

Report - Health
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CITY AND COUNTY OF HONOLULU

DEPARTMENT OF HEALTH

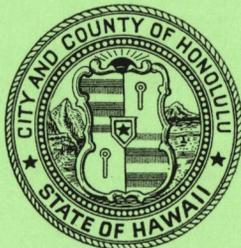
City and County of Honolulu.

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MAYOR'S OFFICE
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HONOLULU

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annual report
1959

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Maluhia Chronic Disease Hospital
1027 Hala Drive
Phone 82951

Emergency Receiving Station
and Ambulance Service—Honolulu
1027 Hala Drive
Phone 61077

Emergency Receiving Station
and Ambulance Service—Kaneohe
Paleka Road, Kaneohe
Phone 241338

Emergency Receiving Station
and Ambulance Service—Waikiki
381 Kapahulu Ave.
Phone 77998

Emergency Receiving Station
and Ambulance Service—Waianae
86-230 Farrington Highway
Phone 214122



DEPARTMENT OF HEALTH
CITY AND COUNTY OF HONOLULU
1027 HALA DRIVE
HONOLULU 17, HAWAII

DAVID I. KATSUKI, M.D.
City and County Physician

RAYMOND HIROSHIGE, M.D.
Assistant City and County Physician

August 31, 1960

Honorable Mayor Neal S. Blaisdell
City and County of Honolulu
Honolulu, Hawaii

Dear Mayor Blaisdell:

In accordance with Section 12-107, Charter of the City and County of Honolulu, 1959, I respectfully submit the annual report of the City and County Department of Health for the year 1959.

Your continued support, interest, and assistance in our program made the year 1959 a highly successful one for the department.

Respectfully,

DAVID I. KATSUKI, M. D.
City and County Physician

July 73

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ACKNOWLEDGMENT

I wish to express my sincere appreciation and gratitude to the employees of the department for their devotion and dedication to their work.

THE ORIGIN OF AMBULANCE “AMBULANCE”

“Queen Isabella of Spain introduced ambulancias at the siege of Malaga in 1487—wagons equipped for the transportation and emergency treatment of casualties.

“The word ‘ambulance’ is derived from Latin (ambulare—to move about) and French. Literally, the word means “a walking hospital.”

“Napoleon’s leading army surgeon, Jean Larrey, made use of the first modern type of field ambulance during 1792.

“The British Ambulance Association of St. John of Jerusalem, founded in 1878, probably was the first ambulance service for sick and injured civilians.”

From the American Druggist, 11/2/59

EMERGENCY SERVICES

The City and County Department of Health was reorganized in January 1930. It has since grown in size and personnel in keeping with the growth of the City of Honolulu and augmented by increasing public demands. The City and County Department of Health is made up of two main and several subdivisions. The main divisions are the Emergency Ambulance Service and the Maluhia Hospital. The subdivisions, extended around Oahu are the City and County Emergency Ambulance Service Units. The Kailua and Wailupe units operate on an eight-hour basis, five days a week, Fridays through Tuesdays and holidays. The Kaneohe, Waikiki, and Waianae units are on a twenty-four hour basis, every day of the week. The Waianae unit began operating on a 24-hour basis in August 1959 in a small room loaned to us by the Waianae Fire Department. In April 1960, it occupied its new quarters adjoining the Waianae Fire Department.

In October 1959, ambulance transfers of private non-emergency cases were turned over to a private enterprise. This new policy has enabled the City and County Emergency Ambulance Service to better the service to the public. In the past, ambulance transfer work has interfered in our emergency work because of misuse and abuses of the ambulances.

The subdivisions render first aid and ambulance service on all emergencies. The Emergency Service provides, in addition to first aid and ambulance service, certain other services, one of which is the out-patient department for indigents and medical indigents. This department provides clinical services Mondays through Fridays, from 7:30 A.M. to 4:30 P.M. If patients need clinical attention after hours and weekends, service is rendered them through the Emergency Unit. Services provided are:

- (1) Physical examinations from school, foster home pre-placement examination, DSW employability, Social Security disability, camp, CPA and others.
- (2) Treatment consists not only of examination and medication but also includes comprehensive laboratory work, x-ray studies, etc.
- (3) Follow up return appointment slips are issued to the patients to provide continuity of treatment.
- (4) Admissions from private hospitals, other agencies and nursing homes to Maluhia Hospital.
- (5) Requests for hospitalization for surgery, etc., from out-patient clinics of private hospitals.
- (6) Administration of salk vaccine and other immunization vaccines to the indigents and medical indigents.

Dr. Raymond Hiroshige, Assistant City and County Physician, has the direct supervision of the Emergency Ambulance Service and its subdivisions. He has a staff of ten licensed doctors, seven registered nurses, one supervising ambulance driver, one assistant supervising ambulance driver, 33 ambulance drivers and 19 attendants to carry out the all important functions of this division on the island of Oahu.

EMERGENCY SERVICE BUSINESS OFFICE

This section of the City and County Department of Health, handicapped by limited help, handles the following:

Industrial Accidents: Overall responsibility of all City and County industrial accidents.

Physical Examinations: Schedule and process all civil service pre-employment physical examinations.

Schedule and process all City and County annual physical examinations.
Schedule and process all police reserve physical examinations.

Schedule and process annual physical examinations of drivers of City and County vehicles.

Clinical Services: Tally and report all out patients at Emergency Ambulance Service units. Tally and report on all out patients by our rural physicians, who are City and County Medical Officers in the employ of City and County Department of Health.

First treatment of employees (City and County) sick calls.

Regular periodic medical visits to Palolo Chinese Home and Manoa Convalescent Home.

Medical Care Program: Recording, tallying, reporting and checking of all invoices from private hospitals, doctors, and clinics on services rendered to indigents and medical indigents.

Others: File and report on all emergency treatment cards. Type, file and report all ambulance cards. File, record and report all sex, A&B, drunk driving cases and prisoners. Billings for pre-placement physicals, out patient treatments, and ambulance services. Account receivables for ambulance services. Receipting and depositing all revenues and refunds.

Typing and reporting all autopsies done by the City and County Department of Health.

Miscellaneous funds.

THE MOBILE DENTAL UNIT

During the calendar year 1959, the Dental Mobile Unit made its customary rounds to 37 rural schools. This figure represents an increase of 7 from the previous year. Because of these additions, it was necessary to modify our planned schedule so as to accommodate the new schools. It was necessary to shorten certain previously scheduled calls. However, the unit was still able to give preference to DPW patients.

The unit received its usual fine cooperation from the various health coordinators, vice-principals, principals, etc., in expediting its work when it called at the various schools. Many parents have expressed appreciation for the dental service.

PATHOLOGY DIVISION

The Pathology Division of the Health Department is concerned with the clinical pathology of patients seen at Maluhia Hospital, the Emergency Unit and the Outpatient Department. It also is concerned with the performance of autopsies of a primarily medico-legal nature.

The clinical laboratory procedures are performed by a staff of laboratory technicians who do hematological, urological and blood chemical evaluations. They also determine blood and urine alcohol concentrations in cases of suspected drunk driving and in practically all violent deaths investigated by the Coroner's Office.

X-Rays not requiring the capabilities of a Roentgenologist are performed by the clinical laboratory technicians.

With the adoption of the City Charter, the office of the Sheriff will be abolished at the end of 1960 and the functions of this office will be assumed by other City Departments. A newly created department of the Medical Examiner assumes the duties of the previous ex-officio Coroner and the Coroner's Physician. This change will permit proper medico-legal investigative methods to be followed, providing a qualified man is appointed to the office.

The appointing authority for the Medical Examiner would be better if comprised of an ex-officio commission instead of a single elected official, since the Medical Examiner is under constant counter-pressures in his efforts to determine, establish and record facts. He should have indefinite tenure of office and be kept as free as possible of meddlesome pressures.

The establishment of the office of Medical Examiner in the City & County of Honolulu is the culmination of a twelve-year effort to replace an antiquated, outmoded, cumbersome and ineffectual investigative system, wherein the authority was vested in completely untrained and uninterested hands, by a system where the proper investigation of questionable and violent deaths is in the hands of trained, experienced and qualified people. This will help to attain the ultimate goals of the qualified medico-legal investigator, who wants only to assist in the prosecution of the guilty and the absolution of the falsely accused.

The campaign for the establishment of the office of Medical Examiner was initiated and continuously espoused by the present City & County Coroner's Physician.

LABORATORY & X-RAY DIVISIONS

When the Emergency Unit of the City & County Health Department was opened on January 1, 1931, there was no laboratory. All work was sent to Queen's Hospital. In 1937 the first technician was hired. The department found that this step resulted in marked savings in dollars and time, as the doctors received results of examinations much more promptly and at a fraction of the previous cost. However, the laboratory was sparsely equipped and in need of more equipment.

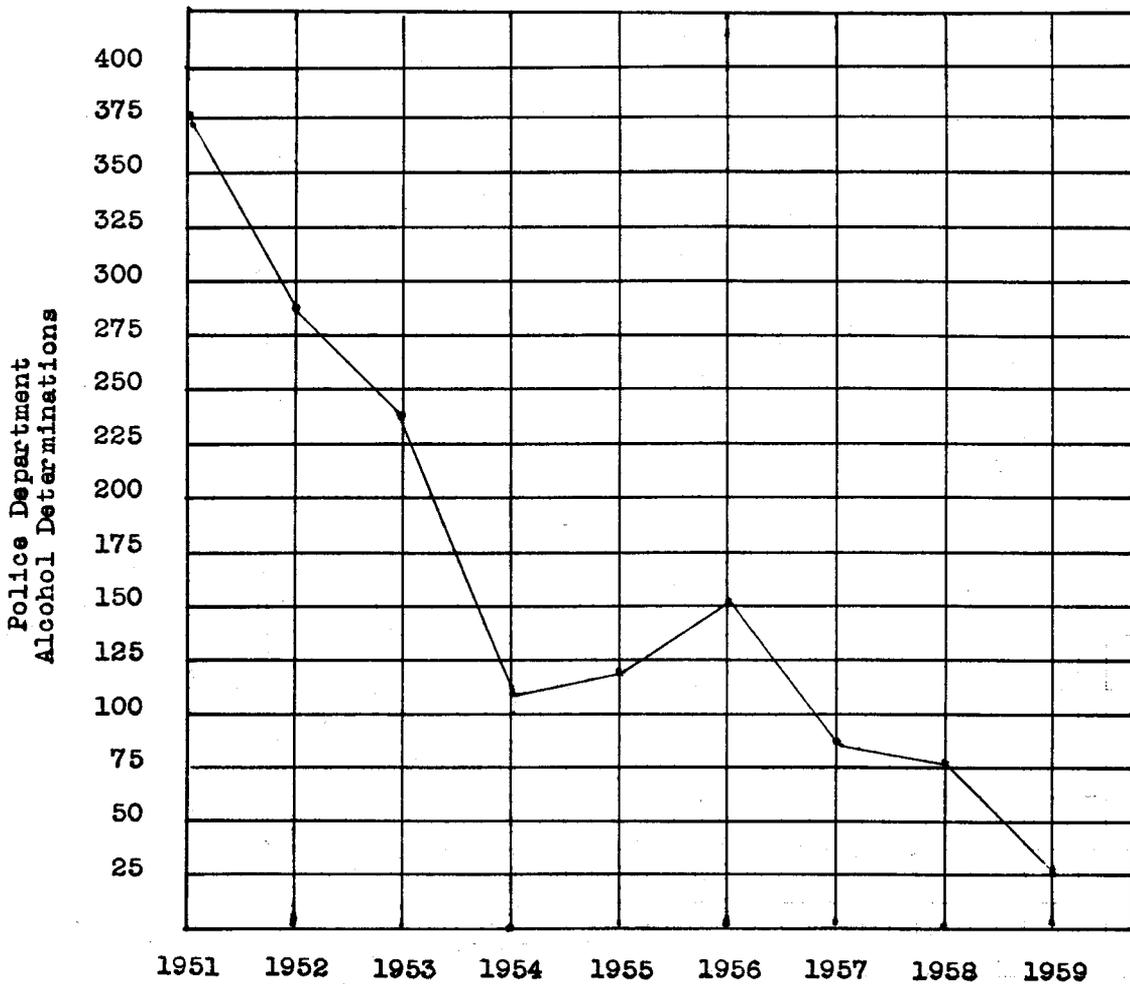
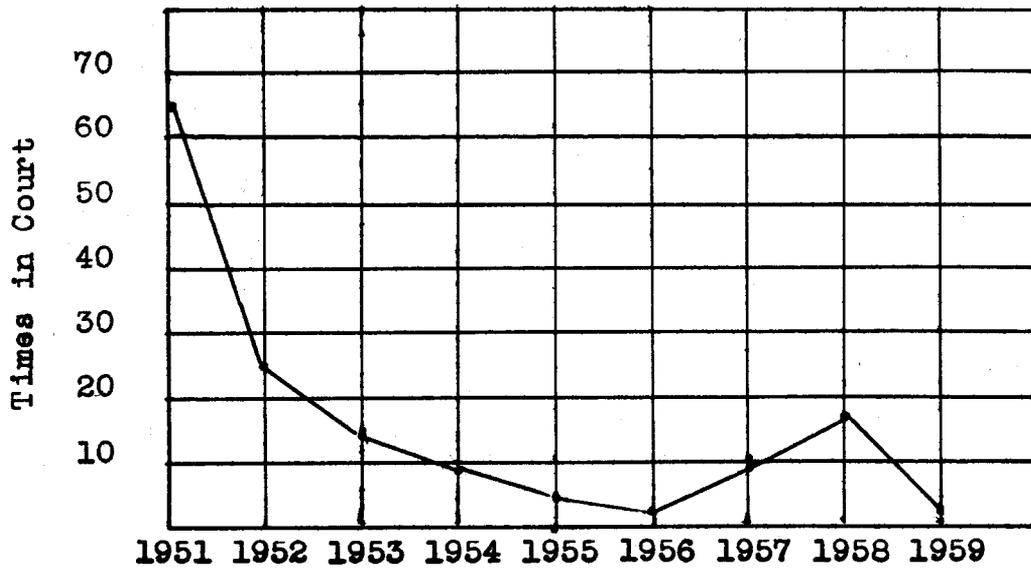
Each year showed a gradual and steady increase in the number of examinations. In 1942, with the war on, an assistant technician and laboratory helper were added through the Office of Civilian Defense. X-rays are also mentioned in the records for the first time.

During these years the technicians performed tests on out-patients and in-patients of the City & County Indigent Home (opened in October 5, 1931), which consisted of Cottages A, B, and C. They even made occasional home visits. In 1949 a new chronic illness hospital was added to the cottages, and the name was consequently changed to "Maluhia Hospital". The services of a technologist and laboratory aide were engaged in April, 1950, thus eliminating the "to and fro" trips for the Emergency Unit technicians, much to their delight.

Records from this period through 1951 are incomplete. On the whole, statistics climbed steadily. Today the figures are quite impressive. Reasons for this are: (1) The over-all growth of the hospital from three dilapidated cottages to the present modern, efficient plant has been tremendous. (2) The turnover is much greater at the present. Patients are being discharged to relatives or nursing homes to make room for others. This results in more laboratory work because of more patients. (3) Doctors are more aware of the value of the laboratory. (4) The laboratory has enjoyed great progress, especially in the field of chemistry. At its inception only the basic examinations were done. With the acquisition of space and equipment, it has been possible to branch out in all directions. This has been a great saving to the City and County, because, heretofore, specimens had to be sent to outside hospitals. The equipment has more than paid for itself.

There is only one exception to this expansion and that is in the matter of police alcohol determinations. There has been a dwindling number of specimens collected, with even rarer appearances at court trials. In 1951, 377 alcohol determinations were carried out for the Police Department with 65 occasions for the technologists to testify, as compared with 1959, when merely

25 specimens were analyzed for alcohol, with 3 court appearances. The following graphs serve to illustrate this:



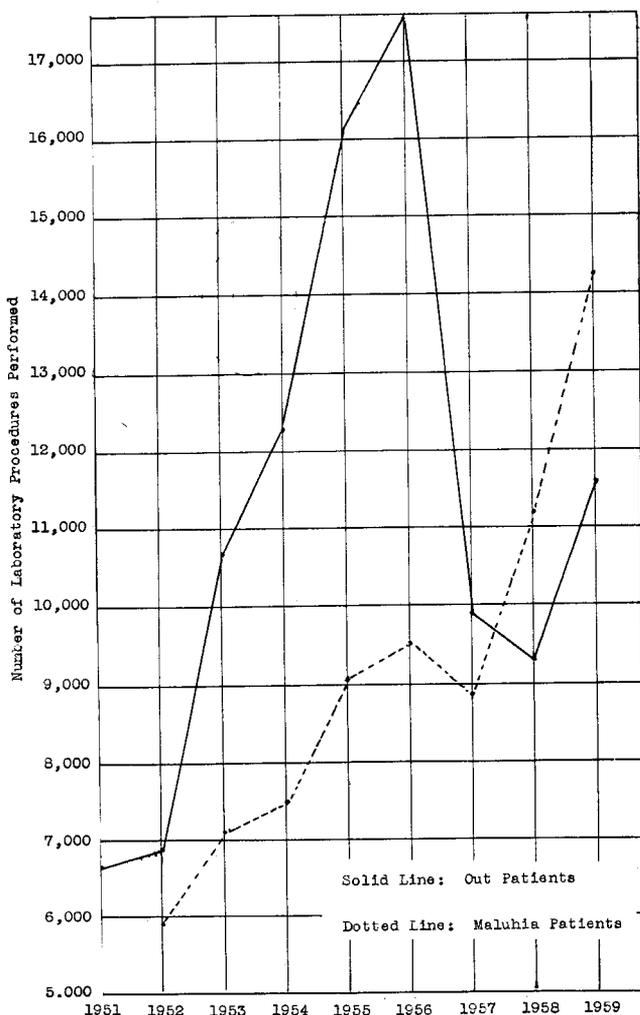
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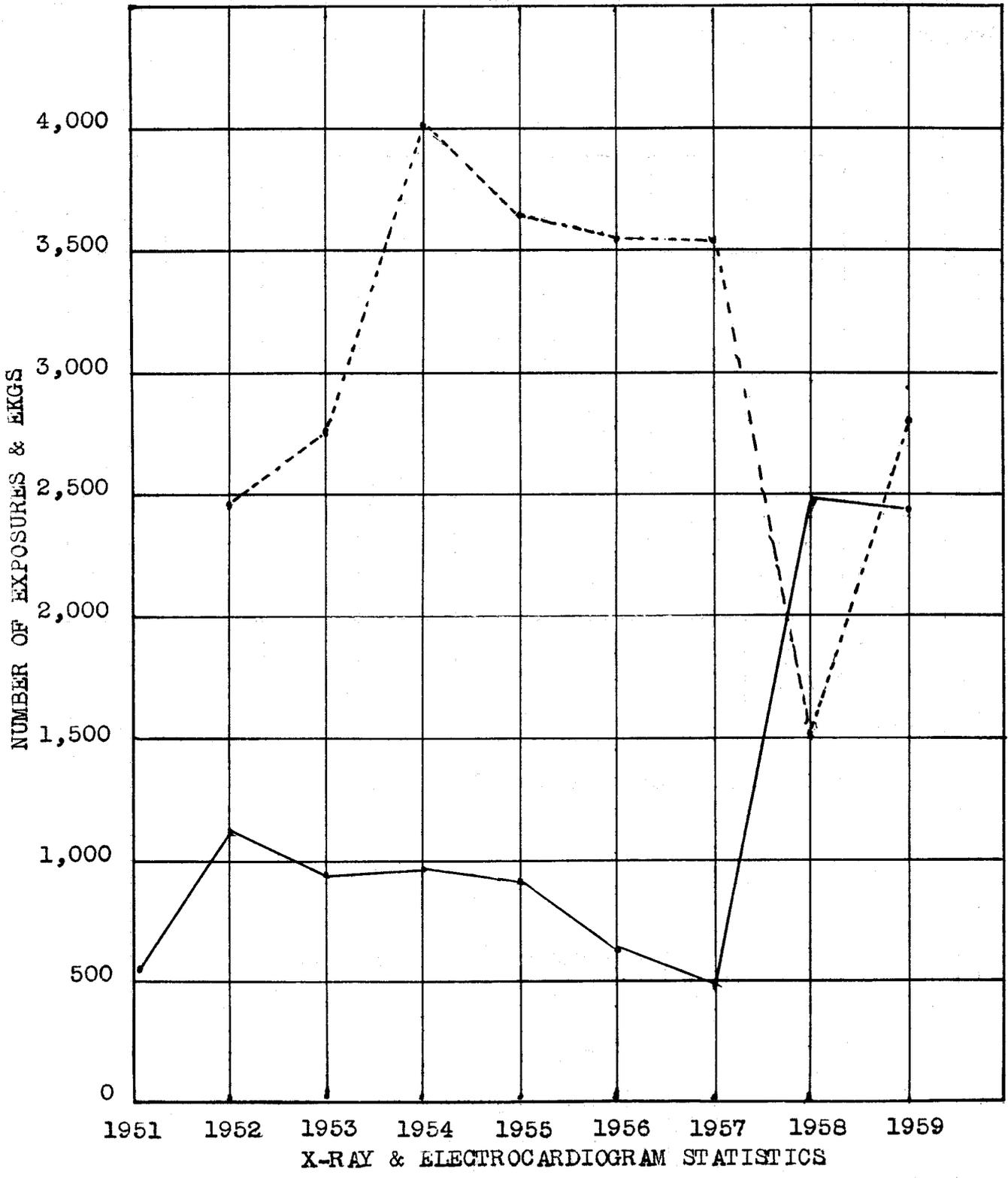
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CITY AND COUNTY OF HONOLULU

Court appearances are not confined to cases of drunken driving. A technologist may be called to testify on her findings in rape and autopsy cases. The Coroner's division has always taken advantage of the laboratory's facilities. In circumstances of death by violence, alcohol determinations are also made. In addition to these, blood typings, bacteriological smears, chloride, specific gravity, and other tests are done as required.

Annual physical examinations on 2,400 City & County employees—policemen, firemen, and drivers—do much to swell the figures. Kahn tests and hemoglobin determinations are run on their blood samples, albumin, sugar, and microscopic examinations on their urines. The laboratory personnel is kept at a slightly maddening pace for five to six months. All applicants for City & County positions undergo the same routine with blood typings and, in many cases, back X-rays in addition.

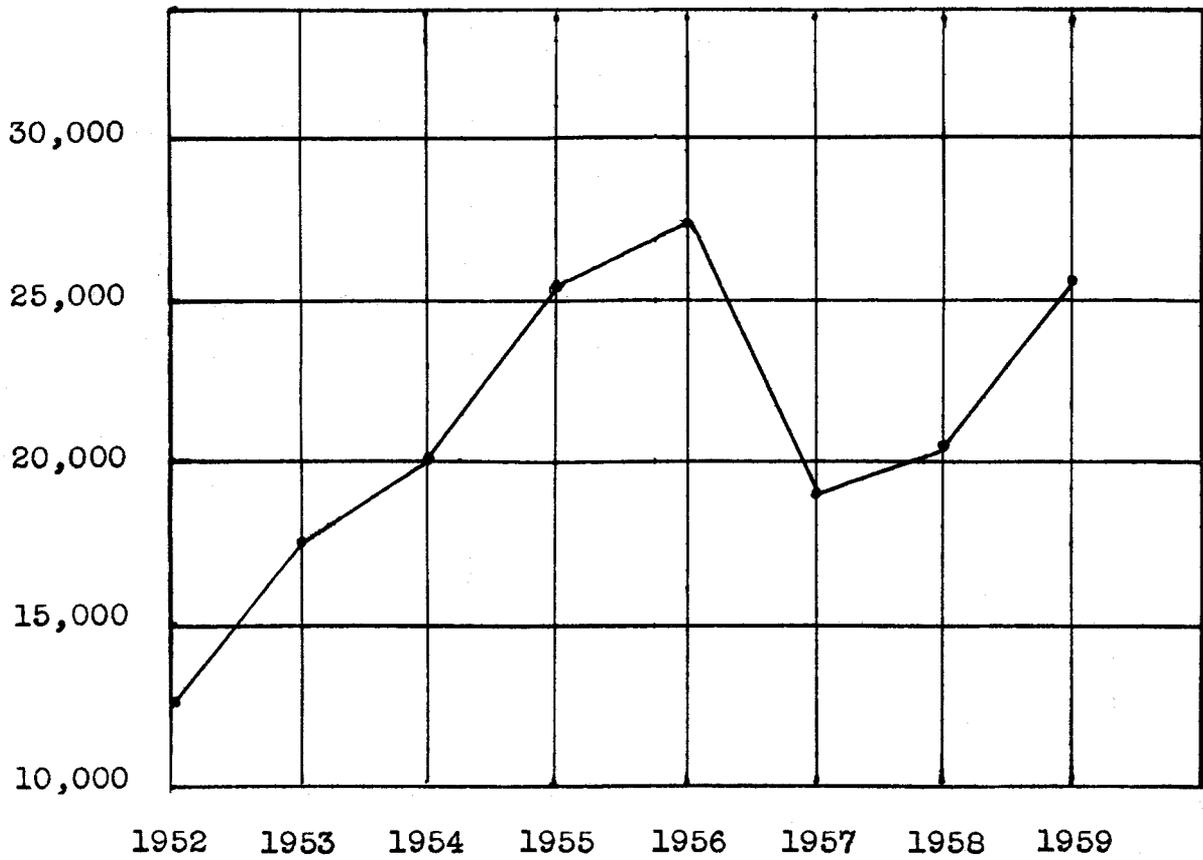
The remaining statistics will be presented in graphic forms. X-ray figures include electrocardiograms, which were instituted perhaps around 1952. Graphs start with the year 1951, due to incomplete data on previous years.





Solid Line: Out-Patients
Dotted Line: Maluhia Patients

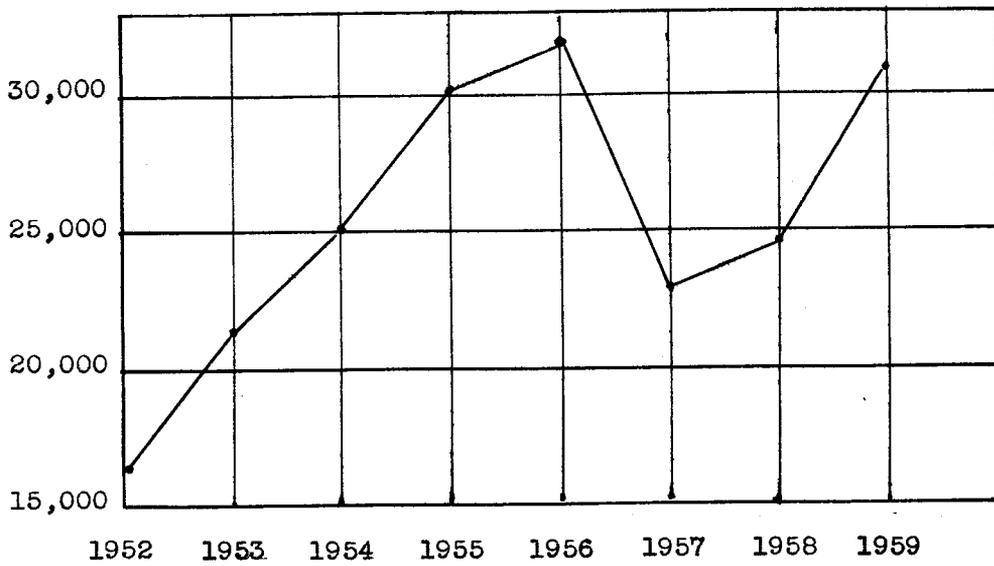
In-patients and out-patient figures were combined and the results plotted on graphs. The following are self-explanatory:



TOTAL LABORATORY PROCEDURES



TOTAL X-RAYS & ELECTROCARDIOGRAMS



TOTAL PROCEDURES
(LABORATORY, X-RAY & EKG)

On Page 10 it will be noted that the Out-patient figure for 1956 constitutes the high point on the graph. It is felt that this fails to reflect a true picture, as venous punctures were counted and entered into the statistics. Since this routine procedure is merely a mechanical means used to obtain material for examination, this inclusion has been discontinued. Whether this was taken into consideration in any of the years before or after 1956 and 1957 is not known. In 1957 there was, too, an appreciable drop in blood counts and typings and Kahn tests.

On Page 11 the graph is prepared under the titles of "Out-patients" and "In-patients" for want of better names. This is really a confusing situation, as "Maluhia patients" also include any of those persons who had had any X-rays taken on parts of their bodies other than extremities, which were done at the Emergency laboratory. The reason for this was that the X-ray machine at the latter place was limited, it being a portable machine. Since the annual reports at Maluhia Hospital were not differentiated between in- and out-patients until 1958, the statistics necessarily included everything. In reality, the gap between the two curves is misleading.

1959 has been a year of growth. The workload showed an increase of about 25% over the previous year and it is expected that the upward trend will continue. New equipment was put into operation, new procedures were added and the old improved upon. The hiring of another technologist increased the number to four, but there yet exists a great need for another laboratory assistant. Our present one is finding his duties somewhat overwhelming, since he is kept on the run, trying to cover both laboratory and X-ray divisions. However, this problem will probably resolve itself when the Emergency Unit will be once again divorced from Maluhia Hospital in a matter of months to occupy new quarters in the old Sears building.

If this seems more like a history rather than an annual report, it is because this has been the first time narrative reports have been prepared by each department and it is felt that a background is essential to show the true growth of the laboratory.

MEDICAL ASSISTANCE PROGRAM

NINTH YEAR OF OPERATION UNDER THIS DEPARTMENT

Since the passage of Act 129 (Chapter 48, R.L.H. 1955) in 1951, this department has maintained a program of medical care for needy persons. The history of public medical care in Hawaii goes back to the days of the monarchy, the missionaries and the whaling ships. Various forms of services were provided for the needy sick. Our present program had its beginning with the Department of Public Welfare (now called the Division of Social Welfare, Department of Social Services) on July 1, 1943. It was transferred to county governments on July 1, 1951 by Act 129, however, the Board of Health (State Health Department) was named the supervising agency for the program. By the Statehood Reorganization Bill of the last Territorial Legislature in 1959, the authority as a state supervising agency was transferred to the Department of Social Services. Considering the long historical background, our role in providing public medical care is very brief, yet the staff of this department has a certain feeling of pride in having contributed to the continuous development of an essential public program.

The statute, for administrative purpose, names two groups of persons as being eligible for help under this program, namely, the indigent and medically indigent. We prefer the simple term "needy sick" as it is more descriptive of the people who, due to circumstances beyond their control, must seek medical aid for relief from the ravages of illness, disabilities from injuries and infirmities of old age. "Indigent" is a time-worn term based on a charity concept and the Elizabethan Poor Laws. The statute defines indigents as persons receiving economic (financial) assistance from the Department of Social Services. Their financial situation is such that they are unable to meet their basic needs of food, shelter and clothing on a level "compatible with decency and health." Medical indigents are able to meet the cost of daily essentials. They are not poor enough to be eligible for financial aid from the Department of Social Services and not rich enough to provide medical care for themselves in time of illness. The philosophy underlying this statute, like the Public Assistance Act, is the conservation of human resources.

The method of determining eligibility for medical care does not differ much from the methods used by local jurisdictions throughout the nation. A recipient of economic aid is certified for medical care by his social worker of the Division of Social Welfare. The medically indigent applies for help at the Financial Investigation Division of this department. A medical social worker evaluates the applicant's available resources and monthly expenditures in order to decide on his application. It is said that with the existence of an efficient public medical care program no person in the community need to go without care when needed.

The nine years of experience has shown us that a large percentage of persons who receive help are elderly single individuals and the physically disabled whose subsistence level nearly equals the existing public assistance standard. The other group is comprised of large families whose income level is such that they are only able to meet their daily essentials. The causes for people to seek aid are not any different from those reported by public assistance agencies throughout the nation. The problem is financial in nature resulting from unemployment, parental separation, de-

sersion, neglect or death, large families with limited resources, physical and mental incapacities, limited retirement benefits, births out of wedlock, etc.

Patients eligible for medical assistance are placed under staff services of private clinics and hospitals. It has been our observation that (1) patients have shown positive acceptance of staff care and have not regarded such care as being inferior to services rendered by private physicians, and (2) shopping around by patients among various clinics and hospitals has been negligible. Concerning the first point, people in the health and social welfare fields throughout the nation have debated on private vs. staff services for indigents and medically indigents. Proponents of private care have stressed the importance of doctor-patient relationship and free choice of physicians. As attested by current practices on the mainland, this system has not received widespread public support so far. It is said that although this system has considerable merits, it is exceedingly costly and administratively cumbersome.

Vendor payment method has been in use since the beginning of the medical care program here. Cost of care for eligible patients is paid directly to the vendors of medical care (hospitals and clinics) by this department. Another method of payment suggested by some authorities in the social welfare field is the recipient payment method. Eligible patients are given cash (possibly in monthly installments) from the agency administering the program. The patients in turn make their payments to the vendors of medical care. Whether this method is in use anywhere on the mainland is not known to us. The thinking underlying this method, like in welfare payments, is that clients, although dependent on a public agency for support and/or medical care, should be given every opportunity to maintain self-respect and feeling of individual worth through direct participation in the economic life of the community. The complaints by hospitals that they have extreme difficulty in collecting patients' share of the cost of hospitalization (cases in which partial help is given by this department) seems to indicate that this payment method has serious shortcomings.

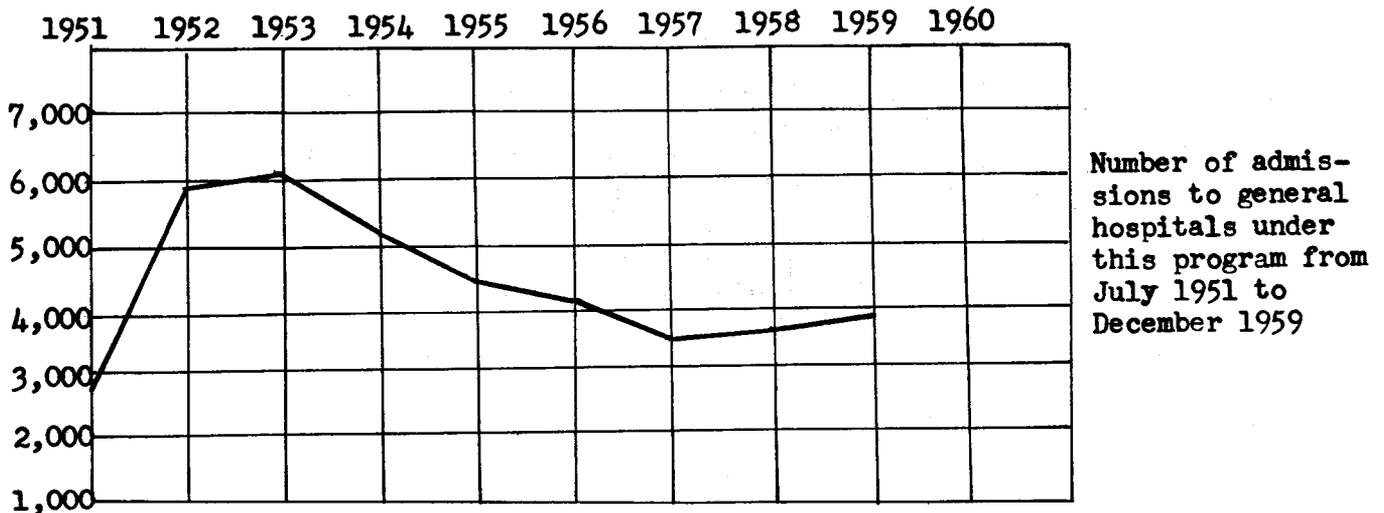
With financing problems and program objectives in mind, the department entered a phase of evaluation of the total program in 1956. A manual of procedures and assistance standard for medical services was adopted in early 1957. This was followed by a system of medical authorization for hospital care. These served as systematic controls for the expenditure of funds as well as ways to reach the desired goal of furnishing all necessary services for the emergency care, prevention and "rehabilitation of patients" as expressed in the law. The impressive number of people for whom outpatient services were made available and corrective appliances furnished under this program since 1951 is indicative of the perspective we have maintained in the preventive and rehabilitative aspects of medical care. It is not merely a life-saving program as it may appear on the surface. Unfortunately, however, the department has not always been able to keep a straight course on program objectives due to the problem of financing. No doubt, the goal of providing all types of services for medical rehabilitation of possibly every eligible patient will cost tremendously more than present allotments will allow. It can be said that this department has done well in administering this program within its financial limitations. We are cognizant of the fact that our effort to rehabilitate patients is of great importance to a public assistance agency just as much as

their attempt to meet their program objectives of social and economic rehabilitation of their clients is important to this department.

Of particular concern to this department—perhaps to all counties—is the possible effect of inadequate finances on the medically indigent caseload. Federal matching for the indigents is given important consideration in giving priority to this group over medically indigents. Our standard of medical assistance was adjusted downward as our expenditures rose and the net result was increased number of rejections of applications made by persons who claimed inability to meet the cost of private care. The present standard of assistance for eligibility determination should be maintained at all cost. We have within this standard a minimum-maximum scale for essential living expenses. Any attempt to reduce the present standard to the level approximating public assistance standard is regarded a short-sighted plan as it will disqualify hundreds of presently eligible persons. The medically rehabilitable persons who are not poor enough to be on the welfare roll and not rich enough to afford medical care could become neglected, and with prolonged neglect the possibility of rehabilitation becomes less and they may eventually need to turn to public assistance for long-term help. Our monthly statistical reports from 1951 have consistently shown that there is a large number of people in the community who fall within this group.

It appears clear that this program has helped thousands of people to better health, self-respect and self-sufficiency.

Public Medical Care Program Has Served Thousands of People Annually



The number of admission to general hospitals in 1951 is comparatively small as the program was transferred to this department on July 1st of that year.

Although this chart shows a downward trend in the number of admissions, it can be readily seen there was a tremendous number of persons who benefited from this program.

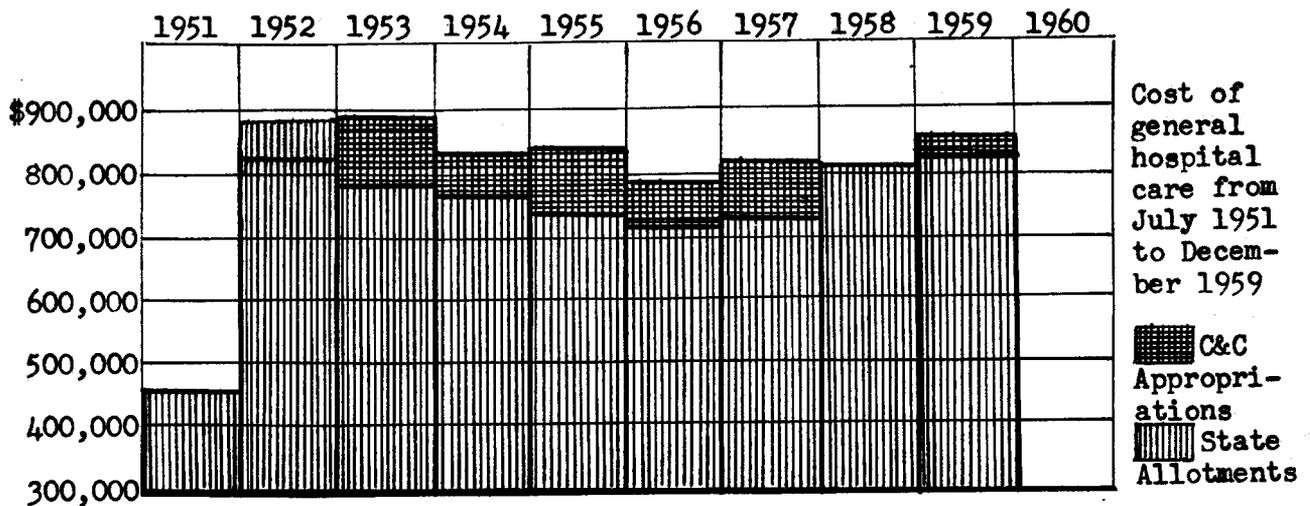
The steady decline in the number of admissions since the peak year (1953) was caused by several factors. Generally, the downward trend depicts an encouraging picture. The number of rejections for hospital care by reason of inadequate funds was negligible, therefore, it did not cause any appreciable effect on the rate of decline.

The downward trend since 1953 is consistent with the brightening economic picture of the community since the recession following the termination of Korean Conflict. With improving labor market, the number of unemployed and persons on relief declined resulting in significant decrease in the number of applicants for public medical care.

During the past decade, there has been a tremendous increase in the number of wage-earners insuring their families against the cost of care in the form of private medical insurance. No doubt, this has contributed to the decrease of our caseload.

Advancement in medicine is steadily reducing the need for hospitalization for some types of illnesses. Where patients were admitted for short-term treatments for precautionary measure many of them are now being treated successfully on an outpatient basis with new improved drugs.

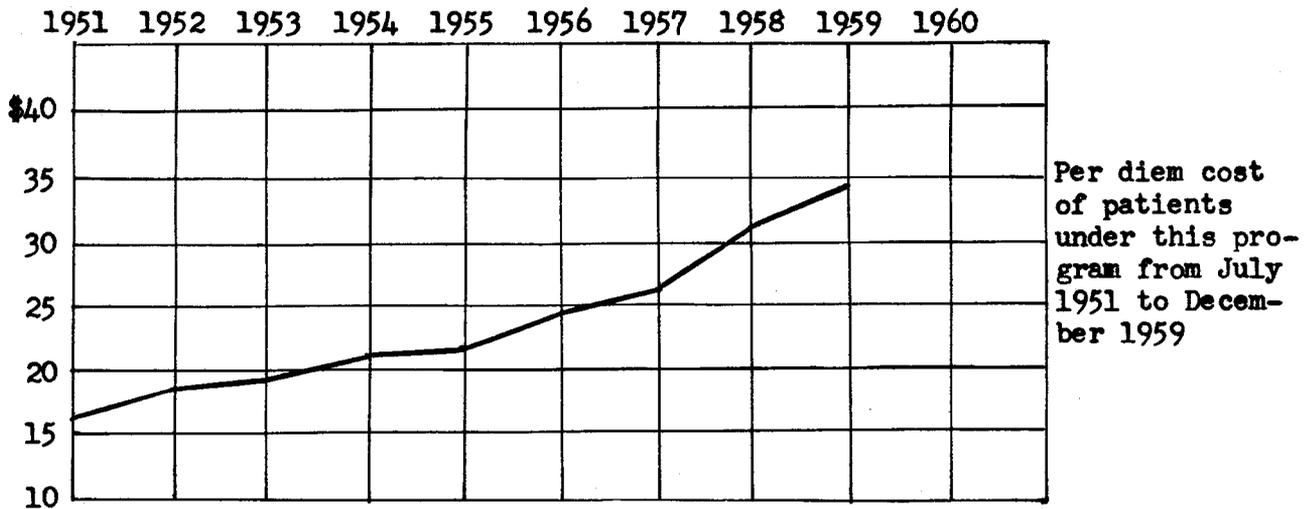
Despite Decreasing number of Admissions Expenditures Remain Nearly Same



The number of persons served under this program since 1952 decreased to nearly half the number, however, the cost of the total program has remained constantly high, the cost (with the exception of 1956) varying between \$800,000 to \$900,000 annually. During the same period the per diem cost in general hospitals more than doubled, the 1959 cost being \$34.50 per day. In view of this, any reduction of allotments in financing this program can only bring adverse effects on patients, particularly on the medically indigents who are the first to be affected when funds become critically low.

In addition to meeting the total administrative cost of operating this program, the City and County of Honolulu has appropriated (with the exception of 1952 and 1958) large sums of money to meet the cost of general hospital care.

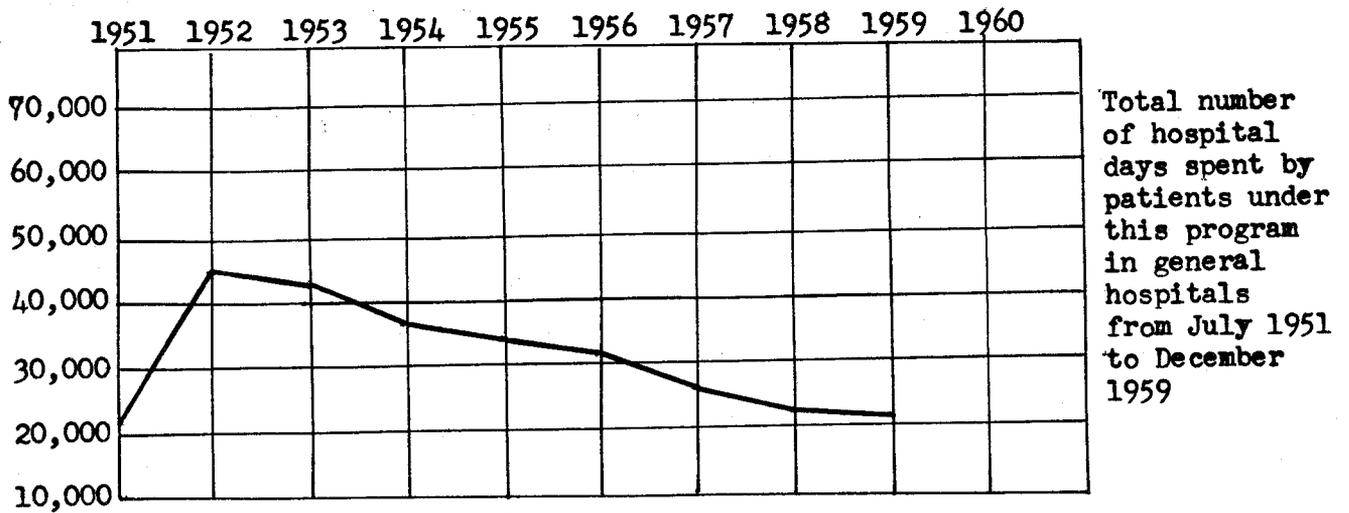
There Has Been Constant Increase In the Cost of General Hospital Care



The continuous rise of hospital care cost during the period shown on the above graph is consistent with the trends reported throughout the nation and no stabilization or leveling off of cost appears in sight. In view of this, and as part of sound program planning, increased funds should be made available. Without increased allotments, this department, like most counties in the State, may be faced with the necessity of lowering its medical assistance standard. Another alternative would be the deferring, or even rejecting certain forms of recommended care for some eligible patients—probably the medically indigent. Should any of these courses of action be taken, services made available to patients would be mostly on emergency and palliative level.

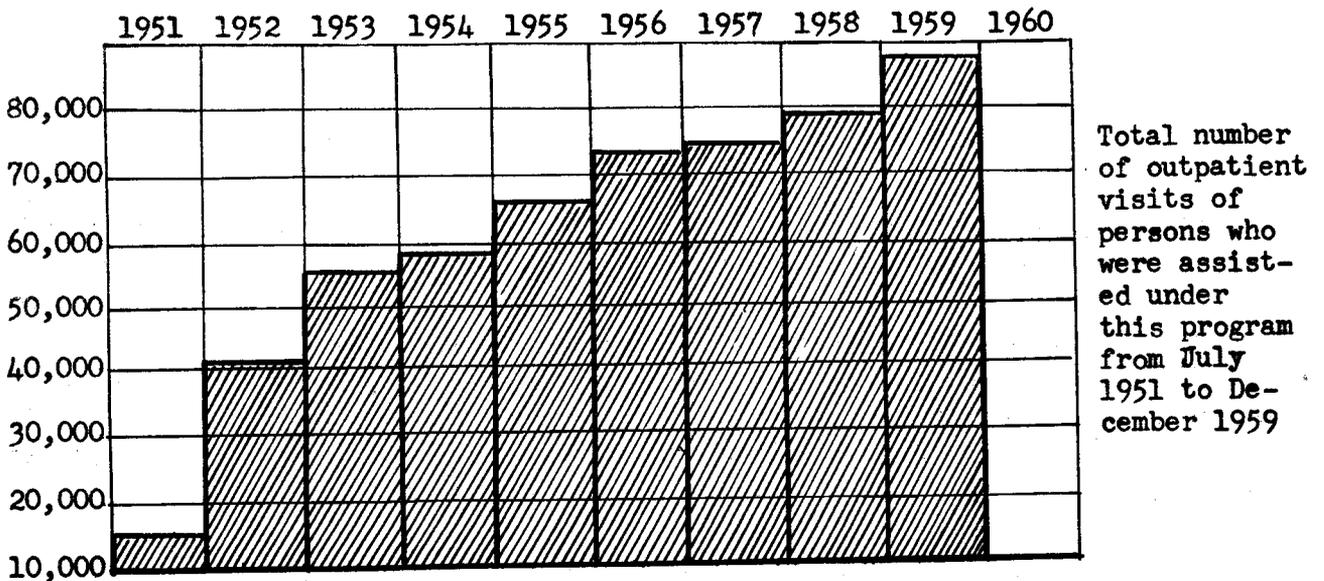
For many patients, our own resources, Maluhia Hospital facilities, had to be utilized in order to keep the cost of this program within a safe margin. When ready, many patients were transferred to Maluhia Hospital for convalescent care. In this way, patient days in general hospitals were reduced. This is another way the City and County of Honolulu contributed heavily in meeting the total cost of the program. Without this facility the annual cost of the program would have skyrocketed far beyond the manageable level.

Several Factors Caused a Continuous Decrease in Hospital Days



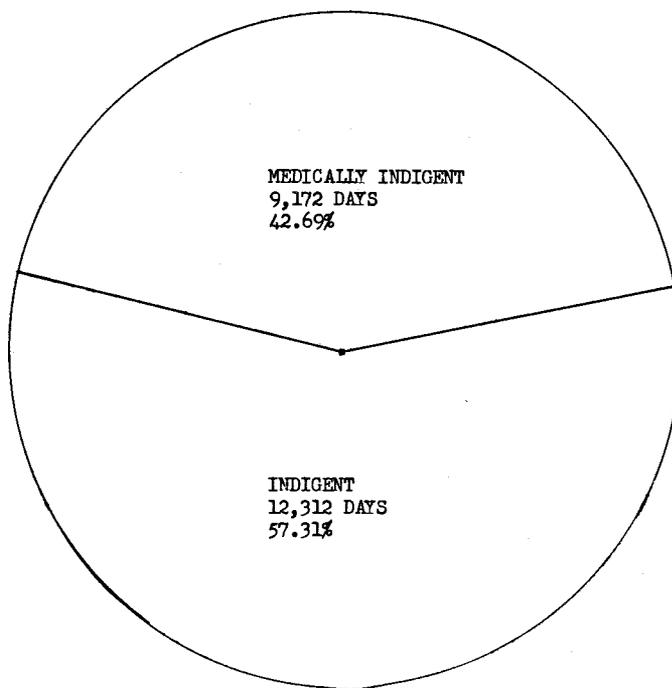
The downward trend shown on the above graph is similar to the decrease in the number of admissions during the same period. The reasons were due to consistent decrease of the number of applicants resulting from improving economic condition, transfer of patients to Maluhia Hospital and improved method of care and use of new drugs.

There Has Been A Great Emphasis on Outpatient Care

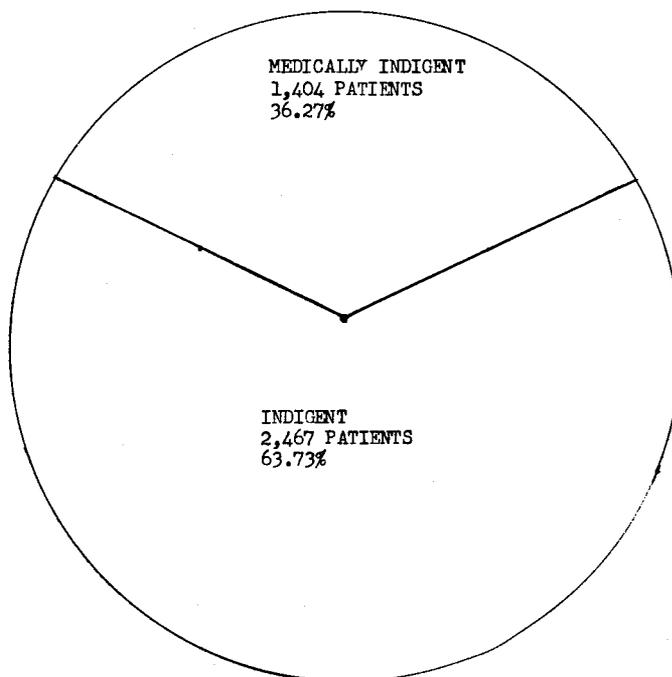


While the number of admissions decreased steadily, the number of outpatient visits increased tremendously. This is indicative of great emphasis being placed on treatment on outpatient level. Increased expenditure for outpatient services is worthwhile as it can result in savings eventually. People are showing greater interest in seeking early and adequate outpatient care.

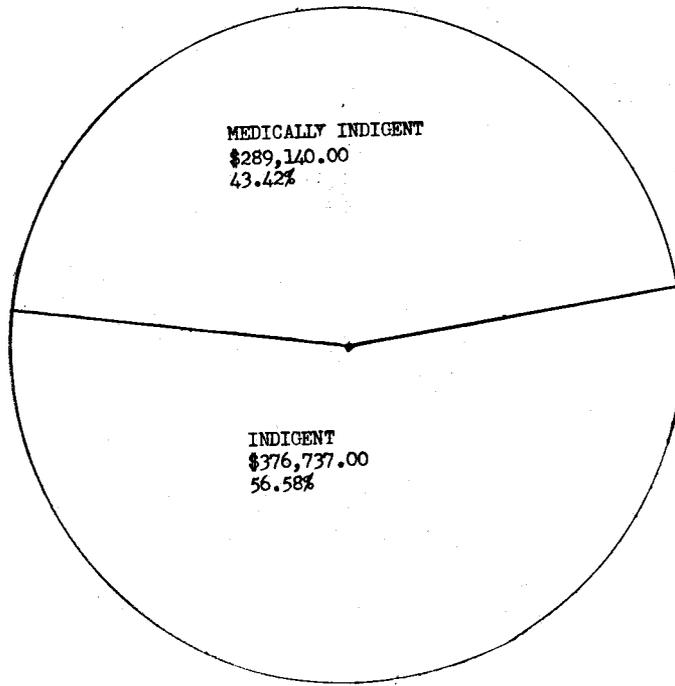
PATIENT DAYS 1959



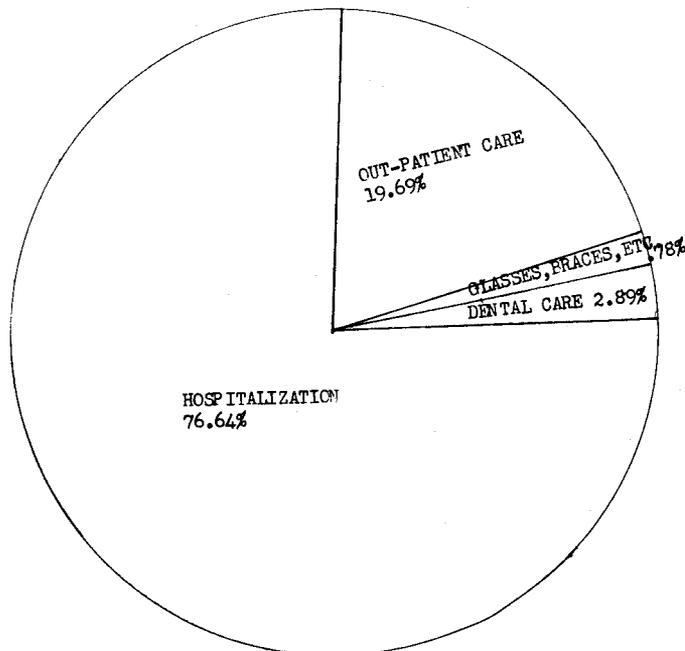
NO. OF IN-PATIENT CARED FOR 1959



COST OF IN-PATIENT CARE 1959



TOTAL COST OF MEDICAL CARE PROGRAM 1959



COMMITMENT OF PATIENTS TO STATE MENTAL HOSPITAL

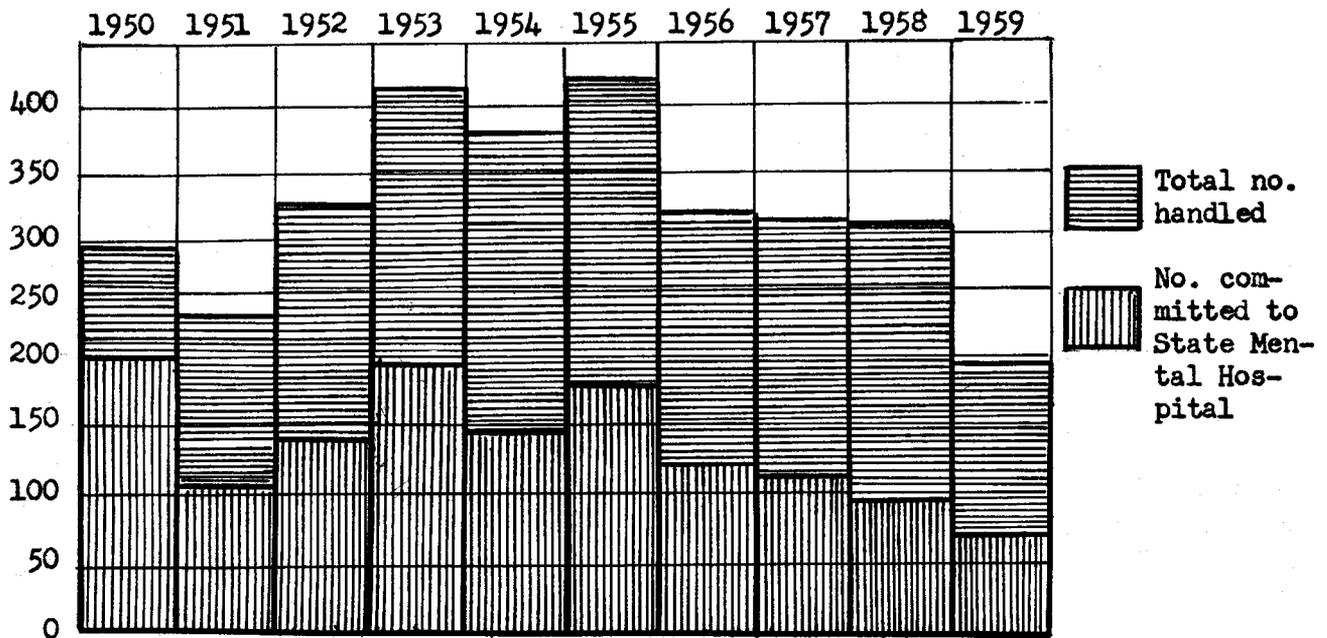
Processing applications for commitment of the mentally ill and persons habituated to the use of alcohol and drugs to the State Mental Hospital is an important function of this department. Our responsibility for the maintenance of this program dates back to the establishment of this department which, perhaps, has had the most colorful historical background among the many departments in this county.

The duty of rendering services under this program has been centralized under one social worker of the Financial Investigation Division. Simply speaking, these services can be classified as (1) processing of applications for commitment, and (2) rendering consultation service to private physicians, and medical, social and law-enforcement agencies on matters relating to the legal aspect of commitment and procedures. Although the existing statutes concerning commitment enable private physicians (with license and two years of medical practice in Hawaii) to commit their mentally ill clients, they have depended heavily on the Financial Investigation Division for the total service of commitment. This extensive use of the division by various public (including the Mental Health Division of the State Health Department) and private agencies is perhaps complimentary in that this is indicative of our having received community-wide recognition as a public agency for the legal commitment of the mentally ill. Considering the long process involved in completing each application, the caseload carried annually by this office is considered very high. Strenuous efforts have been made by us in recent years to encourage hospitals and private physicians to process their own cases, however, the response has been very poor. Inasmuch as the existing statutes on commitments name government physicians as responsible agents for examination, determination and commitment of the mentally ill and persons habituated to the use of alcohol and drugs, the Financial Investigation Division has no justification in refusing to accept applications and referrals made by private hospitals and physicians. The difference in the language as expressed in the statutes is that private physicians may but government physicians must examine patients for commitment.

Like physical illness, mental illness is not only the poor man's disease. It strikes at any cross-section of the population—the poor and the rich, the socially prominent and the unknown, male or female, the young, middle-aged and the aged, as well as people of varied racial backgrounds. It seems to strike a segment of a given population in greater frequency. (No adequate social data is available to validate this statement.)

An interesting observation in our work was the frequency of cases we came across in which well-meaning relatives, or petitioners for commitment lacked adequate insight into the problems of the mentally ill or the emotionally disturbed. Many patients appeared to need favorable environmental changes and sympathetic understanding more than anything else. Perhaps, such lack of understanding will be reduced to the minimum as the community organizations for better mental health continue to do their job of public education.

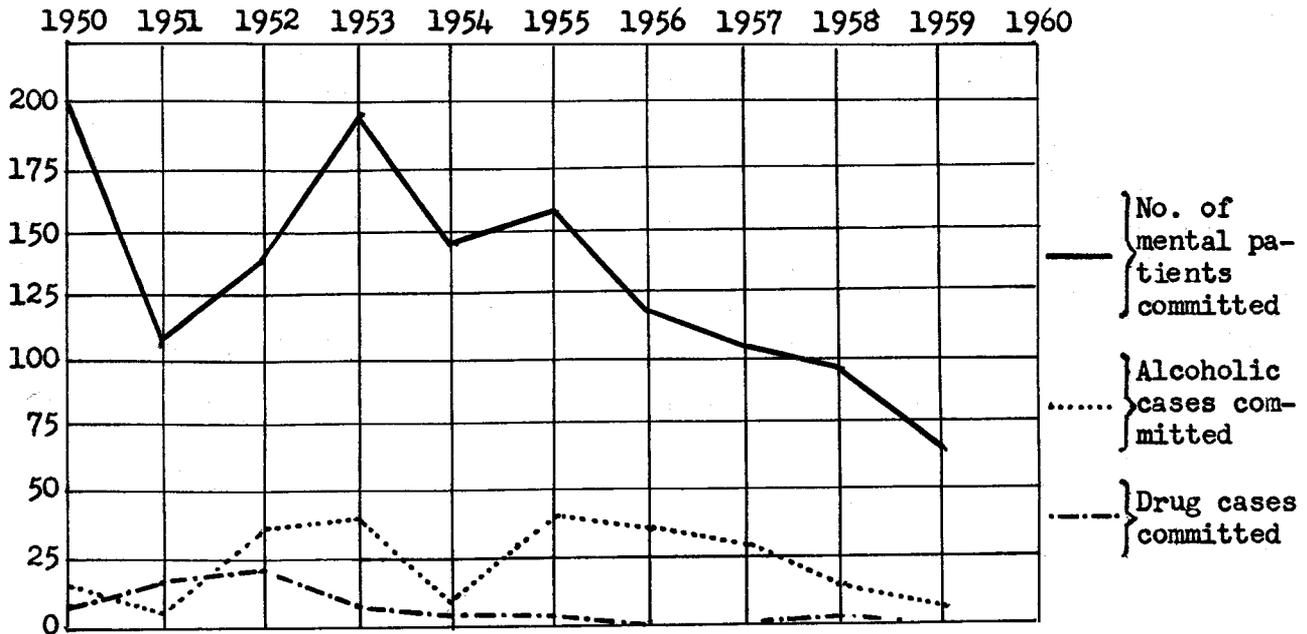
Number of Cases Processed for Commitments from 1950 to 1959



For the past 10 years, the ratio between the number of persons not committed and the number of persons legally committed to the State Mental Hospital through this department has remained relatively constant. The larger number of persons not committed annually is of great significance to the community as it points out the need for progressive plans for preventive care and treatment of the emotionally or mentally disturbed.

The foregoing graph is not a comparative study of the number of persons found to be in need of commitment and the number found to be non-committable. In any given year, there were several patients who were found to be committable by our Medical Officers but relatives changed their mind later as they felt sorry for admitting them into a mental institution.

Commitments Through This Department Have Decreased Since 1953



Of the total number of mentally ill patients admitted to the State Mental Hospital through this department in 1959 as shown below, slightly over 50% of them were readmissions. It should be noted that since the number committed through this office by no means represents the majority of patients committed annually to the mental institution the foregoing statement should not be considered as being applicable to the State Mental Hospital. However, it brings out the point that rehabilitation of such patients following discharge is a challenging task to public and private agencies.

COMMITMENTS DURING 1959

Number of mentally ill patients handled.....	179
No. of patients committed.....	59
1st admission.....	29
2nd ".....	18
3rd ".....	9
4th ".....	0
5th ".....	3
No. of patients not committed.....	120
Number of Alcoholics handled.....	23
No. of patients committed.....	9
1st admission.....	7
2nd ".....	1
3rd ".....	1
No. of patients not committed.....	14
Number of Drug cases handled.....	0

DIVISION OF DENTAL CARE

The organization of The Division of Dental Care of the City and County Health Department, was initiated by an enactment in The Territorial Legislature in 1939, mandating The City and County to maintain a dental division. The purpose was to provide dental services to the welfare and medically indigent patients. This program began with a full time dentist and his assistant in a Mobile Dental Unit, scheduled once a year in the various public schools in the rural districts, rendering dental care to all eligible patients, minors as well as adults. Consequently, The Health Department, in 1950, established the second dental unit at Maluhia Hospital staffed with a dentist and his assistant. This unit schedules all eligible patients in the city as well as the rural areas.

For the calendar year of 1959, the combined visits and operations of the two units totaled —7836 visits, 19,034 operations.

	Visits	Operations
Maluhia Dental Unit.....	4488	11,167
Mobile Dental Unit.....	3348	7,857

MALUHIA HOSPITAL NURSING SERVICE

The growth of Maluhia Hospital from three small cottages to the present beautiful Hospital has been tremendous, reflecting the progressive trend of the City and County of Honolulu. We are still struggling steadily toward better patient care and service to this community for patients in need. The cottages were primarily for domiciliary cases but now we have more acute cases, fresh surgical cases, and completely bedridden patients who require constant care. The nursing care at Maluhia Hospital has been drifting away from long term chronic illness to more acute and short term types of illnesses thru the necessity of keeping the cost of medical care down and trying to operate within budgetary limit. The patients range from the very old to tiny babies who are given room, board and care while awaiting vacancies to occur at Waimano Home. The severe cardiacs, terminal cancers, and acute asthmatics need especially alert attention. The added duties of spoon feeding so many helpless patients increase our work load but the patients are never left hungry.

Our patient-nurse ratio was formerly one professional nurse to 80 or more patients. A slight reduction to one R.N. to 65+ patients exists at present. We would comfortably use more professional nurses. Our practical nurses and hospital orderlies ratio has been one to 20 patients. At present the ratio is about one to 10-15 patients. Vacations, maternity leaves and long illnesses add greatly to the present shortage of personnel.

Unlike the other general hospitals, the nursing staff at Maluhia Hospital has added problems even in an ordinarily simple process, such as discharging a patient. Other agencies have to be contacted since so many patients have no money, no relatives and no place to go. Frequently it takes months for proper placement. Another difficult area is the handling of deaths in cases in which the patients has no family.

Arrangements for orthopedic and surgical out patient clinic appointments to other hospitals have to be made well in advance for ambulance service.

Internes from Kuakini Hospital are now supplementing the medical staff. They record and elaborate on all personal histories, give physical examinations and contribute immeasurably to the care and welfare of the patients. They are on duty six days a week and on call every other night.

Medical charts never before used in Maluhia Hospital have brought us up to date in keeping accurate records of our patients, which, incidently, increase the work load of the professional nurses as it takes so much time to go through 60 to 70 charts daily for each 8-hour shift.

A continuous in-service training program has been initiated which has contributed much to the interest and morale of the personnel as well as to better patient care. Special on-the-job training, follow up and constant supervision have resulted in improved nursing care. Use of film strips, lectures by doctors on diseases and treatments, new equipment demonstrations, and talks on the latest new drugs being used have been on the agenda. Patients in Maluhia Hospital are very fortunate in that the latest and the most effective drugs regardless of the cost have been obtained for their benefit.

The following volunteer workers have contributed immeasurably to the health and welfare of our patients:

Three times a year the Kapiolani Technical School Practical Nursing division bring their students to Maluhia Hospital for pre-clinical experience, such as the actual care of patients. The students are accompanied by their two staff instructors who supervise the students with the help of Maluhia staff.

From time to time during the year, the Red Cross Volunteers have given graciously of their time in helping with the actual nursing care of patients, using skills learned in the Red Cross Home Nursing Course.

We have had many hours of unselfish and willing service given us by several lovely teenage school girls. Their help in Specified Duties which have been approved for Volunteer Junior Aides is greatly appreciated.

The nursing staff has been a group of much older people than generally hired at other hospitals but they are hard working individuals. Recently, we were able to employ a few "young bloods" directly from the Practical Nurses Training School, who have given great satisfaction.

In conclusion, there is steady progress in the quality of service in spite of the shortage of personnel. With the population of Hawaii increasing so rapidly we will be called upon to serve more people and we are determined to extend such service to the best of our abilities.

MALUHIA HOSPITAL

DEPARTMENT OF CLINICAL MEDICINE

Maluhia Hospital is situated at lower Alewa Heights overlooking at one extreme Diamond Head and Honolulu Harbor and to Tantalus and Punchbowl on the other. It has a bed capacity for 230 patients at present and is a hospital for the chronically ill and incurable diseases. Maluhia Hospital has made continued progressive advances in the hospitalization and treatment of medical and surgical conditions during the past year.

The admission of the acute medically ill into Maluhia Hospital has changed the program of nursing care and medical management. What was mainly a hospital for chronic illness, Maluhia Hospital has made a step into the management and treatment of acute medical conditions. To do this, Maluhia has improved greatly its clinical procedures to facilitate hospital nursing, hospital records, charting, laboratory and x-ray services, with a view to higher standards of good hospital management of patients and record. It is to be noted that chronic disease cases are not neglected. On the contrary, acute and chronic illnesses are both given the same preference for admission and the equally same standard of medical care.

The most outstanding feature during the past year was the Intern-Resident Program affiliation with Kuakini Hospital to accomplish the increased work demand on the medical staff. A small increase in the number of graduate and practical nurses was also necessary to accomplish this end. The Intern-Resident program has worked to mutual satisfaction of both Kuakini and Maluhia Hospitals. The Intern Program has also evolved a consulting staff of Surgeons and Medical Internists from Kuakini Hospital. These consultants have graciously given their time and services for the welfare and comfort of patients. Two interns are at Maluhia Hospital to attend patients at all hours, in addition to two senior medical officers who supervise, instruct and assist them in their training while at Maluhia.

To augment the Intern Program, a monthly medical conference and a weekly surgical round were instituted at Maluhia Hospital by the Kuakini Hospital medical and surgical staff. At these meetings, cases of general academic interest, for diagnosis or for surgical opinion, were discussed. It is hoped that these conferences will continue and further develop the interest in the Intern Training Program.

The change in the clinical program in the past year has brought increased workload upon hospital services due to shortened hospitalization of the acutely ill. This rapid turnover and increased workload have likewise made demands on other departments. Shorter hospital stay required more intensive care and follow-up—greater use of laboratory procedures, more x-rays, more drugs, increased use of Central Supply Room, and a higher standard of medical care. These demands, however, were met without the desired increase in personnel—particularly in the nurs-

ing, occupational and physical therapy departments, the x-ray and laboratory departments. It might be said that the workload has substantially been greater in the following departments: medical staff, medical social service, laboratory and x-ray. The medical staff is cognizant of the demands placed upon the laboratory and x-ray departments and hereby wishes to acknowledge sincere appreciation to the help given. The laboratory and x-ray departments are regarded as the hub of activities within a hospital.

SURGICAL TREATMENT—Surgical male and female wards have been in operation since last year. Its existence is primarily due to the suggestion and effort of the surgical staff of Kuakini Hospital. Its purpose is obvious. Patients requiring operations are transferred to Kuakini where all types of surgery are performed by the Kuakini surgical staff. Following surgery, patients are returned relatively early to the surgical ward at Maluhia where subsequent care and treatment are supervised by the Kuakini surgical resident staff.

The efficient cooperation of the surgical staff of the Kuakini Hospital is greatly appreciated and acknowledged.

SUMMARY: Maluhia Hospital has long been considered a place for chronic, incurable or terminal diseases. This concept is gradually changing because of acute medical illness requiring highly skilled judgement, diagnosis and treatment. It is more than just offering food, shelter and nursing care. Attention is being gradually directed to achieve more permanent result by arranging for follow-up appointments in the Out-Patient Department to those with chronic illness upon discharge from the Hospital. The medical social service, physical therapy and occupational therapy have each constituted a small but essential cog in the wheel of teamwork in the treatment of patients as a whole.

The Maluhia Hospital Medical Department wishes to acknowledge grateful appreciation for the kindness of the consultants in the Emergency Unit of the City and County Health Department in their cooperation in the management of Maluhia in-patients.

OCCUPATIONAL THERAPIST SECTION

Believing that an unhappy patient does not respond to treatment as quickly as one who is cheerful and relaxed, the Occupational Therapist section endeavors to help him in two ways. In the first place, admission to a hospital is always upsetting—sometimes a terrifying experience. To offset this we must provide means of demonstrating the friendliness of all those surrounding the patient, and, where indicated, supply diversion with forms of reading matter and a radio. For those who require spiritual security, a fine group of inter-denominational volunteers give religious counseling. Other volunteers chat and play games with the lonely, write letters for the handicapped, conduct a shopping service, and arrange flowers throughout the institution. For certain specific cases we can call on the Bureau of Sight Conservation and the D.P.I. provides instruction for patients of school age. Another resource is the Library of Hawaii, which maintains a regular stock of reading matter. Thanks also goes to the Musicians' Union for boosting the morale of the patients with a monthly concert. Grateful mention should also be made of those volunteers who serve in the Thrift Shop, run by the Hospital Auxiliary to raise funds for the endless "extras" so helpful in building morale. Much time is spent too by these women in collecting and sorting donations and working up projects for the patients out of these materials.

In addition to this service, which is in large measure public relations, the Occupational Therapist must consider the patient as a member of the community, even if more or less handicapped, not simply as a case of chronic asthma or a broken leg. In an effort to eliminate circumstances contributing to hospitalization, the patient must have instruction to develop new and former skills and must build self-confidence through counseling and socializing activities with other patients. Collaboration with the medical social worker is essential in this area and we hope in the course of time to establish a closer knit team.

A third function of Occupational Therapy is training in self-feeding and clothing. Although desirable, such steps toward independence cannot be undertaken at this time because of limitation of staff.

MALUHIA HOSPITAL PHYSICAL THERAPY

1959 was the usual busy year. The Physical Therapy Section administered treatments such as heat, hydrotherapy, electric stimulation and functional rehabilitation to the sick, injured, and disabled.

Industrial Accident cases were approximately the same in number as last year. Four departments with the highest number requiring Physical Therapy Treatments were the Police, Refuse, Fire, and Health Departments, respectively.

With the purchase of twelve new collapsible wheelchairs and necessary equipment, a functional rehabilitation program aimed toward maximum independence in activities of daily living got off to a favorable start in January.

Some nine adult and ten student aide volunteers helped tremendously with this program.

Again lack of another qualified Physical Therapist made it difficult for one therapist to treat the large number of out-patients and in-patients.

MALUHIA HOSPITAL DIETARY SECTION

Dietary Section has three basic responsibilities. One is the care of the patient, or what is often termed "therapeutic dietetics;" another is the production of the food or what is referred to as "administrative dietetics;" and the third is teaching. All of these functions are coordinated with all other sections of the hospital and are operated primarily for the good of the hospital and the patients.

A good state of nutrition is the dietitian's responsibility to the patient, and the rule applies to the regular diets as well as to the therapeutic diets for patients who require special menus. All diet prescriptions are filled by our section, and the same care and accuracy applies here as that of other sections in carrying out the doctor's orders. Food consumed is just as important to the dietitian as food served.

Constant aim is to improve the patient's food standard. Recently the patients' food service was changed from decentralized to centralized system. Eventually, all of the patients will be served through the centralized system. Trays are completely set-up in the main kitchen by kitchen employees under the supervision of the dietitian. This system is most desirable since duplication of employees and equipment is eliminated, left-overs are reduced; serving portions are standardized; food service is directly supervised by a dietitian; and noise and food odors around the bed side of patients are minimized. The disadvantage of centralized system is that the food may become cold if the trays are not distributed immediately upon arrival to the floors. We feel that the advantages outweigh the minor disadvantage noted.

Food is not only essential in the successful treatment of the patient but plays an important part in influencing the morale of the employees. The pay-cafeteria with partial self-service takes care the employees who are interested in buying their meals at this hospital. When the pay system was started in November, 1959, many who had complained of the "inferior free-food" insisted that the improvement in our food must be due to new cooks or new recipes. The psychological effect of paying for your own meals was amazing. The outstanding result of the new system is the great reduction in food waste. When the employees received "free-meals" they had little appreciation of their value.

The dietary section is responsible for the expenditure of a large portion of the hospital dollar, and such expenditure must be carefully controlled thru well planned menus, wise buying, and close supervision of food preparation. Expensive, complicated diets, steaks and chops, or costly fruits and vegetables do not always signify a better state of nutrition. On the contrary, good food need not be expensive food but well-balanced with high nutritive value. It is impossible to plan menus which are popular to all as food habits of individuals vary greatly. Menu-planning is not a simple task of writing a list of popular and palatable foods. It is based on cost time, personnel required for the production, and the equipment available. Our present kitchen is not set-up for wide range of menu items. Variety need not be expensive food but adequate equipment and lay-out are required. It is this section's sincere hope that in the very near future the much "dreamed-of-kitchen" will be realized for efficiency, attractiveness, and ease in maintenance.

MALUHIA HOSPITAL BUSINESS OFFICE

The Business Office, Maluhia Hospital, is responsible for the hospital's business activities; and the servicing of Divisions and Sections within the Department of Health.

The activities of the business office includes accounting, care of patient's monies and valuables, billings, cashiering, budgeting, personnel, payroll, inventorying, telephone operation and keeping records to account for the financial condition of the Department of Health, City and County of Honolulu.

MEDICAL RECORD DEPARTMENT

The installment and development of a centralized medical record system is perhaps one of our most significant accomplishments in the operation of Maluhia Hospital the last two years. Ever since this hospital received recognition as a medical institution for the chronically ill from the United States Surgeon General and gained membership in the Association of Western Hospitals in 1956, the entire staff has pitched in to help improve our hospital standards. One phase in this important undertaking was the installment of a centralized unit system of filing on November 1, 1958. It had been long recognized that the medical and nursing staff had been seriously handicapped in the treatment of patients as the old records kept on loose 5 x 8 cards were difficult to use and did not contain sufficient information.

Presently, our record number is above 3200. This alone can well explain the importance of an orderly method of record keeping and filing. The creation of our medical record department was well justified in terms of improved services to our patients and to agencies which are also concerned over the health and welfare of the same persons in whom we are interested. With our improved medical records, better information can be furnished to inquiring agencies, such as the Department of Social Services, Public Health Nursing Service and the Bureau of Old Age and Survivor's Insurance. The medical records system also maintains statistical data which is so essential to the over-all operation of the hospital.

MALUHIA HOSPITAL SOCIAL SERVICE

The primary responsibility of a social service in a hospital setting is to render supportive services to the medical division so that patients may receive the full benefits of hospitalization from the time of admission to discharge. Its value to the hospital is dependent upon the understanding of its functions and the use of its staff by other members of the institution, such as the medical officers, nurses and administrative staff. The role of our Social Service was not clearly understood until 1956 when the services of this section were re-evaluated and its program objectives defined.

The activities of Maluhia Hospital Social Service are unique in some respects and its duties are multitudinous and multifarious. This uniqueness is attributable to the function of the hospital which is a public medical institution for the chronically ill. Majority of its patients are elderly persons with financial problems, and it is inevitable that they would have problems of living arrangement, adjustments and health supervision. Although the bed capacity of this hospital is not nearly as large as some of the private general hospitals in the city, the age, social and economic characteristics of our patients require a strong social service section which is capable of rendering fast and efficient services to all patients. Ever since Maluhia Hospital received recognition as a hospital for the chronically ill in 1956, there has been increasing demands for services from this section. Many elderly persons not requiring hospitalization were admitted to Maluhia by our outpatient department and private physicians only for the purpose of having them placed in nursing or boarding homes by our Social Service.

Maluhia's patient load is a conglomeration of chronically ill senior citizens of varied racial backgrounds. It has long been noticed by the Social Service that the community as a whole has not paid much attention to the needs of the aged. The often-repeated remarks by well-meaning people that elderly patients are being to Maluhia Hospital for custodial care for the remainder of their life make sense particularly when we have a long list of patients awaiting placement year after year. This is revealing in that it points out our community's great weakness, that is its lack of responsibility in providing for adequate nursing home facilities for these unfortunate senior citizens. The Social Service was forced into developing private resources for these patients. Through the efforts of this section, four private boarding and nursing homes were opened for the aged. These homes soon became over-crowded as other public and private agencies began using them.

The senior citizens are not problems to the community, but like in childhood, they are exposed to various economic and social problems which they are, in many cases, unable to cope with and for which they need community-wide attention and assistance. They are people with feelings, desires and hope and the general public should look at them as individuals having a niche in the society of ours. Maluhia Hospital has provided a form of security to thousands of these citizens, but because of the ever-increasing aged population in Hawaii our efforts have been spread too thinly and have not reached far enough. The hospital administration and Social Service feel much gratified over the recent re-awakening of the general public in looking into its responsibilities to the aged.

Historically, the senior citizens of Hawaii had positions of great influence and respect. In old Hawaiian cultural practices, the old patriarch and matriarch were well cared for and their positions were elevated to that of heads of the household. The Oriental immigrant laborers brought with them similar cultural practices. Filial piety and responsibility for the care of kith and kin continued to exert great influence in the care of the aged. Cultural conflicts and replacement of old customs were the inevitable result of inter-racial mingling. Somewhere along our recent history, the senior citizen was forgotten. The tremendous number of unattached adventurous immigrant laborers who came to Hawaii half a century ago and who contributed to the development of our industries are our senior citizens now.

Perhaps, there are two reasons for the general public's recent awareness of its responsibility to the aging. First of all, the national leadership taken by the Federal Government with its various programs, such as the Old Age Insurance, public housing, committees for the study of the aging, has impressed state and local authorities to meet their share of responsibility. Secondly, Hawaii has entered a period of tremendous increase in its senior citizens.

Our Social Service staff believes that one of the urgent matters the Governor's Committee on Aging should look into is the possibility of establishing a foster home placement program for the aged, possibly with the Department of Social Services. The establishment of nursing home facilities, preferably under private management, is also critically needed. If relief is not near in sight, this department may be forced into enlarging its Social Service staff in order to help develop private resources for placement of our many patients who have been on our discharge list for many months.

MALUHIA HOSPITAL STOREKEEPER SECTION

The Storekeeper Section of Maluhia Hospital presently consists of one personnel, a Storekeeper, who is responsible to the Administrator of Maluhia Hospital and the Assistant City and County Physician, for the proper receipt, storage and issuance of all drugs, medical supplies, equipment, staple foods and miscellaneous supplies.

This requires the maintenance of accurate inventories and record keeping as the Storekeeper is accountable for all items received by him. He also has the added responsibility of maintaining proper stock levels at all times to avoid shortages in the event of a dock strike or emergency.

In addition to issuing the above mentioned items to Maluhia Hospital, drugs and medical supplies are issued to the Honolulu Emergency Hospital, Kaneohe Emergency Unit, as well as all other Emergency Units, Palolo Chinese Home and Honolulu Jail.

It has become apparent that the responsibilities and duties required of the Storekeeper in this sections have increased throughout the years to the extent that it can no longer be handled adequately by a single person. Efforts are now being made to employ an Assistant Storekeeper to alleviate some of the heavy workload of this section.

SERVICE SECTION

IKE KAHI HE MEA OLUOLU NA HANA MAIKAI, HE MEA PAHA' O' HA O NA' E IKA LEHULEHU.

This section embraces the Laundry and the Maintenance Department. They are similar to the "stage hands" in the production of any stage play. They are unseen by the audience of the theater and must toil in the shadow of the stage, and must step aside for all other departments since it lacks the technology in the medical field and the dignity of the clerical workers and consequently, prestige, it receives little recognition, though it has always been an integral part of the hospital.

The visible cleanliness of the patients and employees relies heavily on the Laundry Department. Hundreds of items are washed, pressed and issued daily. The work here is tedious, dirty and unrewarding, but "tattle gray" is never a problem, but a challenge.

To the Maintenance Department falls the responsibility for the physical cleanliness, appearance and the maintenance of the inside facility of the hospital and its equipment and furnishings. Its activities extend over a wide range of services. Repairs of many intricate medical equipment and instruments, operation of a large steam generating plant, the maintenance of the grounds of the hospital, aid to the Occupational Therapist, aid to the Dietary Section, and in addition, maintain the buildings and equipment of the outlying station of the City and County Department of Health at Kailua, Kaneohe, Waianae, Waikiki and the Wailupe Emergency Units. It has direct effect on the health, comfort and morale of the patients, doctors, visitors and all hospital personnel.

HOUSEKEEPING SECTION

The main functions of the Housekeeping Section are the supplying of linen to the hospital and keeping the building clean. These services are maintained by a Housekeeper, two Seamstresses and two Custodians.

Under the skillful hands of the two Seamstresses, a steady flow of new linens are made and a tremendous number of old linens are salvaged by mending or by cutting them up and making smaller items from them. In 1959, 4622 pieces of new linens were made, 12474 pieces were mended and 15002 pieces were salvaged.

Good housekeeping is a must in a hospital. It also plays an important part in public relations and with a helping hand from the administration, we are constantly striving to meet these challenges.

FUTURE PLANS FOR THE HEALTH DEPARTMENT

MALUHIA HOSPITAL

It is hoped that the existing wooden structures which were condemned by the Fire Marshal in 1951 will be replaced with a fireproof building.

The replacement of lost beds is sorely needed if we are to keep down the cost of Indigent Medical Care, especially with the 30-day limitation in general hospitals. Without additional beds to care for sub-acute medical cases which Maluhia Hospital can handle itself rather than sending to private general hospitals, the Indigent Medical Care Program will sustain a considerable deficit which the County will be required to assume. The Maluhia Hospital should acquire facilities for extended care for more and more semi-acute cases such as post-operative care, milder short term acute infections such as upper respiratory infection, abscesses secondary to diabetes, and recovery periods for fracture cases.

By order of the Fire Marshal, it is imperative that the laundry and kitchen facilities be modernized for safety reasons. This in return will bring about increased efficiency, economy, and production.

EMERGENCY FIRST AID AND AMBULANCE SERVICES

Because of the shifting of population into the Kalihi area, the Department hopes to have a new emergency ambulance and first aid unit adjacent to the new Kalihi Valley Fire Station if finances permit. To serve the public more efficiently and properly, the Department hopes to operate the Wailupe and Kailua Emergency Ambulance and First Aid Units on a 24-hours, 7-days a week basis. This too, is also subject to finances.

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