Just where do you put two-hundred-year old hand-carved doors? The new developer custom condominium homesites at The Queen Victoria allowed Mrs. Bickson to showcase her antiques into her new home. This and having long time Honolulu residents as neighbors make The Queen Victoria the city’s most desirable address just steps from the Academy of Arts.

For an appointment: Rosemary Zais, Coldwell Banker Pacific Properties, 732-1414;
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A Call to Physician Authors

We are always looking for interesting scientific articles and we would like to hear from more of you. The Hawaii Medical Journal is a peer reviewed publication and covers a wide variety of topics. To submit a manuscript please call us for manuscript guidelines. Fax or call for your requests to: Hawaii Medical Journal, 1360 S. Beretania Street, Honolulu, Hawaii 96814, Phone (808) 536-7702 or Fax us at (808) 528-2376.
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**Editorial**

**Norman Goldstein MD**

**Report to the 140th HMA Annual Meeting**

*October 17-10, Kauai, Hawaii*

The Hawaii Medical Journal is alive and doing well! Despite the “thin” issues in 1995 and 1996, because of budgetary restraints, we have had some very special issues.

In 1995, they included April—*Medicine, Law and Bioethics,* May—*Fred Reppun Memorial issue,* June—*Fred Gilbert Festschrift,* July—*Military Medicine in Hawaii,* November—*History of Medicine in Hawaii.* In 1996, the March Special issue was dedicated to *Vog* and the September issue to *Domestic Violence.* A special issue in December will deal with *Death with Dignity.*

Thanks to the Guest Editors for these issues: S.Y. Tan, MD; Bob Nordyne, MD; Ben Berg, MD; John Breinich, MS and Al Morris, MD; and the 1996 Guest Editor: Florence Chinn MD.

The reference staff of the Hawaii Medical Library has graciously continued to prepare our invaluable Index to the Journal.

Our regular columns by Russell Stodd MD and Henry Yokoyama MD continue to be very popular, according to the Readers Survey done in October 1995. Because of our limited funds, the manuscript pages as well as some of our other regular columns had to be kept to a minimum.

We published 80 manuscripts in 1995 and 36 from January to October 1996. Many thanks to our 157 Peer Review Panel members which were listed in the January 1996 issue (page 5), our hard-working staff, Carol, Becky and Noreen. Jan Estioko worked with us for eight years, but is no longer with the Journal. Dietrich Varez’ art continues to give us a very “Hawaiian” feeling to our covers, and Pacific Printing and Publishing continues their excellent services delivering the Journal on time, every time.

Our major problem is financial. For many reasons, we are not getting enough advertising income; hence, “thin issues.” *Members can help by suggesting drug company representatives, car sales people, bankers, etc. who should contact the HMA office and take out ads.* A physician’s business card, referral page is also planned. The Journal is very highly respected by the media in Hawaii. We also became a member of the Hawaii Publishers Association in 1996.

The Journal must continue publishing, not just for the members/ readers, but for the continued prestige of the Hawaii Medical Association.

**Euthanasia Conference—Denver**

The Hemlock Society will sponsor its Ninth Annual Euthanasia Conference on November 8 and 9, 1996 in Denver, the new home of the Society. (A report of the conference will appear in the December issue of the Journal—The Special issue on Death with Dignity.)

Hemlock Hawaii hopes to have established members as well as new members attend. For further information, contact: Folly Hofer, RN, MPH, President, Hemlock Hawaii 1434 Punahou Street, Suite 504, Honolulu, Hawaii 96822-4721 Phone (808) 946-4452, Fax (808) 949-4965 (Folly #501)

The Journal welcomes Letters to the Editor on this subject as well as any of our articles.

---

**HMA President’s Message**

**Carl W. Lehman MD**

EUREKA! The HMA now offers to its members, the financial management expertise to manage retirement plans by a corporation (SEI), who in the past accepted only accounts of 250 million dollars or larger. Through the HMA, members may use SEI to manage their retirement plans. There is still a $150,000 minimum requirement, but that is achievable by most doctors after contributions for a number of years. The cost of management fees through this large organization is less than half of what most of you are paying to brokers at this time, to manage your retirement fund investments. The savings from these lower fees will pay for your HMA, the AMA dues, with personal savings to the HMA member. This action by the HMA resulted from Dr “Len” Howard’s efforts in finding this opportunity for the HMA. For more detailed information on this project, please read Dr Howard’s message in the forthcoming Hawaii Medical Newsletter.

The HMA held a 1-1/2 day Strategic Planning session in August 1996, facilitated by the AMA’s vice-president Strategic Planner, Mr Bruce Balfe. We derived at a consensus to focus on assisting members with financial and management problems in their practices.

In addition to the above project, we initiated two other activities this year which may greatly benefit members.

1. Central verification of credentialing is now available through the HMA to decrease the amount of forms required of you to complete for each hospital and managed care group that participates with us.

2. Our attorney, Lisa Tong, will critique contracts submitted by third party insurance companies, manage care organizations, hospitals, etc. and provide legal information (not legal advice) to our members.

We believe that the above tangible activities provided by the HMA more than offset the members annual dues. I encourage you to take advantage of these opportunities. I also ask that you support the AMA which has been most successful in influencing the language and passage of many bills through the Congress this past year. The HMA has been politically active in our state legislative activities this past year and plans to maintain our active presence at next year’s Legislature through our Analyst (better than a lobbyist) who represents us at all times during the Legislative session.

As my term of Presidency for the HMA is nearing completion, I wish to express my deep appreciation to the membership for the honor and privilege you have given to me to preside over this most prestigious organization.

This my last message has been the most difficult for me to write, not because of lack of topics, but because of the multitude of activities and subjects that we address in organized medicine.

---

**Mahalo and Aloha**

Thanks to Lori Arizumi of the Hawaii Professional Media Group for helping the Journal with our advertising for many years. Lori now represents the Hawaii Dental Journal.

Welcome on board Michael Roth and Frederick Berg of Roth Communications.
The Role of the Medical Technologist in Medicine

Patricia Taylor MS, MT (ASCP) CLS
Associate Professor & Chairman
Medical Technology Division
John A. Burns School of Medicine

The role of the medical technologist in medicine is always changing and that is even more true in today’s world. Indeed downsizing, right sizing, mergers, re-engineering, restructuring, and reorganization are familiar terms to these health professionals. Added to the many changes are the numerous regulations such as the Good Manufacturing Practices required in Blood Banking and the Clinical Laboratory Improvement Amendments of 1988. Finally, trends like point-of-care testing and managed care create a scope and a rate of change that has great significance.

Even medical technologists actively involved in providing the fundamental laboratory services have new dimensions to their positions whether it be the technology itself, supervising others or dealing with billing codes. These professionals have long been responsible for quality assurance in the laboratory which involves accuracy in specimen identification, viable reagents, proper methodology, functioning instrumentation and responsible distribution of results. Generally they work behind the scenes.

Some of the unique opportunities emerging for medical technologists are positions on institution-wide committees to develop policies and problem solve, trainers on specific hospital wards or for entire facilities to oversee the point-of-care testing and as consultants in establishing all the systems and documentation needed for testing in physicians offices. Some have traded a microscope for a telephone and serve as client service representatives on the front line to facilitate the numerous issues that surface in the clinical laboratories.

Medical Technology includes five major disciplines: hematology, clinical chemistry, microbiology, immunology and immunohematology or blood banking. The medical technologist is educated in all of these as a generalist but it has been common in larger facilities to work as a specialist. Recent trends call for a return to the generalist role and many are refining old skills. New roles better utilize the many skills and competencies of today’s medical technologists. In fact, medical technologists are being recognized by a new name which is clinical laboratory scientist. This title more appropriately reflects their background and helps to avoid confusion with the term medical technology which often is used in describing technological advances in medicine like specialized care units or imaging devices.

The education of clinical laboratory scientists in Hawaii has quite a history. This year marks the 50th anniversary of awarding the baccalaureate of science degree in medical technology at UHM. While the initial curriculum involved a senior-year rotation in a clinical laboratory to learn all the skills needed for the profession, modifications in the curriculum have added professional courses on campus starting in the freshman year. Early courses acquaint the students with the profession before they apply for acceptance into the junior year. Additional courses in the profession during the junior and senior years enable students to acquire professional level knowledge, skills and attitudes in the academic setting. A clerkship of six-weeks is designed between the junior and senior year which gives students an opportunity to gain personal experience in a clinical laboratory. A problem-based learning component is offered during this clerkship and students are linked by distance technology as needed. This summer a PBL section had students from Arkansas and Saipan linked with their classmates on Kauai while the tutor was in Honolulu. All students return to campus for their senior year. After earning the degree, they spend a final six-months clinical training rotation in a laboratory refining skills gained in the classroom and on site. Distance learning technology links students on Oahu and Hawaii. The student then takes a national certification examination which is required for employment and seeks state licensure in those states where such exists. The baccalaureate degree prepares students to be marketable professionals.

The job market is changing dramatically. About two years ago in Hawaii and nationally there was a shortage of clinical laboratory scientists. Last year jobs were hard to find. However, in the last two months most to all of the graduates have been hired here and in selected areas of the mainland.

The Division of Medical Technology is part of the John A. Burns School of Medicine. Faculty in the Division serve as tutors and resource people among other roles in the MD-PBL program. At times learning activities bring the students in medicine and medical technology together which facilitates their teamwork in the marketplace. The Division utilizes distance technology linking faculty in multiple sites on four islands. Clinical faculty in the many facilities together with faculty on campus provide an invaluable partnership in planning and delivering this curriculum.

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Long Term Low Dose Interferon Alpha-2b in the Treatment of Chronic Hepatitis B in Multi-Ethnic Patients in Hawaii

Nathaniel Ching MD *, James Lumeng MD **, Ronald Pang MD **, Glenn Pang MD**, Fung Wa Or BA***, Natascha Ching BA, and Clara Ching PhD ***

The antiviral and immunomodulatory effects of interferon were assessed in the treatment of chronic hepatitis B in multi-ethnic patients to prevent viral replication and chronic liver damage. Five million units of recombinant interferon alpha-2b were administered three times a week for 48 weeks to a group of 18 chronic active hepatitis B patients. A complete response was defined as seroconversion to anti-HBe and/or loss of HBs antigen. Seroconversion to anti-HBe in 5 of 12 (42%) chronic active hepatitis B patients occurred after 48 weeks of therapy. HBV-DNA decreased to undetectable levels in 8 of 12 (67%) patients. This chronic low-dose interferon administration regimen demonstrated responses comparable to other studies.

Introduction

Chronic hepatitis B is a major public health problem in Hawaii because of the large immigrant population from Asia and the Pacific Basin. Exposure to hepatitis B virus (HBV) often results in chronic hepatitis that can significantly increase the risk of developing cirrhosis and hepatocellular carcinoma.1 Approximately 30,000 to 40,000 in Hawaii have been infected with hepatitis B virus (HBV). The estimated carrier rate in Hawaii is 2-3%, higher than the 0.5% of the mainland United States.2 In acute HBV infection in adults, 90% of those infected will develop a primary antibody response; 5 to 10% of patients will develop chronic inflammation.3 More than 90% of neonates born to HBeAg-positive mothers have been reported to develop chronic HBV infection.4 Interferon has been shown currently to be the most effective therapy in approximately 30 to 40% of chronic hepatitis B patients5,4,5 because of its antiviral and immunomodulatory effects. Perillo et al6 have reported hepatitis Be antibody (anti-HBe) seroconversion and loss of HBV DNA in patients treated with interferon with (36%) and without (37%) prednisone. Long term remission with formation of anti-hepatitis Bs antigen (anti-HBs) was observed by Korenman et al7 in patients followed for 3 to 7 years after interferon alpha-2a therapy. This represents a hopeful therapeutic option for patients who are not able to spontaneously suppress the HBV infection immunologically.

Based on our previous experience with interferon protocols in selected cancer patients,8 the daily administration of 5 million units interferon daily over 16 weeks as utilized by Perillo et al9 would not be a tolerable dose for our population in Hawaii because of the constitutional symptoms of interferon. In our cancer patients, we first used a lower interferon dose, 1 million units, administered three times a week because the rest periods made this therapy more tolerable and natural killer cell function was better maintained.10,11 The majority of our chronic hepatitis B patients were fairly asymptomatic before therapy and gainfully employed. Fatigue and weakness resulting from the medication would preclude many from continuing their occupations.

A Phase II protocol was initiated to treat chronic hepatitis B patients to determine the effect of 5 million units of recombinant interferon alpha-2b (Schering-Plough Corporation, Kenilworth, NJ) administered subcutaneously three times a week for a period of 48 weeks. The objective was to utilize the antiviral and immunomodulatory effects of interferon to prevent viral replication and the chronic liver damage with the increased risk of developing hepatocellular carcinoma. These studies indicated that this interferon dose and schedule could suppress HBV replication and result in HBeAg seroconversion and normalization of biochemical liver function activity.

Materials and Methods

Patient Population

Adult volunteers were recruited from the database of hepatitis B carriers maintained by the Hawaii Department of Health.12 These patients were re-staged for HBV serological markers: hepatitis B e antigen (HBeAg), antibody to HBeAg (anti-HBe), hepatitis B surface antigen (HBsAg), antibody to HBsAg (anti-HBs) and serum alanine aminotransferase activity (ALT), to determine the stage of their hepatitis B infection. From this database, 17 of 95 (18%)
patients screened had chronic active hepatitis B: HBsAg and HBeAg positive; ALT levels were 100 IU/L ± 128. Gastroenterologists also referred patients for evaluation and therapy.

Chronic active hepatitis patients, HBeAg and HBsAg positive for greater than 6 months, anti-HBe and anti-HBs negative, ALT levels >1.3 x high normal (45 IU/L), were selected for therapy.

**Interferon Therapy**

Eighteen chronic active hepatitis B patients were treated with recombinant interferon alpha-2b (Intron-A, Schering-Plough Corporation, Kenilworth, NJ). Three million units were administered subcutaneously 3 times per week for 2 weeks and, if tolerated, the dose was increased to 5 million units for a total of 48 weeks.

Patients received their injections in the Ambulatory Oncology Clinic or chose to voluntarily self-administer their medication after training by the Oncology Nursing Staff. The dose was reduced to 3 million units when platelets were <100,000 or granulocytes were <1000. All patients signed written informed consent for treatment with this interferon protocol approved by the Institutional Review Board.

**Evaluation During Therapy**

Patients were evaluated during therapy for hematological, biochemical and serological profiles. Blood was collected for complete blood and platelet counts; liver function tests including serum alanine and aspartate aminotransferase and gamma glutamyl transpeptidase activities (ALT, AST, GGPT) prior to therapy, after 2 weeks, monthly during therapy and 2-3 months post therapy. The serological markers for HBV, HBeAg/anti-HBe and HBsAg/anti-HBs, were evaluated at baseline, after 6 months, at the completion of therapy, and 2-3 months post therapy by the Enzyme Immunoassay (Abbott Laboratories, Abbott Park, IL). All evaluations were performed by the same Clinical and Reference Laboratories.

A complete response was defined by loss of HBeAg and/or the formation of anti-HBe or anti-HBs; non-responders showed persistence of HBeAg. A clinical response was defined as the normalization of serum ALT levels.

**HBV DNA Assay**

A sensitive and quantitative radioligand molecular solution hybridization assay kit for HBV-DNA generously supplied by Abbott Laboratories (Abbott Park, IL) was used for evaluating viral replication and monitoring antiviral therapy. Aliquots of serial serum samples from each patient stored at -70°C were tested for HBV DNA at baseline, 2-3 months intervals, the end of therapy and 2-3 months following therapy. The assay utilizes a single-stranded I-labeled DNA probe complementary to HBV DNA sequences and with a minimum specific activity of 10 cpm/μg. Sensitivity of the assay was 1.5 pg HBV DNA per ml of serum or approximately 4.5 x 10E5 HBV genomes per ml serum.

**Statistical Analysis**

Results are expressed as arithmetic mean ± S.D. except where noted. Data was analyzed with the Sigma Stat program (Jandel Scientific, San Rafael, CA). Continuous variables were analyzed by linear regression and/or the non-parametric Kruskal-Wallis technique. The IBM 555X and PS80 PC computers were used.

**Results**

**Study Population**

The average age of the chronic active patients was 33 ± 10 yrs; 10 of the 18 (56%) were males. Baseline liver function tests (ALT, AST and GGPT) were increased in the chronic active patients: ALT = 96 ± 74 IU/L, AST = 62 ± 39 IU/L, GGPT = 141 ± 304 IU. Immigrants from Vietnam represent the major ethnic group of patients (39%); Filipinos, 22%; Chinese, 17%. All were gainfully employed, housewives or students except for three unemployed medical recipients.

**Toxicity**

With this interferon protocol at a reduced dose of 5 million units three times a week, 6 of 18 (33%) patients ceased therapy on their own choice. Their reasons included: inability to care for family (2) or to tolerate the side effects. (2) Two gave no reason for terminating treatment.

Although we used a lower dose IFN protocol, 3 of 18 (17%) chronic active patients required dose reduction from 5 to 3 million units because of intolerable constitutional symptoms. In two patients, platelets decreased below 100K. One patient on Dilantin required a dose reduction to 1.5-2 million units because of granulocytopenia.

**Biochemical Liver Function Tests**

Assessment of biochemical studies for liver function revealed increased ALT levels in the chronic active hepatitis patients which returned to normal levels in those completing 48 weeks of therapy, p < .05 by ANOVA analysis (Figure 1). This occurred whether or not seroconversion occurred. The non-responders had flares of ALT levels after discontinuation of interferon therapy.

**Serology of HBV Markers**

Serological markers for HBsAg/anti-HBs and HBeAg/anti-HBe were assessed to determine the outcomes. Loss of HBeAg and seroconversion to anti-HBe occurred in 5 of 12 (42%) patients after interferon therapy with no relation to the dose received. One patient responded after only six months of therapy; a sixth patient was HBV DNA and HBeAg negative after six months of therapy but did not form anti-HBe. In chronic active patients requiring the full 48 weeks of therapy, antibodies to HBeAg were not detected until 2-3 months post therapy. Seroconversion of HBsAg was not observed. Of the six responders, five were U.S. citizens and there was one female immigrant. Sex was equally distributed.
The remaining six patients were non-responders (HBsAg+, HBeAb-). Follow-up studies will be continued. The ethnicity of the six non-responders of the chronic active hepatitis B patients were Vietnamese (2) and Chinese (2) immigrants, and Filipino (2) born in Hawaii. The six who ceased therapy were not evaluable and were also immigrants, Vietnamese (5) and Chinese (1).

**HBV-DNA**

Ten of the twelve patients had elevated levels of HBV-DNA before therapy. All six responders had no detectable HBV-DNA after treatment. Two of the six non-responders did not have measurable levels of HBV-DNA after therapy although no HBV antibodies were formed.

**Discussion**

In this study with multi-ethnic patients, we observed the antiviral effect of interferon in 67% chronic active hepatitis B patients who showed progressive decline in HBV DNA during therapy. We achieved a 42% HBeAg seroconversion and HBeAb formation rate in patients who completed the 48-week interferon course. This Phase II protocol of 5 million units interferon alfa-2b administered subcutaneously three times a week for 48 weeks to patients with hepatitis B infection yielded comparable results as reported by Perillo et al 10 using 5 million units daily for 16 weeks and including pretreatment with prednisone. HBeAg seroconversion occurred in 30 to 40% of their patients with loss of HBV DNA in 40 to 50%. Similar rates of seroconversion were reported by Reichen et al 14 with either 1.5 or 5 million units interferon alpha 2b three times a week for 4 months with and without a preliminary course of prednisonase therapy. HBeAg seroconversion was not observed in our studies although Korenman et al have reported that anti-HBs may appear at an average of 3 years after treatment.

We have used an interferon dose and schedule of 5 million units three times a week subcutaneously over a longer period of 48 weeks with minimal effect on blood counts. This Phase II protocol would allow greater tolerance of this medication in chronic hepatitis B patients. After approximately 9 months, the cumulative dose of interferon would be equivalent to the daily administration of 5 million units for 16 weeks as used by Perillo et al. Furthermore, patients treated in an outpatient environment would be able to continue their productive work to minimize economic loss.

With this interferon dose, however, six (33%) Asian immigrant patients still discontinued treatment. The constitutional symptoms were most disturbing to these patients who were essentially asymptomatic before therapy. Some were unable to continue working. Our cancer patients have tolerated higher doses but may be more motivated to continue than the chronic hepatitis B patients.

Hawaii has a large percentage of affected Asian-Pacific patients because of the large immigrant population. The Asian male has been observed to be the most resistant to treatment.15 Lok et al 16 reported spontaneous seroconversion in 31 of 142 (22%) HBeAg positive Chinese patients observed up to 60 months. They predicted a 17% one year seroconversion rate. However, none of our Asian non-responders demonstrated seroconversion one year after completion of interferon therapy.

In this study, most of our non-responders were Asian male immigrants; male responders were USA or Hawaii-born. Three female responders, two Hawaii-born and a Filipino immigrant had progressive decline in HBV DNA after interferon therapy. A sustained therapeutic effect in these young females may prevent the vertical transmission of HBV to their newborn and subsequent chronic antigenemia.

We monitored the antiviral effect of interferon by serial quantitation for HBV-DNA using the solution hybridization assay. Eight of twelve (67%) chronic active hepatitis patients had undetectable levels of HBV DNA after the end of therapy. An antiviral effect of interferon is indicated with no seroconversion, as yet, in 2 non-responders. Follow-up studies are planned in these non-responders with no detectable HBV DNA.

Our diverse group of Asian patients represents a major public health problem and challenge for developing effective therapeutic interventions in Hawaii. The possibility exists that these patients may have had prolonged infection since childhood resulting in the transcription of virus to their hepatocytes and may be more resistant to interferon therapy. The elimination of chronic HBV infection is greatest if treated relatively early when viral HBV DNA exists in the non-integrated or episomal state. 17 With the high carrier rate in Hawaii, early detection and treatment as well as vaccination will be necessary for the prevention of the sequelae of chronic HBV infection.

**Acknowledgments**

We gratefully acknowledge the generosity and support of Schering-Plough Corporation, Kenilworth, NJ for providing recombinant interferon alfa-2b (Intron-A) for patients whose third party payors refused payment. We appreciate the donation of the HBV DNA asay kits from Abbott Laboratories, Abbott Park, IL and thank Jeff Wernke, PhD and staff for their invaluable research support, advice and technical assistance. The Nursing Staff, Oncology Unit, St. Francis Medical Center and the Hawaii-Biological Response Modifiers Research Staff are acknowledged for their dedication, cooperation and assistance during this interferon treatment protocol with our patients.

**References**

We have over 200 specialists who can immediately turn to one another for assistance. But we’re not here just for each other. Straub would like to be a valuable resource to other physicians in Hawaii as well. Many of our specialists regularly visit the neighbor islands and are available for consultations.

We respect the relationship you have with your patient, which means we work closely with you to meet your needs and then return your patient to your care as soon as possible.

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Give us a call today. After all, we’re here to help you help your patients.
Teen Perspectives on HIV and the Relevance of Hawaii’s Health Providers

Robert J. Bidwell MD, Charles W. Mueller PhD, Eberhard Mann MD, Stephanie Mew, Candace Goo, Heather Dunbar, University of Hawaii; Gene McGrady M.D., Morehouse University; Mildred Vera PhD, University of Puerto Rico; Edward Liebow PhD, Richard H. Lovely PhD, Battelle Seattle Research Center, Seattle, Washington

Based on focus group interviews with adolescents from an urban Honolulu community, the present article describes how these adolescents view HIV, HIV-prevention and the role of health care providers in addressing HIV-related needs. Although medical providers are known to be knowledgeable experts in a variety of health care areas, other research points to an underutilization of this potential. While knowledgeable about HIV, many of the youth in this study continue to engage in risky behavior. Few perceive they have others they can meaningfully talk to about their HIV and other health concerns. Even when probed for, almost none of these teens saw health care providers as pertinent to HIV or their health beyond the traditional illness/prescription role. Suggestions for ways to get more involved in the prevention of HIV and, more generally, positive health development in teens are discussed.

Over the past decade there has been increasing evidence that Hawaii’s adolescents may be at significant risk for Human Immunodeficiency Virus (HIV) infection. While there have been only 5 reported cases of AIDS among Hawaii’s adolescents aged 13 to 19 years, representing less than 1 percent of total cases, 261 cases (14 percent of total) have been reported among young adults aged 20 to 29 years.1 Because the delay period between HIV infection and a diagnosis of AIDS has a median range of eight to eleven years, many of those diagnosed with AIDS in their twenties were likely infected as teenagers. The seroprevalence rate of HIV among Hawaii’s adolescents, another indicator of risk, is unknown. It has been estimated that perhaps 3000 to 5000 individuals of all ages in Hawaii may be HIV positive. Youth of color may be at special risk for HIV infection. While the majority of Hawaii’s AIDS cases to date have occurred among Caucasians, the proportion of cases among Asian/Pacific Islanders has increased steadily, from 18 percent in 1989 to 25 percent in 1996.1

Ninety-five percent of AIDS cases in Hawaii have resulted from sexual activity and/or injection drug use. Although seroprevalence rates are uncertain, recent studies have documented the high rates of HIV-related risk behaviors among Hawaii’s youths. A 1990 Hawaii Department of Health survey of Oahu 10th graders found that 43 percent were sexually active.2 Of these only 39 percent had ever used any form of contraception (not necessarily condoms). In a 1994 Hawaii Department of Health survey of seventh through twelfth grade students on Oahu, Kauai, Maui and the Big Island, 20 percent of seventh and eighth graders and 45 percent of ninth through twelfth graders said they had had sexual intercourse.3 One quarter of both sexually active grade groups had had sex with four or more partners in their lifetime. Two thirds of the sexually active seventh and eighth graders reported that their first sexual intercourse had occurred before the age of 13. Less than half of sexually active students used any effective contraception the last time they had intercourse. Concerning substance use, the survey reported that the incidence of alcohol use in the previous month was 31 percent for the younger grade group and 49 percent for the older students. Marijuana use in the previous month was 16 percent and 29 percent respectively for each group. Ten percent of seventh and eighth graders and 17 percent of older students had used some other illegal drug in their lifetime. Injection drug use was not specifically surveyed.

Health providers traditionally have assumed the dual roles of treating illness and promoting health and well-being. In the latter role providers screen, educate and counsel their healthy patients not only to prevent illness but to assure that their patients may achieve their full potential for physical, psychological and social well-being. Several professional guidelines and standards of practice related to adolescent preventive health care have been established.4,5,6,7 Most of these specifically affirm the responsibility of health providers to discuss in a substantive way HIV and HIV-related risk behaviors with their adolescent patients. The American Medical Association’s 1992 Guidelines for Adolescent Preventive Services (GAPS) is considered by many to be the current “gold standard” of adolescent preventive health care.8 GAPS recommends that health providers see their adolescent patients yearly between the ages of eleven and twenty-one years. At each visit there should be an age-appropriate discussion of a wide range of health issues, including substance use, psychosocial development and sexual behaviors including specific discussion of abstinence, HIV and safer sex. It also recommends that policies on the provision of confidential care to adolescents be established in all clinical settings. Professional organizations, such as the American Academy of Pediatrics, have also espoused the principal of every child and adolescent having a “medical home” where health care would be provided in an “accessible, continuous, comprehensive, family centered, coordinated and compassionate” manner.9 Medical student, resident physician and
nursing training curricula at the University of Hawaii also emphasize the need for health providers to address the entire breadth of medical and psychosocial issues with adolescent patients on a regular basis.

Despite the recognition that health providers have a responsibility to join in efforts to prevent adolescent HIV risk behaviors, there is considerable evidence that they may not be fulfilling this role. Survey research has shown that many physicians, for example, do not routinely take a sexual history of their adolescent patients or provide counselling about HIV, sexuality or a variety of other HIV risk behaviors. Marks et al reported in 1990 that only one in ten pediatricians regularly saw teens for sexuality-related concerns or substance use. Fewer than half provided anticipatory guidance related to sexuality. Bradford and Lyon's study of Pittsburgh pediatricians showed that only 35 percent provided AIDS counselling to adolescent patients and a minority provided any gynecologic (29%), family planning (20%), drug and alcohol (27%) or depression (33%) counselling. Only 32 percent acknowledged "always" or "frequently" discussing AIDS with their teen patients.

A survey of Washington, D.C. physicians found that sexual histories were taken in only 60 percent of new teen patient visits and less than half of continuing patient visits. Blum et al in 1995 reported on a chart review survey of adolescent patients in four settings—private pediatric practice, family practice, a school based clinic and a community teen clinic. Less than 45 percent of charts in each setting reflected any screening in the areas of emotional health, sexuality or substance use. The highest rates of documented screening were in the teen and school based clinics. The lowest rate of screening was in pediatricians' offices. In contrast, physical health screening was documented in more than 95 percent of all clinics' charts. Nussbaum et al demonstrated that physicians' gender may influence the willingness to discuss sexuality with teen patients. They found that 88% of female pediatricians but only 39% of male pediatricians routinely took sexual histories of fourteen to fifteen year old girls. A significant differential appeared even among sixteen to seventeen year old girls, with overall only 69% of pediatricians willing to discuss sexuality.

Survey research indicates that many physicians feel untrained and uncomfortable in discussing HIV-related issues with adolescents. In 1978 The American Academy of Pediatrics Task Force on Pediatric Education cited knowledge and skills in adolescent medicine as among the major deficits in pediatric practice. Blum and Bearinger in 1990 reported that nearly half of physicians in a national survey (including pediatricians, family practitioners and internists) felt insufficient training was a significant barrier to working with adolescents. Among areas of perceived inadequate training were alcohol/drug abuse (39%), homosexuality (54%), STDs (16%), family planning (22%) and delinquency (55%). Seventy-four percent of physicians acknowledged that adolescents were their least-preferred age group. Only 32 percent were interested in improving their perceived deficits in working with teens. Levenson et al in 1986 found that only 13 percent of pediatricians felt they were adolescents' preferred source for health information, with only 3 percent ranking themselves as the most frequently used source. In the study by Marks et al, most pediatricians said that adolescents rarely came to them for mental health or sexuality issues. Reports indicate that pediatricians feel less competent in sexuality-related care than other primary care specialists. Bradford's survey of Pittsburgh pediatricians found low levels of comfort in addressing various adolescent health issues related to HIV, with only about half of physicians comfortable in discussing sexuality, HIV or STDs.

Several surveys have shown that adolescents see physicians as one of the most authoritative sources of health-related information. Furthermore, teens list sexuality, substance use and HIV as among the subjects they are most interested in discussing with physicians. Other adolescent surveys, however, tend to confirm the picture of physicians unable or unwilling to discuss HIV and associated risk behaviors. A study by Hingson found that although 80 percent of the teen respondents had seen a physician in the past year only 13 percent had been counselled about AIDS. In fact in several surveys, adolescents ranked physicians last as an actual source of information about HIV or sexuality. Joffe et al reported in 1988 that three-fourths of college freshmen had received no counselling on eleven of fifteen topics they were most interested in discussing with a physician, including STDs, contraception, alcohol/drug use or depression. Overall, internists were more likely to provide counselling than pediatricians or family/general practitioners. A survey of Boston 9th and 12th graders by Rawitscher et al, found that a majority of students wanted information about HIV, STDs, sex and condoms. They would like a physician to discuss with them their personal experiences related to these same issues, but most would be uncomfortable initiating a discussion of these on their own. Only 37 percent of the 12th graders had ever discussed sex and 28 percent had ever discussed HIV/AIDS with a physician.

When queried about perceived barriers to working with adolescents, physicians cite lack of training, time constraints, inadequate reimbursement, physician image, physician discomfort, office setting, confidentiality concerns, and a generally alienating system of care. There are clearly other barriers to the provision of quality health care to adolescents. While most surveys suggest that over half of teens see a physician at least once a year, many of these contacts may be for acute illness or sports physicals and may not include discussions of adolescent risk behaviors. In a national survey of office visits by adolescents it was found that the mean duration of visit for adolescent patients was fourteen minutes. Marks et al reported in their survey of suburban New York pediatricians that an average of twenty-eight patients were seen in a seven hour clinic day. The average office visit lasted fifteen minutes and only a small minority of physicians scheduled longer visits for new or returning adolescent patients.

Because there is evidence that the risk for HIV infection among Hawaii's adolescents is real and because research in other communities suggests that health providers may not always be meeting adolescents' needs in the area of HIV prevention, it is important to obtain a better understanding of adolescents' perspectives on HIV and the relevance of Hawaii's health care providers. A previous study conducted by the authors attempted to evaluate the responsiveness of health clinics, social service agencies and schools to the challenge of HIV-prevention among Kalihi-Palama youths. In general, health clinics appeared most responsive, although often in a tertiary prevention mode, with little outreach and relatively few teens contacts. The present study looks at the other side of the coin. In order to allow adolescents a relatively unstructured opportunity to express their perceptions related to HIV-related issues, a qualitative study design was developed. Through a serious of focus groups, adolescents were asked to describe the meaning of HIV in their lives. Through succeeding focus groups, patterns of teen experience and perceptions became apparent. These patterns related to adolescents' HIV-related knowledge, behaviors, perceptions of risk, perceptions of HIV-prevention messages, and the role and relevance of health providers in their lives. Based on these findings, recommendations are presented that may enhance the role of health care providers in the prevention of HIV infection among Hawaii's adolescents.
Dynamic Duo

Benzamycin® prescribed with tretinoin¹ for rational acne therapy², ³

- Efficiency of 3 modes of action using only 2 products
- Prescribing Benzamycin® in addition to tretinoin provides:
  - reduced erythema¹
  - faster lesion clearing⁴

BENZAMYCIN® Topical Gel
(3% erythromycin, 5% benzoyl peroxide)

Adverse conditions infrequently reported include dryness, erythema and pruritus.
Clinical Pharmacology: Erythromycin is a bacteriostatic macrolide antibiotic, but may be bactericidal in high concentrations. Although the mechanism by which erythromycin acts in reducing inflammatory lesions of acne vulgaris is unknown, it is presumably due to its antibiotic action. Antagonism has been demonstrated between erythromycin and clindamycin.  
Benzoyl peroxide is an antibacterial agent which has been shown to be effective against Propionibacterium acnes, an anaerobe found in sebaceous follicles and comedones. The antibacterial action of benzoyl peroxide is believed to be due to the release of active oxygen. Benzoyl peroxide has a keratolytic and desquamative effect which may also contribute to its efficacy.  

Methods  
A total of 125 Kalihi-Palama youth (66 females and 59 males) between the ages of 12 and 19 participated in focus group interviews over the course of six months. Participants were recruited through word-of-mouth and flyers distributed by health, social, and educational providers in the neighborhood. Nineteen separate same or mixed gender groups were conducted. Group size ranged from 2 to 15 and most participants within each focus group were known to each other prior to participation. Most youths were of Asian, Pacific Islander, or “cosmopolitan” background.

Using a modified Grounded Theory approach topic order and content across focus groups continually evolved over the course of the study. All group discussions were recorded and transcribed verbatim. Findings for each group were examined and further clarified in one or more subsequent groups. As new ideas and insights emerged, they were pursued in subsequent groups. Group facilitators used probes for clarification, validation of what was being said, and encouragement for active participation. Final transcripts were coded using The Ethnograph V4.0, a computer-based qualitative text management program, which allowed for further data analysis and provides a stored record of all discussions, coded by content type.

Results  
One of the most striking findings of this study was the participants’ eagerness to discuss HIV within the broader context of their lives. They expressed a clear preference for a group setting in which they were not lectured about but judged, had complete freedom to express and explain their feelings, perceptions and experiences. As one teen noted, “At school, they lecture. They just talk. They no like let us talk. And it gets boring, yeah?, after a while. But like you guys asking us, and it’s fun communicating.” It was in the context of these open discussions that the teenagers taught us about the meaning of HIV in their lives, and the perceived relevance of health providers.

Adolescent Experience of HIV  
In a previous article, the authors discuss greater detail adolescents’ construction of HIV and HIV-prevention. To summarize, the teen participants generally view HIV in negative terms with a range of emotional responses—fear, anger, and sadness—often connected to the expectation of social ostracism or death. Despite the strong emotional response, there was an admission that HIV was seldom discussed with family or friends, except perhaps in a bantering manner. It also was agreed that the risk of HIV was generally not on the minds of participants in the minutes preceding risky behaviors (usually unprotected sex) though occasionally it might be after the act was completed. The possibility of pregnancy appeared to be more consciously considered than HIV in these situations. In general, any post-coital concerns about HIV were short-lived.

Knowledge and Perceptions of Risk

In general, the teen participants showed good knowledge of HIV, its effects on the immune system, associated risk behaviors and safer sex practices. When misconceptions were expressed, the groups were often self-correcting as other participants provided more accurate information. Misconceptions were usually...
in the direction of overestimating risk (for example, transmission by mosquitoes) rather than denying the danger of known risk behaviors. Perhaps related to this was the participants’ marked overestimation of HIV prevalence among their teen peers with estimates ranging from 25 to 75 percent of Hawaii’s adolescents being HIV-positive. However, only one teen acknowledged knowing personally another teen who was HIV positive.

HIV Risk Behavior

Despite good knowledge of HIV and personal perceptions of risk, about half of the teen participants acknowledged being sexually active. Very few reported using condoms consistently; in fact, most did not use condoms at all. Both boys and girls generally believed that responsibility for deciding to have sex or use condoms lay equally with both partners. Many reasons were presented to explain the onset of sexual activity (eg., peer pressure; “fun”) and the failure to use condoms (eg., “no like”; boring; “don’t think, no like stop”). None of the participants openly reported either homosexual or bisexual behaviors. Repeatedly, the teens spoke of sex taking place in the context of concurrent alcohol and drug use. Several groups described “house parties”, “hotel parties” and “beach parties”, where youths of a variety of ages come together unchaperoned to partake in an abundant availability of drugs and sex.

While drug use was acknowledged by most of the teen participants, none spoke of personal use of injection drugs, including steroids. However, many of the teens had self- and friend-applied tattoos, which often involves the sharing of needles.

Perception of HIV Messages and Messengers

Schools, television, radio and newspapers were cited most often as providing information about HIV. Teen-focused media messages were felt to be no more effective than school health class curricula in providing information or changing behaviors related to HIV. In fact, the teens appeared skeptical that any of these isolated attempts to influence behavior would be successful. When asked how HIV messages could be made more effective, the teens appeared to take upon themselves the responsibility for change, or lack of it. As one boy put it, “It’s up to you. You make your choices. If you take the wrong, it’s your fault....Right now we’re walking a line between choices; and if you take the wrong path, then it’s up to us....to walk out there and walk the right path.”

Those “messengers” viewed most positively were the counselors, teachers, and others who took the time to talk with the teens about their lives without lecturing or judgement. These relationships allowed the teens to be more open and honest in discussing their risk behaviors and concerns.

Perceptions of Health Care Providers

How do teens see health care providers in relation to their general health and risk for HIV? The participants in this study gave the distinct impression that health providers are relatively peripheral figures in their lives. There was little indication that they are seen as significant sources of HIV information or have any special relevance to whether or not a youth might decide to engage in HIV risk behaviors. Among 125 youths in 19 groups, only two mentioned health providers or clinics as somewhere they would go to ask about HIV if they had concerns about it. Only one teen indicated that she had gone to a clinic where there had been a discussion of HIV and safer sex and a provision of condoms.

In almost every group in which health providers were mentioned, the discussion was brief and in terms that portrayed providers as primarily technicians—people one might go to for the human equivalent of an auto tune-up or safety check. Even with strong prompting, teens gave little indication that they would consider going to health providers for health information or a discussion of personal problems or concerns that were not directly medical in nature. Health providers and clinics, as described by these teens, are places one would go to get a physical exam or “check-up”, a blood test for HIV, an STD check, a pregnancy test or for medicine to treat an illness. One teen, when asked if a health provider had ever talked to him about violence, drugs, sex or HIV, answered, “No. They no say about HIV. No talk about gangs, nothing. They are just there for give me medicine.” Another teen in the same group responded, “Should get more doctors talk to you one on one, talk to you about AIDS and all that stuff...cause every time you check-up for one appointment, they would be someone telling you about not doing this, not doing that, right? And you will always have ‘em in your head, about that thing....”

Teens come into contact with health providers in a number of settings including at school, in clinics and through the media. However, most references to health providers in this study were related to going to a provider, usually for the treatment of some medical problem. Interestingly, this was often put in terms of going to a building or place—“Kapiolani”, “Kaiser”, “KKV”, “Kalili-Palama”, or “clinic”—rather than to a specific individual or type of provider (eg, doctor or nurse). A number of participants could not recall where they went for care, giving vague approximations such as “down by Liliha.” School nurses were not mentioned in any of the focus groups.

Discussion

Local adolescent behavioral surveys and Hawaii age-specific HIV/AIDS data indicate that Hawaii’s adolescents are at real risk for HIV infection. A large percentage of Hawaii’s teens are sexually active and as the teen participants in this study indicated, alcohol and drugs often serve as social “lubricants” that facilitate the onset of sexual activity. While health care providers are logical players in the effort to prevent HIV infection among teens, research in other communities suggests they may not be fulfilling this role. With insufficient training or interest, and an average office visit of 14 minutes, it is difficult to address issues such as home life, school performance, extracurricular activities, drugs, sex and depression in a meaningful way. The teen participants in this study, like those in other communities, generally perceive Hawaii’s health care providers as distant figures, technicians whose function is to diagnose illness and provide medicine.

A caveat or two are in order. It would be unfair to suggest that all health care providers fit this perception. Many providers undoubtedly do an exemplary job of promoting teen health and others do the best they can do within imperfect settings and systems of health care delivery. Furthermore, the teen participants of this study are representative only of themselves and not of all Hawaii’s teens or even of all teens in Kalihi-Palama. In a group setting it was not always possible to explore the nuances of teens’ perceptions related to health providers. The picture they painted was therefore necessarily done in broad strokes. Nevertheless, these youths came from diverse backgrounds and spoke openly about their lives. Their observations are instructive and can help health care providers reflect on their work with teens and consider opportunities to increase their relevance in the fight against HIV.

How might health care providers become more relevant to their teen patients/clients? Changes might occur both in the context of present practice settings and at a systemic level. In a health provider’s office or clinic setting, there could be a shift from the “medical home” model, viewed narrowly by teens in this study, to a “health home” model. In a “health home” a teenager would not only get
“check-ups”, immunizations or blood tests but would on a yearly basis sit down with a health provider to talk about both medical and psychosocial health issues (as recommended by GAPS). These meetings would be confidential two-way discussions and would help increase trust and openness between both teen and provider. This study and many others confirm the generally high level of HIV knowledge among teens. This suggests that providers should avoid knowledge-only based discussions and spend more time discussing in depth teens’ behaviors, perceptions and concerns in the broader context of their lives. Such visits would provide a lifelong model for the teen demonstrating the breadth of health issues a provider should be able to address. Such visits will necessarily be longer than traditional visits. For example, some providers schedule 45 minutes for all new teen patients and 30 minutes for continuing patients who have not been seen recently.

Providers in group practice, community health centers and other settings might explore the usefulness of reaching teens through a group discussion format. One of the most significant findings of this study is the ability of teens to engage in open and lively discussions of their lives. The authors found that the groups were most responsive when they were made up of peer friendship groups, and were facilitated in a flexible, nonlecturing, nonjudgmental style. Refreshments also seem to help. Such groups may be a more efficient and meaningful way of reaching larger numbers of teens and helping them see health providers in a new light.

Systemically, there are other actions that could help improve the relevance of health care providers in promoting adolescent health. Curricula in adolescent health, both for health providers in training as well as for those already in the community, must go beyond simply the development of adolescent health screening and counseling skills. These skills, while essential, will not be implemented without an honest discussion of the practical aspects of how to employ them in the context of busy and cost-conscious health care settings. Secondly, managed care systems could work together with health providers to develop local “gold standards” for adolescent “well-teen” and acute care visits. Through periodic and thorough quality assurance chart reviews, managed care programs can assure that their clients/patients are receiving the quality care they deserve from networks of providers. Additionally, consumers (in this case teens and their parents) need to be educated about what kind of services their health providers should be offering. In relation to adolescent health this means the provision of confidential and comprehensive care through yearly visits that cover both medical and psychosocial concerns. A 14 minute visit should lead consumers to shop elsewhere.

There are also opportunities for providers to go beyond the walls of their offices to reach teens in other settings. Many have done so already through advocacy activities, developing community health screening programs, volunteering as sports team health providers, or as speakers in school health classes. Another community involvement could be through taking part in the expansion of Hawaii’s school-based and school-linked health centers. In the past, some providers have opposed such centers because they were seen as interfering with the “medical home”. This study has shown us that in this respect, many teens are “homeless”. Physicians and other health care providers can take a lead in resurrecting the concept of comprehensive school health centers and create a true “health home” model for adolescents in partnership with other community health care providers.

Given the present system of health care deliv-
ery, health care providers may never be the primary players in the promotion of adolescent health. The responsibility for assuring teen health is shared with teachers, counselors, social workers, clergy, government officials, the media, families and teens themselves. Nevertheless, the participation of health care providers is essential, because of their special expertise, respected position in the community and their true concern for the health of young people.

References

The meeting was called to order by Dr Carl Lehman, President at 5:35 p.m. Present: J. Spangler, President-elect; L. Howard, Treasurer; R. Kimura, Secretary; F. Holschuh, Immediate Past President; AMA Delegate: C. Kam, R. Stodd; AMA Alternate Delegate: A. Kunimoto; Speaker: H. K. W. Chinn; County Presidents: E. Bade, T. Crane, T. Smith; Councilors: T. Au, P. Chinn, P. De Mare, M. Shirasu, W. Young, B. Shitamoto; Past Presidents: J. McDonnell, Medical Students: J. Ing & D. Onaga; Young Physician Delegate: C. Goto.

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

Minutes: The minutes of the August 2 meeting were approved with corrections.

Dr Lehman reported; 1) that a HMA Workers’ Compensation seminar is scheduled for September 23 at 5:30; 2) He met with the freshman medical students on August 9; 3) He joined others with Mayor Jeremy Harris for a breakfast meeting; 4) Drs De Mare and Lehman met with press and media regarding FDA authority to regulate advertising and selling of cigarettes, especially to minors; 5) he was interviewed by Sandra Sagisio of KGMB regarding reform of health insurance and fraud and abuse; 6) Drs L. Howard and Lehman attended a 2 hour Welfare Reform Task Force session encouraging training for a life of independence. 7) he encourages physicians to sign up with the AMA’s Grass Roots Hot Line by calling 1-800-833-6354 and entering the ME number on your AMA membership card. You may also check the AMA Grass Roots Home Page which provides up-to-date information on political action from the AMA; 8) The Gang of Six met and discussed the decrease of Medicaid funds.

Dr Lehman thanked Council and members of the HMA for the privilege of serving as President of the organization. Dr Holschuh, Immediate Past President of the HMA thanked Dr Lehman on behalf of Council for his dedication and hard work throughout the year. A round of applause was given and a lei presented to Dr Lehman.

Mrs. Gutteling, President HMA Alliance read her extensive annual report on the fundraisers, and projects done throughout the year on behalf of physician members.

For Action

1) Council approved the Finance Committee recommendations that; a) HMA change auditors and approved the extra funds for next year’s audit; b) Mr. Vernon Woo, outside legal counsel who was on retainee be placed on a fee-for-service status effective 10/1/96; c) to change portfolio management companies from East Pacific Investment to SEI, for HMA’s employee pension fund and provide, for HMA members office pension plans and, personal portfolios; d) the HCMS contract fee be reduced to $6,000; e) the proposed draft of the budget for 1997 be approved for submission to the House of Delegates in October.

2) Council approved the Hawaii Physician Alliance, Inc.’s request to do a presentation at the annual meeting on their for-profit MSO.

3) Council passed a motion that the Membership Benefits Committee investigate a better Hawaii Medical Library rate for all physicians in Hawaii.

4) Council approved the Tobacco Task Force’s recommendation to request monies with the American Cancer Society, for a grant on tobacco prevention and the HMA provide kindred services such as, use of meeting rooms, clerical equipment, etc. Council also approved the committee’s recommendation that Dr Shirasu and HMA staff make every effort to make space available at the annual meeting so the Tobacco Task Force and the State of Hawaii Tobacco Prevention and Education Committee and Domestic Violence Division can display information.

5) Council approved of the concept of electing two Alternate Delegates. They would attend AMA meetings at their own expense. The HMA President previously served as an alternate.

Component Society Reports

Honolulu - Dr P. Blanchette is continuing to visit hospitals and physician meetings to promote the benefits of joining the HCMS. Her next visits will be at Wahiawa and Kuakini Hospital. The topic to be discussed at the first general membership meeting will be the new MSO.

Kauai - Dr T. Crane reported that Kauai County is looking forward to the annual meeting. He also brought up the discussion of fees charged for using the Hawaii Medical Library. Please refer to action item on this issue.

Hawaii - Dr E. Bade reported that their County did not meet this past month, however will be meeting in a couple of weeks for the election of officers.

For Information

Fetal Alcohol Syndrome Conference: This conference will be held in October 1997 by the Hawaii State Foster Parents Association and is asking for HMA’s support in volunteers, materials and supplies, etc. This is being referred to the Maternal Perinatal Mortality Study Committee and Children and Youth Committee for discussion.

HMA/CIVS.—Two meetings have been held with 4 organizations who are considering the service at the present time.

Strategic Planning.—Dr Lehman reported that the HMA held a strategic planning session and are awaiting Mr. Bruce Balfé’s (of the AMA) report on the session and suggested areas of change.

Coalition for Quality End-of-Life Care.—The HMA Committee on Ethical Concerns will be writing a resolution on the issue and bringing it to the House of Delegates.

Meeting was adjourned at 7:45 p.m.
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A Victory for Physician-Assisted Suicide

by A.A. Smyser

Reprinted from the Star-Bulletin 3/19/96, Hawaii’s World

Editor’s Note:
These two issues of Bud Smyser’s “Hawaii World” Star-Bulletin articles continue our series on Death with Dignity, reprinted with the permission of the Honolulu Star-Bulletin and the author. The jury is still out on the final decision. Look for the Special Issue on Death with Dignity in December.

It has not been fully grasped, but in Hawaii and eight other Western states it has been legal since March 6 to assist a suicide. It probably will remain so at least until that day’s 8-3 ruling of the 9th U.S. Circuit Court of Appeals is appealed to the U.S. Supreme Court.

Washington state, whose law against assisted suicide was overturned, has until early June to file an appeal. The current legality of assisting a suicide is confirmed by Hawaii’s senior judge on the appeals court, Herbert S. Choy. He was not on the panel that heard the Washington case but he is one of 13 senior (or retired) judges who still help the 25 active judges with their heavy caseload.

Even though a window of opportunity is open to legally assist suicides in the Western U.S. I know of no evidence that doctors, patients or even right-to-die organizations are rushing through it.

There are at least three reasons why:
• Everyone is cautious, doctors included. The window could close again if Washington appeals, as expected, and gets a stay order.
• Rules and regulations are not in place.
• Without a doctor’s help, right-to-die candidates and their friends will have a hard time laying their hands on the medications needed to do the job.

Barbiturates are the drugs of choice, I was told by Dr Richard MacDonald, who is the national medical adviser for Hemlock U.S.A. Plenty of doctors know how to use them. He says: (1) start with an anti-nausea medication, (2) take the barbiturates mixed in something like orange juice to get rid of the bad taste, (3) drink something to speed up absorption in the bloodstream. Booze will do.

Trouble is a lot of pharmacies don’t even stock the barbiturates any more because doctors hardly ever prescribe them, MacDonald says. Other effective and non-toxic sedatives have taken their place.

You might get them in Mexico. Even there you would need a doctor’s prescription. In some cases this could be fast and cheap but there’s no general rule.

And going ahead on a do-it-yourself basis without a doctor standing by could be botched, lead to emergency room care and even prolonged disablement.

The plastic bag method of taking a sleeping pill, then pulling a plastic bag over your head and fastening it tight around your neck with a rubber band also has had a few grotesque failures. It is unattractive for survivors even when it works.

The very clear social goal of all right-to-die advocates should be to have the process safe and even pleasant when a case justifies such help—and is a confirmed and reconfirmed conscious choice of the subject.

Derek Humphry, author of “Final Exit,” which prescribes dosages, has described cases of family and friends gathering around for “departures,” or at least just before the final act, and going away with very good feelings. I’d find it comforting to check out the way myself at the right time.

The 11 member court decision includes over 150 pages of the majority judgment plus dissents. The majority ruling written by Judge Stephen Reinhardt is said to be carefully crafted to stand by itself as a strong, persuasive presentation to the U.S. Supreme Court.

The high court in 1990 upheld a constitutional right to die in a complicated Missouri case that left controls to the states. It hasn’t yet ruled, however, on the right to assist a death.

Newly available and commended by Hemlock U.S.A. sources is “A Model State Act to Authorize and Regulate Physician-Assisted Suicide.” It was developed by a panel of nine doctors, lawyers and scholars and published in the Harvard Journal on Legislation, Volume 33, issued in January. More on it in a future column.

A Model Law on Physician-Assisted Suicide

by A.A. Smyser

Reprinted from the Star-Bulletin 3/21/96, Hawaii’s World

On a very timely basis, the Harvard University Law School’s Journal on Legislation has come up with “A Model State Act to Authorize and Regulate Physician-Assisted Suicide.”

It is timely because, by a U.S. appeals court decision, a window of opportunity for such deaths is open right now in Hawaii and eight other Western states. The U.S. Supreme Court conceivably could extend the opportunity nationally as early as next year by upholding the Western region decision.

The model act in many respects matches a law approved by Oregon voters in a 1994 referendum but meets several of the objections to that act raised by a federal district judge in Oregon.

The nine authors of the proposed law—two years in the drafting—are from the fields of law, medicine, philosophy and economics. Their spokesperson is Charles H. Baron, professor of law at Boston College. Their product is detailed in Volume 33,
Life in These Parts

Miscellany

Doctor on Board

An ophthalmologist colleague recounts the following vignette. He had just settled down into his seat on an Air France flight bound for Paris holiday. Once airborne, he noticed a gentleman across the aisle drinking, rather a lot. He would order another glass as soon as he finished one and the pattern continued for sometime.

The gentleman got up to make his way to the back of the jet, no doubt to relieve a certain urgency. There was big thud—the man had collapsed in the aisle. The other passengers gathered around and the flight attendant got alarmed. Soon there was a call overhead, “Is there a doctor on board?”

My colleague had hoped to remain anonymous, but he made himself known to the attendant. As they walked to the rear of the aircraft, he wondered what he’d do. “Yes, ophthalmologists are doctors too, but the man certainly doesn’t need an acute refraction.”

The patient was lying face down, semi-conscious. He was roused and offered his services. “Can I help you? I’m a doctor.” “So am I,” the patient replied looking at my colleague through the corner of his eye.

“If I had to guess, I’d say you’re a Zen Buddhist.”

“Just too much damn champagne!”

Shafiq Quadri Toronto—Stitches, October 94

Q. What did the Zen Buddhist say to the New York hot-dog vendor?

A. “Make me one with everything.”

From Laughter, The Best Medicine
Reader’s Digest June 96

Scene: The Oprah Winfrey Show

“Today, the subject is ghosts.”

“How many of you believe in ghosts?” Most of the hands went up.

“How many of you have seen a ghost?” A third of the hands went up.

“How many of you had sex with ghosts?” A lone hand went up.

“You sir, did you have sex with ghosts?” “Oh, pardon me, Mam, I thought you said goats.”

A Robert Kessler joke heard by humorist Myron Shirasu

Community Acquired Pneumonia in the Managed Care Era:

Jeffrey Golden, Professor or Clinical Medicine, UCSF. July 22, 1996. Roy’s Restaurant

General Discussion

500,000 patients are hospitalized with pneumonia each year and 10% of these hospitalized patients die because antibiotics are started too late.

Etiology of Pneumonias

Strep pneumonia; mycoplasma; viral; Legionella; Chlamydia; Hemophilus; Moranella...But in 50% of cases, we never know the exact etiology.

Pneumonia in elderly

• Etiology
  - Influenza 33.7%
  - Catarrhalis 31.4%
  - Pneumonia 7%
  - Mixed 17.4%
  - Gm negative
• Predisposing Factors
  - Aspiration and cigarette smoking.
  - Elderly Hospitalizations
    - Mostly pneumococcal bacteremia.
    - Mortality: Overall 30.5%; ICU - 86%
• Clinical Features in Elderly pneumonia:
  - 27% lethal; high index of suspicion necessary
• Sx & Sy’s in Elderly Pneumonia:
  - Confusion
  - Insidious deterioration
  - 40% lack fever & cough

***Acute confusion, lethargy, tachypnea

“We need up front time with antibiotics. Treat Early & Treat Broadly”

***Notypical clinical pattern whether the organism is pneumococcos, Legionella, or mycoplasma.

Office Evaluation

• Chest X-rays:
  - Takes 6 weeks to normalize
  - Lobar: typical

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Notes Henry N. Yokoyama MD

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HAWAII MEDICAL JOURNAL, VOL 55, OCTOBER 1996

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A Model Law on Physician-Assisted Suicide
Continued from Page 214

The argument for this intrusiveness is that it protects both physician and patients and guarantees against going down the "slippery slope" to casual suicide, even murder, that foes of assisted suicide say will be abused.

A distinction is made on "assisted suicide" in which a physician prescribes a potion and—preferably, say the authors—attends the death while the patient self-administers the potion. The model law does not approve the alternative of "euthanasia," in which the physician actively administers death.

All hospitals and health personnel who choose to abstain for reasons of conscience are protected, as are the people who help administer death so long as they meet the requirements of the law. Under the proposed law, life insurance could not be voided.

The privilege of physician-assisted death is limited to person 18 or older suffering "intractable and unbearable illness." This is defined as "a bodily disorder (1) that cannot be cured or successfully palliated, and (2) that causes such severe suffering that a patient prefers death."

This definition split the commission, with the minority favoring limiting assisted suicide to the terminally ill. The broader definition, the report says, could cover cases "such as AIDS, advanced emphysema, some forms of cancer, amyotrophic lateral sclerosis, multiple sclerosis and many other debilitating conditions."

One of Hawaii's leading thinkers on medical ethics is Kenneth Kipnis, professor of philosophy at the University of Hawaii. He says we must decide soon how to handle assisted suicide, yet are woefully unprepared. The Harvard proposal could provide a starting point for a Hawaii blue ribbon committee to develop a recommendation for the 1997 Legislature.

Editor's Note:

Position Available

Hawaii Osteoporosis Center.— Full time position available. Both clinical and research duties. Training provided. Generalist (including IM and GYN) preferred. Regular hours. Send resume and letter to: Hawaii Osteoporosis Center, Attn: Carolyn, An affiliate of the Mana Institute, 401 Kamakee St., Honolulu, HI 96814.

Private Practice Haven.— No HMO's. St. Thomas, USVI. Cardiac Diagnostic Services, Inc. is looking for an ambulatory based Cardiologist with little hospital responsibilities. Partnership is available. Cardiac Diagnostic Services, Inc., c/o Dr Osborne, St. Thomas, USVI 00801.

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The Weathervane

It's best to stick to your principles—if you have any.

Treading where no other Hawaii physician has trod, and striking a major blow for medicine in party politics, Philip Hellreich, MD, Kailua dermatologist, was appointed to serve on the Republican Party Platform Committee in San Diego, California. Never the shy one, Phil was instrumental in placing planks in the platform to provide for (1) Medical Savings Accounts, (2) Elimination of fraud and abuse rules and (3) Elimination of the gag rules imposed by certain HMOs. Way to go, Phillip!

There's gold in them thar pigeons.

As if there weren't enough deception in the medical world, Summit Technology Chairman David Muller allegedly transferred 850,000 of his shares to an offshore company and sold them after he mysteriously received confidential documents form the FDA indicating that rival Visx excimer laser was "commercially more appealing." Once approved, Visx's laser for photorefractive keratotomy (PRK) would likely far outsell Summit's laser. With release of the information Summit stock went from $22 in April to $6. Some angry investors have brought suit against Summit alleging illegality in its FDA studies and in the manner in which it sold the laser and recorded revenues. How often investing doctors resemble those wooly ovine creatures obligingly lined up to donate their largesse to the clippers.

It's not an optical illusion. It just looks like one.

Perhaps you did not know that TWA flight 800 was carrying a box of donor corneas headed for France. Important point is that the box was carried in the cockpit of the Boeing 747, and no one ever opened it or inspected it after it departed the Baltimore eye bank.

The power of the state is always in inverse ratio to the power of the nation.

A rose by any other name would smell as sweet, or as pungent in this case. The Illinois Department of Public Health has challenged the Rush Eye Laser Center as to whether the center should be licensed under the state's Ambulatory Surgical Treatment Center Licensing Act. Like Hawaii's Certificate of Need law, the Illinois Department of Public Health controls ambulatory surgery centers, and perceives another area to exercise control over free enterprise in medical care. Despite reams of contrary evidence, CON laws prevail in many states, eliminating competition, protecting vested interest, and increasing the cost of medical care. Here in the land of Aloha, the Department of Accounting and General Services (DAGS) has said that the law does not control medical costs, and Governor Cayetano asked the legislature to do away with it. No way! It live on for at least another five years, because our legislature is so efficient in taking care of our entrenched institutions.

Old doctors never die. Young ones do.

A 33-year-old doctor was beaten, raped, sodomized and strangled in her office at Bellevue Hospital by a mentally ill, homeless man who had been secretly living in a hospital storage room. She was five months pregnant with her first child. Her husband brought suit claiming negligent security at the institution, and asked for $25 million. The city's lawyer offered $2 million to settle the case. Although witnesses acknowledged the hospital's fault and negligence, the jury decided against the widower and awarded no damages. Perhaps it is not relevant, however, juryes appear to judge personal injury cases differently when taxpayers are the deep pocket.

The enemy of every honest man is the politician seeking power.

In Washington, your House of Representatives, ignoring recommendations from the AMA, elected by a vote of 212-210 to continue allowing tobacco growers to receive federally subsidized crop insurance and advice from agricultural extension agents. Critics of the $25 million program said that a crop that kills 400,000 smokers a year has no business getting government support. Not surprisingly, the vote was more regional than partisan.

There is almost nothing you can't be put in jail for now.

When dealing with the Internal Revenue Service, it is important to know when to call your attorney. A Houston plastic surgeon has been fighting the IRS for over 17 years although he did nothing wrong. A 1979 routine audit turned up no violations, but acting upon tips from two former employees, the IRS pursued the case. The Criminal Investigation Division was called in, and went around the doctor to obtain hospital records. Some hospitals gave in and revealed patients' records, names and addresses. Many of his patients were outraged, and blamed the doctor for the loss of confidentiality. In an unbelievably protracted case, there was no evidence that the doctor broke a single tax rule or underpaid his obligations by one cent, and ultimately the government has since cleared him fully of any wrongdoing. Yet, his many court campaigns include four trial-level proceedings, six federal appeals, and a petition to the US Supreme Court. The point here is that once a government agency begins an investigation, finds nothing serious, but has invested significant time and effort, instead of cutting losses, the investigation takes on a life of its own. As in the persistent persecution of Dr Zelko in Hilo over a prescription for appetite control, the agency goes to ridiculous lengths to try to nail the doctor. The ultimate sin is that those agents who cause so much personal damage to the reputation and peace of mind of the doctor and his family, are never brought to account for their transgressions.

Addenda

❖ Out of every tax dollar paid by New Yorkers, 21 cents goes for addiction and substance abuse. The total cost to NYC a monstrous $20 billion in 1994.
❖ Sex education in schools seems to have little or no effect on sexual activity, contraceptive use or teenage pregnancy.
❖ Beauty, is in the eye of the beerholder.

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