HAWAII MEDICAL JOURNAL

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HAWAII MEDICAL ASSOCIATION · 1856 ·

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HPAS

Hawaii Patient Accounting Services

"Setting Hawaii's physicians free"

HAWAII MEDICAL JOURNAL

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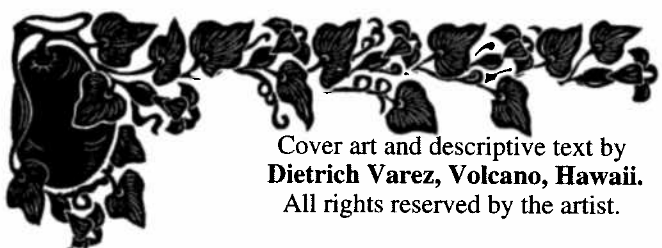

Cover art and descriptive text by
Dietrich Varez, Volcano, Hawaii.

A Chant for the Three Winds of *Molokai*

A hula chant tells of a giant calabash in which the goddess *Hina* kept three windstorms to release at will.

Hina's permanent residence is at *Kaluaaha*, a cave dwelling hidden at *Paoiki* Ridge. Protective eyes guard the *Koolau* district's *Wawahonuaaho*, the great wind gourd; sealed within are the three storms of *Hina*.

Hina opens slightly the gourd cover. The *Ilinahu* wind gushes forth from *Kamakou*. Trees are uprooted and thrown over as in the path of the *Ilinahu* and shrubbery is twirled, sweeping down and out to sea. *Hina* opens halfway the gourd cover causing skies to darken on *Pailolo* channel. Lightning flashes and thunder cracks shaking the island. Wild gusts of wind cause ocean floods; such is the way of the *Uluhewa* wind.

The worse storm is released, the *Luluku*. Crushed are the chiefs; crushed is the land. This is the way *Molokai* the child is protected—Great *Molokai*, child of the goddess *Hina*.

Editorials

Our First Year
Norman Goldstein MD, Editor

This issue marks the first anniversary of the *new Hawaii Medical Journal*.

In 1994 we published 47 manuscripts, we have a new look with the cover art by Big Island artist Dietrich Varez, our new regular columns "Medical School Hotline," "Military Medicine," "Historical Notes," and the "Hawaii Medical Association Alliance," along with our book reviews and letters to the editor, all have been received very well by our readers. We continue to be pleased with Dr Henry Yokoyama's "News and Notes" and Dr Russell Stodd's "Weathervane."

Our special issues on Organ Transplantation in March, Women's Health in September, and Native Hawaiian Health in December have received accolades. We are pleased to have received requests from Mainland medical journals for permission to reprint articles that have appeared in our *Journal*.

But a medical journal doesn't just happen without a tremendous amount of work. My heartfelt thanks to the authors, peer reviewers, advertisers, and a special *mahalo* to our dedicated HMJ staff.

What's ahead for the *Journal*? In addition to a wide variety of manuscripts, we will have three special issues in 1995:

- In April we will cover Medicine, Law, and Bioethics through the ingenuity of guest editor S.Y. Tan MD.
- In July we will discover the innovations of Military Medicine in Hawaii with guest editor Ben Berg MD.
- In November, co-editors Al Morris MD and John Breinich will outline the History of Medicine in Hawaii.

We also are considering several other special issues, including connective tissue disease, drug dependency, environmental issues, euthanasia and the right to die, geriatric medicine, medical school issues, new technologies in medicine, Oriental medicine—East meets West, an allied health issue, pediatric medicine, rehabilitative medicine, sexually transmitted disease, and sports medicine.

Stay tuned for more information, keep reading, and sending us your comments and your manuscripts.—NG.

■

AMA House of Delegates

Straight and True: Setting Medicine's Course for the 21st Century
James S. Todd MD
Executive Vice President

Mr Speaker, members of the House of Delegates, distinguished guests, ladies and gentlemen. Listening to John Seward a moment ago, I was struck when he said we were not going to just "talk the talk," but that we will also "walk the walk." And I thought—that means we need to know where we're going. And in the legends and lore of these beautiful islands, there are stories that can guide us.

You know, Hawaii was discovered more than a thousand years ago by epic island voyagers who were led first by circumstance and then by courage to venture far beyond their own horizons.

This is the most remote island chain in all the seven seas. How in the world did they find it?

Well, those early Polynesians were among the greatest ocean navigators the world's ever known. They had no maps. They had no instruments. No, instead they followed their own inner compass.

And they rowed their enormous wooden canoes always into the rising sun. The stars kept their course straight and true until they reached this land of lava and fire and ferment.

And now, just like those ancient mariners, this House of Medicine returns to these same fantastic islands determined to set our own steady course and eager to reach beyond our own horizons.

We certainly find ourselves in different waters since we last met. As Bob McAfee [AMA President] just told us, the great debate over health system reform is already a rapidly fading fable.

There will be no single sweeping wave of reform this year, or next year, or the year after that.

Instead, we will achieve change the way the public and many in this House wanted to in the first place—we'll do it the old-fashioned way—gradually, one step at a time.

But remember this: Although Washington was unable to unlock the gridlock in 1994, it will be a totally different political world when the new Congress convenes in 1995.

And we have already salted most pieces of pending legislation with policies straight from this House: Patient and physician protections. Antitrust relief. Professional liability reform.

And while we kept these issues on the table, we succeeded in taking off the table the issues most onerous to most physicians: Big bureaucracy. Price controls. Quality control by government fiat.

The bottom line is: Comprehensive reform may have hit a brick wall, but the agenda of this House did not.

This is not to mean that we are in for smooth sailing. Far from it.

The private sector is full of hazards. Some are marked; some are unmarked.

Don't forget that while Washington

fiddled, the giant insurance companies and huge hospital networks were setting the marketplace on fire. And they touched off a gold rush out there that threatens to undermine quality and undercut patient care.

Don't get us wrong. We are not opposed to managed care. But we are opposed to managed profiteering. And left unchallenged, the managed profiteers in the private sector pose just as strong a danger as the heavy hand of big government in the public sector.

In the year ahead we plan to confront both.

That is not to say the federal government has no role. It does. The country needs the government to help set the rules, develop the guidelines, lay the foundation on which reform can be built.

And for physicians, our firmest foundation is patient protection. This is our agenda for the new year. And with Congress undergoing volcanic changes of its own, we will be able to advance our agenda.

But do not be lulled into complacency.

Yes, there will be a new mentality in Washington, one that can be friendly to medicine. But it is also a mentality that is down-right determined to cut the deficit and trim the budget—and that means Medicare.

The big battle in the next Congress will not be over health reform. It will be over Medicare, and it will be the mother of all Medicare battles.

I tell you now—we must be ready. You must be ready. The AMA must be ready if we are to come through the storms that most assuredly await us.

A few minutes ago, John Seward told us of the sea change in your AMA's mission and structure. And he told us the course corrections we must make for the voyage ahead.

Our navigators—your Board of Trustees—laid down our course. Let me tell you how we are following it. We clarified our mission. We tightened our focus.

We took a look not only at how to do our job. We looked at what that job should be. If it was part of our past, we put it aside. If it is part of our future, we put its name on our door.

We reconfigured our internal structure. We applied all the buzzwords of business management: Reconfigure. Reinvent. Reengineer.

And now we have a redefined AMA structure where form follows function.

Where operations are executed by four action groups. Their names describe the AMA of the 21st century. Standards. Advocacy. Federation. Business.

Let's take a quick look:

The first group is called Scientific, Educational and Practice Standards and Policy.

Setting the standards that guide our profession—this is the heart and soul of what this House and this AMA are all about. It's what Joe Painter tells us is the taproot of medicine. And it is the base root of our House.

And for our profession to remain deeply rooted, our standards need to keep up with the forces that are reshaping medicine every day. In this new world of cost containments and mega-sized mergers, the bottom line threatens to undermine the very quality of the care we provide.

So we created a new operations group to respond to what's happening in the marketplace.

This group has a clear charge: To develop and enforce the standards America's physicians must have if we are to fight off the forces that would diminish the quality of medical care our patients expect us to deliver.

The core of professionalism remains unchanged: Science. Education. Public health. Clinical care. And ethics.

These standards have been the AMA's cornerstone through the 19th and 20th centuries. And with new standards for how we deliver health care in this country they will remain our cornerstone far into the future.

This next group will make sure it happens. Its name is Health Policy Advocacy, and it does what it says.

This is our national action campaign team; it advocates health policy.

Communications, policy, lobbying—all clustered under the same umbrella, with the same purpose: To create excitement. To build public and political support for the principles and policies this House knows are necessary for physicians to deliver good health care to their patients. It's just that simple.

How we do it is going to look and sound different. Our advocacy will be more personal, more direct. It will be more like a real campaign. The private sector will become a Class A target. Success will be measured by impact.

The next group is where the needs of our profession intersect. It's called Constituency and Federation Relations and Membership.

Again, form follows function. The function is to make sure the AMA serves its members as the voice of American medicine. The form is this great partnership of physicians we call the Federation.

It is the leaders of the sections, the advisory committees, the medical societies, plus members new and yet-to-be, because together we are the profession!

And, in an all-new way, the public will be a part of the partnership, too, with a broad-based campaign to turn the public into well-informed, active advocates for the medical, scientific and public health issues that touch all their lives.

The fourth action group recognizes that the AMA is a major international business entity with products and services, markets and merchandise, real estate and investments. How we do as a business will determine how we do as an association.

Our success as a business is now the business of a new group called Business and Management Services.

Its job: Run our business like a business. Cultivate a new business culture within the AMA. Build the quickness and the keenness of the Association's business skills. Identify and develop new products and services that will add to our financial base and to your benefits as AMA members.

This, then, is what the AMA stands for today: Standards. Advocacy. Federation. And Business.

But our AMA is so much more than just boxes on an organizational chart.

Our AMA is people. You and me and all of us right here in this room. Plus literally hundreds of thousands more. All those physicians back home, present members and future members, from the ones fighting flu, to the ones curing cancer; doctors helping life begin, and doctors refusing to help life end.

We are as diverse as all America. But more than anything else we hold this in common: That whatever our trials and tribulations, we belong to the most exacting, the most exciting, the most rewarding profession there is.

You know, more than a century ago Mark Twain, of all people, made it all the way to these islands. Truly, he was a Connecticut Yankee in King Kamehameha's paradise.

And when he wrote about how he felt about Hawaii, he might as well have been talking about how most physicians feel about medicine.

Listen to what he said, and you decide if this is what medicine does to you.

He said:

"It haunts my sleeping and waking . . .

Other things leave me, but it abides."

Medicine is indeed a great journey—an epic voyage that takes us to places we couldn't possibly imagine—even in our wildest dreams. It haunts our sleeping and our waking. And I know that other things may leave us, but I believe it is medicine that will abide.

Thank you, and Godspeed in the work that lies ahead.

Drs Todd and Seward gave these speeches in Honolulu on Sunday, December 4 during the AMA House of Delegates Interim Meeting opening session.

Built to Last: Power Tools, Old Saws, and a New AMA

P. John Seward MD
Chair, Board of Trustees

Mr Speaker, members of the House of Delegates, distinguished guests, and ladies and gentlemen.

And what should I add when we're in Hawaii? *Aloha*—of course. *Aloha* is a warm and wonderful word that universally means: "Hawaii." We say it all the time. But do you know what *aloha* really means? *Alo* means to face and *ha* means breath of life.

Aloha. Literally to face the breath of life. And that's exactly what this House is: The breath of life of medicine.

So, *aloha*. This is why we are here. And it's why I'm here. Because I have a message for you today that turns face to the future and breathes the breath of the future into our whole profession.

As AMA Chair, you can be sure I have something pretty momentous to say on that score, so I've asked your Speaker's indulgence to come before this House today, before you even begin.

So, listen up! Because your Board has news to deliver to you this morning— news so essential to the work of this House that it will affect every decision you make as delegates, not just now, but years into the future.

The new AMA Strategic Plan you received along with your resolutions is far more than its name implies. Far more.

In fact, this so-called Strategic Plan is really a massive and strategic shift in our entire AMA mission and structure — what they call a paradigm shift, a virtual sea change.

And it makes quite a story.

Now we all know that nobody spins a yarn like Bob McAfee. Nobody.

So what I'm going to tell you today is not a fairy tale but there is a story behind it. It's a John Seward story, and it happened to me.

It started with a feeling we've all shared: I wanted to become a doctor, from the time I was a boy.

And I knew exactly what kind of doctor, too—a plastic surgeon. Caring for those to whom plastic surgery was anything but a luxury: Pediatric cancer patients. Accident victims. Burn patients.

But during my residency at the Mayo Clinic, I developed rheumatoid arthritis. My own hands were operated on, ending my surgical career, and bringing me, with a sudden kind of serendipity, to a small town in northern Illinois to work with a crusty old codger known as "Dr Bob."

You can imagine that I didn't think much of what he might know. How could I? I still knew it all myself, for Pete's sake.

So we worked out a kind of edgy peace. And we rocked along like that until one fall day when the phone rang to announce an emergency: A farmer with his hand and arm caught in a corn-picker.

We raced off, me grabbing my little black bag on the way—even though it hardly held more than a stethoscope and my sandwich for lunch—and the old doctor driving like mad in his beat-up Dodge, bouncing over dirt roads and crashing headlong through a fence—and directly into the cornfield.

And I'll never forget this: He was whistling the notes of "The Marseilles," the French national anthem. I was more along the lines of "Nearer My God to Thee!"

Suddenly it was over, and we were skidding to a stop, right beside that corn-picker. And he turned to me and slowly said, "So, doctor. Whatch'a gonna do now?"

All the arrogance went out of me. I was in real trouble. Because I suddenly had to admit they hadn't prepared me for corn-pickers in my days up at the Mayo Clinic.

And then old Dr Bob—cool as a cucumber—opens up his trunk, takes a screwdriver and a wrench out of his tool box, and with a little smile says to me:

"C'mon. I'll show you how to take a corn-picker apart to get a hand out. I do it all the time."

What medicine is facing today is no different from my experience in that cornfield: A crisis that tells us we can fix what's wrong so long as we have the right tools and are willing to use them.

But just like the corn-picker, it's a crisis that no one has ever prepared us for. A reality that's outside the rules.

Well, it's time for us to re-write those rules so we end up holding the edge on that reality.

Let us not forget that our AMA stands on a firm foundation that has served American medicine well through the generations: Advocating for the health of the public through the rigors of science and technology, and setting the standards of medical excellence itself.

This mission—this tradition—is as familiar to us as our own Hippocratic Oath. And it is on this solid, steady base that we will transform the AMA of the present into the AMA of the future.

Our vision is clear. This is what it is:

First, we will aggressively define and redefine the standards of health care delivery in a practice environment radically different from a generation ago.

One hundred forty-seven years ago the physicians of America came together "to promote the art and science of medicine and the betterment of the public health." At each critical crossroad in our history, physician leaders just like you—sitting in those same seats—realized that if our profession was to survive and succeed, we needed new standards to meet the demands of new times.

So we added ethics, education, and clinical practices. And now we stand at yet another critical crossroads where healthy profits too often supersede healthy patients. Where they're rewriting the rules of the game, and rewriting the way we practice medicine right along with it.

So it is time for us to change again, with an entire new set of standards on how physicians deliver health care in a marketplace that is undergoing profound and fundamental change.

Listen to what this means: If we do not assert our own expertise—if we do not assert ownership of our profession and our practices—then someone else will.

This is our top priority—because it is the profession's top priority. And it is your top priority.

Standards and ethics are the bedrock of our past. We must make sure they are the bedrock of our future.

Standards is only part of our vision. Advocacy is the other part. We will advance a new national advocacy with a one-two, public-private punch like you've never seen before.

In the public arena, our policy advocacy will be more aggressive, more finely focused, pursued with greater intensity. Always aimed at protecting the relationship between physician and patient. Always aimed at elevating the standing of the entire profession. That's punch number one.

Here's number two: In the private arena, we will open a new frontier of private sector advocacy. Here, too, fighting not just for the patient-physician relationship—but also fighting for excellence and quality of care.

The physicians of this country made quality the hallmark of American medicine. We will not allow the budget bureaucrats to take it away just to feed the bottom line.

My friends, we've worked together in this House for a long, long time.

And I can tell you this is not a flight of "feel good" rhetoric for the post-reform 90s. It's not hypothetical. It's real. And it's happening in real time, right now.

I'm talking about a shift in the AMA's total mind set that can carry us—patients and profession—through in good health far into the 21st century.

About re-creating an AMA that is focused. Selective. Leaner. Knowing who we are—and who we are not. An AMA that is impact-oriented. Information-driven. On the leading edge when it makes sense.

But above all—connected—to our members and the world around us.

A change so powerful it literally changes the face of this House —so we reflect the face of our profession in the years to come.

And let me tell you this: The Board is looking at every aspect of the AMA, from the EVP office down, to the housekeeper's office up.

If I sound excited—it's because I am excited. Your whole Board is excited.

Because this is a new beginning—a real turning point in our history. The AMA is creating tools of change on your behalf and for your patients. Actively creating our new world of tomorrow based on what we truly believe, and the work we truly do.

And I'll tell you something else.

We don't plan to just talk the talk. This Board is going to walk the walk. And today I'm the first one out the door.

Starting today, your Board is going to start selling this message.

Buttonhole us in the halls. Bring it up in the reference committees. Ask us what you need to know. Tell us what you want us to know.

➤ *Continued on Page 397*

Medical School Hotline

Student Profile of the Class of 1998 at the John A. Burns School of Medicine

Satoru Izutsu, PhD
Associate Dean and
Chair, Admissions Committee

The Class of 1998, 26 men and 30 women, began their four years of medical education in August 1994. This class is the sixth group to undertake the medical education curriculum in the format of problem-based learning.

From a total of 1,730 applicants, 86% declared the Mainland or the Pacific Islands as their residence. A total of 229 were granted interviews.

The average age is 24 years with a median of 23 years. The spectrum of ethnicity found in Hawaii is represented with 16 Japanese, 11 Caucasians, 7 Hawaiians, 5 Filipinos, 5 Chinese, 4 Other Asians, 3 Koreans, 1 Chamorro, 1 Malaysian, 1 Maori, 1 Mexican-American, and 1 Vietnamese.

Sixty applicants qualified for eight slots designated as *Kulia*. *Kulia* is an affirmative-action program for underrepresented minorities, Hawaiians and Filipinos in Medicine, in Hawaii.

Twelve students had graduated from Punahou, 6 from Iolani, 4 from Mililani High School, 3 from Kamehameha, 2 each from Waiakea High School, JFK High School (Guam), Maui High School, and St Joseph's High School. There was one from each of the state's high schools, as well as 6 from Mainland high schools, one from a foreign country, and one with a Graduate Education Diploma.

Ninety-seven percent entered with Bachelor of Arts or Bachelor of Science degrees and eight hold Masters degrees. Of the colleges attended, more than one-fourth attended the University of Hawaii. Fifty-five percent attended public colleges and 45 percent came from private colleges. Sixteen majored in biology, 4 psychology, 3 engineering, 2 liberal studies, 2 chemistry, 2 physical therapy, and 2 zoology. Majors in Asian studies, public health, history, Japanese, pharmacy, speech, education and others made up the remainder. All have had experiences, either professionally or as volunteers, in the delivery of health care.

The Admissions Committee consists of 13 members who come from the school of medicine faculty, the community-at-large, and the undergraduate college. Members are appointed by the Dean and serve on staggered terms, two or three years. Seven of the members are women. The major ethnic groups in Hawaii are represented. The Committee meets September through May.

The documents presented to the Admissions Committee consist of the following for each applicants: Hawaii resident status; academic scores (Grade Point Averages and Scores from the Medical College Aptitude Test); interviews; essays that reply to the questions, "Why medicine?" and "Why the John A. Burns School of Medicine?"; letters of recommendation; and, a biographical sketch and transcripts from the American College Admission Service (AMCAS). The deadline for submission of all documents to AMCAS is December 1.

There are 61 interviewers from throughout the medical community, clinical and basic sciences. Interviewers attend training sessions at the beginning of each school year. Each applicant is responsible for scheduling the interviews.

Two demonstrations in Problem-based Learning are conducted annually by JABSOM. All applicants and interested students are urged to attend a session.

Each student is assigned a faculty adviser during the first orientation week. Students are closely monitored by the advisers throughout the four years and are encouraged to seek their assistance.

The members of the Class of 1998 are on their way to becoming physicians. They have been selected in the best way we know to ensure that the community will be served by men and women who will have had the benefits of a solid and respectable medical education.

HMA Council Highlights

November 4, 1994
Roger T. Kimura MD, Secretary

The HMA Council meeting was called to order by Dr Frederick C. Holschuh, President at 5:35 pm.

Present were: Drs F. Holschuh, President; C. Lehman, President-elect; R. Kimura, Secretary, J. Spangler, Treasurer, A. Don, C. Kam, A. Kunimoto, H.K.W. Chinn, E. Bade, M. Joshi, R. Goodale, T. Smith, T. Au, P. Chinn, W. Dang Jr, P. DeMare, R. Hollison, S. Hundahl, K. Thorburn, J. Betwee, M. Shirasu, B. Shitamoto, P. Kim, C. Kadooka, A. Bairos, W. Dang, G. Goto, J. Lumeng, W. Chang, J. McDonnell, S. Wallach, C. Goto; L. Nishi representing the HMA Alliance.

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

• Dr Holschuh informed Council: 1) that Dr Andrew Don is the chair of the Governor's Advisory Committee on QUEST and reminded them that any requests or concerns regarding QUEST can be forwarded to Drs Don or Holschuh. 2) The American Medical Association interim meeting will be held in Hawaii on December 4 to 7, and physicians are encouraged to participate in the reference committee hearings.

• Mrs. Lillian Nishi reported that the Alliance's goals for 1995 are to increase the HMAA's membership, to be active in legislative issues, and to raise funds.

Council Actions

• Approved the Membership Benefits Committee's recommendation to add Hawaii Auto Mart as an HMA membership benefit.

• Passed that HMA survey its members concerning the Med-QUEST program. The Executive Committee and staff will design the survey.

• Approved the Membership Benefits Committee's recommendation to take *no* further action on Resolution No 2, which proposed a new seat on the HMA Council for a representative from any association of multispecialty physicians having more than 100 members and to modify the bylaws to allow this action.

• Passed two motions about Nurse Prescriptive Authority: 1) That in the best interest of the patients supervision must be present or the formularies must be very limited. 2) That the HMA President write a letter to the Board of Medical Examiners or the Formulary Advisory Committee stating the need for supervision in the strongest language possible. It also will be suggested that minutes be taken at the formulary advisory meetings.

Component Society Reports

Honolulu.—Dr K. Thorburn reported that the HCMS inauguration of new officers will be held on November 18. Dr Danelo Canete will be the incoming President.

Hawaii.—Dr E. Bade reported that Hawaii County will be holding a meeting on November 17, and they will elect new officers.

Kauai.—Dr R. Goodale reported that Kauai County will meet in early December to elect new officers.

Maui.—Dr M. Joshi reported that Maui County had a meeting on November 3. He plans to host weekly discussions at his home regarding medical issues and to get more physician input.

West Hawaii.—Dr T. Smith reported that they will have a meeting on November 22 for the election of new officers and to discuss Medicare forms and regulations.

For Information

CME.—Dr DeMare reported that in September he had attended an ACCME meeting in Chicago. The ACCME (the governing body for CME in Hawaii and in other states) will make some changes. It will become a bigger organization and will retain more staff; there will be more rules and regulations for CME approval.

Nominations to AMA Council.—The HMA Executive Committee renominated Dr Stephen Wallach to the AMA Council on Legislation.

Inappropriate Use of DEA Number Resolution No 5: Dr H.K.W. Chinn reported that Resolution No 5 is already AMA policy. Council referred the resolution to the Legislative Committee as it needs to be introduced as legislation.

1994 Annual Meeting.—Dr M. Shirasu reported that the exhibitors were pleased with the format of the meeting, and it was an all-around success.

Long-term Care.—Dr P. Blanchette reported that she had attended a meeting on long-term care and future funding.

Project HOPE, a proposed State tax to fund long-term care services in Hawaii, was presented. This concept was not well received. The Japanese Chamber's Long-term Care Committee is working on an alternative proposal for financing long-term care; prior to any legislation, careful analysis of the implications of various financing options must be completed.

Harm Reduction Resolution No. 1.—Resolution No 1 was referred from the House of Delegates to the HMA Executive Committee, who referred the resolution to the Alcohol and Other Substance Abuse Committee. The committee is not scheduled to meet prior to the AMA House of Delegates in December, and it was recommended by AMA Delegate Calvin Kam MD that the Council approve a substitute resolution. This resolution would ask the AMA to study the issue of harm reduction and report its findings to the state medical societies. The substitute resolution has been submitted to the AMA.

HMSA Letter.—HMSA's annual letter regarding its fee increases has raised some concern. 1) One physician said that HMSA has unilaterally decided to change the contract; 2) In order to get their fees allowed by January 1, physicians would have to submit them before November 1 (HMSA requires a 60-day leeway). The HMSA letter has been referred to the HMA/HMSA Committee for review and a report to Council.

The meeting was adjourned by Dr Holschuh at 8:30 pm.

Transjugular Intrahepatic Portosystemic Shunt (TIPS): Treatment of Esophageal Variceal Bleeding

Lansdale D.C. Lau MD, Linda L. Wong MD, Naoky C.S. Tsai MD,*
Kevin N. Kon MD,* Livingston M.F. Wong MD

Management of esophageal variceal bleeding continues to be a difficult problem for the practicing physician. TIPS is an interventional radiologic procedure that involves creating a channel within the liver between the portal vein and the systemic circulation using an expandable metallic stent. Ten patients underwent TIPS at St Francis Medical Center and the technical success rate was 100%. Complications have been minimal. One patient has died from progressive hepatic failure and carcinoma, and 1 patient underwent liver transplantation. The remaining 8 patients have a patent TIPS in place and have not rebled.

Introduction

Ideal management of acute variceal bleeding in the 1990s requires a closely coordinated effort between the primary care physician, gastroenterologist/hepatologist, surgeon, and interventional radiologist. All patients with suspected acute variceal bleeding should be managed in the intensive care unit with adequately trained nursing personnel. The latter play a critical but often unappreciated role in the minute-to-minute patient management. The goals of this team effort are to achieve hemodynamic stability, to prevent and treat complications, and to control bleeding. All 3 goals must be addressed simultaneously and within hours of the patient's admission.

Major causes of early mortality from these bleeding episodes include aspiration pneumonia, renal failure (from hypovolemia), encephalopathy, sepsis and multi-organ system failure. These complications can be managed by aggressive fluid resuscitation, correction of coagulation defects, lactulose, gut bacterial decontamination with broad-spectrum, non-absorbable antibiotics, and nutritional support.

There have been many modalities used to control bleeding, such as vasopressin/somatostatin infusion, balloon tamponade, endoscopic sclerotherapy (EST), endoscopic band ligation, surgical portosystemic shunts, and esophageal transection. In recent years, EST has emerged as the treatment of choice to achieve hemostasis acutely and prophylactically. Notwithstanding all efforts, end-stage liver disease still has a dismal 5-year survival rate. The natural history of variceal bleeding is such that 50% to 60% of all bleeding will stop no matter what therapy is used.[1] About 20% to 30% of variceal hemorrhages will be massive and may result in death.[1-3] Furthermore, less than 40% of these patients will be alive one year after their first variceal bleed.[1,4] The ultimate treatment, and the only one that also will eliminate the underlying liver disease, is liver transplantation; the scarcity of donors, however, limits its widespread use.

We now add TIPS to our list of treatment alternatives. TIPS is an interventional radiologic procedure that creates an artificial shunt through the liver parenchyma from the portal vein to the systemic circulation with the use of an expandable metal stent.[5] It is essentially a side-to-side portocaval shunt without the morbidity and mortality of a surgical procedure.

Methods and Materials

This study is a retrospective review of the early cases of transjugular intrahepatic portosystemic shunts performed at St Francis Medical Center. Patients were referred from throughout Hawaii and Guam for assistance in management of esophageal variceal bleeding.

All patients underwent extensive evaluation with laboratory data to include assessment of renal function, liver function, coagulation parameters, and ammonia level. Esophagogastroduodenoscopy had been performed on all patients either at St Francis or by referring gastroenterologists to confirm the presence of esophagogastric varices. All patients underwent abdominal ultrasound with Doppler to assess patency of the hepatic and portal venous systems and the status of the liver.

Prior to TIPS, all patients received intravenous hydration and prophylactic antibiotics with cefoxitin. TIPS was performed in the special procedures room of the radiology department, and an anesthesiologist was present to monitor the patient and provide intravenous sedation.

The technique as described by Dr Ernest Ring at the University of California at San Francisco was used.[6] A jugular vein puncture was performed and a catheter and guide wire were advanced through the superior vena cava. An initial pre-TIPS inferior vena cava pressure was obtained. The right or middle hepatic vein was then catheterized, and a 16-gauge Colapinto needle was passed from the hepatic vein into the right or left portal vein. A guide wire and catheter then were advanced into the main portal vein, a pre-TIPS portal vein pressure was obtained, and the pre-TIPS portal vein-IVC gradient was calculated. A portal venogram was performed to confirm correct placement and to assess anatomy and visualize esophageal varices. The parenchymal tract between the hepatic and portal veins was dilated with an angioplasty balloon. A metallic stent then was placed in the tract, a post-TIPS

Departments of Surgery and *Medicine
University of Hawaii, John A. Burns School of Medicine
and St Francis Medical Center

Send reprint requests to: Linda L. Wong MD
1329 Lusitana Street, Suite 709
Honolulu, Hawaii 96813

portal vein-IVC gradient was obtained and a portal venogram was repeated to assess the shunt. Esophageal varices were embolized with stainless steel coils if significant flow in the varices persisted after stent placement.

Patients were observed post-TIPS for procedural complications, evidence of encephalopathy, progressive liver failure, or recurrence of bleeding. Following TIPS, abdominal ultrasound with Doppler was performed every 3 months for the first year to assess velocity across the TIPS and direction of flow within the portal vein.

Results

Ten patients underwent transjugular intrahepatic portosystemic shunt at St Francis Medical Center during the 11-month period between March 15, 1993 to February 15, 1994. Of these 3 women and 7 men, the mean age was 48.4 years (range 38 to 73 years). The etiology of liver failure included alcoholic cirrhosis in 6 patients, and 1 patient for each of the following: Cryptogenic cirrhosis, hepatitis C, hepatitis B/hepatoma, and hepatitis C/ alcoholic cirrhosis. All 10 patients had esophageal variceal bleeding, and 1 patient also had severe ascites which was refractory to medical management. These patients had 2 to 4 episodes of variceal bleeding, and 6 patients had multiple sclerotherapy sessions. Six patients were actively bleeding within 1 week prior to TIPS, and 1 patient was bleeding in the 24 hours prior to the procedure.

TIPS was performed by a single interventional radiologist (LL) and the technical success rate was 100%.There was technical difficulty in 1 patient who required 2 sessions to complete the TIPS. In this particular case, the portal vein could not be located; a portal venogram via a superior mesenteric artery injection was performed to identify the course of the portal vein, and the TIPS was then successfully performed. The mean portal vein-inferior vena cava gradient was 21.9 mm Hg pre-TIPS and 10.3 mm Hg post-TIPS. All procedures were accomplished under local anesthesia with intravenous sedation. The mean procedure length was 2.7 hours (range 1.3 to 4.0 hours).

All patients remained in the intensive care unit or the post-anesthesia recovery room for a 24-hour period following TIPS. The mean hospital stay following TIPS was 4 days (3 to 5 days). The only procedural complication was a pneumothorax, which was successfully managed with tube thoracostomy.

Patients have been followed for 12 months post-TIPS. One patient died as a result of progressive liver failure and hepatocellular carcinoma 2 months following TIPS. One patient underwent a successful liver transplant 228 days following TIPS. The shunt was noted to be patent in his explanted liver. Of the 8 remaining cases, 1 patient developed a stenosis of the draining hepatic vein at 2 months. This was manifested by recurrent ascites and hydrothorax which had been initially controlled with the TIPS. The stenosis was successfully restented, and this patient currently is doing well. In this series of patients, the primary shunt patency rate is 90% and the secondary patency rate is 100%. One patient demonstrated clinical evidence of encephalopathy, which was controlled with lactulose. This patient had mild encephalopathy prior to TIPS. The mean ammonia pre-TIPS was 39.7 μmol/L and in the peri-procedure period this increased to a mean of 81.4 μmol/L. Three patients are currently on lactulose for an elevated ammonia, but none of these patients has clinical symptoms of encephalopathy. One patient had a significant rise in AST from 37 IU/L to 1104 IU/L (this patient suffered no consequences and his AST has since returned to normal), otherwise there was no significant change in bilirubin, AST, protime, or alkaline phosphatase in any of the remaining patients during the immediate post-procedure period. No patient has had recurrence of variceal hemorrhage.

Discussion

The first human intrahepatic portosystemic shunts were done in the early 1980s by Colapinto et al, who created a tract in the liver using a balloon catheter. These channels generally occluded within 30 days because of the elasticity of the liver parenchyma.[7] The first successful TIPS in a human was performed in Germany in 1988 by Richter et al using an expandable metallic stent devised by Palmaz.[8] Since this first shunt, the procedure has been widely accepted in both the academic and community settings.

There is a growing body of data now available in the literature reporting efficacy and short-term follow-up.[6,9-14] The largest published series are by LaBerge et al[6] and Roessle et al,[11] both with 100 patients. Although randomized, double-blind studies comparing TIPS with other forms of therapy are not available, some reproducible results have been reported and preliminary conclusions can be drawn.

TIPS has been performed on patients with cirrhosis of all etiologies, the most common being Laennec's cirrhosis. Patients of all Child's classes have been included. Liver function tests are usually abnormal. Patients aged 5 years to 84 years have been treated, with men treated more frequently than women.[6,9-14]

The most common indication has been recurrent bleeding esophageal varices, refractory to endoscopic sclerotherapy. Additional indications include acute variceal bleeding not responsive to sclerotherapy or due to gastric or ectopic varices, and ascites refractory to medical therapy.[6,9-11,13-15]

Early studies reported technical success rates of 75%,[16-17] but more recently, because of the refinement of the technique, this has improved to 90% to 100%.[6,10-11,14-15,18-20]

TIPS has been shown to be effective in controlling variceal bleeding in 86% to 100% of cases and in decreasing ascites in 70% to 100% of cases.[6,9-15] After creation of the shunt, portal blood flow has been shown by Doppler sonography to increase by 250%.[11] A reduction of the portal-systemic gradient by 50% to 75% usually is achieved [9,11,15] Portal venography performed during the procedure usually shows immediate decompression of esophageal varices.[6] Endoscopy performed within a month of the procedure has confirmed resolution of the varices in almost all cases.[21]

Improvement of the ascites occurs rapidly over the days following the procedure; increased renal blood flow results in increased urine volume, improved creatinine clearance, and natriuresis.[22] These findings also explain improved renal function in some TIPS patients with renal insufficiency.[23]

The incidence of complications directly related to the procedure is less than 5%; these include complications of placing a central venous catheter (pneumothorax, hemothorax, neck hematoma), fever, stent migration, bleeding (hemoperitoneum, liver hematoma, hemobilia), hepatic artery injury, bile duct injury, renal failure, and respiratory failure.[6,11,24]

Long-term complications seen with portacaval shunts also can be seen with TIPS, since TIPS is essentially a side-to-side portacaval shunt without an incision. Progressive liver failure can occur because blood flow is diverted from the hepatocytes.

LaBerge et al[6] had a 9% mortality from progressive liver failure because a large number of their patients had severe (Child's C) cirrhosis. On the other hand, Roessle et al, who had fewer Child's C patients, had no deaths from progressive liver failure.[11] Both authors describe asymptomatic transient elevations in liver functions in some of their patients.

Progressive liver failure also can be manifested as new onset or worsening of hepatic encephalopathy. This has been a major problem with surgical portacaval shunts.[25] The incidence in TIPS patients appears to be 15% to 30%. The encephalopathy is usually not severe and is usually well-controlled with lactulose.[5,6,20,26-29]

Long-term shunt patency poses a major question. The best available data is 3 year follow-up by LaBerge et al (80% primary patency and 100% secondary patency) and Roessle et al (67% primary patency and 100% secondary patency).[11,30] Other investigators with shorter follow-up of 12 to 18 months have reported primary patency of 17% to 82% and secondary patency of 83% to 97%.[12-13] Thus, the best estimate at this time, based on the above data, is that up to 33% of these shunts will fail in 3 years.

These authors also have shown, however, that failed shunts due to stenosis or occlusion usually can be reopened through a transjugular approach, resulting in secondary patency rates approaching 100%. In order to detect shunt stenosis before shunt failure and rebleeding occurs, Doppler sonography now is being used.[32-33] A strategy of close surveillance and early reintervention may be the answer to long-term patency.

Current research is also focusing on the biochemical and cellular processes that control the response of blood elements and the vessel wall to the metallic stent. Stents coated with heparin and other materials are being studied in experimental models.[34]

The results of TIPS in the first patients at our center have been encouraging and are comparable to those reported in the literature. So far, we have achieved 100% technical success and have had no recurrent bleeding. One shunt stenosis, manifested by recurrent ascites, was successfully restented and complications have been few. Long-term patency rates and changes in hepatic synthetic function will need to be observed closely. Like other centers, a number of our patients will undergo liver transplantation. In these patients, TIPS will have served as a valuable bridge to transplantation, preventing life-threatening variceal hemorrhage before an appropriate donor organ becomes available.

Summary

The management of bleeding esophageal varices continues to be one of the greatest challenges for the practicing physician. Recent advances in endoscopic techniques, pharmacologic intervention, surgical decompression procedures and liver transplantation have resulted in a more hopeful outlook for patients with this problem. TIPS has now been added to the list of possible therapies. Despite impressive short-term results, more data, including controlled clinical trials comparing TIPS with standard treatment options, are needed to determine relative long-term patency, efficacy, and overall survival. Notwithstanding, TIPS has become widely used in the treatment of bleeding esophageal varices because of its relative noninvasiveness, safety, and excellent short-term results. Its future, although uncertain, is promising.

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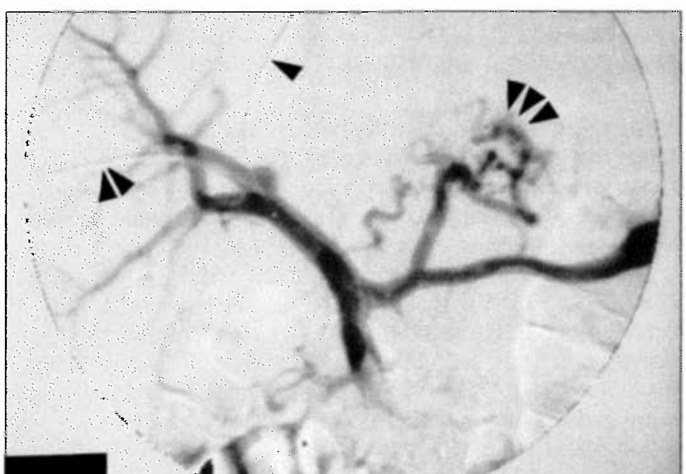

Fig 1.—Contrast radiograph showing TIPS catheter (single arrowhead) running from hepatic to portal vein, a percutaneous catheter (double arrowhead) within the portal vein, and esophageal varices (triple arrowheads).

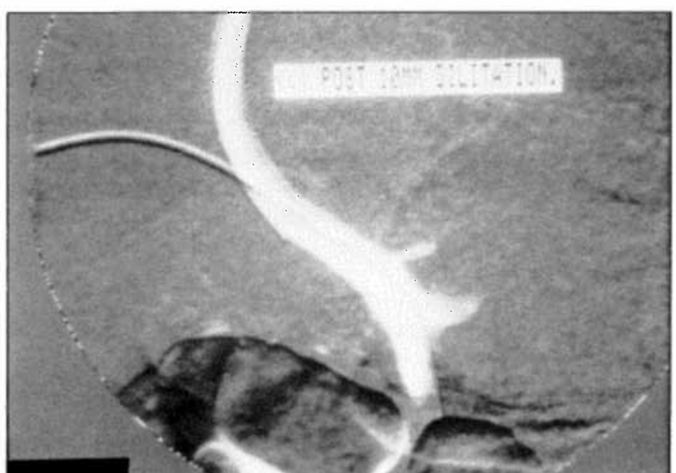

Fig 2.—Radiograph showing contrast flowing through newly created shunt running from portal to hepatic vein.

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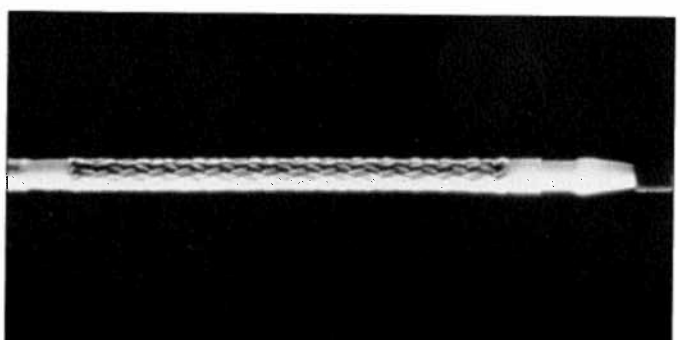

Fig 3.—Stent used in TIPS, closed position.

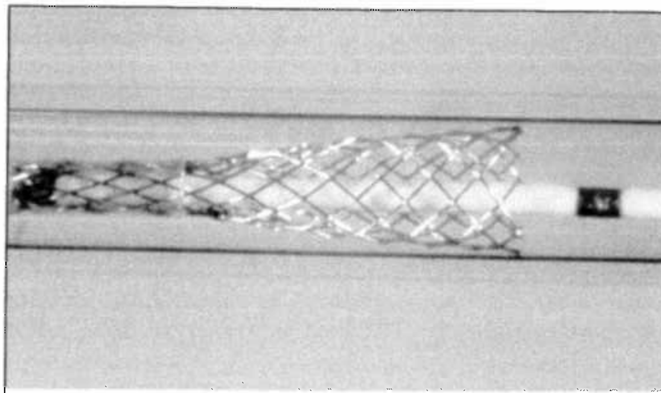

Fig 4.—Same stent expanded as it is used.

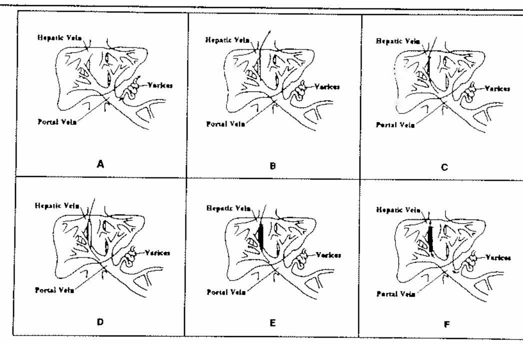

Fig 5.—TIPS. Entering hepatic vein, catheterize the portal vein by traveling through liver parenchyma (B). Guidewire is shown in C; subsequent dilation of tract with balloon (D). Stent is placed and further dilated if necessary (E). After removing catheters, a newly created portal systemic shunt (F).

Fig 6.—Oblique cut through excised liver from patient 2 (liver transplantation) showing patent shunt running through liver parenchyma. (Courtesy Department of Pathology, St Francis Medical Center.)

Fig 7.—Close-up view of Fig 6 displaying the stent within the shunt created via TIPS procedure. (Courtesy Department of Pathology, St Francis Medical Center.)

Organizational Response to Adolescent HIV Risk

Charles Mueller PhD,* Eberhard Mann MD,* Robert Bidwell MD,* Edward Liebow PhD,** Richard Lovely PhD,** Gene McGrady MD,† Mildred Vera PhD††

Using semi-structured interviews, the present study examined organizational responses to adolescent HIV risk in an urban Honolulu community. All 23 health, social service, and educational organizations studied have been impacted by HIV. However, the overall organizational response has been compartmentalized and limited. Recommendations concerning improved organizational responses are provided.

Introduction

The response of public and private health, educational, and social service organizations toward adolescent HIV infection and its prevention has been slow for several reasons.

First, the small number of actual AIDS cases among teenagers (less than 1% of the total AIDS population nationwide as well as in Hawaii) has obscured the true infection rate and thus diminished a sense of urgency. However, with an average latency period of 10 years from infection to illness manifestation, AIDS data on adolescents can be collected only from adults in their 20s. This group constitutes a rapidly rising 19% of the total AIDS population and about 16% of its members are women.[1]

Second, the Centers for Disease Control has collected separate data on adolescent AIDS only for the last 5 years. Teens are the least researched group within the HIV population, and information on the course of illness, response to medication, and service utilization is much less well known than for the adult or pediatric age groups.

Third, affected teens are the age group most difficult to reach. Disenfranchised, ethnic minority, and gay youths are overrepresented in the HIV-infection spectrum, but health services are even less available to *marginalized* than to mainstream youths. Constraints on agencies related to consent and confidentiality policies and confusion as to whether confidentiality policies for sexually transmitted diseases (STDs) apply to HIV further complicate service delivery.

Fourth, unrelenting controversy about the content and methods of AIDS education has hampered the development of effective prevention strategies directed toward young people.

Finally, evidence suggests that physician-adolescent contacts are too short or infrequent and lack routine sexuality and drug-use history-taking and counseling to allow for a meaningful role in adolescents' lives related to HIV prevention.[2-4] Furthermore, a 1991 sample survey of Oahu tenth graders found that half reported having no personal physician.[5]

Only scant information is available in the U.S. and in Hawaii on the scope and quality of HIV services developed by new or existing community organizations in regard to adolescent AIDS. The extent to which HIV programs reach and influence youths is unclear.

As part of a larger NIMH-funded study on social networks of young ethnic-minority adolescents (ages 12 to 15) living in high-risk settings in Puerto Rico, Atlanta, Seattle, and Honolulu, the Hawaii research team conducted an exploratory survey of the organization of HIV services provided to Kalihi-Palama youths. The type and quality of responses to HIV by health and other community service organizations and their inter-organizational environment were assessed. We focused on 12 to 15 year-olds because this group has been studied the least and yet represents the age at which the incidence of unprotected sexual behavior and substance abuse remains fairly low, while by ages 16 to 18 most of these youths will be engaging in high-risk behavior, and interventions may be too late.

Methods

Through an open-ended interview and a review of organizational documents, one or more key informants from 23 agencies provided information about their general mission, goals, and services; provision of HIV-specific services; the institution's formal and informal conceptualization of HIV infection risk for 12 to 15 year-old youths; and the staff's perception of the effectiveness of their programs. All agencies resided in or served youths for a specific urban Honolulu neighborhood, Kalihi-Palama.

Organizations were selected by using a mix of an a priori fixed list and snowballing approach, where interviewees could suggest other organizations for additional interviews. Agencies included health clinics, social service agencies with youth programs, agencies with services for specific ethnic groups, HIV-specific agencies, and private and public schools.

All interviews were conducted between January 1992 and December 1993. Oral and written materials were reviewed and summarized. Data analysis included qualitative and quantitative approaches. The qualitative analysis focused on organizational responses to HIV, organizational perceptions of HIV risk in the target population, and organizational perceptions of effectiveness of HIV services.

*University of Hawaii
**Battelle Seattle Research Center
†Morehouse School of Medicine
††University of Puerto Rico

Address reprint requests to:
Charles W. Mueller PhD
University of Hawaii
School of Social Work
2500 Campus Road
Honolulu, Hawaii 96822

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The quantitative analysis identified organizational characteristics of overall responsiveness to HIV services to young teens. Here, 2 judges read the interview materials and independently rated each agency along a number of dimensions. The major dependent variable consisted of a 6-point scale describing the agency's overall response to HIV services for young teenagers, ranging from no response (1) to direct, proactive, and effective response (6).

Results

Data from 23 agencies were available for analysis: 5 agencies primarily engaged in health care delivery, 14 social service agencies, 3 HIV-related school education programs, and 1 agency providing primarily HIV education and HIV-specific support services. Except for the latter, all agencies had been established prior to the AIDS epidemic. All had added or incorporated some form of HIV services into existing programs without changing or adjusting their general program mission or overall goals, except when funding demanded some specific HIV intervention. For example, an ethnically focused service agency provided HIV brochures in native languages to immigrants. Staff training in HIV issues was provided generally through sporadic in-service lectures, but rarely was extra staff hired to organize or coordinate HIV-related programs. Instead, staff was diverted from other ongoing programs. The intensity of agency involvement, in the absence of written curricula or program guidelines, largely depended on the designated staff members' own initiative.

The dilution of personnel resources without clearly defined goals often led to conflicting priorities within agencies and contributed to a lack of staff confidence in their own expertise. Furthermore, in the absence of clear policy statements and guidelines in many organizations, everyday staff provided HIV education and service at their personal discretion.

Many staff members from social service agencies voiced discomfort in discussing sexual issues with teens. For many, sex and HIV education were considered "health issues" that could be handled better elsewhere—for example, in schools where teaching HIV-related subjects is mandatory, or in health care settings. Sometimes, cultural sensitivities and embarrassment played a role in avoiding sexual topics considered deeply private, particularly among Asian/Pacific Islanders.

With the exception of public school programs and one health agency, all organizations were privately funded or volunteer based. The majority had public fund support for other components of their programs. We found that the type of funding had little influence on the creation of HIV-related services unless a specific mandate was given. This was a rare occurrence.

All agencies recognized a need for HIV prevention services. Community youths were perceived to be at risk for infection primarily through sexual behavior; injection drug use was uniformly considered rare and not of great significance. Compared with other compelling social, educational, and psychological needs, however, HIV risk *in itself* was not seen as a high priority, but "just one of many problems."

Table 1.—HIV Responsiveness Scores as a Function of Agency Type

Agency Type	n	Mean	Standard Deviation
Health	5	4.20_b	.45
Social Services	14	2.25_a	1.25
School	3	3.83_{ab}	.76

Note.—Means with different subscripts are significantly different, $p < .05$ with Bonferroni correction. Higher scores indicate greater responsiveness.

Overall responsiveness of programs to the HIV challenge was independently assessed by 2 raters. Interrater reliability was .78. When scores disagreed, the arithmetic mean between the 2 ratings was taken. These average responsiveness ratings were then subjected to a one-way analysis of variance comparing health, social service, and education agencies (scores from the one HIV organization were eliminated for this analysis). A significant overall effect, $F(2,19) = 7.22$, $p < .01$, and subsequent least significant difference tests (with Bonferroni correction) indicated that the community health clinics were rated higher than the social service agencies in the vigor of their response to HIV (Table 1). However, these health clinics functioned primarily in a tertiary prevention mode with limited outreach efforts. Aside from providing medical services, many health clinics offered information, protective devices (eg, condoms), and HIV testing and counseling to their adolescent patients on request. The total number of teens reached was low, both because of the individualized nature of the service and the fact that few teens, especially 12 to 15 year olds, use health services or initiate requests for HIV information or services on their own.

HIV-related programs by youth social service agencies or schools often were restricted to providing basic HIV/AIDS information by handing out brochures, giving sporadic talks, or answering specific questions when teens asked—a rather infrequent event. While protection through condoms was usually discussed, only a few agencies made them available to sexually active teens. HIV prevention programs specifically directed toward young teens were not available except in school educational programs, and services for gay youths were nonexistent.[6]

No agency in the survey had a formal protocol for evaluating the effectiveness of its HIV-related interventions. Informal assessments were restricted to subjective impressions by staff with a general consensus that improved knowledge about HIV seemed unlikely to change teen behavior. The adolescents' own perceptions about the usefulness of HIV-related services was unknown. Generally, well-established interagency relationships did not seem to extend to HIV services.

Discussion

The results of this survey indicated a poorly integrated, fragmented, and insufficient response to HIV by community organizations designated to service youths in this urban community. Most interventions consisted of attempts at education through occasional lectures or handouts of printed brochures. Social skills training to negotiate safer sex practices or teaching the use of and providing access to protective devices (condoms) was rare. With the exception of the school programs, the number of adolescents reached was small, and they were usually served for reasons other than HIV prevention.

While research on organizational responses to the AIDS epidemic has been scarce, it describes a limited, inconsistent reaction by the majority of agencies throughout the U.S.[7-8] Our data reflect a similar picture in our target community. At the time of our study, agencies that attempted to incorporate HIV ser-

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Bone Mineral Content in Hawaiian, Asian, and Filipino Children

Marcella K. Nowack MS,* Shawna Brizzolara MD,*
David A. Lally PhD**

Os calcis bone mineral content (BMC) was measured by single photon absorptiometry in 86 children, ages 6 to 13 years from Hawaiian, Oriental, Caucasian, and Filipino ethnic groups. Pearson correlations indicated significant positive correlations between BMC and age, height, and weight. However, there were no significant differences in age, height or weight between ethnic groups. ANOVA revealed a significant effect of ethnic group on BMC with the Hawaiian group having a significantly higher BMC than the Asian or Caucasian groups. When age, height and weight were controlled for, ANCOVA still showed a significant effect of ethnicity on BMC. The current findings suggest that ethnic differences can develop early in life.

Introduction

Adolescence is a crucial time for the development of bone mass. Rapid increases in skeletal mineral are necessary to support increased body weight, muscle mass, and muscle strength. Previous studies of adults have identified many factors that influence bone mineral status including ethnic group, sex, exercise, and nutrition. Current data now indicates that similar factors also affect the skeletal development of children. Li et al found black children 1 to 6 years of age had a higher mean bone mineral content (BMC) than white children.[1] In another study, Bell and co-workers found that bone mineral density was greater in black than in white children between the ages of 7 and 12 years.[2] Contrary to these findings, a study by Gilsanz et al reported that vertebral bone density did not differ between black girls and white girls before puberty.[3] Most studies have compared bone mass in white and black subjects but have neglected to assess peoples of the Pacific. Hawaii encompasses many different ethnic groups including Hawaiians, Asians, Caucasians, and Filipinos. We studied the os calcis bone mineral content in children from these ethnic groups to determine whether the inter-ethnic differences found in other populations also occur between these groups.

University of Hawaii
*Department of Obstetrics and Gynecology and
**Department of Biomedical Sciences
1319 Punahou Street, Suite 833
Honolulu, Hawaii 96826
(808) 956-6439

Address reprint requests to:
Marcie K. Nowack
John A. Burns School of Medicine
Department of Obstetrics and Gynecology
University of Hawaii
1319 Punahou Street, Suite 833
Honolulu, Hawaii 96826

Materials and Methods

A group of 44 boys and 42 girls between the ages of 6 and 13 years was studied. The subjects were recruited at a children's fitness fair sponsored by the University of Hawaii John A. Burns School of Medicine and consisted of Hawaiian, Asian, Filipino, and Caucasian ethnic groups. Height and weight of each subject was measured at the time of the bone test. Each subject completed a questionnaire regarding basic physical characteristics, medication and vitamin use, exercise and calcium intake. Because of the vast array of mixed ethnic groups in Hawaii, the parents of each subject were asked to categorize their child into one of 4 ethnic groups based on their genetic dominance. The Hawaiian group included subjects of Polynesian descent, and the Asian group included Japanese, Chinese, and Korean subjects. BMC of the dominant os calcis was measured by single-photon absorptiometry with a Siemens OsteoAnalyzer Model Number SPSHA110.[4] All measurements were made by the same technician. The OsteoAnalyzer was standardized with a known phantom before the testing was performed. Because the data were obtained in a public health fair, it was not appropriate to ask the girls about the onset of menarche.

The data were analyzed using the SPSS statistical package. The procedures used were primarily analysis of variance (ANOVA) and analysis of co-variance (ANCOVA), Pearson correlation and partial correlation. All tests of significance reported employed two-tailed p values.

Table 1.—Age and Physical Characteristics of Subjects

Group	Age	Height (in)	Weight (lb)
Hawaiian (26)	9.5 ± 1.8	55 ± 5.1	80 ± 30
Asian (42)	9.1 ± 2.0	53 ± 5.0	72 ± 29
Caucasian (11)	8.5 ± 1.6	54 ± 3.8	71 ± 17
Filipino (6)	8.7 ± 1.2	54 ± 3.5	68 ± 19

Note. Analysis of variance showed no significant differences in age, height, or weight between ethnic groups ($F < 1.8$ and $p > .150$ for all).

Group	Age	Height (in)	Weight (lb)
Boys (44)	9.2 ± 2.0	54 ± 5.0	78 ± 33
Girls (42)	9.0 ± 1.7	53 ± 4.7	70 ± 21

Note. Analysis of variance showed no significant differences in age, height, or weight between the boys and girls groups ($F < 1.9$ and $p > .176$ for all).

*Values represent the means and standard deviations of the mean.

Results

Age and mean physical characteristics of the subjects are listed in Table 1. All tables contain the mean and standard deviation of the mean. Age, height, and weight did not differ by ethnic group ($p = 0.5$, 0.14, and 0.6, respectively) or by sex ($p = 0.6$, 0.9, and 0.2, respectively). Pearson correlations on all the children indicated significant positive correlations between bone mineral content (BMC) and age ($r = .53$), height ($r = .70$), and weight ($r = .69$) $p < .001$ for all (Table 4). BMC and calcium intake were not significantly correlated. Results of mean BMC measurements for each ethnic group are given in Table 2. Analysis of variance indicated a significant effect of ethnic group on BMC ($F = 3.76$, $p = .014$). Duncan multiple range test showed that the BMC of the Hawaiian group was significantly higher than that of the Asian and Caucasian groups. Results of the effect of ethnicity and age on BMC is shown in Table 3. Analysis of co-variance in all children showed that when age, height, and weight were controlled for independently, there was still a significant effect of ethnic group on BMC ($p < .045$ for each case).

Discussion

The results of this study suggest that BMC at the os calcis is higher in Hawaiian children than in Asian, Caucasian, and possibly Filipino children. (Because of a low representation of Filipino subjects in this study, the data pertaining to this ethnic group are weak.) The magnitude of the BMC difference found between these ethnic groups is similar to comparisons of black and white children.[5-8] Bell et al studied black and white children between the ages of 7 and 12 years and their data suggested the bone mineral density of the midradius, spine, and hip were greater in black than in white children. They also found body weight and age to be important determinants of bone mass and some influence of sex differences at this age.[5] Our study indicates similar findings with significant positive correlations between BMC and age, height, and weight. However, these variables did not differ by ethnic group (Table 1), and we still found a significant effect of ethnicity on BMC (Table 2). Using analysis of co-variance and controlling for weight and age, ethnic group still has a significant effect on BMC ($F = 4.50$ and 3.71 respectively, $p < .015$ for both), indicating that the difference in BMC between ethnic groups is not caused by weight or age. When height is controlled for, there is a decrease in the F value to 2.81 ($p = .045$), suggesting that part of the effect of ethnicity is due to height; however, there is still a significant part of the effect of ethnicity on BMC that is unexplained by any other variable. Our current findings suggest an ethnic difference in BMC independent of body weight, height, or age. As shown in Table 2, when the boys and the girls from each ethnic group were analyzed separately, ethnic group was marginally significant among the girls ($F = 2.73$, $p = .057$) and nonsignificant for the boys ($F = 1.75$, $p = .172$). We have no clear explanation for why there was an ethnic difference in the girls and not the boys. One suggestion may be that boys tend to be more active and

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Table 2.—Os Calcis Mean Bone Mineral Content Levels (mg/cm2)

	Boys	Girls	Total
Hawaiian	318 ± 58 (14)	345 ± 82 (12)	330 ± 70 (26)
Asian	283 ± 54 (22)	278 ± 60 (20)	281 ± 56 (42)
Caucasian	283 ± 42 (6)	286 ± 70 (6)	284 ± 55 (12)
Filipino	360 (1)	275 ± 41 (5)	289 ± 50 (6)
Total	297 ± 56 (44)	296 ± 70 (42)	296 ± 63 (86)

Analysis of variance showed a significant difference in BMC between ethnic groups ($F = 3.80$, $p = .014$) with the Hawaiian group having a significantly higher BMC than the Asian and Caucasian groups. When only the girls were analyzed, ANOVA was still significant ($F = 2.73$, $p = .057$) with the Hawaiian girls being higher than the Asian; however, no significant differences were found in BMC between ethnic groups of boys ($F = 1.75$, $p = .172$). Analysis of variance showed no gender difference in BMC with these subjects ($p = .96$).
Values represent the means and standard deviations of the mean.

Table 3.—Effects of Ethnicity and Age on Bone Mineral Content in Normal Children

	BMC (mg/cm2) at Age 6 to 7	8 to 9	10 to 11	12 to 13
Hawaiian	275 ± 38 (4)	317 ± 31 (9)	336 ± 83 (9)	425 ± 66 (3)
Asian	251 ± 42 (8)	267 ± 45 (17)	300 ± 64 (8)	319 ± 63 (8)
Caucasian	238 ± 39 (2)	256 ± 38 (5)	331 ± 43 (5)	
Filipino	317 (1)	252 ± 35 (3)	332 ± 41 (2)	
Total	260 ± 41 (15)	277 ± 45 (34)	323 ± 65 (24)	347 ± 78 (11)

Analysis of variance showed significant ethnic differences in BMC in the 8 to 9 year olds and 12 to 13 year old age groups ($F = 4.22$ and 6.06, respectively, $p < .03$ for both) with the Hawaiian group having a higher BMC level. As expected, analysis of variance also showed a significant difference in BMC between age groups ($F = 8.23$, $p < .001$).

Values represent the means and standard deviations of the mean.

Table 4.—Ethnic Group Bone Mineral Content by Age, Height, and Weight

Bone Mineral Content	Weight	Height	Age
Whole Population	.692 83 p = .000	.701 84 p = .000	.534 84 p = .000
Hawaiian	.762 25 p = .000	.711 25 p = .000	.526 25 p = .003
Asian	.633 41 p = .000	.641 41 p = .000	.521 41 p = .000
Caucasian	.816 12 p = .001	.726 12 p = .006	.613 12 p = .023
Filipino	.840 6 p = .018	.824 6 p = .022	.460 6 p = .180

Medicaid Recipients and Psychiatric Treatment

Wallace K.C. Chun MD
Department of Human Services, Med-QUEST Division

This is the third article published in HMJ with the same title. The first was published in June 1989[1] and the second in June 1992.[2] Both outpatients and inpatients on all islands were discussed in the previous 2 articles; this article will discuss only inpatients on the island of Oahu. The inpatient data in the previous articles covered all psychiatric admissions to hospitals on all islands; this article will cover only Medicaid recipients admitted to psychiatric wards in Oahu hospitals. The data from 2,500 inpatients were analyzed in each of the previous articles; this will analyze the data from 1,060 inpatients. The data were collected over an 18-month period from September 1992 to February 1994.

Patients and Methods

Patients

Unlike the previous reports, the data on inpatients are confined to Medicaid recipients who were admitted to the psychiatric inpatient units at The Queen's and Castle Medical Centers on Oahu.

Methods

In the previous reports, the data on inpatients were obtained from Medicaid Form 1144, which hospitals are required to submit for all Medicaid psychiatric admissions. In this report, the medical records, as well as other reports of patients admitted to the psychiatric units at Queen's and Castle, were reviewed to determine if they were Medicaid recipients at the time of admission.

Results

Although the data in all the reports were collected over 18 months, the number of admissions was fewer in this report because only Medicaid recipients were counted. The number of admissions to Castle was greater than Queen's (554 versus 506). This may not be an accurate reflection of the numbers of Medicaid patients admitted to the two facilities, because some of the admissions to Queen's were Medicaid recipients who were not identified as such at the time of admission. It is estimated that if an accurate recount of Medicaid admissions at Queen's were made, the number of patients admitted to both facilities would be nearly equal.

The distribution of patients by diagnosis and sex is nearly the same in all 3 reports with one exception: The diagnosis of substance abuse. It appears that the number of substance abusers who were admitted had increased significantly, but the apparent increase is probably an artifact. In the 2 previous reports, substance abusers were given the diagnosis of depression because Medicaid did not pay if the primary diagnosis was substance abuse. In this report, substance abusers were dually diagnosed as depression/substance abuse, and these admissions were identified as substance abusers instead of as depressives.

Table 1.—Distribution by Hospital, Diagnosis, and Sex

	Queen's			Castle			Totals		
Dx	Men	Women	STot	Men	Women	STot	Men	Women	GTOT
SCH	105	69	174	71	62	133	176	131	307
DEP	60	59	119	58	65	123	118	124	242
DYS	1	3	4	0	1	1	1	4	5
BIP	21	36	57	10	20	30	31	56	87
ALC	7	8	15	40	19	59	47	27	74
SUB	19	15	34	99	46	145	118	61	179
OBS	16	12	28	4	0	4	20	12	32
OTHER	32	43	75	22	37	59	54	80	134
TOTALS	**261**	**245**	**506**	**304**	**250**	**554**	**565**	**495**	**1060**

DX = Diagnosis; SCH = Schizophrenia; DEP = Depression; DYS = Dysthymia; BIP = Bipolar; ALC = Alcohol; SUB = Substance abuse; OBS = Organic brain syndrome; STot = Subtotal; GTot = Grand total

Table 2.—Percentage of Admissions—Distribution by Diagnosis and Year

Diagnosis	1987	1990	1993
SCHIZOPHRENIA	30	29	29
DEPRESSION	16	25	23
DYSTHYMIA	13	2	<1
BIPOLAR	10	11	9
ALCOHOL	6	4	7
SUBSTANCE ABUSE	3	8	17
ORGANIC BRAIN SYNDROME	2	1	3
OTHER	19	20	13

For the diagnoses of alcohol and substance abuse, Castle admitted 4 times the number that Queen's admitted because Castle has an alcoholism and addictions program and Queen's does not.

The distribution of patients by the number of admissions is different in this report. In the first 2 reports, about three-fourths of the patients (1,927 or 77%, and 1874 or 75%) had only one admission. In this report, about three-fifths of the patients (654 or 61%) had only one admission.

Discussion

An analysis of the data on inpatients over a 7-year period (1987 to 1993) shows:

- The distribution of patients by diagnosis is nearly the same in all 3 reports.
- The distribution of patients by number of admissions is similar in the first 2 reports (all psychiatric admissions on all islands) but is different in the current report (psychiatric admissions of Medicaid recipients on Oahu only).

When admissions to psychiatric wards are studied and Medicaid recipients are compared to the general population, the following conclusions can be made:

1. The percentage of Medicaid patients who were hospitalized only once during the 18-month study period of this report (66%) is less than that of the general population (in studies of 2 earlier 18-month periods, 77% and 75%).
2. Likewise, the percentage of Medicaid patients who were hospitalized more than once is greater than that of the general population (34% versus 23% and 25%).
3. Multiple admissions of Medicaid recipients accounted for 62% of the total admissions, while multiple admissions for the general population accounted for 44% and 48% of the total admissions.

In summary, Medicaid recipients were readmitted more frequently than the general population, and their readmissions accounted for a higher percentage of the total admissions.

- Of all the inpatients covered in the 1989 and 1992 reports, there were 342 patients who had been admitted at least once in both reports. In the 1989 and 1994 reports, the number is 105, and in the 1992 and 1994 reports, the number is 167. There were 43 patients (4% of the Medicaid recipients in the 1994 report) who had been admitted in all 3 reports. Twenty-seven patients in this group (63%) had at least 2 admissions in the 1994 report. This group can be considered to be the core of the chronically mentally ill with multiple hospitalizations in the past 7 years.

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Table 3.—Distribution By Year and Number of Admissions

No. of Admissions	1	2	3	4	5	6	7	8	9	10	12	Totals
Year												
1987	1927	359	120	57	25	5	5	2				2,500
1990	1874	370	134	58	28	15	9	5	5	2		2,500
1993	700	207	78	31	17	13	5	5	3		1	1,060

Table 4.—Distribution of Patients with Admissions in 2 or 3 Reports

	1989/1992	1989/1994	1992 /1994	1989, 1992/1994
No. of Patients in both Reports	342	105	167	
No. of Patients in 3 Reports				43

Organizational Response to Adolescent HIV Risk

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vices into existing programs lacked clearly defined goals related to this effort. Funding was either absent or had to be diverted from other programs. HIV services were given low priority in view of other pressing service needs. Inconsistent staff training and discomfort with the subject matter also hampered the development of effective, consistent HIV interventions. These agencies deferred most often to mandated HIV education in schools, which teaches knowledge about HIV. It is well established, however, that knowledge alone does not change high-risk behavior.[9]

The results of this study suggest that in order for HIV/AIDS-related programs to be successful, several minimal conditions need to be fulfilled (Table 2). They include well-defined AIDS/HIV-specific organizational goals and policies, designated funding, selection of experienced and culturally sensitive key personnel, incorporation of community involvement and natural social networks, and thoughtful evaluation. In many communities, these conditions have been met better by new, small community-based organizations formed directly as a result of the HIV/AIDS crisis.[10] Such an approach would allow a specific focus on HIV programs without competition for financial and staff resources from other programs within the same institution. Unfortunately, at the time of our survey the only HIV-focused agency did not effectively reach a large number of young teenagers. A separate organization with a focus on HIV prevention in adolescents and a combined health and psychosocial approach is needed.

Table 2.—Conditions for Successful HIV/AIDS Programs

1. A clear mission and legitimate, well-defined AIDS/HIV-specific organizational goals.
2. Funding targeted at these specific goals.
3. Selection of experienced key personnel.
4. Adequate risk perception of target population by staff.
5. Cultural sensitivity to population served.
6. Community involvement and support.
7. Recognition and utilization of naturally occurring social networks of youth.
8. Effective evaluation.

The results of this study also suggest that while those health agencies surveyed appeared more proactive in their HIV activities, they reached relatively few younger adolescents. This study did not compare Hawaii's physicians' similarities to Mainland physicians, where it has been noted consistently in studies that due to time constraints, lack of comfort and lack of training, sexuality, and drug abuse are not discussed with most adolescent patients. Concerns about underutilization of physician services have fostered the local movement to develop school-based health centers in Hawaii. Physicians, who generally are respected as authorities in health-behaviors of adolescents, can increase their influence in several ways. In clinical care they can follow the "Guidelines for Adolescent Preventive Services" (GAPS) of the American Medical Association. They will need to routinely and confidentially discuss sexual activity, drug abuse, and other risk behaviors with all adolescent patients. Physicians who serve as consultants or on boards of directors of youth agencies can help assure that proactive HIV/AIDS prevention programs are developed. They can lobby legislators for funds to support such programs. Finally, they can participate in the development of a statewide collaborative network of adolescent-focused HIV prevention services that would include private and public health and social service agencies, schools, churches, the business community, and public officials. Anticipatory guidance related to STDs, safer sex practices, pregnancy and contraception should be provided by all youth agencies before, not after, a teenager becomes sexually active.

Very little research has been done on the importance of community organizations in the social networks of adolescents and how these organizations actually influence teen behavior. Initial findings soberingly suggest that young teens more often follow the beliefs and behavioral choices of often misinformed peers and parents rather than those of teachers or community agencies who frequently lack credibility or access.[12] More extensive social network analyses of adolescents may provide important information to community agencies on how to develop HIV-intervention programs that are not only accessible but also utilized by teens or by those persons who have the greatest likelihood to influence teen behavior. We plan to continue such research.

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Bone Mineral Content in Children

➤ *Continued from Page 387*

physical activity affects BMC. However, we did categorize the subjects into active and inactive groups and found no significant association of activity with BMC.

Reid et al found BMC at the forearm bone of Polynesian women was about 20% higher than that of white New Zealand women.[5] In the subjects we tested, we found that BMC at the os calcis is about 20% greater in Hawaiian girls than in Caucasian girls, suggesting that the factors responsible for this difference operate early in life.

The reasons for inter-ethnic differences are not certain. In blacks, an increase in muscle mass has been shown that may be causally related to higher BMC. Hawaiians resemble blacks in having more muscle and denser bones than whites.[6] Muscle mass may influence bone mass by determining the magnitude of the forces transmitted through the skeleton. Another consideration is the differences that have been found between blacks and whites in the level of calcitropic hormones, which may be important to the development of a higher bone mass.[7] However, in another study by Reid and co-workers, their results demonstrated that Polynesians have slightly lower levels of 25OHD than whites, but did not differ significantly from them in other biochemical indices of calcium metabolism.[8]

In summary, differences in BMC by ethnic group, age, height, and weight were observed: BMC was higher in Hawaiian than in Asian or Caucasian children. A greater number of Filipino children need to be included in future studies to make a stronger representation of this ethnic group. The data suggest that ethnic differences may develop early in life. If these differences are maintained into adulthood, then different ethnic groups would differ in susceptibility to osteoporosis later in life.

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Classified Notices

News and Notes Henry Yokoyama MD

Life in These Parts

Bumper stickers.—A pickup truck with the message, "The worst day fishing is better than the best day working."

The April of Her Age.—Hilo psychiatrist **John Cummins Mebane** has authored a soft-cover book, *The April of Her Age*, a romantic novel about Princess Kaiulani, a vibrant young teenager, and Robert Louis Stevenson, a frail, middle-aged, married author.

Unforgettable Event

Retired eye doc **Bob Wong** has been one of the major contributors to the John A. Burns School of Medicine for many years. One day, some years ago, Bob was invited to visit the school to view one of his contributions. The 1968-69 contribution had been designated for an anatomy department library. He entered the anatomy room where 25 to 30 gleaming white skulls awaited his inspection. Bob was relieved to learn later that the skulls were Hong Kong imports and hence not *kahuna* hexed.

(A Becky Kendro contribution.)

Triathlon Medics

Kona pediatrician **Bob Laird** is in his 13th year as medical director of the ever-popular Gatorade Ironman Triathlon. Fifty-eight physicians from all over the world comprised part of the 300 volunteers (which also included 88 nurses, 29 paramedics, emergency medical technicians, intensive care technicians, and even a race psychologist and a minister.) Last year, the triathletes required 498 medical visits, 269 intravenous medications, and 6 were hospitalized.

HMA President

Fred Holschuh, ER physician and immediate past chief of staff of Hilo Medical Center was installed as HMA President in October at the HMA's 138th Annual Scientific Meeting at the Ritz Carlton Mauna Lani.

Fred attended Columbia Medical School, interned at Queen's and took his residency at Kauikeolani Children's and spent two years in the U.S. Public Health Service Indian Health Service. He is co-founder of the Hawaii Emergency Physicians Associated, and past president of the Hawaii County Medical Society.

Physicians Speak Up

In October, **J.I. Frederick Reppun** comments on the successful occupation of Haiti and suggests, "Why not go a step further and require that the Haitian military is abolished as well? Why does that small, poor country need military forces at all? Certainly not for offensives, and not even for defense, now that the Caribbean and the Americas are largely governed by democracies."

Physician Moves

In September internist **Denise L. Parnell** opened her office at St Francis Medical Center, 2228 Liliha Street, Suite 307. Internist **Anthony Paul Siu** joined the Central Medical Clinic at 321 N Kuakini Street, Suite 201. Psychiatrist **Gerald A. Correa** joined the Kapiolani Counseling Center Aiea satellite, 99-115 Aiea Heights Drive, Suite 276.

In October ophthalmologist **Melanie Tantisira** joined the Camara Eye Clinic at St Francis Medical Office Building, Suite 106.

Oncologist-hematologist **John Hayward** joined the Kauai Medical Group.

Family practitioner **Marie Agleham** joined the Kuhio Medical Center on Kauai.

Medical Tidbits

- The October issue of *Archives of Pediatrics and Adolescent Medicine* published a study that is several years old showing that hospital gowns and scrub suits do not promote infection control as long as hands are washed. **Marian Melish**, head researcher for the study at Kapiolani neonatal intensive care unit, says gowning just costs money—$120,000 a year to launder scrubs at Kapiolani.
- Researchers found that surgeons do a better job at the operating table with a little background music. A study of 50 men, ages 31 to 61, who regularly listened to music when operating showed lower blood pressures and pulse rates and improved nonsurgical mental exercises.
- A study of nationwide hospital discharge data of 205,021 patients aged 65 and older who had MIs in 1987 suggests that costly operations such as bypass did little or nothing to extend their lives.
- Yo-yo dieting.—NIH researcher **Susan Yanovski** and her colleagues with the National Task Force on the Prevention and Treatment of Obesity reported in JAMA that repeated bouts of weight loss and gain did not increase body fat, raise the risk of heart disease, or psychologically harm the dieter—and that yo-yo dieting is preferable to remaining obese.

Qualifying for Medicaid in Nursing Homes—Congressional Changes

- You can have no more than $2,000 in savings, excluding the value of your home.
- If you gift assets to your children to qualify for Medicaid, you may have to wait 36 months before getting assistance. Under the old law, you could receive Medicaid no matter how much you gave away, but now if you gift $300,000 or more, you may have to wait up to 100 months.

Sportsmen and Sportswomen

The Hole Truth.—Soon after my husband and I played golf for the first time, I overheard him talking to a friend about it. "I wish my wife would take up the game," his friend said.

"It was great having her along," replied my husband. "But it sure is tough saying, 'Nice shot, honey' 142 times with any sincerity."

(Barbara Oakes, *Readers Digest*, July 1994)

In God We Trust.—I teach mathematics in Pittsburgh at Duquesne University, which was founded by the Holy Ghost Fathers. Once I was part of a golf foursome with Father Roach, then the University's chaplain, and two other priests. As we were getting to tee off, Father Roach turned to me, "Dan, you keep score," he said. "You are the only one we trust."

(Donato DeFelice)

A Few Choice Pet Peeves.—

- Ball washers go dry.
- Range balls from the nearby practice range litter the rough of a hole where your drive has disappeared.
- When a player in the group ahead, already holding up play, circles back looking for a lost club.
- The golf cart runs out of power going uphill on the 12th hole, the farthest point from the club house.
- Your partner runs out of balls on the front nine.
- Your opponent hits a putt and immediately begins to complain, only to see the ball go into the hole.
- The automatic sprinklers come on and spray you as you address the ball.
- You are not invited to play through a slow group—or you are invited to play through and promptly rush dub your next shot.
- The wind shifts and gusts against you at the top of your backswing.
- The practice green proves to be half as fast as the greens on the course.
- People mark their balls with quarters or 50-cent pieces.
- A player has $2,000 worth of clubs, but never has a tee to his or her name.
- You've changed into your spikes and the tile floor in the rest room is as slippery as a skating rink.

(Nick Seitz, *Golf Digest*, December 1994)

Condensed Excepts from Stitches

Overheard in a dental office.—As a discussion about *euthanasia* was underway, one patient piped up, "We'd do better to worry about the *youth* in our country, instead of those in *Asia*."

(Susan Perry, Ketchikan, Alaska)

Two for One.—In the middle of a busy shift in the ER, the charge nurse asked me to see a very sick child in the pediatric room.

I started to interview the parents while examining the child in the crib. The child, about 18 months old, was sitting quietly wearing only a diaper. As I got the details from the parents, I examined the child from head to toe. To my amazement, the child appeared perfectly well. In fact, she started to laugh and coo and became quite playful. I turned to give them my reassurances, when I found them looking at me with amazed horror.

With her mouth hanging open, the mother said, "But doctor, that's not the sick one!" Only then did I notice the five-month-old limp, sweaty, red-faced youngster hanging over his father's shoulder.

I may have said something like, "I like to warm up on the healthy one," but I don't think they believed anything I said after that fiasco.

(Jonathan Isserlin)

The Wrong End.—One very busy day at the office, with all the examining rooms full, the waiting room full, and of course the phone ringing urgently, I has a patient ready for a pelvic and Pap smear. At the propitious moment of insertion of the speculum, I said, "Say aaah."

"What did you say?" she replied.

There's no graceful way out of that situation.

William Calderwood
Sun City West, Arizona

A Brain User's Guide to Aging.—"Scientists are certain that a robust older mind is affected by influences that occur throughout a life time."

- Seek variety—it's the spice of life.
- Be flexible.
- Find peace—those who are depressed, anxious, angry, or discontented are vulnerable.

In Childhood:

- Eat right—breast-feeding fosters a healthy brain.
- Get lots of stimulation.
- Stay in school; education boosts late-life skills.

Young Adulthood:

- Make many friends.
- Find a mentor.
- Marry someone smarter than you.
- Take adult courses, but don't cram.

Middle Age:

- Develop expertise.
- Save more.
- Achieve your major life goals now.
- Enjoy the bustle.
- Avoid burn out.

After Age 65:

- Seek new horizons.
- Engage the world.
- Take a daily walk.
- Keep control.

From *U.S. News*, November 28, 1994

Excerpts from "You Know You're a Mid-Life Male When..."

A compendium of mid-life humor compliments of Abbott Lab.

- You play baseball on Sunday and hurt till Wednesday.
- The hair in your ears is longer than the hair on your head.
- You turn out the lights for economic reasons instead of romantic reasons.
- Your diastolic blood pressure is higher than your golf score.
- Attractive women feel safe enough to flirt outrageously with you.
- *Dribbling* no longer makes you think of basketball.
- Tying your shoes becomes an aerobic exercise.
- You start sleeping on the other side of the bed to be closer to the bathroom.
- Your arms aren't long enough to hold your reading material.
- Your systolic blood pressure is higher than your IQ.
- You start *arranging* your hair instead of combing it.
- You feel like the morning after when you didn't do anything the night before.
- You're absolutely certain they're building stairs steeper these days.

Potpourri

A hospital director was a strict advocate of managed health care: Three days and you're out. No discussion, no sob stories, no exceptions. One day he passed on and found himself in the anteroom to heaven. "Hmm," said St Peter sternly as he closed the director's file, "I guess we can admit you."

"Thank you," cried the director. "I was a bit worried. People accused me of being rigid, insensitive, and uncaring, but now you've let me into heaven!"

"Well, yes," said St Peter, "but only for three days."

From "Laughter, the best medicine,"
Readers Digest, November 1994.

Recent studies claim there are millions of adults who can't read or count. And if you don't believe it, look at the folks in front of you at the express checkout.

Jay Trachman, *One to One*

A cowboy applied for an insurance policy. "Have you ever had an accident?" asked the agent.

"Nope," replied the applicant, "though a bronc did kick in two of my ribs last summer and a coupla years ago a rattlesnake bit me on the ankle."

"Wouldn't you call those accidents?" asked the puzzled agent.

"Naw," the cowboy said. "They did it on purpose!"

Our Daily Bread

There was no respect for youth when I was young, and now that I am old, there is no respect for age.

Huntington Potter and co-workers of Harvard Medical School published in *Science* stated that a drop of tropicamide can allow for an early diagnosis of Alzheimer's disease. Eager to grasp all bits of information regarding this common ailment, the evening TV news and newspapers tell us that a dilute solution of tropicamide will result in a 23% pupil size change in Alzheimer's patients compared to a 5% change in normal patients. Obviously much more study and data collection must be accomplished before ophthalmologists become first-line diagnostic sources for Alzheimer's disease.

On the whole humans want to be good, but not too good, and not quite all the time.

After 10 years and many thousand reports, the Prospective Evaluation of Radial Keratotomy (PERK) has at last been released. Eighty-five percent of patients saw 20/40 or better without glasses after surgery, but the media gave wider coverage to the 43% incidence of delayed hyperopic shift. One might even get the impression that the big-pocket laser people are steering the media in an attempt to undercut (no pun intended) RK in favor of photorefractive keratectomy. Would business people do such a thing? If a simple, safe, inexpensive, cost-effective operative procedure produces the desired result, why would anyone buy a half-million dollar machine that requires technicians and exotic gases? The years of technical labor, investment, multiple studies, incredibly expensive devices, and stock sales could be seriously threatened if photorefractive (laser) keratectomy (PRK) does not win the hearts of all who desire refractive surgery. Perhaps we need a new social law, "the medical-industrial complex fuels medical care inflation."

We are born princes and the civilizing process makes us frogs.

The saga of Dr Samuel Pallin and his patent for the so-called cataract *chevron* incision continues. He was attacked by Dr Herve Byron writing an editorial for *Ocular Surgery News*, and Dr Pallin defended himself by accusing OSN of a hatchet job. He explains his behavior by claiming that "many colleagues" think that patenting a technique is a fair way to establish originality, and that ophthalmologists are subject to the laws of this country. For purposes of the record, harken to Paragraph 9.08 of the *AMA Code of Medical Ethics*: "The intentional withholding of new medical knowledge, skills, and techniques from colleagues for reasons of personal gain is detrimental to the medical profession and to society, and is to be condemned."

Please, Uncle Sam, I would rather do it myself.

If any one item of American political philosophy came out of the recent election (except in Hawaii!), it is that Americans want a 180-degree turn in their leadership. Without question they want less not more government. Therefore, it follows that programs that encourage individual management, such as freedom of choice of medical care, tax deductible IRAs, welfare redefinition, and reduction of the tax burden, are what the majority of voters expect.

No matter how you slice it, managed competition sucks.

The National Rural Health Association (NRHA) has joined the National Association of Community Health Centers (NACHC) in its suit against the Department of Health and Human Services to stop implementation of Medicaid waivers allowing statewide managed care operations (HMOs). As stated in last month's "Weathervane," waivers have been granted to Hawaii, Tennessee, Oregon, and Rhode Island. The NRHA asserts that the waiver programs have caused material harm to rural residents who rely on federally qualified health centers and rural health clinics. If the court supports the law suit, Med-QUEST will be jeopardized.

The trouble with the rat race is that even if you win, you're still a rat.

If you endured a decrease in your net income for 1993, you are among the national average for physicians. The most recent findings of the *Medical Economics'* ongoing survey revealed an 8.38 drop in median net income for office- based MDs and DOs. Hardest hit were physicians in the far west (including Hawaii), where the median net income fell by 14.18. The culprit in most cases was not a decrease in revenue, but inflation and rising office expenses.

Dr Kildare, would you dare kill?

And in Oregon the voters cast their ballots in favor of a measure allowing doctors to assist terminally ill patients to commit suicide. The AMA Board of Trustees flatly opposed the issue stating that it is fundamentally inconsistent with the physician's professional role in caring for patients. Citing the Hippocratic Oath, "*primum no nocere*" ("First, do no harm"), Board Secretary, Thomas Reardon MD, a family physician in Portland, Oregon, spoke for the Board in rejecting the concept. The problem for the AMA Board and for practicing physicians is that many Americans believe that terminally ill patients should have the right to physician-assisted suicide. Oregon's statute is the first to be passed by the electorate, and other states are sure to follow.

Glory may be fleeting, but obscurity is forever.

Do you want to drive a safer automobile? According to the Institute for Highway Safety, the Volvo 240 (4 door) has a death rate of zero, where 100 represents the average! Next safest is the Plymouth Voyager passenger van at 18, followed by the Mercedes 190 D/E at 27, and the Buick Riviera at 36. The least safe is the Chevrolet Corvette at 327, followed by the Pontiac LeMans (2 door) at 300, Isuzu Amigo 291, Ford Mustang 264. Driver profiles are not included in the study.

Addenda

- There is nothing so small that it can't be blown out of proportion.
- Philosophy teaches us to bear with equanimity the misfortunes of others.

Aloha and keep the faith—rts

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P. John Seward MD

➤ *Continued from Page 378*

And when we leave this lovely place, help us take the message back. Because that's exactly what we're going to do. Your Board is going to take this message on the road.

We're going to take this message—about this House and about this AMA—to physicians in every corner of the country.

And we're not just going to talk. We're going to listen. We need your feedback. We need their feedback. We need all of you to help make this what we all want it to be.

Because, together we are the profession. You. And me. And all of us. We are the profession!

Finally, I never told you what happened that day, out in the cornfields in Illinois. Fortunately, it had a happy ending.

Hand and patient both survived the experience. And so did this doctor—because we had the right tools and knew how to use them.

You know, on behalf of your Board of Trustees, I took the extraordinary step of coming before this House today to let you know that your AMA has the right tools.

The challenge is to know how to use them.

It is our challenge. It is your challenge.

And with the help of this House, together I know we will use them well.

Let us begin—now.

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