States have educated health practitioners to be more responsive to the needs of this population, growing religious and conservative influences in American life have resulted in a resurgence of what is known as “reparation” or “conversion” therapy intended to change the sexual orientation/identity of gay men and lesbians. However, these therapeutic interventions are generally unsuccessful which attests to the highly resistant and perhaps ingrained nature of sexual orientation.12, 15

Sexual Diversity in Asian and Pacific Island American (A/PIA) Populations

Most Asian and Pacific Island cultures have documented the existence of same-sex behavior and relationships for centuries. In the Philippines, bakla refers to a man who assumes a female gender role and sometimes same-sex roles and behaviors, similar to the mahu in Native Hawaiian or Kanaka Māoli (indigenous people of Hawaii) culture.14-16 During Captain Cook’s early voyages to Hawaii, members of his crew chronicled the importance of aikane, who were male consorts of the male ruling class of Kanaka Māoli.17 There are also accounts of same-sex roles and practices in Samoa with the ja'afafine, the Tongan fakaleti, and in Korea, Japan, and China. 14, 18-22

For Asian and Pacific Island peoples who have either been colonized in their own homelands (such as Hawaii or Samoa) or have emigrated to the United States, some suggest that the influence of Western religiosity, social norms, and acculturation/assimilation patterns have altered once-acceptable variations in values and practices regarding sexuality.23 In addition, the contemporary portrayal of gay men and lesbians as Caucasian contributes to the perception of many A/PIA populations that homosexuality is a White phenomenon, thereby disavowing the existence of gay men and lesbians in their own A/PIA communities.24-26

A/PIA Gay Men and Lesbians in Hawaii

The scarcity of studies about lesbian and gay life among “local” A/PIA communities in Hawaii can be explained by a number of factors. First, many of our “local” cultures value the maintenance of social order and are careful to protect and uphold the collective well-being of the family from anything that will bring public humiliation upon them. As Alexander Nakatani, Maui-born father of two sons who died of AIDS recalls about his upbringing, “I knew how important it was to keep shame from visiting our family... Honor and shame... I think they live in the walls of every Japanese house.” 27 While many European American cultures reinforce social norms through guilt, the collective and public nature of shame in Japanese, Chinese, Filipino and other “local” A/PIA cultures is linked to the loss of “face” that results from conducting oneself in a socially unacceptable manner. Having a gay or lesbian family member is considered deviant in most A/PIA populations who reside in Hawaii regardless of the extent of their acculturation to American norms and beliefs. In addition, traditional A/PIA values about the privacy of intimate matters such as sexuality preclude discussion about such topics among “local” families or in other settings throughout Hawaii including schools, churches, and doctor’s offices. Finally, the relatively insular nature of island life discourages many people from sharing information that is perceived to be discrediting or embarrassing - such as the existence of gay or lesbian family members - for fear that in the “small town” character of Hawaii it is likely that a co-worker, neighbor, or acquaintance will find out.

For lesbians and gay men in Hawaii who are also “local,” learning to develop and enact their lesbian/gay identities requires a delicate balance of personal needs and social obligations.

Conflicting Loyalties to Family and Self

One study of sexual and racial/ethnic identity among Hawaii-born, “local” lesbians and gay men suggests that the inherent tension of adhering to “local” A/PIA values regarding loyalty to one’s family while simultaneously developing an autonomous sexual identity is a significant stressor.28 As a part-Hawaiian gay man stated, “As long as I don’t talk about ‘it’ my parents and I get along.” In other reports of “local” A/PIA gay and bisexual men in Hawaii, participants reported that while their families of origin (parents, siblings, aunts, uncles, grandparents) were important social supports, the family relationship was also the source of greatest internal conflict.15, 28 Many “local” gay men and lesbians state that they are reluctant to either disclose or non-discretely enact their homosexuality for fear of losing the connection to their families. As a “local” Japanese-American lesbian stated:

I thought, I can’t possibly do this [be a lesbian]. My family will hate me... because family and the notion of family was so important in Hawaii.29

A common reaction of A/PIA parents when they discover they have a gay son or lesbian daughter is, “What will people in the community think?” Because the concept of “saving face” is an important aspect of many Asian American cultures, one study found that A/PIA gay men and lesbians who choose to remain closeted with their parents also do so in the A/PIA community for fear of being socially stigmatized.30 As argued by Wong, et. al.,14 “a stronger value (is) placed on loyalty to family roles than on the expression of one’s own sexual desires.”

Social Distancing Linked to Social Stigmatization

In a study of gay and lesbian youth in Hawaii initiated by the 1990 Hawaii State Legislature, many young people and service providers reported acts of harassment and discrimination such as ridicule, taunting, and physical assault from peers and strangers.31 More disturbingly, many of these incidents occur in the presence of authorities such as teachers, counselors, or youth workers who either do not intervene or sometimes are responsible for precipitating them. These situations result in many local lesbians and gay males isolating themselves from others, becoming more secretive about their sexual conduct, and engaging in risk behaviors such as unsafe sex, drug use, and running away from home.

In addition, “local” A/PIA gay men and lesbians commonly report that they purposely leave home to attend school or take jobs on the Mainland where they will feel more comfortable “coming out.” A part-Hawaiian lesbian who grew up on Molokai and now resides in California recounts that she originally went to the Mainland to “try to get ahead”:

I came here for an education to work my way home and here I am after twenty something years! My mom said to stay here because the job situation at home wasn’t very good. I think another reason why I stayed here was I wasn’t out. 32
In one study, local Japanese, part-Hawaiian, and Hawaiian-Puerto Rican lesbians mention that they were more likely to be public about being gay on the Mainland than at home in Hawaii because as one noted “there was no family and I could start fresh. I could hold hands in public and not have to think about it, and nobody in my family knew.”

Finally many “local” A/PIA lesbians and gay men report trying to balance pride and comfort in privately being gay while preserving their familial relationships by publicly not “acting” gay. Wong, et al. suggest that this private-public tension is not necessarily incongruent as long as one’s private behavior does not interfere with one’s social behavior. So for example, if a local gay man engages in a same-sex relationship that is discrete and private, while maintaining his social role as a fun-loving (heterosexually-seeming) guy at the baby luau, he may find such an enactment acceptable not only to himself internally but externally to his family. However one significant consequence of this compromise is that many must live what A/PIA lesbian activist Michiyo Cornell calls “the great lie” which dissociates them from parts of themselves, but also from their families and communities.

**Health and Mental Health Consequences**

Most of the health and mental health effects documented among lesbians and gay men are due almost exclusively to societal denigration known as homophobia, which is the fear and hatred of gay men, lesbians, and anyone perceived to be other than heterosexual. Bidwell’s study of gay and lesbian youth in Hawaii reported that many young people in this population who choose to be more self-accepting and perhaps public about their gay/lesbian identity risk harassment, rejection, and sometimes peer violence. National studies of gay and lesbian youth document the prevalence of homelessness, truancy and sexual exploitation among this vulnerable population.

A 1989 study by the U.S. Department of Health and Human Services estimated that gay and lesbian youth are 3-5 times more likely to consider, attempt, and perhaps complete suicide than other adolescents in the U.S. Bidwell found repeated accounts of suicidal ideation and attempts in his interviews with Hawaii youth providers, parents, and young people themselves. A worker at the Queen Liliuokalani Children’s Center estimated that five gay/lesbian teenagers who received services at the program had attempted suicide during Bidwell’s study period.

“Local” gay men and lesbians throughout Hawaii report histories of drug abuse, depression, and anxiety associated with issues including: confusion regarding their sexuality; stress in balancing their gay and family relationships; and lack of peer and social support. In addition, “local” lesbians and gay men may delay or forego health care because of past experiences with homophobic providers, with whom they are ashamed of talking about sex-related problems such as STDs/HIV especially related to same-sex conduct.

However, the most pressing health concern involving this population in Hawaii is the rate of HIV/AIDS among “local,” A/PIA gay men. In Hawaii the largest proportion of AIDS cases is among men who have sex with men. While Caucasians represent the largest ethnic group in the category of men with AIDS in Hawaii, the number of White men diagnosed with AIDS is generally decreasing while there is a significant upward trend of HIV infection among the second highest ethnic population in the men who have sex with men category, which are Asian and Pacific Islanders.

Therefore, while the proportion of reported AIDS cases in Hawaii due to men who have sex with men has decreased over time, there has been an increase particularly among Native Hawaiian and Filipino gay and bisexual men who reside in the State. It is argued that the difficulty in reaching “local” gay men with HIV/AIDS prevention messages is that many are ashamed to acknowledge their sexual identity for fear of rejection; the lack of social networks and support that incorporate the cultural needs of non-Caucasian gay men in Hawaii; and, “local” gay men are engaging in HIV risk behavior such as unsafe sex and intravenous drug use in discrete settings where their public identities as gay and “local” will not be exposed.

**Implications for Health Care Providers**

For Asian and Pacific Islander, “local” gay men and lesbians, the enduring stigmatization associated with homosexuality coupled with “local” values and attitudes about the importance of family and maintaining social relationships has resulted in covert and overt acts of discrimination against them. The particular manner of dealing with this issue is described by one A/PIA researcher as, “don’t ask, don’t tell, don’t know.”

In order to work more effectively with this population there are a number of practice implications for physicians, nurses, allied health providers, mental health clinicians and other health professionals in Hawaii. First and foremost, health professionals have a responsibility to become educated about the unique and challenging issues of being “local” and gay in Hawaii. There is a prevalent misconception that “the gay problem” is a “Haole” matter, and that there are no or few “local” gay men or lesbians. It should be self-evident that homosexuality - as with heterosexuality - is found cross-culturally including throughout all parts of the State of Hawaii. Denying that “local” gay men and lesbians actually live and walk among us in Hawaii is probably the major barrier to health care for this group.

Gynecologists and other women’s health providers must not assume that every local Japanese woman who comes in for a PAP smear is having sex with men. Physicians, nurses, and allied health professionals need to sensitize their interactions with clients and patients by attaining knowledge of and skills to address sexuality, homosexuality, and same-sex intimacy in the context of our “local” Hawaii and traditional A/PIA cultures, and to do so in a non-judgmental manner.

Due to the “small town” nature of life in Hawaii, many gay men and lesbians need to be reassured about the importance of confidentiality in the provider-patient relationship. The fact that local gay men from the Neighbor Islands will sometimes fly to Oahu for HIV testing or other health care is evidence of the effects of social stigma that many are trying to avoid.

Finally, individual health providers and health professional associations must advocate for increased training and continuing education for medical and health practitioners on sexuality, gay and lesbian health issues, and the unique needs of “local” sexual minorities in Hawaii.
W. Mitchell Sams, Jr.'s Open Letter to His Son:

Dear Hunter: Now that you have completed the first three years of medical school and are increasingly excited about patient contacts and your future role as a physician, I'd like to take this opportunity to pass on to you some thoughts that I have developed over many years of practice and that, if followed, are certain to make your own professional life more rewarding and your patients more satisfied.

* Don't forget to smile as you enter the patient’s room. Such a simple gesture is terribly important and puts the patient immediately at ease.
* Remember that a patient often is frightened and lonely. Take the time and expend the effort to sit down with that patient, relax and just talk and listen, rather than standing as though you are in a hurry to leave the room.
* Write your notes about the patient and your prescription in the patient’s room. It is much more meaningful to them and permits you to spend more time with the patient. They may think of other questions important to them when you are relaxed.
* Touch the patient, even if just lightly on the arm. This shows you are not afraid of catching whatever they have (whether skin diseases or not), but also conveys concern and understanding. It can be a magnificently important gesture.
* Learn some "nonessential" information about the patient, such as hobbies, recent trips, children’s achievements and ambitions. Then make a note of this in the chart and bring up the subject again on the next visit. You will be amazed at how impressed the patient is with your "memory" for these events.
* It is o.k. to express confidence in helping the patient that may not be totally justified by the options. The patient’s confidence in you and in the real possibility of improving his or her condition can enhance the healing process.
* At the same time, tell the truth. If the disease is not curable (such as psoriasis or atopic dermatitis), say so, but quickly add that it can be controlled with appropriate therapy. I liken psoriasis to arthritis or diabetes, neither are curable but both are usually controllable. Patients seem to understand and accept that better.
* If you are running behind schedule, apologize to the patient as you enter the room. It puts them off guard if they were planning to complain and lets them know you are aware that their time is limited. This shows you are not afraid of catching whatever they have (whether skin diseases or not), but also conveys concern and understanding. It can be a magnificently important gesture.
* Express your appreciation often and sincerely to the people who help you be what you are — your colleagues, your nurses, your residents, your receptionists. You will not be a success without them. Be sure you let them know that.

MISCELLANY

There is the story of the computer that was ordered to translate a common English phrase into Russian and then translate the Russian back to English...What went in was "Out of Sight. Out of Mind." What came out was "Invisible Insanity."

POTPOURRI

A BIG HELP....

One day a patient came in and breathlessly described what sounded like a truly ghastly car accident that she’d witnessed at her corner. "There was blood everywhere," she panted, "and cries and groans for help." "I was very proud of myself, Doctor. I remembered all my first aid course work — I took a deep breath, put my head between my knees and didn’t faint!"

Dr. Marion Rogers, Vancouver Stitches, Aug 99

JUST PERFECT....

A friend was applying for immigration into Canada and submitted himself for the required physical examination. The examining physician was young and obviously a recent medical graduate. As he finished, he explained, with an apology, that he was required to perform a rectal exam. He was as embarrassed at having to do this as my friend was at having to submit to it.

After the examination, the physician said, "I am sorry I had to do that, but you know, only perfect assholes are allowed into Canada!"

Dr. Michael Golbey, Kelowna, B.C. Also from Stitches...

CONFERENCE NOTES..."Angina and Silent Ischemia"

VP William Parmley, Prof of Medicine, UCSF...7-15 Fri Am Conference, Kam Aud, GMC

Discussion:

Silent Myocardial Ischemia (SMI): Incidence: 4% of population...Angina and SMI: 34% of episodes are silent...SMI is not benign...Prognostic implication of SMI with stable angina: Risk of death or adverse outcome come...SMI with Unstable Angina: Increased risk 3-4 times of adverse outcome...SMI plus risk factors increases potential of death...SMI is marker of more severe disease. Post MI: Increased risk with SMI.
* SMI diagnosis c Treadmill...

CAST Study: CABG vs Medical therapy: Neg treadmill = better prognosis than positive treadmill. Adverse prognostic sign when ischemia occurs without pt perception viz SMI... (Smoking: acute risk factor which is reversible)

Framingham Follow Up:
% of silent MI's: men = 28%; women = 35%; elderly women even higher

Summary:
MI = Imbalance of oxygen supply & demand:
  a. HR + BP = Rate/Pressure gradient
  b. Reduced demand = BB (Beta Blockers)
  c. Reduced supply 2° to: ± vasoconstriction + stenosis + blood flow: a little constriction = MI.

Rx Demand (HR & BP) vs Supply (vasoconstriction)
Rx: a) ↓ demand + b) ↓ vasoconstriction

re Demand: a) Circadian rhythm...MI’s occur Monday mornings (getting up to go to work) Re Sudden Cardiac Death: Less MI’s \( \neq \) ASA qd (Physician MI Study) viz platelet aggregation factor

Why AM? Surge in BP, HR, catecholamine—plaque rupture; stickier platelets...

Therapy: Ischemic Heart Disease....

1. Variant Angina: a) Ca CB (eg amlodipine...every CaCB works) + b) Nitrates
2. Stable Angina: a) Beta blockers: Rx of choice; Betablockers > nitrates
3. Vasoconstriction: a) Ca CB + nitrates ie combination Rx

re Beta Blockers (BB): effective in post MI; ↓ HR = most important; ↓ mortality

BB ROLE IN CIRCADIAN RHYTHM:

a. Reduces AM surge (eg c afeinolol) b. BB works best in AM hours...

CaCB Role: Niphepredine GITS (Procardia XL) (long acting CaCB) Uniform 24° level. But with Niphepredine GITS: no difference in ischemic events; whereas BB reduces AM ischemic events...

**SMI Therapy(may be worthwhile...Should we pursue RX?)

In Stable Angina: Revascularization group has best results. If SMI shows \*High Risk Ischemia by quantification \( \neq \) ETT; ECHO MUGA; Perfusion; AEM etc and if all these tests are positive, revascularization is indicated in SMI...

W. Mitchell Sams, Jr was president of the American Academy of Dermatology when he wrote the above letter which appeared in the Dermatology World Vol #10 October 1996. Ed. We keep a copy of the letter on our desk as a constant reminder.)