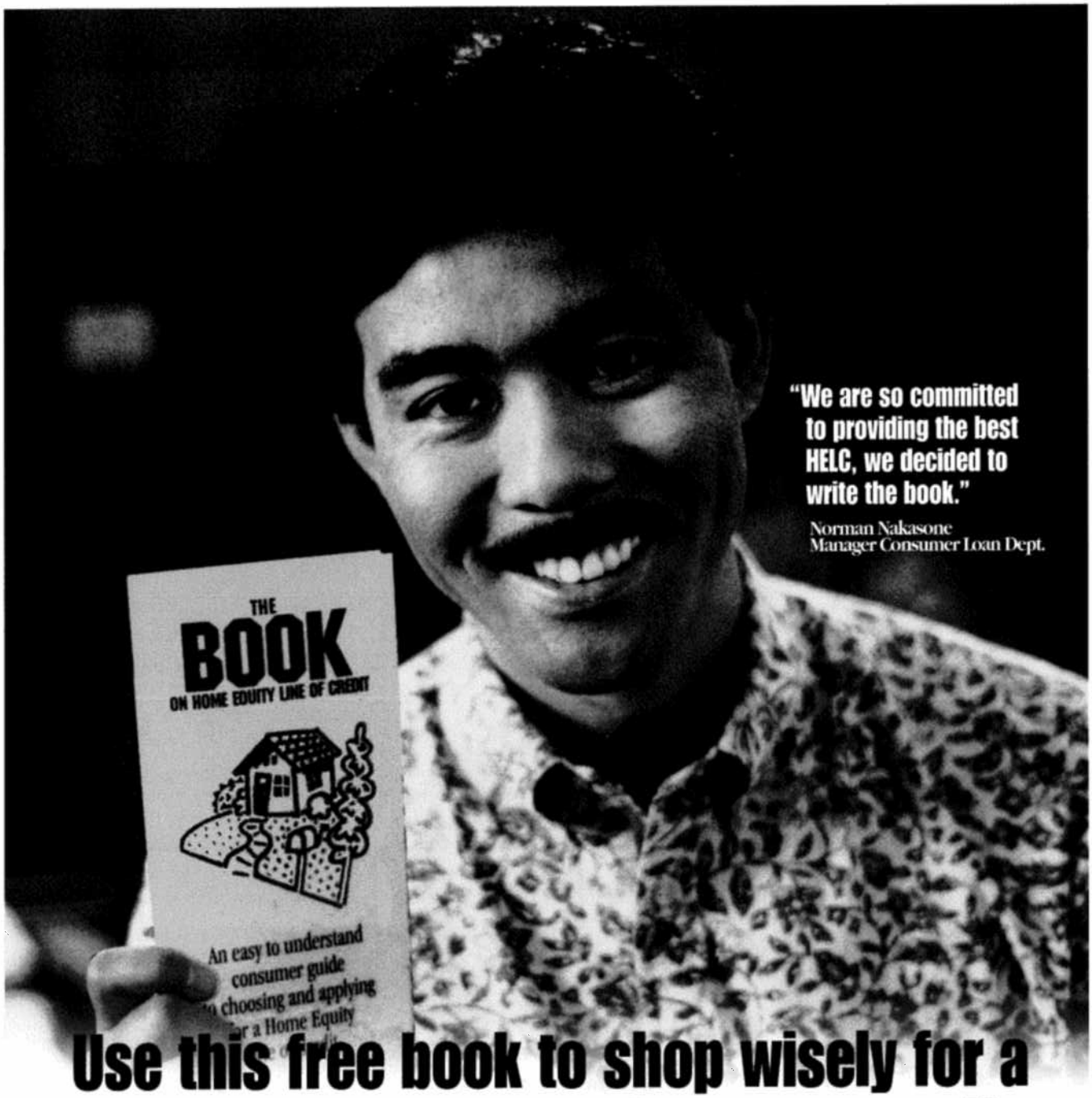

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(Continued from page 216)

problem in the latter instance is any personal strife (and there will surely be some) that living and working together brings into being.

A recent article in the *Wall Street Journal* commented that none of the above measures, nor any consultants, are going to be able to solve the real problem of declining reimbursements. Most or at least many physicians are already working at peak productivity and there's not a great likelihood of increasing quantity in many offices. Reimbursement has become a territory controlled almost solely by insurance carriers, government, and the marketplace. Physicians rarely count for much in this process. Will this scenario become more true in the future? I think so.

Where then will this leave solo practitioners or small office clinicians, and what means will be left to them to enable them to continue "winging it" alone if they choose to do so? The answer clearly and simply is that physicians must focus on establishing and maintaining lean, efficient, well-organized and well-monitored practices. The one thing the physician still controls is the staffing of the office, procedures and overhead expenses.

To accomplish this "lean machine", where does one begin? First, by recognizing that overstaffing and assuming that work is done efficiently and cost-effectively are luxuries that can no longer be part of the modus operandi of physicians' offices. Good business practices must be followed.

The luxury of having multiple offices with the inherent duplication of supplies, staff and other expenses, and waste of valuable time will need serious assessment to justify the continuation of those offices. The value of multiple offices must be weighed against all these offsetting expenses. What criteria do we use to make those decisions? The logical starting place would be a survey of the patient population. Simply ask: "Would you stay in my care if I centralized my practice?" If the answer is, "Yes", why not consolidate? We know that in most instances efficiency comes with consolidation if it is implemented correctly. On the other hand, if patients are resistant to traveling any distance, that second office is needed. Look to every possibility of consolidating what can be shared and streamlined, thus avoiding duplication as much a possible.

Certainly computerization should help to accomplish both efficiency and elimination of duplication. Technology is definitely a tool, if used correctly, that could be tremendously helpful in achieving the goals of an efficient and cost-effective office. With the wave to change to electronic data submission and fund transfer, technology must be considered. However, technology is dependent upon people, beginning in the implementation stages and continuing through the managerial area of a practice. Those resisting computerization are fighting a losing battle because all the *powers* in industry, business and politics have identified the paper problem as the first foe to attack in the realm of administrative changes. As painful as it will be, it is the coming thing and physicians had better be prepared.

There are many products offered, ill-chosen ones will only come back to haunt you. Both physician and manager should spend time in choosing the technology that will launch them into the new wave of claims, remittances and electronic fund transfers. Many offices that are already computerized will have to upgrade to accommodate the changes in the industry. This is an inherent problem faced by an industry exploding with knowledge and advances every day.

Given the almost unlimited products available, for what should the physician and manager be looking? My first suggestion is a program that will not be antiquated within a year, one that has the ability and flexibility to change. Most important, it must allow for inexpensive change so that the budget isn't whacked everytime a new technology is introduced in the market, or a carrier or the government changes coding or other requirements.

Second look for a product that is supported by a company that will be able to respond to your needs effectively, quickly, efficiently and comprehensively. Look for a vendor or company that is committed for the long haul to the medical profession and has depth and experience in a wide range of fields applicable to technology for use in the medical office. Each practice will have its own special needs and weaknesses and these should be considered in implementing the choice.

Very important in the choice of a technology is whether it allows for the maximum flexibility in the Hawaii market. We know there is a dearth of experienced workers in the medical field so a system that will allow maximum flexibility in hiring and training employees is essential. The feature to look for in a system would be one that has tremendous capability of being "smart on line", ie one that has many checks and validations that remove the margin for error in the input of data.

Physicians need to relearn and rethink all the options available to allow them to maintain a degree of autonomy. Too often I have seen offices that become totally dependent on one or two employees. If possible, employees should train each other to do the job equally well.

Independent physicians choosing to continue solo practice and still survive in the managed care climate (that we know will come, for better or worse) must have the ability to network and connect with other solos and small groups in order to negotiate with carriers and employers for a patient base. The best way to do that is to have a well-run, well-strategized office that uses state-of-the-art technology and an office that is efficient and cost-effective. The managed care concept is here. The varied ways in which to become a player in this new format of delivering health care can be accomplished by joining PPOs, HMOs, networks, foundations or whatever other creative modes that yet may come. Every physician must acquaint herself or himself with these new concepts of delivering health care to patients.

Change within the health care system has been volatile. In the 1960s there was the advent of specialization, sub- and sub-sub-specialization of medicine. There was a demise of family practice. Now, as we enter the 1990s, we see the demand for family practice *specialists* far out-pacing the available supply and the educational system's rate of production. What has remained a constant, however, is patients' demands for medical care that is immediately available when the crisis strikes, and the need for kind and caring healers. The method whereby this will be delivered can change, the environment can change, the emphasis or focus can change, but the hoped for end-results will remain constant.

Physicians' practices will be the primary targets of changes within the health care industry and in revamping the health care delivery system. Physicians must be prepared,

(Continued on page 226) ➤

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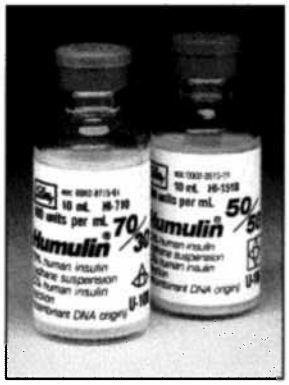

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In Pursuit of Excellence: A Model of Collaboration for Nurses at Hawaii State Hospital

Charlotte MF Trotter RN, MS*

In 1989 the Hawaii Medical Journal *devoted an issue to the status of mental health in Hawaii and mental health leaders in the State criticized the lack of involvement by the University of Hawaii[1,2,3]. This paper is written in response to the challenge and will discuss a dynamic model based on collaboration between the Hawaii State Hospital (HSH) and the School of Nursing of the University of Hawaii (SoN), that was implemented in September 1990. Since the publication of* Magnet Hospitals. Attraction and Retention of Professional Nurses[4] *there has been much interest by service organizations in defining the factors that build excellence[5].*

Background

In 1974, HSH lost its accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). One of the reasons cited was the shortage of nursing staff. Since 1986, Hawaii has ranked 51st in the nation in terms of the quality of care and services delivered in the public sector to the disenfranchised who suffer severe forms of mental illness[6]. The United States Department of Justice (DoJ) examiners continued to monitor the mental health system and services at HSH, which they found alarmingly deficient in terms of the settlement agreement[7,8].

Mental health is a major public health issue. Alarming statistics indicate that 1 in 5 Americans at some point in their lives will suffer from a mental disorder[9]. Though many mental health professionals work within the private sector, strong evidence indicates that the public sector's responsibility will be focused more on the seriously and persistently mentally ill (SPMI): The growing number of the homeless and those in trouble with the law, and the frail elderly. Probably >10,000 people fall into the category of SPMI[10]. These populations are considered to be difficult to work with at best. It is not surprising therefore that attracting qualified compassionate staff to provide the proper services continues to be a major challenge.

In Hawaii, lack of adequate training and education of staff have been cited in both external and internal reviews to be among the problems of our mental health system in general and HSH in particular[6,11,12]. There is a need not only to recruit, but also to retain qualified and prepared staff.

The problem with the shortage of psychiatric nursing personnel is well documented[13,14,15,16]. Nurses represent the largest group of the professional core providing mental health care in the country and the largest group practicing in state mental hospitals. In 1984, 31% of all employed psychiatric nurses were working in public mental hospitals (nurses, N=14,873, psychiatrists, N=3,665, social workers, N=3,935, psychologists, N=1,461). In 1987 in the U.S., there were slightly more than 50,000 professional psychiatric nurses[17]. Kramer projected a need to double this figure by 1990 if each patient in need of psychiatric services was to receive 6 hours of psychiatric nursing care a year[14].

Because of the current and projected shortage of nurses, aggressive efforts to attract nurses into the field of mental health need to occur. At the same time, preparation of the nursing staff now employed at HSH is necessary so that staff can assume the roles and functions dictated by changing trends.

Fox, speaking at the Western Interstate Commission for Higher Education (WICHE) workshop on "The Changing Roles of Nurses in State Hospitals", emphasized the need for collaboration between universities and mental health systems[17]. She encouraged working together in mutual support, since both university schools and public mental health systems have difficulty with the recruitment of nurses. She suggested that nurses who want degrees could be attracted to state hospitals if established programs and rewards for obtaining educational degrees were available in situ. Faculty also need research facilities, support and access to clinical nursing staff to identify and discuss appropriate research questions.

> "Staff will respond positively to being involved in research and they will want to work in a facility where something is happening in nursing. The state hospital becomes a vehicle for professional advancement and a supplier of students. The university can be used to enhance the commitment of employees to the state hospital by enriching the work experience and providing educational programs for advancement"[16].

R & R at HSH

A Recruitment and Retention (R&R) project that addressed the education, training and recruitment needs of nursing staff at HSH was developed by faculty members of the University of Hawaii's SoN to assist in correcting reported deficiencies within the nursing-care delivery system. The Department of Health Behavioral Health Administration funded the 3-pronged project which focused on: a) Advanced education for nursing staff; b) consultation; and, c) continuing education courses for staff. This project was initiated in September, 1990.

The goal

The overall goal is to improve the quality of nursing care provided to the seriously and persistently mentally ill patients at Hawaii State Hospital by creating a learning

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community within the hospital setting.

"Learning communities" are a result of deliberate restructuring of the nursing curriculum so that students are actively engaged in an academic relationship with other students and with faculty over a longer period of time than is possible in the usual traditional courses[18]. Other characteristics of learning communities include strategies to maximize student-centered learning, a sense of family environment, commitment to lifelong learning, and a greater level of personal interaction between students and faculty. The need to be creative in choosing teaching strategies that enhance different learning styles is well documented in the teaching and learning literature[18,19,20,21].

Advanced education for nursing staff

The first component of the project provides for nursing staff to continue their formal education within the University of Hawaii system. Employed nurses return to school to complete baccalaureate and master degrees in nursing, working reduced hours and receiving full pay. Nursing staff have enrolled for the first time in general education courses at community colleges with tuition paid by the grant. A payback clause has been formulated which expects 2 years of continual employment for each year of academic support.

Fifty of the nursing staff at HSH have been involved in this component. Three have completed their degrees and currently 20 are enrolled in University classes.

Nurse specialists consultation/clinical

The second prong provides 5 Clinical Nurse Specialists (CNS) who have joint appointments at the SoN. They provide services 80% of their time to selected in-patient units at HSH. Role-modeling of clinical skills and expertise in psychiatric nursing is the major focus of this group. In addition, 4 other CNS provide weekly consultation services to the staff at HSH. Two of these nurses are also Advanced Nurse Practitioners who focus on the medical services provided to the patients at HSH.

These nurse specialists work closely with the Nurse Executive Group to develop the foundation of practice of psychiatric nursing for HSH. The CNS participate in Quality Management, Policies and Procedures, and Peer Review; these are standing nursing committees that work on operationalizing the Standards of Psychiatric Nursing for practice at HSH. They also participate in hospital interdisciplinary committees.

The CNS also work with the nursing staff on the hospital units to integrate and adapt the materials developed by working committees.

Continuing education

The final prong consists of education classes for nursing staff at HSH. Courses have been developed to meet the determined needs of the nursing staff. The CNS develop and teach courses in pharmacology, leadership and management, contemporary psychiatric nursing, group dynamics and the therapeutic use of self on the part of paramedical assistants. These courses are repeated several times a year making them available to all interested staff (22 courses have been offered to date).

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An evaluation form was developed in consultation with staff development personnel for use in all classes offered at HSH.

A data base is maintained for analysis, feedback to instructors and critical evaluation by the department.

Purchase of educational computer-assisted instructions, videotapes, texts and journals enhance the continuing education offerings and support the principles of adult learning.

Coordination and administration of the project

The chief of the department of nursing at the HSH is on the faculty of the SoN and is assigned as the nurse manager to HSH for 80% of his or her time. As a nurse-leader, the chief guides the development of a nursing philosophy needed to build the morale of the nursing team and establish a therapeutic milieu. He or she is responsible for planning, organizing, and implementing all the nursing activities at the Hospital. The chief provides leadership in developing policy and procedures, standards of care and quality assurance indicators. He or she meets and reports to the Administration at HSH and generates quarterly reports to the Department of Justice.

The mental health educator coordinator (MHEC), 50% Full Time Equivalent administrator/principal investigator is on the faculty of the School of Nursing. She directs all aspects of the project in collaboration with the nursing administration at HSH. The MHEC recruits, advises and supports students throughout the course of their studies and acts as a resource for all staff at HSH interested in higher education. She coordinates the CNS group and provides a communication link between the hospital community and the Hawaii Council of Psychiatric/Mental Health Clinical Nurse Specialists, which acts as an advisory board to the project. The MHEC provides expertise and consultation to the staff development program at HSH.

The rationale for this position is based on the belief that application of acquired knowledge and skills is integrated into practice and results in delivery of care if the educator facilitates and supports the process in the actual work milieu.

Evaluation

A long-term study was designed to examine educational factors that have an impact on nursing recruitment in a public state hospital. Specifically, 4 questionnaires were constructed to measure outcome goals and criteria of the R&R project which relate to an environment conducive to: a) Learning from expert consultants (CNS); b) obtaining higher education; and, c) participating in continuing education.

Time 1 (April 1991) data were collected at 9 months into the project to provide information as a basis for continuation and modification of the project. This evaluation occurred 6 months after the DoJ settlement with the State of Hawaii and allowed time for the change process to be established.

Time 2 data were collected in November, 1992 and are being analyzed. The results will be ready for publication by the end of 1993.

This indeed is a time of great challenge and change for the staff of the entire HSH. The intent of the University of Hawaii and the Department of Health collaborative project is to assist the nursing staff in assuming leadership, executive and therapeutic roles, that are necessary for the successful transformation of Hawaii State Hospital into a fully accredited institution of care, teaching, learning and research for the seriously and persistently mentally ill.

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HENRY N YOKOYAMA MD

Mike Okihiro's Retirement Roast

Randon notes therefrom

The Cannery Aug '92

Daughter, May: "Dad's been threatening to retire. Unconventional? He's definitely his own person. When Straub had it's annual formal dance, Dad wore his aloha attire.

"In a letter to the editor, he proposed a golf course on the Kapaa landfill. 'What can be more lovely than a golf course on the site of an old garbage dump?' "The Okihiro Syndrome or apraxia of descending golf stroke," the article appeared in the *Golf Digest* and in the *Hawaii Medical Journal."*

Daughter, Michele: "Dad has said when he dies there will be no inheritance. He has left us with the value of our education."

Mel Yee: "Mike's favorite expression: 'Ah...this patient...Waste time, this kinda case'."

Dick Kawata: "The last time I roasted Mike was at his 60th birthday, maybe 15 years ago. He's only 65? He looks older. Evelyn asked me to roast him. That would take over an hour, but to praise him a few seconds will do.

"I thought he retired a long time ago. I would call his office and he and Evelyn would be on a trip to Augusta, Pebble Beach, etc, all those juicy convention sites. Why did I think he retired? It dawned on me that it was his potbelly. No one has a potbelly like his. Retirement? Not by choice; all those unpaid bills. Can he make it on his social security? The AMA told him he has to retire. Lately he has been sticking those EEG wires up noses and in ears. Rumor is that 'He's kinda losing it'.

"You guys are wondering what he's gonna do: next week he's signing up for a crash course in Japanese. Then he will apply for a job as a tour-bus driver, 'Mina sama china man hatto' and Evelyn will distribute bento to the tourists. He will be going to the Ala Moana Shopping Center to 'talk story' with fellow retirees. Thursday afternoons he will hustle golf bets at the Mid-Pac Country Club. He'll have enough money.

"About hustle, this is a true story. Mike had a monthly meeting at Queen's lasting from 7 to 7:30 in the evening. He would call me up. I live in Nuuanu and Mike lives in Kaneohe. He would come over and ask my wife, 'How's your shoulder', 'How's the kids flu?'. He would ask me, 'How's your hemorrhoids?' Two or three weeks later we got a house-call bill from his office. I protested, and he answered, 'Well, I asked about the kids, that's a house-call.' Next time he came over, 'How's the kids' flu?' No response from my wife. 'How's your hemorrhoids?' I replied, 'None of your damn business.'

"You know how Mike hates lawyers. He attended an AMA convention in New York and found a brass rat in an antique store marked at $500 that he bartered to $100. When he left the store with the brass rat, the rats in the neighborhood followed him, just like the Pied Piper. He threw the brass rat into the East River and the rats all jumped in and drowned. Next day, he showed up at the antique shop and inquired, 'Have you got a brass lawyer?'

"Seriously, I have a lot of respect for him. Man to man, friend to friend, he's a doctor's doctor. He's straightforward and honest. He always defended what he felt was right. He is a dedicated husband and father. He made sure that his kids attended the best schools."

Carl Kaizawa: "Mike is a no-nonsense, down-to-earth kind of guy. He loves to sing, especially in a crowd. When we attend the Rainbow games on the bus, Mike would sing the 'Star-Spangled Banner' from beginning to end. At the UH–Michigan game, after the UH band played the alma mater, Mike turned to the group, took off his jacket and proudly showed his Michigan T-shirt. Mike will be happy singing in his retirement."

Tom Kobara: "Mike had a reputation at Straub that he was an average neurologist, but had a terrible bedside manner. He would tell the patients, 'You know what you have? Piss-poor protoplasm'.

"Mike has a wicked 'stink eye'. In the Chapman Mix at Mid-Pac, poor Evelyn would take her 3-wood on the 17th hole and hit the ball OB and get a 'stink eye'."

Mel Yee: "Mike wanted me to get interested in sports, so he had me betting in football pools. All those Michigan games I bet on–if only I had bet against Michigan I'd be a rich man."

George Kimata of the DJ's: "Mike was a player-coach and he doesn't like to lose. We would round the bases like a coupla Kaneohe ice wagons. We played baseball together the past 12 to 13 years. Once Lynette Furukawa wanted to play on our team. Mike only laughed, Hah! Hah! Hah! So one day she got into the same elevator with Mike, her jugular pulsating and gave it to Mike. The play- ers all start in the outfield. As they get older and can't see very well, they get to play first base, and finally when they really can't see, they get assigned as catchers. Our team has plenty of catchers."

Dave Sakuda of the rival Rascals: "Three things we all have in common: How we run the bases, how we all look stoned after 2 drinks, and I forgot what was the third. We played softball on rival teams for about 12 years–I'm on the other side. I had heard rumors that he was a compassionate physician, but as coach Mike showed no compassion and everyone got the shaft. Neurologists must be a special breed. Mike is very subtle."

"Don Ikeda says: 'Business is bad, you guys shouldn't beat them so much.' So back in 1986, the Rascals had won as usual. For the post-game dinner, we got to eat, not in the Gold, not even in the Silver, but in the Bronze room at the Wisteria for presumably a 7-course dinner. *Musubi* without even *ume*. The highlight was sliced ham, seafood was *namasu* with imitation abalone. We all have stories to tell, Mike, thanks for the memories."

Mel Yee: "The Okihiro Syndrome is the triad of Inspiration, Integrity, and Generosity."

Mike Okihiro: "Wassamata, you guys jealous? You doctors, I want you to promise me that when I go, no CPR. Don't beat my chest and blow hot air into my mouth. Now I can take my time and smell the flowers. I'll see what comes along."

Re his career: "My father was a fisherman, his father was a fisherman and his father's father was a fisherman. But my father told me 'Don't be a fisherman'.

I love baseball. During the war we couldn't play baseball in Kaneohe, but Mid-Pac had a baseball team. That's why I went to Mid-Pac.

After graduation, I joined the army, but the war soon ended and I had the GI bill. We never heard of college in the country, but somehow I ended up at Michigan. Michigan Med School was great; I interned at Queens and from Queens I went to the Mayo Clinic, where Ralph Beddow trained. After finishing at Mayo, I came home, needed $11,000 to start a practice. I went to the bank; the loan officer was a classmate I knew. He asked, You got any collateral? I replied, Yeah, my four kids. So, no loan, no practice. That's how I got hired at Straub Clinic. You know, it's all been luck. I never planned things. They just happened."

Henry Yokoyama
News Editor

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Viewpoint from Maui News

by Russel T Stodd MD

Karl Marx has been dead for 110 years, and the failure of his economic philosophy was underlined for all time by the destruction of the Berlin Wall. Yet despite the obvious, the dream of central management in opposition to free enterprise lives on, right here in Hawaii.

In 1976 during the Ford administration, a comprehensive health planning law was enacted that was intended to monitor and direct major health expenditures. After several years, Congress recognized that the program was not effective, and federal funding was withdrawn. Many states discontinued the process, but in Hawaii the mechanism was continued in the state budget under the encompassing title, State Health Planning and Development Agency (SHPDA). Taxpayers of Hawaii are paying in many ways for this bad law that was deemed a failure by the State's own accounting agency, the Department of Accounting and General Services.

SHPDA has served to deny, delay, frustrate and even bankrupt well-intentioned, knowledgeable business and medical people seeking to provide medical facilities and/or equipment. To obtain a certificate of need (CON–the heart of the "planning" process), a potential builder/investor must document in detail what is intended, where it will be located, how it will be funded, whom it will serve, how it will be staffed, how it will impact other medical facilities, what income it will generate, etc., etc., *ad absurdum*. The completed document would rival the tax law.

After considerable expenditure of months of planning time, manpower and money, the applicant must appear before redundant councils and beg for approval. However, even if that approval is forthcoming, all the data must go before one person at the apex of the pyramid, and that person is the sole and final judge as to the granting of the certificate! This powerful individual at the summit is a gubernatorial appointee with no defined qualifications.

A superficial inspection of SHPDA's actions on Maui will reveal that a surgical center, an extended care facility, a Lahaina emergency unit, a small Lahaina hospital—all planned and funded by private parties—have been denied or discouraged by the SHPDA law. In addition, the action of the state agency in regard to denial of a privately funded MRI facility was a shameful display of state manipulative power, under the guise of a CON choice. How preposterous! Is this America, land of the free, or someplace else?

At this time a CON application is pending for additional and vitally needed beds at Maui Memorial Hospital. Also, a necessary helipad for emergency evacuation of critical patients into and out of Maui Memorial Hospital must also go through the crazy quilt CON maze. One can only ask why we must endure the absurdities of this complex, obstructive law, which has obviously failed in both direction and function?

Recently, the local arm of this mechanism, a group of well-meaning citizens called the Tri-Isle Subarea Health Council, listened to testimony directed toward the need for a cancer therapy group unit in Wailuku. To their credit the local council endorsed the plan, but the real question is why should there be such a council at all? Does it make any sense that a qualified professional, willing to risk his own capital and eager to provide a vital service that the community needs, should have to prove to a clumsy, stratified, bureaucratic structure that he should be permitted to do so?

If Hawaii's citizens were confronted by a similar law to control and direct

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VIEWPOINT
(Continued)

where and what grocery outlets should be allowed (and to deny certain ones), or to dictate the sale of automobiles, or to decide what any other legitimate business enterprise should be allowed, if they were faced with such an abusive statute, we can be certain that the law would be struck down. Why therefore is medical business treated in this manner? One is inevitably led to the conclusion that the state Department of Health with its posturing gurus is determined to squash any sort of private competition.

This law must be discarded—not modified, not cleaned up, not corrected—simply discarded. Planning from the top fails, and there are truly thousands of irrefutable examples to establish that fact. The Berlin Wall came crashing down, remember?

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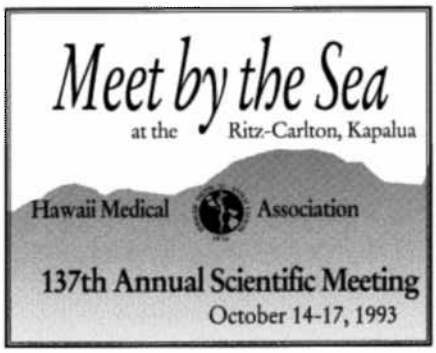

SALMONELLOSIS IN HAWAII: 1987 TO 1990
(Continued from page 214)

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Erratum:
In a recent Journal isssue (52/6–June 1993) on p. 168, right head column in the paragraph near the bottom beginning with "According to the author...", the sentence should read:
"Recently, the 1975 ogre of sudden death", instead of Sudden Infant Death. The author, Bob Dimler, of the article ADHD REvisited, brought this to our attention and added; "Although I will say I've seen a few 'hyperactive' babies. The sudden deaths have been of cardiac origin." Sorry, Bob, the error may too have been "whimsical" on our part.

The editor

ONE RX FOR SOLO SURVIVAL
(Continued from page 218)

educated and committed to accepting the changes in the way they practice.

Being more efficient in business will be one of the ways physicians can allow themselves the time to practice their skills. To accomplish this task, it will require skilled assessment of the one practice, and a commitment to accept new and innovative ideas. The reward could well be the achievement of that dream in the front year of medical school: Of being a healer and clinician, rather than a paper pusher!

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(Mrs. McKenzie has been involved in health care for many years. Her emphasis and research in law school was in the medical-legal area. She has written and made speeches in local and international forums. An active member of the local medical community, Mrs. McKenzie is presently a marketing consultant.)

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

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WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Bristol-Myers Squibb Company

THE PRAVACHOL® DIRECTION
IN LIPID MANAGEMENT

Effective lipid management doesn't have to be tough

- Improves key lipids — significant reduction in LDL-C[1]
- Excellent safety profile
- Easy for patients — once-daily dosing, well tolerated
- Usual dose: 20 mg once daily at bedtime, with or without food

PRAVACHOL®

pravastatin sodium 20 mg tablets

PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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