PREFACE

Oral history has its roots in the sharing of stories which has occurred throughout the centuries. It is a primary source of historical data, gathering information from living individuals via recorded interviews. Outstanding pediatricians and other leaders in child health care are being interviewed as part of the Oral History Project at the Pediatric History Center of the American Academy of Pediatrics. Under the direction of the Historical Archives Advisory Committee, its purpose is to record and preserve the recollections of those who have made important contributions to the advancement of the health care of children through the collection of spoken memories and personal narrations.

This volume is the written record of one oral history interview. The reader is reminded that this is a verbatim transcript of spoken rather than written prose. It is intended to supplement other available sources of information about the individuals, organizations, institutions, and events that are discussed. The use of face-to-face interviews provides a unique opportunity to capture a firsthand, eyewitness account of events in an interactive session. Its importance lies less in the recitation of facts, names, and dates than in the interpretation of these by the speaker.

Historical Archives Advisory Committee, 2007/2008

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ABOUT THE INTERVIEWER

James E. Strain, MD

Dr. Strain was in private practice and actively involved in the teaching program at the University of Colorado from 1950 until 1986. He became president-elect of the American Academy of Pediatrics in 1981 and assumed the presidency in the fall of 1982. In 1986 he accepted the position of executive director of the American Academy of Pediatrics where he served until 1993. After his tenure at the Academy, he returned to Denver where he resumed his teaching responsibilities as clinical professor of pediatrics at the University of Colorado.

Dr. Strain first met Dr. Sia in the mid-1970s when he was president of the Colorado Chapter of the American Academy of Pediatrics and Dr. Sia was president of the Hawaii Chapter. Later, Dr. Strain was elected chairman of District VIII during which time Dr. Sia was the alternate chairman of the district. They also served together for a number of years as oral examiners for the American Board of Pediatrics.

When Dr. Strain assumed the position of executive director of the Academy, he became interested in community pediatrics and was instrumental in establishing the CATCH program. It was during that time that Dr. Sia began to promote the concept of a medical home for disabled children, a project that was later formally included as a division within the Department of Community Pediatrics. Dr. Sia deserves our highest praise for establishing a concept which is now widely accepted as the best way of providing quality care to infants, children and adolescents.
Interview of Calvin C. J. Sia, MD

DR. STRAIN: My name is James Strain, and I’m interviewing Dr. Cal Sia on the 14th of August 2004, for the Oral History Program in the [American] Academy of Pediatrics. The interview is being conducted in the home of Dr. Sia.

Cal I want you to tell me a little bit about your family: your grandparents, your parents, brothers and sisters

DR. SIA: Jim, thank you. I’ve got a very interesting background because my father was born in Amoy, China, and my mother was born in Honolulu, Hawaii. Her parents were both from Canton, China. They were educated in a missionary school and attended missionary medical school. At that time, my grandfather on my mother’s side fell in love with this young woman medical student. At that instant of love, they wanted to get married, but my great grandfather, who was from the middle class didn’t want him to marry this young woman because she was an orphan and going to be a doctor. She was only five foot tall. They were so madly in love that after they graduated and found out that Hawaii needed physicians, they got married and moved to Hawaii as the first Chinese physicians.

Grandpa at that time practiced general practice. Grandmother was delivering babies. It’s interesting, back in the 1890s, Grandpa was Dr. Khai Fai Li. Married, they were Dr. and Mrs. Khai Fai Li, but she independently practiced as Dr. Tai Heong Kong. When you talk about woman libbers, she was one of the original woman libbers, practicing as Dr. Kong in the 1890s, and they practiced, both, for fifty years in Hawaii.

They raised a family of nine children, of whom three became doctors. My mother was the oldest daughter. And all went through college. My mother went to graduate school at Yale [University] for music and did work there. My father’s father died when my father was only 12, so he worked himself through school, obtaining a scholarship, through a missionary college, to go to Western Reserve University [now Case Western Reserve University] Medical School. He went through the medical school in Cleveland, Ohio in the years around 1918, during the infectious disease years of the flu epidemic, and got very interested in working infectious diseases. He went on to Rockefeller Institute [for Medical Research], after his internship in internal medicine training, and became a fellow at Rockefeller Institute. He met my mother on a weekend at a Chinese students’ association.

My father sang, and my mother played the piano, and they met, and within the week they got engaged and soon after married and settled in New York for a year. Rockefeller was setting up a first medical school in Beijing, China, Peking Union Medical College, which is where they returned and
settled and raised their family. So I was born in Beijing, China, where my
dad was a professor. He started off in academia doing research and teaching
of medicine. He was very strong in infectious diseases, doing work originally
on pneumococcus at Rockefeller Institute and then streptococcus and all the
problems related to the infectious diseases in China.

Of note on my father’s side, because of his interest in infectious diseases, was
Kalazar or Black Fever. He did a simple blood test, called the Sia’s water
test, which is dropping blood in water; and if it precipitates, it’s a positive
qualitative screening test for Kalazar. He asked his colleague, Wu Hsien,
who developed the initial Folin-Wu new quantitative blood glucose test to
study this further based on Euglobulin, but this was not pursued.
Subsequently, Waldenstrom developed a quantitative test based on this Sia’s
test for macroglobulinemia.

Well, we were under this academic influence, my older sister, my younger
sister and I, till I was 12, when we were occupied by the Japanese during the
Sino-Japanese War, and after two years we left Beijing for Honolulu, where
my mother’s side of the family lived, because my father determined China
during wartime was not the proper atmosphere to raise adolescent children,
growing children. He received a visiting professorship at University of
Hawaii. We came under the guise of a professorship in 1939, having left
everything in Beijing, and never returned. He was with the university in
microbiology, teaching, and subsequently went into practice in the forties,
when there was a lack of physicians with World War II coming.

So I came to Honolulu in 1939, at the age of 12, having gone through Chinese
school through sixth grade. I entered a public school for my intermediate
school, and then went to Punahou School, which was the oldest west-of-the-
Mississippi prep school, so to speak, and graduated in ’45 and got drafted in
the Army. World War II hadn’t ended yet. When I got out, I went to
Dartmouth College. I was in a three-and-a-half-year setting, but I spent an
extra year to be a pre-med and get into medical school and got in medical
school and graduated in 1955.

I subsequently—prior to this, perhaps, I should mention, I met my wife,
Kathi, while I was in college at Dartmouth. She was at Pine Manor Junior
College. I persuaded her to stay on at Simmons [College], and we got
married in 1951. She was my bride throughout medical school, helping me
go through medical school. Because we had a son, I chose the military
because it was a one way of doing my internship and still existing financially,
and spent a year in William Beaumont General Hospital [now William
Beaumont Army Medical Center] in the general rotating internship.

At that time, I was thinking about continuing the military training, but it was
also a quandary because I was very interested in staying with academics and
training. I applied to Cincinnati [Children’s Hospital], where Ashley Weech accepted me, but the salary was thirty-five dollars a month. [Laughs] Those days, there was very little, and with a child and a family, I came back to Kauikeolani Children’s Hospital, where the salary was two hundred dollars a month. [Laughs]

DR. STRAIN: Was Dr. [Irvine] McQuarrie the chairman? Had he come from Minnesota?

DR. SIA: He had retired from Minnesota after his glorious years there. He trained seventeen full professorship chairmen at that time; then he came back to reinvigorate our residency program and get it back to standards. I came back as one of his first residents. He was a great mentor, who helped me really look in terms of where pediatrics was going. So I spent the next two years at Children’s Hospital in Honolulu, and he really introduced me to some of the giants of pediatrics at that time. We had a visiting professorship, which he initiated, and these visiting professorships started with three months here. When you got to know these visiting professors the first month, the rest was really a pleasure to know them as a human being.

And the giants were here, such as Henry [C.] Kempe, Bill [Waldo E.] Nelson, and many more that I could mention that we knew. Ed [Edward B.] Shaw, who was very active in the Academy. There was a range of researchers, academicians in practice. In those days, I think the giants of pediatrics reflected a general pediatric knowledge, with subspecialty not as strong. The later groups that came were also friends of mine, not only from Samuel [Z.] Levine, in prematurity, New York Hospital-Cornell Medical Center; Bill [William] Silverman from P and S [Columbia University College of Physicians and Surgeons]; and others, such as Sydney [S.] Gellis, who really helped me discover many areas of interest. Perhaps the two that I would say really got me involved with what I’m doing were Henry Kempe, in terms of the battered child, in 1961, and Bob [Robert E.] Cooke, who showed me what children with special health care needs were, the handicapped children involved with Harriet Lane [Home for Invalid Children], which personally sort of brought me to my interest in terms of broad scope. Over all, we had a nice breadth of people that I got in with.

DR. STRAIN: Sounds like you had an excellent residency.

DR. SIA: I was very lucky to meet them.

DR. STRAIN: Yes. How did you happen to go east to undergraduate and graduate school?

DR. SIA: I guess one of the things I wanted was a contrast from our Polynesian atmosphere, from the West Coast. Most Hawaiian children
would go to the West Coast, and I felt very strongly that I wanted to go to the East Coast, and that’s where I ended up. I originally was going to go to Cornell [University], but because I got out of the Army in February and Dartmouth would take me then, I ended up at Hanover, New Hampshire, and I really enjoyed the years there.

DR. STRAIN: And your fourth year, I think you took at Columbia.

DR. SIA: Yes, three years at Dartmouth. I graduated from Dartmouth and then put in an extra year to do my work for pre-med.

DR. STRAIN: And then you had a family connection with Case Western Reserve.

DR. SIA: Yes, with my father, and that was where I ended up. And I have a son who also graduated from Case Western Reserve Medical School subsequently.

DR. STRAIN: I see. Well, I wanted to ask you about that. You told us where you met Kathi, and your family, and how you had your first son while you were in medical school.

DR. SIA: Right.

DR. STRAIN: And I would like to know more about your sons and what they’re doing now.

DR. SIA: I have three sons, and, again, we were very fortunate. I think Kathi has been really the base, keeping the family together and raising our children together. All three sons, who are two years apart in schooling, so to speak, ended up on the East Coast. My first son was at Harvard [University]. He was very interested in journalism and was an investigative reporter for the Baltimore Sun for seventeen years and now is the managing editor, senior editor for the Congress Daily AM. Prior to this, he was with the National Journal News in Washington, D.C. He was based there with the Baltimore Sun for four years and then moved on.

Our second son went to Brown [University] and then went to law school at Villanova [University], and came back as a lawyer, attorney. He is a defense attorney. [Laughs] He defends us in malpractice and is the senior partner of a thirty-partner organization in town and very successful.

Our youngest son is the one who went to Dartmouth and Case Western Reserve and Stanford [University School of Medicine] and was its chief resident in pediatrics and then came back. He has been in solo practice and is enjoying himself as chief of pediatrics at our tertiary medical center for
children and also has been recently honored to be on our Blue Cross-Blue Shield board of directors. So I think he’s moving in the right direction.

I don’t know whether I’m getting into too many details.

DR. STRAIN: No, no. No, this is fine. This is what we want.

DR. SIA: And that’s where you can eliminate, I guess.

DR. STRAIN: Yes, you can do whatever you want with that once you get it back.

Okay, we’ve talked about your family history and your personal history. We’ve covered that, and where you took your education. Then I need to know about your professional history. What did you do after you finished your residency?

DR. SIA: Jim, that’s a very interesting question. Because of my background, I think from the very start of my China-U.S. background, coming to Honolulu as a Chinese, I always felt that I should go back to China and contribute to China. And after my pediatric residency, Fred [Frederick C.] Robbins, who was my mentor at Reserve, offered me a fellowship to do sudden infant death, SIDS, that he was working on, and I thought this was a great opportunity. In fact, prior to that, in the spring I had gone back to Hong Kong with my wife to buy winter clothing for my son and myself and Kathi, to be prepared for this fellowship. But the public health fellowship did not come through, and Irvine McQuarrie had said, “Don’t be a parasite on medicine, or pediatrics. You’ve got to get a PhD/MD,” which he really has enforced with all his chairmen, if you look at his chairmen. I felt very disappointed in not being able to get this fellowship and wasn’t sure which way to go. But as things turned out, I decided to open my own practice. That’s how I decided to struggle and open a solo practice. I have to tell you, that first month, my nurses made more than I did. I collected zero. [Laughs]

DR. STRAIN: You did a lot of sitting.

DR. SIA: Exactly. But one of the things it afforded me to do is to think what type of a practice I could establish and how I would practice and how to work the office staff to my liking and train parents, empower parents, so to speak, to be good parents to their children and practice pediatrics as you’d like to do. So for the next five years, I worked on this. Henry Kempe in Colorado was way ahead on this at that time, and talked about welcome calls and well-baby care. We had been introduced to Henry [K.] Silver for a three-month visiting professorship, so I had both Henry Kempe and Henry Silver’s insight as to what Colorado was doing, and developed a practice where I would take everyone. And, being the young man on the block, I got all the bad patients.
But I used this as a way to generate a training of a practice that would evolve—and perhaps when I look back, it was the first concept of the medical home. Accessible. Welcome calls in the mornings. A set pattern with my nurses, trained. I worked out a system of appointments; I worked out allotment of time; and worked out a system of care for well-child care, emphasizing well care where preventive care was perhaps not being reimbursed. But I said this was important and if patients were going to see me, they were going to pay for it. And those who couldn’t, we would try to set up a separate entity. I was involved with a well-baby clinic, the maternal-child health, through the department of health and supported the concept of continuity of care, community-based care through these efforts in the first five years.

Part of the time spent paid off, perhaps, in my practice because I was also able to devote more time to what I wanted to do. So after five years, I formed the first specialty clinic, bringing into this small practice an endocrinologist and cardiologist. We called ourselves the first Children’s Medical Clinic in Honolulu. But unfortunately, the specialty practice didn’t go well, so after ten years we disbanded. I remained in the solo practice and just brought on an associate. So my practice was established by a pattern that I really wanted in terms of the concept of family-centered, community-based, accessible, comprehensive care. Being a pediatrician, it would entail all aspects, and also in terms of continuity of care that would be culturally sensitive, as we go along. And compassionate.

DR. STRAIN: Was your office in the inner city?

DR. SIA: It was outside of the hospital.

DR. STRAIN: Adjacent to the hospital?

DR. SIA: No, not at all. We were completely apart. In fact, we were on the third floor of a three-story building with an elevator. But most people said you had to have a ground floor office. [Laughs] I started out on the ground floor, but went to the third floor and stayed there for my length of practice, five years, which was very interesting in terms of establishing a pattern. And the pattern was important, because as the young physician on the block, I took premies. Nobody wanted to handle premies. At that time, we had five hospitals, and I had to go to five different hospital nurseries to take care of them. And then the problems—we had no resources, and we had to follow up on resources with the families. And we had handicapped children. All of this led towards my overall thinking of where things should be organized.

DR. STRAIN: Did you make house calls?
DR. SIA: Yes, we made house calls. And I think the real coup, I felt, was the one house call for a 2-year-old who had stomach pain and who had blood in the stool and intussusception. We brought it right to the hospital and had a dramatic result. The difference a house call made was thrilling. I used to go to the emergency rooms to see my patients, as part of the training, so the parents wouldn’t call me unless it’s a real emergency. I went for everything in those early years because that way, the family developed some trust, and it was that trust that made a big difference in the late phone calls, the calls at two, three am that pediatricians don’t like. And I think that continuity is very important, and a time factor was very important. I think most doctors today don’t recognize that.

DR. STRAIN: What was the economic status of most of your patients?

DR. SIA: Imagine the fees we charged! Two dollars, three dollars!

DR. STRAIN: Was it cash?

DR. SIA: Cash.

DR. STRAIN: There wasn’t much insurance?

DR. SIA: No, there was insurance. We had a Blue Cross-Blue Shield called HMSA [Hawaii Medical Service Association]. Then, as the seventies came on, we had the federal insurance coming in. But initially it was cash or Blue Cross-Blue Shield, and those were very basic. The other thing which I found, and it’s a real characteristic of practice today, is the emphasis on immunizations. It’s not immunization, it’s the care that’s more important. If you go just for immunizations, it doesn’t pay off in the long run. It’s what you build in terms of well-child visits that they’re willing to pay for.

DR. STRAIN: Okay. That’s an interesting story about your practice and professional history. Let’s talk a little bit, Cal, about your community service. In your curriculum vita you indicated that you had, pretty early on, an interest in children with disabilities.

DR. SIA: This gets back to advocacy with your patients at the start. When you have time, you become a strong advocate to get as many resources as possible for that patient, for that problem. So when I had a low birth weight infant who needed support, whether it’s feeding or respite care or other support services, I looked to the community because the community needed to develop support services. For a child who had speech, language delay, for a child who had other problems, I would try to look for resources.

Now, I realized from the very start that I couldn’t do it alone, so I looked for help in people who were equally concerned, from the other, inter-
professional areas, the providers. And there were public health nurses who were challenged just as much as I was, and were similarly devoted to children. There were speech language therapists. There were schools that were developing and evolving, but they didn’t have a multidisciplinary approach for advocacy. I became the stimulus in looking for this for the parent, and the parent then got involved.

And this is where I got involved, perhaps, in 1961 after two years of practice, in the school for the deaf. I was a school physician. Nobody wanted to take the deaf and the blind. I got involved with learning disabilities, neurological impairment, kids who were not congenital birth defect kids but looked normal, yet had problems. So this was the Variety School that I founded in terms of the learning disability. And that was before ADHD [attention deficit disorder with hyperactivity]

DR. STRAIN: You actually founded that school. Is that right?

DR. SIA: It was started—

DR. STRAIN: For learning disability primarily?

DR. SIA: Learning disability, that’s right. And this was ADDH. We called it hyperkinetic minimal brain dysfunction those days, if you recall. It’s very much popularized today, but these are things we went through with amphetamine, if you recall. The change, as I say, is a gradual change, but the basic structures are there. Through these efforts, I was able to advocate, through private and public foundations and public support, to develop a school called Variety School for learning disabilities.

DR. STRAIN: Now, was that a part of a school system in Honolulu?

DR. SIA: A private school.

DR. STRAIN: You did hire teachers?

DR. SIA: Right, and speech language therapists and all the special ed types of services that such a center provides.

DR. STRAIN: And with the basic courses as well, or did the children go to other schools and then come to Variety School?

DR. SIA: Basic. It was contained.

DR. STRAIN: I see. All educational and health needs were covered.
DR. SIA: Right, and we started with early age. Then I got involved with Easter Seals and cerebral palsy, with others, because of the challenge of the patient load that I had, in advocating for them and how to make changes. This was very significant in terms of community because pediatricians weren’t involved at that time with this.

DR. STRAIN: Because of your involvement with all of these organizations for the disabled, did that create an increase in the number of patients you were seeing with disabilities you were seeing in the office?

DR. SIA: No, not necessarily, because what I did was to begin to get the [American Academy of Pediatrics—Hawaii] Chapter doctors involved, which increased my patient load at the time, but not the numbers of handicapped children, because most of them were established.

DR. STRAIN: With other pediatricians.

DR. SIA: With other pediatricians.

DR. STRAIN: Now, you also developed an interest in child abuse prevention, and you mentioned early on that Dr. Kempe had something to do with that. And, of course, he was one of the real advocates for prevention of child abuse in Colorado. He came to Colorado really as an infectious disease person, but really, I think, his major interest became child abuse.

DR. SIA: Right.

DR. STRAIN: And he spent some time with you. Can you tell me a little bit about that?

DR. SIA: Actually, I was fortunate because Dr. Kempe came back in the fifties, when I was a resident, and came back again many times. He came first in ’56, ’58, and then in the sixties, and really introduced a broad scope. His field was smallpox, and eradication of smallpox was one of the major areas of infectious diseases. But when the battered child syndrome came on in ’61, he really brought attention to this, and we got involved probably in the sixties, as we went along, in looking at the environmental risk.

Three things came into mind in my practice that were sealed by my exposures to various things. When we talk about children and children with special healthcare needs, one is development delay, the Easter Seals children, the children with muscular dystrophy, the CPs [cerebral palsy], the Down’s syndromes. Two, were those who were biologically at risk, those who were involved with genetic diseases or with low birth weights. But the third area, which is probably the greater area because the first two are maybe only 10 percent of your practice, the third area is the environmentally at risk, and
this is child abuse and neglect, and I think emotional neglect, behavioral problems are going to be much more of a problem.

This was where I started in the sixties to look at the environmentally at risk, which is very significant in terms of the change in thinking of what a pediatric practice sees today when we look at autism, when we look at some of the mental health problems that children are being faced with. So all of this comes back in a circle. It’s a cycle as we go along. And what basically both Ray [E.] Helfer and Henry Kempe taught me is breaking a cycle. How do we break the cycle? In child abuse and neglect, Henry taught me that you break the cycle at three ages. The best payoff is at the time of birth or prenatally. Second is at entrance to school. Third is at adolescence. These are eras when prevention and early intervention are very critical.

END OF TAPE 1, SIDE A

DR. STRAIN: Dr. Kempe developed a family stress index early on and probably talked with you about it, the early recognition of mothers who presented risk factors even as early as in the newborn nursery.

DR. SIA: That’s right. And getting back to the thinking that I just brought up is that this cycle of breaking the cycle of abuse is very significant in terms of where we are today. Denver was the one that we modeled our program of family stress index that he developed, and this was prenatal. At time of birth, we would have a questionnaire with the mother or parents, and a check-off list, and it was red flagged if it was significant and followed up with home visits.

DR. STRAIN: There were frequent health visits, as I understand it, that you adopted here in Hawaii.

DR. SIA: Yes. As the community projects evolved, then, from the developmentally delayed, the biologically at risk, the environmentally at risk. So I got started on the child protective services, and probably founded—not probably, I founded in 1970, through the legislation, our Children’s Protective Center [of Oahu]. My other strong interest in the community from the early age group, is school health, because I got involved with the Academy’s Section on School Health and initiated our school health project in 1970 in Hawaii, through efforts of legislation.

DR. STRAIN: Okay, Cal, I’d like to talk to you a little bit about your activities within the American Academy of Pediatrics. Can you talk about the Academy, the AMA [American Medical Association] and the American Board of Pediatrics? I’d like to start with the Academy. How did you initially get involved with chapter activities here in the state?
While I was a resident, ’56 to ’58, the local Honolulu Pediatric Society became very active in supporting our pediatric residency program education. To elevate the quality of care, the Honolulu Pediatric Society decided to take a strong stand on making our Children’s Hospital an effective children’s tertiary center, and that’s why McQuarrie was here. He was very much the stimulus for elevating quality of care in medical education in general for Hawaii. It’s through these efforts that they also combined thinking about joining and forming a chapter. So when I got out in practice, the chapter was established in the early 1960s.

Leadership became one of timing. As I got more seasoned as a practitioner, I became an active member of our chapter and then became chairman by default. And by default, I was so involved with the community as a young pediatrician on the block that I became re-elected and re-elected three terms, and really got that chapter functioning as a chapter because I was able to be exposed in the sixties with the national Academy of Pediatrics.

What would you say were some of your major accomplishments as chapter chairman here?

I think advocacy on the local level: advocacy in establishing child protective services through the chapter efforts and advocacy in establishing school health services, which was very instrumental in establishing a nurse and a health aide in every school. Up until then, we had no school health system. Advocacy in all the legislative process, we were able to do from the sixties to the seventies in terms of establishing medical home, so to speak, and the Form 14 [Hawaii Department of Education Student’s Health Record], establishing a physician’s name, upon entrance to school for every child. Entering school required immunizations, a physician’s name and any known handicap or problems. That was a Form 14 card, making this a mandatory requirement, including the immunizations, including the TB [tuberculosis] testings that were necessary.

Looking at establishing other avenues of care for children as we go along in the early seventies, we worked with Medicaid, which was coming in, and with establishing EPSDT [Early and Periodic Screening, Diagnosis and Treatment]. And also probably of significance were the early laws that came through regarding handicapped children. I was involved in the sixties and seventies with special education, being the chairman of the State Task Force for Special Education for Handicapped Children, for mentally retarded, the handicapped, the developmentally delayed, the special ed children with learning, language and learning disabilities, in focusing the role of pediatricians as part of multidisciplinary teams.

You mentioned a minute ago that you were a chapter chairman here in Hawaii. It introduced you to the national American Academy of
Pediatrics and what it was doing. And you served in a number of areas eventually at a national level. One was on the Ad Hoc Committee to Study PL 94-142, Education for All Handicapped Children. What did that committee do? Was that advocating for services for handicapped children?

**DR. SIA:** That was a task force that started initially in terms of looking at the ages 3 to 21, all handicapped children, and looking at how individual chapters, individual pediatricians could become more involved. That led to [Public Law] 99-457, Zero to Three to Infants, Toddlers and Preschool Children, the task force that I also was on with Al [Alfred] Healy, which was very significant in terms of changes that were made. The first one, the Education of Handicapped Children—IEPs [individualized education plan] were strictly educational programs, individual educational planning. In 0 to 3, we brought in the families. IFSP [individualized family service plan], individualized family support planning. Families are very critical. We know that. Families need to be a center of advocacy. They’re empowered to move. They’re my allies in moving things.

So what we did from a national point of view is instill IFSPs in the families in 0 to 3, and that was the other challenge of implementing this on a state basis, so I got involved with the early intervention coordinating councils that were established in every state. I got involved in defining of children with special healthcare needs in our state, to be all-inclusive. I got involved in placing this in the Department of Health, which would be much more attuned to prevention and early intervention in the state, so we’re one of the unique states that has the education in the Department of Health in the first three years, which helps the pediatrician, supports the concept of an ongoing flow of health with family support in the first few years. The relationships are critical.

School really is structured. School starts, whether it’s pre-school, 3 to 5, in a different atmosphere with educators. Educators don’t have the same sense of family—of health, support, in its true sense. So this is where my community services and the Academy have helped strengthen the bond of relationships and taught me how to bring up and implement policies.

**DR. STRAIN:** Now, these laws were enacted.

**DR. SIA:** Federal laws on education of the handicapped..

**DR. STRAIN:** Federal laws that came into effect about when?

**DR. SIA:** Sixties and seventies and then eighties.

**DR. STRAIN:** The initial age group was 3 to 21—
DR. SIA: That’s right.

DR. STRAIN: And then 0 to 3 was included.

DR. SIA: Five to 21, and then 3 to 21, and finally in the eighties 0-3.

DR. STRAIN: And this ad hoc committee had to do with trying to establish contacts and implement the activities at the local chapters.

DR. SIA: Right, at that time.

DR. STRAIN: For each group.

DR. SIA: Yes. Right, at that time. So I started being exposed early to the older age group, the school-age group, the pre-school-age group, and then the zero.

DR. STRAIN: Zero to three.

DR. SIA: A big difference, and that’s where the Academy needs to stay on top.

DR. STRAIN: Okay. Another interesting area, and I’m wondering how you got involved in this, was your interest in the Section on Emergency Medicine. Where did you develop an interest in emergency medicine? You became an expert, and you certainly were an advocate for children in the U.S. Senate. Tell me more about the background of that.

DR. SIA: Actually, when you think about prevention, one of the key things we try to prevent is intentional child abuse and neglect. The non-intentional injuries come from falls or burns or other things that we know, and accidents cause critical mortality, morbidity in the first few years. A system of care begins with a medical home concept, the primary care physician. We’re the ones who preach accident prevention, and this is what the Academy has taught me. We talk about first aid, but it relates also to a system of care, for the parent, the mother, the first person at the scene of the accident, for stabilization. Part of the problem is that in accidents on the road, paramedics and the ambulance are not equipped to deal with children. They’re adult oriented.

The other area, as we grow older, is drowning and other accidents. So you go from stabilization, to transportation from the site to the emergency department, which may or may not have someone attuned to the mother and the child’s concern, much less equipment such things as small tubing, IV fluids and other supplies that relate to medications, to stabilization. Even
now, we understand CPR [cardiopulmonary resuscitation] is not for kids. Kids don’t respond in the same way as adults.

One of the reasons I retired or dropped out as chairman of our academy chapter presidency, was I assumed the presidency of our Hawaii Medical Association in ’76 to ’77. This was a challenge to spread what I knew to a greater medical profession. As president, I was able to be exposed to much more. In the seventies, EMS [emergency medical services] was just starting for the adults. This was when the issues of CPR and the transport system came to the fore.

I said, “We need a system of care for children,” and I said, “I’m going to write a bill for emergency medical services for children as a subset of EMS.” I got a bill written, which I offered to Senator Dan [Daniel K.] Inouye, who was in a power position at that time, on the Committee on Appropriations in the [U.S.] Senate. He submitted the bill, but it was during the period of Reaganomics, and in Reaganomics, Republicans controlled this, with [Senator Orrin G.] Hatch very much the key man. We were able to negotiate and work at the federal level, to get the Republicans supporting Inouye and get our bill through in ’84, after three years of [chuckles] fruitless lobbying. I had rallied because I was able, through the Academy’s help on the Committee on Hospital Care, to begin to know some of the people who were involved with emergency medicine. I went to see Dick [Richard E.] Behrman, who was at Rainbow [Babies and Children’s Hospital] in Cleveland, because they were doing some of the early transport work.

Atlanta, Georgia, had another service that was involved with transport work. Other children’s hospitals in various states were also beginning to extend emergency medical services for children, such as in Washington, DC, and Knoxville, Tennessee. I rallied these emergency medical docs who weren’t involved with the Academy, who weren’t involved with the politics that I knew, got their support, and got the different states—worked the lobbying effect federally, and we got the bill through. The authorization went through, but no monies, but the following year we were able to get the monies and established the initial four EMSC [Emergency Medical Services for Children] programs.

It was through these efforts that the Academy appointed me to the committee, the task force, and then the probationary committee or—usually you have a committee before that, ad hoc.

DR. STRAIN: Provisional, provisional.

DR. SIA:   Provisional. And I was the lone practitioner who kept them honest [laughs] through the years, until I served my term. [Laughs]
DR. STRAIN: Well, now, as I recall, that legislation was for pilot projects, at least to begin with.

DR. SIA: Right. That’s right.

DR. STRAIN: And only a few states—

DR. SIA: Four, only four.

DR. STRAIN: Four, okay. And eventually did that become more widespread?

DR. SIA: Oh, it’s dramatic, Jim, because that became an ongoing one that started with $2 million. It got up to $30 million, and it’s still ongoing.

DR. STRAIN: So all of the states now are involved.

DR. SIA: All the states, plus the territories.

DR. STRAIN: Children’s EMS.

DR. SIA: Emergency Medical Service for Children. I’d like to turn this off, but—

DR. STRAIN: Sure.

DR. SIA: There’s a hook on this. [Evidently refers to microphone]

[Tape interruption.]

DR. STRAIN: Okay. I want to talk to you about the CATCH [Community Access to Child Health] program. Did you have a CATCH grant here in Hawaii? Is that how that started? You were interested in that?

DR. SIA: No. Actually—I don’t know whether we need to record this. [Laughs]

DR. STRAIN: Sure, you could always cut it out if you don’t want it.

DR. SIA: Actually, Jim, it’s a very fascinating story because my medical home grant, which I started back in the eighties and got this started and got into the training, brought all fifty chapter leaders together and moved this—by 19—I’m trying to think when CATCH started: 1989, 1991, in that area. I realized as my grant was ending that I wanted to transfer this to the Academy and was involved with Ed [F. Edwards] Rushton. I was involved with Ed because, when he started CATCH, he was very instrumental in calling people who were involved with community pediatrics, so to speak,
and medical home, because we had worked with Florida in our medical training. So I became a District 8 facilitator.

DR. STRAIN: So you didn’t have a project here in Hawaii to begin with.

DR. SIA: I was the key person for CATCH. We worked with Ed in terms of the CATCH program and I was able in the CATCH program to introduce the medical home, that every child needs the services of a medical home and that one pediatrician can make a difference. So the concepts of CATCH were tied together with the medical home, through Ed Rushton, and we were able to influence the eight or nine district facilitators in moving this.

DR. STRAIN: Now, there were other projects other than medical home projects among the CATCH grants.

DR. SIA: Right.

DR. STRAIN: The idea was for a pediatrician to look at the local needs.

DR. SIA: That’s right.

DR. STRAIN: And whatever that happened to be, whether it was medical home or whether it was care for adolescent pregnant girls—

DR. SIA: Access.

DR. STRAIN: Yes, exactly.

DR. SIA: And access to care. And this was the CATCH, community access.

DR. STRAIN: Some of those were focused on the medical home concept.

DR. SIA: Right, but initially it was simply access to care, and access to care enhanced by a medical home.

DR. STRAIN: Yes. Well, now, we need to talk about the medical home concept because that’s what you’re identified with in the Academy, and you’re primarily the person who fostered this idea. Now, I think that you brought it to the attention of the Academy, and you’ve given me a little bit of a background on how that began. Really in your own practice is how this started, from what you’re telling me.

DR. SIA: Yes.

DR. STRAIN: And the home visitation was a part of that in your activity.
DR. SIA: Right.

DR. STRAIN: How did you take this nationally? How did you do this? You mentioned the CATCH program.

DR. SIA: I think before that—and we have to go historically, by dates and times—in the sixties, I was forming my practice, my individual practice pattern. In the seventies, I was beginning to establish relationships with resources—resources of the Variety School, Easter Seals and others, such as the department of health, department of human services, child protective services, school health services. And by the eighties, I was beginning to look at the system of care, and in terms of the system of care, it became a matter of the role of the pediatrician. And the role of the pediatrician regarding child abuse and neglect was to work with the family or family support services, through a home visitor, to facilitate delivery of necessary services, be it for substance abuse or for other problems, and, working with resources in the community, to tie together, in terms of basically moving public agencies, such as the department of human services, or health or education, in support of the family and child.

In terms of the medical home from the individual practice, I felt that if I had more individuals interested in moving this in a systems approach, we could probably do this from their individual practice to the system in their local communities and state. That’s how the medical home system approach became one of training of the medical home to the crisis of the new morbidity, and the relationship of resources in his or her community, the relationship to the system of care as policy and advocacy with family and with the other providers, in a multidisciplinary program.

DR. STRAIN: You were invited to many of the chapters around the country, as I recall. Were those instructional?

DR. SIA: Our grant started out allowing me to go to certain areas that wanted to look at the concept and learn more about it. We had a national conference where we asked the leadership to come to Hawaii in 1989 and subsequently in 1991, to begin to look at, from the department of health, chapter leadership and individual pediatrics, the team approach as to how to develop this. I was asked by Tom [Thomas F.] Tonniges in Nebraska to go there to present this to his community. I was asked by Seattle, Washington, and other states, to go there. Through our grant, we were able to go there and introduce this concept, and gradually with a grant we spread this and developed a more national perspective. Then got into—and I’ll get to ’95 and Ed Rushton. As my grant was ending up, I met with him and suggested that the AAP take over this grant and begin to do the same type of training nation wide, and that’s how our medical home training program became a
community, a team approach, with pediatricians, with the providers of resources, public health nursing, speech-language therapists, home, family support all meeting together. That is in essence the medical home training.

DR. STRAIN: When you started, and maybe even yet, the medical home concept seems to be dealing with, number one, prevention—

DR. SIA: Early intervention.

DR. STRAIN: Early intervention.

DR. SIA: Continuity of care.

DR. STRAIN: And dealing particularly with disabled children.

DR. SIA: Yes.

DR. STRAIN: Do you see that translating into the care of all children?

DR. SIA: Yes, because what I started in the eighties was a system of care for special education, the handicapped child, for children with special healthcare needs. By 1989 President [George H. W.] Bush at that time and President [William J.] Clinton, who was the then chair or president of the National Governors Association, both articulated six goals for education. The number one goal was that, by age ten, all children would be healthy and ready to learn. All children then deserve a medical home. This was my pursuit and has been my pursuit since 1989, in early childhood. So my focus, then, from 1989 was all children, and since 1989 I focused on early childhood education and care, with the medical home, with family support, to bridge this—not only the service area and the training area, but the research area as well, for positive outcomes.

That’s how I’ve led into Starting Points, the Carnegie’s [Corporation of New York] push on early brain development, early child development. Four things are important: responsible parenthood; ensuring good health, including protection from violent and nonviolent injuries and access to care; and ensuring quality child care and education. The fourth and most important is mobilizing communities to action, with special healthcare needs of all children, because in our practice, sure, there may be a certain percentage who are developmentally delayed. I said 10 to 15 percent. Environmentally at risk may be up to 20 to 25 percent. The behavioral problems, the emotional problems, we’re seeing more and more. The complexity of family structures today, the complexity of poverty today, the complexity of our environment today says we need access, a medical home, for all children, and resources, for all children. They may not be as definitive as a handicapped child but other services may be needed. This is very
significant with pediatricians because in your busy practice, with limited
time to see patients, the resources need to be pulled together. We can’t do it
alone. Family is very critical.

DR. STRAIN: How has this been integrated, this concept of a medical home,
integrated into the academy? I know it’s housed in the Department of
Community Pediatrics. What’s the structure of that?

DR. SIA: This is very complex and difficult because pediatric leadership
needs to buy into the total concept. This is not just the staff of the Academy
but all of the pediatric boards and committees. In the last few years, there
has been a generational change now, a movement towards looking at
outcomes, quality care. This is perhaps fostered by our environment, which
is the payers. They’re looking at outcomes and evidence base. And
evidenced-based outcomes is going to mean a concerted effort of many people
working together, many organizations working together that support the
concepts that the child, especially in early childhood, requires family
support. There must be relationship building, working with and building
support among the resources of not just health but of education and all the
things that social policy must change. Is this going to come or not? I think
that’s the $64,000 question. It’s a social policy. We cannot work in silos
anymore. Silos aren’t going to work. And the Academy cannot work alone.
We’ve got to accept the challenges of change to create a partnership with the
family to move forward this agenda, which is a social-health-educational
agenda.

DR. STRAIN: For a long time, the Academy has struggled over the idea of
documenting the effectiveness of the well-child visit.

DR. SIA: Exactly. This is very critical, because the last few years, I’ve
come up with legislation to document the medical home effectiveness, to get
legislation passed that would help research data collection of what we do in
well-child health supervision, in outcomes that we expect with early
interventions, that will enhance our efforts. We’ve had some problems, but
we are moving ahead. Hopefully we can get something done, but, again, the
political climate becomes one of crisis. Money goes to prevention, early
intervention. People ask to buy in.

Part of this, and I will be political, is that we introduced the idea of home
visitors to Howard Dean back in the nineties. We went up there. He has
done good, evidence-based work as to where his program is coming from on
child abuse and neglect. Others have done this. But we need more national
support, a greater impact.

END TAPE 1, SIDE B
DR. STRAIN: Recently there was a meeting, a combined meeting of CATCH and the medical home people.

DR. SIA: That was our first national meeting.

DR. STRAIN: Can you tell me what happened there?

DR. SIA: I wasn’t there.

DR. STRAIN: I see, so you don’t know what came out of it.

DR. SIA: No, but it was a very positive meeting.

DR. STRAIN: It was.

DR. SIA: Yes. There was some concern about the medical home. In March, the American Academy of Family Physicians came out with the future of their academy and their family physician. And out of that, they did say they wanted to articulate the practice of the medical home. Apparently from the report in the AMA journal, [American Medical] News, family practitioners are saying that this is not practical under the present reimbursement system, the medical home practice, the concept. That was probably the one thing that came out of that meeting in terms of their role, but we will be meeting with them on an ongoing basis to see whether they understand. One of the understandings of the family practitioners is that they sort of understand or recognize that pediatricians take care of the early age group.

DR. STRAIN: They accept it.

DR. SIA: They accept that, and they will be taking care of the older age group, and therefore they need to see how they can facilitate better conversation.

DR. STRAIN: Sometimes in the adolescent area there’s even more of a need to look for outside resources.

DR. SIA: Exactly. And the transition is a very important area. One of the concepts of the medical home—I didn’t know if you wanted me to comment—

DR. STRAIN: Yes, anything more you wanted to comment on.

DR. SIA: —is that I feel that the concept is very important from the accreditation, ACGME [Accreditation Council for Graduate Medical Education] side and what they’re training, because it has involved the
ACGME in the type of training that probably should be part of the overall thinking for the future physician, much more so, I think, for the elderly. The elderly today have no medical home. If you have arthritis, you may see your rheumatologist, you may see an internist, and if you see a cardiologist, that’s another subspecialty; you may see oncologists. There’s no interconnection. There’s no way of knowing what medications one is giving versus the other. We then rely on the pharmacy, but there are so many errors ongoing and so many cross medications that are ongoing, and cross testing that’s ongoing, that unless you had a family internist who’s willing to be a medical home, the care is haphazard.

Then to look for resources, much less the medical care, nobody cares. That becomes an individual matter as to resources; so facilitation, advocacy becomes a real problem. Perhaps with over-treating our patients and being too kind to our patients—this is what the younger generation of doctors are seeing. “You all spoil your patients.” [Laughs] Where is the heart? Where is being compassionate with your patients and watching them grow?

DR. STRAIN: Cal, how do you define the difference between primary care and the medical home? In other words, the definitions are somewhat similar: comprehensive, continuous . . .

DR. SIA: I think they’re sort of synonymous in terms of primary care. One of the things that has come up with the medical home over the years has been: “I’m an oncologist, and the patient is now in my hands for complete control of care. Am I not a medical home?” Or “I’m a cardiologist, and it’s a complex heart. Am I not the medical home?” I say if they give the immunizations, if they take care of the anticipatory guidance of a young child, fine; they can do it as a pediatric subspecialist. But if they’re not doing the complete care, then they need to communicate with a primary care physician.

DR. STRAIN: And we need to treat intercurrent diseases in our patients unrelated to their specialty.

DR. SIA: That’s right. That’s right. And this gets back to what is a temporary [pediatric subspecialty] and primary care medical home; or basic understanding of pediatric consultant with primary care pediatrician, the medical home. But I think the definition of medical home needs to be clarified more, because basically the concepts are there for both sides.

DR. STRAIN: Yes, for both primary care and medical home.

DR. SIA: That’s right.

DR. STRAIN: Now, you obviously worked a lot with the disability groups.
DR. SIA: Yes and no.

DR. STRAIN: I’m talking about organizing medical conferences and so forth.

DR. SIA: That’s right. It was focused at the start with the handicapped. We were involved with Surgeon General [C. Everett] Koop’s impact in 1987, which was on the handicapped children or children’s special healthcare needs in family centered care. But at this stage, with the changes going on, it’s now all children. And MCHB [Maternal and Child Health Bureau] is looking at this. I have to tell you that this coming year, MCHB, separate from the children’s special healthcare needs—Peter [C.] van Dyck has a separate body, a child, adolescent and family health group headed up by Dave [David E.] Heppel. They’re pushing early, comprehensive child care with a medical home, which is all-encompassing for all children.

DR. STRAIN: Beyond disability.

DR. SIA: Beyond disabilities. And this is part of the performance outcomes that MCHB has set up, parameters. All families will have a medical home, all children will have a medical home, and families are part of this, in a systems approach to development. So this is not just children’s special healthcare needs but it’s set, in tone, by performance measures, by MCHB, for all children.

DR. STRAIN: Now, I think the Bureau of Maternal and Child Health played a major role in helping you to develop the concept. Did they not?

DR. SIA: Very much. Dr. Merle [G.] McPherson and Vince [L.] Hutchins were primarily supportive of what I’d done, and made me as successful as I could be.

DR. STRAIN: Anything more you wanted to say about the medical home, Cal?

DR. SIA: I think the concept is the important one to recognize, and I’ll repeat it again: accessibility, family centered, coordinated, comprehensive, continuous, culturally effective and compassionate care. Each one is very significant in its own right, and collectively they reflect the type of practice that’s embodied as the ideal for all children.

DR. STRAIN: I think it’s an attractive concept. I think the idea of having a home for a child that coordinates all that’s happening to that child is an exciting idea.

DR. SIA: It’s exciting, yet you must take the challenge of developing the resources and bringing them into play.
DR. STRAIN: Cal, I’m going to move on now to your experience in the political scene in the academy. You were selected to run for vice president on two different occasions. On this last election, you and Dr. [Steven] Berman were people that did not come through the Board of Directors of the Academy. And one of the things that concerns the [National] Nominating Committee is the number of people who vote. You know, we had less than 40 percent of academy members vote.

DR. SIA: I think it was about 30 this time, 32.

DR. STRAIN: I think you’re right. And part of the reason for that is they don’t know the candidates. They say, “I don’t know them well enough to really vote intelligently.” The idea was to try to make the candidates more visible to the membership, and they do that at the annual meeting with the talk and the question-and-answer period. It’s very brief. And the articles in the paper, and then the attendance at district meetings.

I wanted to ask you two things: What was your experience with the attendance at these district meetings? How did you feel about that, number one? And number two, do you have any ideas of how we might better educate the membership on the qualifications of the candidates?

DR. SIA: I could answer the first question very easily. I think the district meetings are excellent for the candidates selected to become the vice president-elect, in the nominations process. The district meetings are important, and I’ve always cherished them because you meet various chapter leaders who are really the heart of the Academy’s work, its functions. Chapter leaders devote a lot of volunteer time, dedication and extra services. And in the district meetings you meet people and get to understand some of the ongoing problems. Leadership means understanding the grass roots, understanding the problems at hand and the challenges that you’re faced with. Unless you work them out, sometimes being in leadership doesn’t mean a thing. And this is why the district meetings are very important.

Unfortunately, they cut down the number of days in the district meetings. We used to have a lot more time for socializing, to develop camaraderie. They’ve cut it down to the extent that there’s not as much time, and social time spent on a one-to-one basis is much more important to me than just to talk from the podium and not be as interactive. This is a fault, perhaps, of funding or otherwise in terms of meeting. Social interchange makes for a lot more thoughtful thinking and the ability to move issues from the grass roots and to understand them better. So I would fault this in terms of what’s going on because just to present something is not a good way to work the candidates. Small interchange is much better. You get to recognize this.
On the second issue, one of the things you know on my CV is that I was on the Nominating Committee back when we, the Nominating Committee, designated one person to become president. I was there for four years, and was chairman the last year. Each year, we gathered all the candidates, the nominations, and among the nine committee members decided how to vote and how to put up a single candidate. There was strength when the organization was small and people didn’t know the people. There was strength in terms of understanding and presenting good nominees. The lack of broad-based input sometimes resulted in a 5-4 vote [Laughs], where choices were made that were perhaps not as judicious or careful.

I think the broadness of a 32 or 40 percent participation is ideal, but, again, with the modernization of our election process, when you get to computerization and segments of populations that could be influenced by just clicking and getting a mass number of people clicking, you can lose an election by votes because of electioneering, capturing, say, 3,000 neonatologists or a greater number of section areas that have more numbers of votes. So this is a very tricky thing in terms of how you arrange it. I have no clear answer as to what’s best.

DR. STRAIN: There’s a fine line between electioneering and making people aware of the qualifications of the candidates.

DR. SIA: That’s right. And I think in the AMA process, even though the House of Delegates, 500, make a final tally, there’s active electioneering, campaigning in the three days, and you have an opposite effect of who’s elected, so it’s a hard choice.

DR. STRAIN: The last president that was selected by the nominating committee was Ed [Edwin L.] Kendig [Jr.]. From then on, largely because of some of the activism coming out of California, there was a change in the constitution that provided for two candidates. And the idea is good. I mean, to give the academy members a chance to make a choice I think is good, but, on the other hand, it’s very, very hard for the average pediatrician to know everything about the qualifications of a person.

DR. STRAIN: It’s been a long process. So it’s hard to arrive at an ideal solution.

DR. STRAIN: I want to ask you one other thing that really, I think, related to the Academy, which was your service on the Committee on Vaccine Compensation [US Advisory Commission on Childhood Vaccines]. Do you have any comments about that? I think you chaired that.

DR. SIA: Yes. Actually, Jim, I got that through AMA [laughs], not AAP. [Laughs] Your name preceded me from AAP. [Laughs]
DR. STRAIN: Well, the AMA has its nominations.

DR. SIA: Yes, AMA and Harry Jonas submitted my name.

DR. STRAIN: How did you like that service? Did you feel it performed an important function, that committee?

DR. SIA: Oh, yes. Again, it gets back to the pediatricians’ role among the families that are very opposed to our promoting immunizations, and families that have children who were supposedly injured by the vaccines. Sometimes we don’t listen enough to try to work out and negotiate their understanding or educate them about some of the processes involved in the transfer of scientific knowledge. It’s not an easy problem when you have plaintiffs’ lawyers and families arguing against this publicly. They’re a small minority. There needs to be a forum in which you try to iron things out before they surface on a broad scope. We see this because our immunization rates really dropped down recently because of concerns with thimerosal and concerns about MMR [measles, mumps and rubella] vaccination. So yes, there is a need for this type of body, and it needs to be a federal body rather than AAP or other sponsors, because we can’t, by dues, sponsor something like this. Our membership would be against it.

DR. STRAIN: It has a broad representation, which I think is good.

DR. SIA: Right. And this is so necessary.

DR. STRAIN: It includes parents and lawyers.

DR. SIA: Yes, but communications are very important, and how this is dealt with in leadership within the federal agency is also important. I’m very happy that we’re trying to work cooperatively through more open communications with the Academy to get more pediatricians aware of just what’s going on, which is apparently true.

DR. STRAIN: Education of the parents, I think, is terribly important.

DR. SIA: Oh, gosh.

DR. STRAIN: And that’s one of the things that really came out of that committee, you know, the patient information sheets.

DR. SIA: Where they get the information from.

DR. STRAIN: Yes, exactly.
Okay, let’s move on to the American Medical Association. You started with the Honolulu County Medical Society. What was your role there?

DR. SIA: Actually, I was involved more on the community and county level in Hawaii to develop interests in terms of participation of pediatricians, but my strong interest became state wide because I found—one of the things in pediatrics is limitation of time. Time means where your commitments are and how many people you’re going to affect. The county level is just Honolulu, while state wide we’d affect the whole island or a whole state. And also because the county worked with the city council and didn’t create programs for all children, the state was the one to affect advocacy for all children.

So from the county, I quickly moved up to the state and moved in different committees and was able to use this as advocacy, in a broad-based area, to advance the cause of child advocacy. I became chair of various things and really chaired the Commission on Public Health of our state [Hawaii] Medical Association, with about ten committees involved with maternal-child health, school health and others, advancing significant projects from the state level in the legislature, which was very meaningful, or through rules and regulations with the departments, to support various areas of child health.

DR. STRAIN: I was interested in your comments that when you became president of the Hawaii Medical Association, it gave you a forum for doing something about emergency care for children.

DR. SIA: Right.

DR. STRAIN: That’s when you really developed an interest in what was happening in emergency care. And you were able to implement that at the community and county level in Hawaii?.

DR. SIA: That’s right. There are opportunities as the state president to do much more on advocacy for children, and the luxury is that most people don’t have the time. [Laughs]

DR. STRAIN: Or take the time.

DR. SIA: Take the time.

DR. STRAIN: Were you ever a delegate to the House of Delegates from Hawaii?

DR. SIA: No, I was president, and then somebody named Jim Strain appointed me [Laughs] as a member of the [AMA] Section Council [on Pediatrics].
DR. STRAIN: That’s right. You got it. Now, I want to talk about that because the Section Council has a very interesting history. Early on, the Section Council of each of the subspecialties would put on a scientific meeting, but that has gone by the wayside. It is no longer educational. I want you to tell me how the Council evolved, because it’s become an important part of Academy activities now in its relationship with the AMA.

DR. SIA: Actually, we had one delegate to the AMA back in 1979 to 1980, and an alternate delegate. We began to meet with ACOG [American College of Obstetricians and Gynecologists], and we began to have a luncheon with the pediatricians who were attending. This was our Section Council on Pediatrics, one meeting, which was the luncheon on a Sunday, when we met all those pediatricians from state societies. They were very unfriendly to the AAP leadership: outspoken, unfriendly. But because I was a state medical association president, I was an ally to them and was able to cultivate trust and began to develop the section council into a meaningful setting, and through the help of the board and the CEO, I was able to talk about geographic representation for the section council. We had a small, select group from the West Coast, the East Coast and the Midwest and developed key past presidents from these states who were also active with AAP, to become colleagues in moving the section council in having a presence in the House of Delegates.

Significantly, the leaders were very loyal to us and to AMA and began to develop more resolutions that were meaningful, which we could introduce, and we began to have a presence over the years. And when the AMA allowed us to increase the number of delegates, we began to look at young leadership that had past state medical association relationship and bring them on as delegates, so now we have five full delegates as our AAP representation, and we have an AMA section council that has been much more active and perhaps more aware of AAP’s involvement with AMA.

In addition, from our relationship with ACOG, we developed and cemented an interchange at each meeting now, where we have a caucus that meets to discuss maternal-child affairs or discuss reports and resolutions submitted to the AMA House of Delegates of mutual concern that will affect health care, and subsequently developed a stronger relationship with primary care, the AAFP, the American Academy of Family Physicians, and the ASIM, American Society of Internal Medicine, now the American College of Physicians. Joe Sanders [Jr.] really brought this about with their executive directors over the last two years, so that we now regularly meet and discuss pertinent areas.

Part of this has been AMA, itself, in terms of its composition and organization, where we’ve met in terms of looking at organizations and realized that among the four so-called primary—ACOG may not be strictly
primary—societies, ACOG, AAFP, American College of Physicians, and AAP, we have a greater number of active members than really the rest of the AMA, so we do have a dominant role if we work together collaboratively.

So this is a present strength of our AMA Section Council on Pediatrics and AAP representation with the primary care, and I think the changes are important because our emphasis really is primary care, but more so, pediatric subspecialists, pediatric surgical specialists, survival in this atmosphere, because AMA is very strong on medical economics, and AAP has not been strong in economics. They’re very strong with the conservative Republicans, yet we’ve been more liberal in working with the Democrats, and we need to come together to interface and work together for the sake of our ultimate goal, which is children and families. How we do this, regardless of politics, is important in the service area but also in the educational area and the training area. It will affect all our next generation as we go along, and we need to go concertively toward the public, be it the community, the state, but also the federal levels.

DR. STRAIN: One of the important functions, I think, in the House of Delegates is to vote on or support or reject resolutions.

DR. SIA: Right.

DR. STRAIN: Where do our resolutions that are introduced by the Section Council on Pediatrics come from? How are they generated?

DR. SIA: What’s happened in the past and still is very critical is our committees or sections are the ones that generate any resolution that is presented to and approved by our board, then submitted to our AMA section council to submit as an AAP resolution. One of the clear factors that one should understand is that AMA policies are set by the 500-odd members of the house. AAP policies go through a longer channel: committee, sections, submission to the board, then a process whereby all committees that are pertinent to the resolution review it, and then the board gives its final approval before it becomes a policy statement. This may take sometimes a year to two years. AMA house decisions are made within the three-, four- or five-day policy House of Delegates meetings. So that’s a difference. The house decides policy, while committees and boards in the AAP make policy, not the membership itself. In the AMA, the board simply implements policy, which is a significant difference. The Chapter Forum, for instance, which is now the leadership forum [Annual Leadership Forum] beginning in August, next week, for instance, is a body that suggests policy and resolutions but doesn’t make policies.

DR. STRAIN: And now includes chapter chairmen, sections, councils, and committees, so it’s a little broader forum.
DR. SIA: Right. But it still goes through a longer process.

DR. STRAIN: It would seem to me that the resolutions being presented by the Section Council on Pediatrics in the House of Delegates have more chance of really being adopted by the house as a result of the individual pediatricians in state delegations, as well as the interests of the primary care doctors.

DR. SIA: That’s right, exactly, because that’s where the numbers count. We represent, what, five delegates out of 500? A very small percentage, so we need the support of the state representatives, pediatric representatives, plus the primary care.

DR. STRAIN: You’re entirely right that you brought a synergy to that that no one else could. I think your credentials, as president of the Hawaii Medical Association, really paid off because I think to have the Academy dictate a resolution to people who were serving on state delegations wasn’t going to fly.

DR. SIA: No, not going to fly.

DR. STRAIN: But I think the fact that you represented both the AMA and the Academy brought together these disparate groups really made a difference in how resolutions were considered.

DR. SIA: This is important in naming your next few delegates as you go along.

DR. STRAIN: Yes.

DR. SIA: Credibility is very key to building that trust. And, Jim, I didn’t want to jump ahead—when AMA honored me a few years back with the Benjamin Rush Award [for Citizenship and Community Service], out of all the House of Delegates members and the membership for community services, that was a major coup for pediatrics. And then this past year, when the Young Physicians Section honored me with the Young at Heart Award, again it suggested pediatricians have arrived.

DR. STRAIN: Let me talk a minute about the American Board of Pediatrics. What was your role there, Cal?

DR. SIA: At the board level, I was one of the early oral board examiners back in the seventies and was an examiner for a long time. I regret that I never became a board member. I, however, recognize that I did not do as much in the academic way that they expected. But it allowed me to do other things.
DR. STRAIN: Cal, I want to ask you a little bit more about the appointed positions. You touched on that already.

DR. SIA: Yes, I’ll take this, because I think my big eye opener was back in the 1970s, when President [Richard M.] Nixon appointed me to become a member of the advisory council of NICHD [National Institute of Child Health and Human Development]. This was a major coup in terms of a private, primary care practitioner being appointed to the illustrious NICHD.

DR. STRAIN: Well, that hadn’t been in existence for too long at that time.

DR. SIA: That’s right. It was a new NIH [National Institutes of Health]—and Bob [Robert] Aldrich was the originator of that. I became a member with distinguished academicians like Sam [Samuel L.] Katz, Phil [Philip R.] Dodge, Heinz Eichenwald. And I was in shock [laughs], because I had been just in primary care practice [laughs] for less than ten, twelve years. But Senator Inouye, a Republican, was the one who appointed me, and President Nixon made the final decision. Those were interesting years because I added a breadth of understanding to the academicians because they had not had a primary care pediatrician, to the extent that when Norm [Norman] Kretchmer came on as director, he kept me on for four more years. So I had good exposure to NIH and understood much more about research and funds that were going to the major ivy leagues, and obviously began to understand more.

Perhaps my biggest link there was the Office of Child Development, which was just starting [in 1971]. Ed [Edward] Zigler was on that, and he came to the meetings, and the Office of Child Development got the Mondale-Brademas bill [named for co-sponsors Senator Walter Mondale and Congressman John Brademas] for children and child abuse and neglect, and that’s how I found out about twelve grants that were coming out. Out of the first twelve grants, I got one for Hawaii, which was our prevention of child abuse, which was the start of our Hawaii Family Support Center [originally Hawaii Family Stress Center] and what I’ve done in the child abuse prevention area, which has been very much a very strong part of what I’m interested in, based on Henry Kempe’s work. So you seize the opportunity, Jim, and look at where things are and then work things out.

DR. STRAIN: You were a governor’s appointee to the White House Conference on Family. I think that was 1980.

DR. SIA: Right. Every ten years there was supposed to be a White House conference, and President [James Earl “Jimmy”] Carter’s theme was a conference on family, so Governor [George] Ariyoshi, our state governor, appointed me, and I chaired, with the local Junior League, our pre-White House Conference and worked on families, again recognizing my

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background in family empowerment and family support. This was a whole
area of advancing the cause and working with different resources to promote
relationships and collaborations. Very fascinating in terms of knowing the
hierarchy of local community, state and federal.

DR. STRAIN: And how to implement some of these programs.

DR. SIA: Right.

DR. STRAIN: You mentioned earlier on that you were an appointee to the project
on Zero to Three. Was that a spinoff of the White House Conference?

DR. SIA: Yes, this was important in terms of when the Public Law 99-457 [Education of the Handicapped Amendments of 1986] came into being.
The states were given the options of developing this and what they would do.
I got involved because of my interest in special education and being chair of
the previous legislative committees. I was involved as the medical input,
pediatric input.

DR. STRAIN: Did that work out well?

DR. SIA: It worked out very well. We got an act passed and got the
definition. I chaired the definitions committee and got this going, and we
were active in pushing Zero to Three. I should comment, this helped me with
my medical home training project because we established one agency for
early intervention, so all pediatricians could simply call Zero to Three if they
had any problems in a child who needed resources and referrals, so it’s a
one-call, one-shot deal for families and children. It’s still in existence today,
and it’s very much of a rich resource in the Zero to Three.

DR. STRAIN: And could they arrange a referral?

DR. SIA: Referral for testing or screening.

DR. STRAIN: Anything that the doctor was concerned about.

DR. SIA: That’s right.

DR. STRAIN: And that’s true of all the pediatricians?

DR. SIA: Anyone can call, which makes it wonderful. So these are the
projects that we see that are gratifying to see, and which enhance the concept
of moving from an individual to the community, to the state, based on a
federal law.
DR. STRAIN: Let’s talk a little bit about grants and contracts. You’re pretty good at this.

DR. SIA: [Laughs]

DR. STRAIN: Now, a lot of your grants came from the Maternal and Child Health Bureau.

DR. SIA: Yes.

DR. STRAIN: You had some other grants.

DR. SIA: The important thing is the stepping-stones. You start with local grants and foundations, and one of the things that you see in advocacy is that you have fellow people interested in areas and how to advance that cause, and you work with them collaboratively. It’s not one individual. I didn’t do it by myself. People have helped me. And, you know, right hand, left hand—there’s always someone who’s going to help support this and really do the bulk of the work, and I get credit for it, which I don’t deserve. So a lot of this has been collaborative and support from just social workers, public health nursing, early educators and others who have really built this whole “grantmanship” as you go along.

DR. STRAIN: Did that include the private grants? Because you had a number of private grants.

DR. SIA: Right.

DR. STRAIN: The Robert Wood Johnson Foundation, the [Annie E.] Casey Foundation, the [David and Lucile] Packard Foundation and the Carnegie Foundation [for the Advancement of Teaching].

DR. SIA: This gets back to relationship and the people with whom you make contacts. For instance, through the oral boards, you know and I know we met a lot of academicians, and it’s these academicians, the leaders you sort of got to know socially. And Cathy [Catherine D.] DeAngelis, back in the seventies, I got to know very well. When I looked at my Healthy Start [Program], I needed an evaluation for this in the nineties, and I asked Cathy for a good evaluator, and that’s how I got Anne [K.] Duggan started in 1991, 1992. I brought her on from [Johns] Hopkins [Children’s Center], although she’s based at Hopkins, to do evaluations for us, and we worked together for the contacts that we had, for funding, for evaluation of Healthy Start that’s ongoing as we go along.

So resources are how you tap in. The Carnegie grant, which was important in terms of early childhood and medical home for all children, that all
children should be healthy and ready to learn, is significant in terms of partnering with the Hawaii Medical Association and the governor’s office. So here I brought health to the governor to tie into early childhood, responsible parenthood, the problems of ensuring good health, quality childcare and mobilized community, which became a statewide involvement. And from there, I initiated Good Beginnings Alliance, which is now our advocacy group for all the different agencies for health, family support and education, that all children will be healthy, safe and ready to succeed by the time they enter school.

So these are how you parlay ideas and not do it by yourself because there are others who are very interested in moving this and sustaining it to move the policies, the programs, the projects along. That’s probably the success I see in sustaining projects.

DR. STRAIN: Those are good suggestions, because I think a number of pediatricians have good ideas and would like to have funding for various projects but don’t quite know how to go about it, and your suggestion is to combine with or develop a consortium with somebody else who has a similar interest.

DR. SIA: That’s right. There are many in your community who are willing and able and do better than you in moving this idea, and you look for the leaders, and the leaders become your partners. In addition, I think the other way I approached this was to pilot. That’s why I piloted with a local foundation, in one area, a healthy and ready-to-learn setting. And I utilized, in 1995, an inter-professional staff of our nurse practitioner, a social worker, a pediatrician and, in terms of family support, the family support services to bring together training. We developed a training program, curriculum, for pediatric residents and OB [obstetrics] residents, to see whether, in placement with social workers, with family support workers, with early educators, with nursing, we could work as a team.

When the money ran out, we had to replicate this in a public setting, like a Head Start setting, but this was worthwhile because in the funding I received, I developed relationships with the University of Hawaii School of Social Work, College of Education, [John A. Burns] School of Medicine, School of Nursing and Department of Public Health [Sciences and Epidemiology] to develop other people interested in early childhood, in inter-professional collaborative training and service. These are things you develop slowly, with what seeds you planted in terms of concept of a multidisciplinary, inter-professional, collaborative, team approach in service, in training and perhaps in research.

DR. STRAIN: You were one of the early consultants on the Head Start program.

DR. SIA: Right.
DR. STRAIN: That’s when the academy had the program.

DR. SIA: And that taught me a lot.

DR. STRAIN: And you went to the outlying areas in the islands—

DR. SIA: That’s right, and I learned from the grass roots, Molokai, which is a very rural, poverty-stricken island, and Hilo—again, a welfare area right now, and then Honolulu, with its suburbs and very strong middle class mixed with welfare children. But in learning Head Start, I also learned birth through three is most critical. And then in 1995-96, with the Carnegie grant, with the early brain development and the science of this, it became even more evident to me we needed to change the environment of relationships, changes and emphasis as we go along.

DR. STRAIN: Are the Head Start programs still ongoing here in the islands?

DR. SIA: Yes. Early Start is the other one that we’re moving into.

DR. STRAIN: Do they work together?

DR. SIA: Yes, they do.

DR. STRAIN: Okay. We talked a little earlier about your awards and honors, and you mentioned the Rush Award. You’ve received many, many awards, Cal. What do you consider the most significant, prestigious? What are most important to you?

DR. SIA: Well, I think the [Abraham] Jacobi Award, which was the AMA-AAP award, was the first major award that helped me introduce my concepts of integrated system of care. Prior to that, the important one, obviously, the one that brought me national recognition, was the Henry Kempe Memorial Award for Prevention of Child Abuse Award, because that gave me a platform to approach the national council and prevent child abuse and neglect, to present the model for Healthy Families America. I think each award that allows you to introduce your ideas is very important, as a measure of advocacy, and that probably helps enlarge educating advocacy by others.

My other important one was simply being honored by the University of Hawaii, since I was not a University of Hawaii graduate, with an honorary doctorate of humane letters. Again, this was very unusual and certainly worthy, in my heart, of recognition by your peers, by your own self. So as you look at this peer wise, the child abuse consortium, the university consortium in Hawaii, AMA and AAP, obviously the Job Lewis Smith Award
and the award in terms of the AAP were very significant in terms of where we are. But ultimately it’s my own bases, which—if anything, my wife’s appreciation of my work. [Laughs] My family.

DR. STRAIN: She’s very tolerant.

DR. SIA: Very. She’s allowed me to do all of this. The awards don’t mean anything unless there’s some appreciation with it at home.

DR. STRAIN: Absolutely. No, Kathi’s an important part of what you’ve become.

DR. SIA: She has really helped me. She has given me the time to do this.

DR. STRAIN: You’ve had many publications, Cal. The one I wanted to ask you about was the chapter you had written on leprosy that was in the *Current Pediatric Therapy*. You were in several editions. Can you tell me a little bit about how that came about?

DR. SIA: Syd [Sydney] Gellis was just starting his book on pediatrics—what was the title of it?

DR. STRAIN: It’s called *Current Pediatric Therapy*.

DR. SIA: *Current Pediatric Therapy*, with his co-editor [Benjamin M.] Kagan. Both were friends of mine. He really wanted to include some rare diseases at that time, and leprosy was one that he didn’t have covered. My aunt was one of three doctors in charge of the leprosarium on Molokai; the other US leprosarium is located in Carville, Louisiana. So we looked at what she had and what information I could gather, and that’s how I got involved with leprosy. But, as you know, my other relationship is that personally my older sister had TB [tuberculosis], and TB and leprosy are similar in terms of a latent type of immune reaction. She had lung removal and had some problems as a young child, adolescent.

So I was personally interested in infectious diseases, besides my father being involved with infectious diseases. As you recall, my early response after residency was to work with Fred Robbins in infectious diseases, so I had a lot of attachments to infectious diseases. Heinz Eichenwald taught me a lot in newborn infectious diseases, so that was part of the area that got me into leprosy and then followed up with vaccine compensation, so I’m a jack of all trades and master of none. [Laughs]

DR. STRAIN: It’s interesting.

I wanted to talk a little bit about your current activities, Cal. You retired from practice in 1996. You continue to be very busy.
DR. SIA: Kathi complains that I am busier than ever. One of the beauties of a success I’ve had is beginning to get onto computers and e-mail. [Laughs] This has made it so much easier to contact people and get on with information, communication exchange. My interest, as I said, has been focused on early childhood, an integrated service systems approach, a medical home for all children, since 1989. I really have felt that if we’re going to accomplish anything, there needs to be a social policy change, which must come by blending funds for children during their critical area, which is early childhood, where we find the payoff probably at its greatest. So my push has been to advance this and advance this both nationally and now internationally.

Over the years, with my inter-professional collaborative training, we tried to work with Japan on inter-professional, collaborative training in early childhood. For three years, we were working with Aprica, A-p-r-i-c-a, Childcare Institute of Japan. It was a private industry and was mainly one that developed the baby strollers and now developed baby safety chairs. I thought that they would be very interested in what we’re doing, because the founder, Mr. [Kenzo] Kassai, was very interested in developing “warm-heartedness” in all children. Warm-heartedness reflected, to me, compassion or nurturing, and I thought I could introduce him and the pediatric leaders whom he was going to designate to be involved, to integrated services.

We worked for three summers on that inter-professional training with Japan and our Hawaii team, but we found that their pediatricians were neonatologists; their private pediatric hospital in Tokyo was a woman’s hospital that dealt with neonatology. He had done some national work with AAP and with the pediatric academic societies and was very well recognized, but they weren’t interested in spreading the word. So when I had the opportunity, when I was asked by the Hong Kong College of Paediatricians, to be AAP’s representative in 2001, I believe, and talk on primary care, I presented the medical home. They had an international conference on primary care and became very interested in the concept.

I then came back and thought I would emphasize medical home for all children, internationally, through the Asian group, the leadership, and last year, in 2003, pulled together an Asian think tank with these leaders from China, Hong Kong, Singapore, Thailand, and the Philippines, through the help and support of one foundation, the Johnson & Johnson Pediatric Institute. We had a very interesting session because I brought together Jack [P.] Shonkoff, whom I had brought here to Hawaii to talk about From Neurons to Neighborhoods, the IOM [Institute of Medicine] report on integrated services for the developing child. I utilized him as a partner with Merle McPherson, maternal-child health; Tom Tonniges from AAP, and
Michael Levine from the Carnegie to really pull it together, and we had a very interesting meeting.

DR. STRAIN: Where was that held, Cal?

DR. SIA: Here in Honolulu.

DR. STRAIN: I see. And this was the Asian think tank on early child development.

DR. SIA: Right, on early child development, a cross-cultural perspective. We subsequently met in the Asian Congress of Paediatrics in Bangkok. Jack and I met with them, and again had an interesting exchange, and we’re planning a second major meeting here of the Asian group. That’s an Asian-US partnership in Early Child Development and Primary Care [AUSP] and now have enlarged it to include India so that we now have India, Thailand, Singapore, Hong Kong, China, and the Philippines. And we have a cross-cultural anthropologist, Dr. Jackie [Jacqueline] Goodnow, coming from Australia, and we’re moving forward in this sense and hopefully will have a third conference next year, to advance the cause. Of interest is, voluntarily, Hong Kong is bringing their director of maternal-child health, and I was able to get World Bank to support China’s Ministry of Education in early child development. And Philippines in early child development to bring together to again look at a broader scope of leadership, grass roots, and try to apply the science of early childhood development into practice, to translate really the science of developing child, the integrated system of approach, into these nations that have, as a base, the old morbidities and also try to look at some of the new morbidities that are coming about, and see what can be done.

DR. STRAIN: Do any of these countries have the funding source and personnel to be able to carry this out?

DR. SIA: The major area of concern obviously is child health care funding for China. There is an uneven balance of wealth, manpower, health care resources, and a big difference of urban versus rural health care practice. There are strong urban hospitals with very weak rural health centers. There has been a void in medical research and training; thus the focus on building this infrastructure and capability. An example is SARS [severe acute respiratory syndrome], last year’s SARS epidemic. The monies go there, but how can you introduce early prevention, early intervention practices for the next generation of children? Nutrition, housing, poverty are major issues in rural areas. But with the influx of monies coming in, the growth spurt, where does health, education, family support come into play?

Singapore, being a small nation, is way ahead, way ahead of even the U.S. There they introduce everything, not just children with special healthcare
needs but programs for all children. But it’s government run. Thailand is a different story. Philippines is much different. They’re similar to China, but they have working mothers who are sent overseas and fathers are taking care of the children. They’re Catholic, so they have big families. How do we introduce improved home care? With grandparents and fathers.

Hong Kong, being British dominated, is very much in tune to moving forward, and they’re looking in terms of introducing more programs. I’ll get back to the Philippines because for the next two years the new president of the Philippine Pediatric Society, Estrella Paje-Villar, has set, as her top priority, with Alexis Reyes and support of Perla de Santos Campo, a Task Force on Medical Home Initiatives. Now, isn’t that something exciting? That makes you at least think that some of the other nations are looking at the broad vision that started here in Hawaii, that AAP has now looked at, and are moving ahead. Top priority for the Philippine Pediatric Society.

DR. STRAIN: That’s wonderful. You know, the programs that you talk about that are successful are in the areas that are ahead in development, I think. They’re not dealing with the common infectious diseases and so forth. And they have the infrastructure to be able to do it. But you hope that’s going to translate into China and the Philippines and Thailand.

DR. SIA: Exactly. It’s a balance. And India.

DR. STRAIN: Right. That’s what we like to see happen, which would have a worldwide impact.

DR. SIA: That’s right. And in doing this, Jim, the United States has to rethink its focus, too, when other nations are beginning to—global changing are affecting all of us, and where World Bank is interested, the economy, manpower, workforce is interested in the next generation, we should really look at it.

DR. STRAIN: Does WHO [World Health Organization] have a role to play?

DR. SIA: I don’t know, but I’m looking at funding for my meetings, and World Bank came through. I’ve done this independently [Laughs] as a practitioner, with no support. [Laughs]

DR. STRAIN: Well, that’s exciting, Cal. It really is. Apart from the Asian issue and the impact you had there, what about the Dyson Foundation Community Pediatrics Training Initiative? You serve on the program advisory committee.

DR. SIA: This is a fascinating approach that enlarges the scope of what I’ve done with the training process of our inter-professional, collaborative training from the university. I should say that when I retired in 1996 that
subsequently, in 1999-2000, Annie Dyson came up with a training program for pediatric residencies in community pediatrics, and I was asked to join her initial group, to be part of this and designate ten universities to receive $2.5 million, over a five-year period, to develop this curriculum, the training of pediatric residents and to demonstrate this as a pilot. When Annie died within a year, of breast cancer, Judy [Judith S.] Palfrey at [Children’s Hospital] Boston became the NPO, national program officer, rather than Annie, herself, and I became the chairman of the program advisory committee. I’ve been very closely involved with this and therefore have a close tie with what’s going on in terms of promoting pediatric residency training and promoting this from the curriculum training program, from the research area, from the collection of data and from the area of advocacy that we all want to get involved with. It’s been an interesting change. A lot is going on, and there’s a lot more to be done. I’ll talk about this in terms of our changes. I personally think there’s a lot more that can be said, but at this stage I will not get into it.

DR. STRAIN: I’m wondering. You’re now professor of pediatrics.

DR. SIA: I’m a 10 percent FTE [full-time equivalent]. [Laughs]

DR. STRAIN: One of your responsibilities is to implement this program on community pediatrics. Tell me how that’s going to work out. Can you give me details about that?

DR. SIA: There are ten universities that got the grant.

DR. STRAIN: And Hawaii is one of them.

DR. SIA: Hawaii is one of them, so in Hawaii I’ve mentored some people who are involved in—obviously with my strength—developing medical home as a premise in training, to get involved from early childhood, school health, adolescence.

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DR. SIA: Community pediatrics is a very important area of the training of pediatric residents, to understand what’s going on as they go out to practice. This is key, because our current RRC [Residency Review Committee] has been emphasizing a lot of work in the hospital with specialists. Yet the bulk of practice, 90 percent, is outside of the hospital practice, and we’re not training doctors to do this, much less for the rural areas. There’s a lot of concern about the future of pediatricians who go out from the current training who haven’t done LPs [lumbar punctures], spinal taps, or don’t know as much about acute care as they should in the rural areas, where they do everything.
We tend to make referrals a lot, and they learn to use consultants much more, and therefore sometimes in terms of practice, if you go into the rural areas, there’s concern as to developing much more independence in thinking and following through in action. In community type pediatrics, we do develop relationships, too, and this is important in terms of supporting the family. The pediatrician, as far as understanding the bulk of the work, needs to get to the community and work with the community and understand the community. This is important.

What I see changes with the current RRC is the lack of understanding or need for this. Part of this is because of the 80-hour work week and the difficulty in slotting positions, because residency training is also fueled by reimbursement by hospitals. The cost of the education is more for service in many hospitals, and reimbursement for inpatient service, with higher income services demanding more services, such as NICU [neonatal intensive care unit], PICU [pediatric intensive care unit]. Hospital stays are being cut down, and how do you relate this to the follow-up care that’s ongoing and handling and managing follow-up care, which is very critical? This is a part of the community pediatrics and understanding.

So medical home needs to be tied together from the tertiary specialists, subspecialists, to primary care, and this is what I’d like to introduce more and more to the primary care doc or to pediatric residents in general that stay in tertiary care, to understand the complexity of working with their families when they’re distanced or away from this.

DR. STRAIN: I think there’s a real difference in what a pediatrician in an urban area, with a medical school nearby will be doing versus what the pediatrician in the rural area will be doing.

DR. SIA: Exactly.

DR. STRAIN: Do you see training programs taking that into account, emphasizing more one aspect of urban care or rural care, depending upon where you’ve got to go into practice?

DR. SIA: This gets back to, “Does one residency training program fit all?” Or do we begin to have emphasis in different residency programs for different areas, which the individual begins to pick and choose? This is a hard decision because in residencies, when you enter the first two years—or the first year, much less—you’re not sure what you’re going to be, and your choices then are influenced by your mentors.
DR. STRAIN: Perhaps that ought to be in the third year when you make your decision as to whom you work with, for example, what office you might be working out of.

DR. SIA: That’s right. And I think we need, equally, the academicians in bench research or research, itself. We are sorely lacking in certain areas. So we need both sides.

DR. STRAIN: Cal, what do you see the future to be of general pediatric practice? And I say that because there’s a lot of concern about that. We have 60,000, probably more than 60,000, pediatricians in general pediatric practice in the United States. There’s an increasing emphasis on the use of, I’ll call them “allied health professionals,” working with pediatricians to take care of the minor problems that children are afflicted with. On the other hand, you see subspecialists who deal with more complicated cases, and as you mentioned earlier, they sometimes assume the role of the primary care doctor or the medical home. Where do you see general pediatrics fitting in the next ten to fifteen years?

DR. SIA: I see the future of care is very much based on the access and reimbursement issue. The access and reimbursement issue is, “Who will subsidize care or pay for care for all children as we go along?” Third-party payers? Which has been the bulk of it. Or federal Medicaid, as we go along, or state? My feeling has been very strong that federal government needs to take care of the poor, and we need a safety net, and how we do this is going to be very much of a political issue. I am concerned that the residents in training who normally would go to primary care may be going towards subspecialty because of the reimbursement issue, and there’s going to be a lack of good, fundamental primary care generalists.

We need the generalists. One of the immediate issues that I see for the next few years is the need for neighborhood health clinics that could become the medical home for continuity of care, for comprehensive care for the poor and to develop settings for comprehensive care that deliver not just health but social and educational support, parent-child educational support as we go along. I think this is one avenue that’s going to have much more attractiveness for those going into community pediatrics, to find positions and move into leadership positions.

Reason for this? I think there’s a push towards comprehensive, one-stop shopping, and I think in the big medical office, the support services are not all there. This includes the social workers, public health nursing or other allied health resources that we need. Team function is very critical. Team function is the way we train our residents to work with and develop models for effective outcomes. Is this going to be done? Can we do it? I think those are the challenges that I’d like to see in pilot projects and develop this and see whether it’s doable. Can it be effective? Can we get these into an
ongoing infrastructure, through training, which then allows service to move ahead? Clinical research to enhance this will be very important, and research in terms of the whole socioeconomic setting.

Some people keep telling me, “Cal, you’re on the wrong track,” that “you’ve got to get rid of poverty first. You’ve got to change the environment.” I’m not sure. I think you work with people and you work with people involved, and it gets back to the child, family and you. As an advocate, I think this is where we need to continue to look at how we can make that change one to one, one to the community, and I hate to use the term village again, but from the village or community, to the state, and then to the federal.

DR. STRAIN: Cal, the Academy has been working for a long time to bring about universal healthcare insurance for children. Now, with your background in the legislative process, how do you see that coming about? Is it possible? Where is it going to go?

DR. SIA: I’m going to be very blunt on this and perhaps stick my neck out because I’ve seen, in the last ten years, all the monies that the Academy put into universal access to care on an overall federal funding that’s similar to Medicare. I see with Medicare we’re running into trouble, and we’re going to run into trouble because Medicare and the Medicare prescription act [Medicare Prescription Drug, Improvement and Modernization Act of 2003] have wreaked havoc on our budget. They’re talking four, five billion dollars, which is going to create problems with Medicaid, capping Medicaid, capping the safety net that we have for children. Our problem has been we haven’t spoken up, then, for the uninsured children who are the Medicaid population.

And I’m saying, and I said this two years ago to the Academy leadership, we need to bifurcate Medicaid to handle a new, innovative approach for acute and chronic care for all children, uninsured, low-income patients. Now, this is a whole, harsh new area that nobody wants to talk to, but because of state-federal funding agreements, we have no universal national policy. Some doctors are paid very well in certain states; some doctors don’t get anything. It’s only unless we have a bifurcation where there’s a universal care for children, acute and chronic, because people are concerned acute care doesn’t take care of the long-term handicapped children and other resources. We need to redesign our system.

I think middle-income, third-party payers again become a real challenge, because in a working employee, family support sometimes comes in second or last, and they’re not covered, so we need to ensure, by some guarantee, that they’re covered in some sort of a policy. We’re also arguing against cafeteria-style coverage. Is it insurance just for catastrophic illness? We in pediatrics need to continue to push preventive and early intervention because
cost effectiveness—we know what we do. If we get more evidence base on what we do, we can enhance the need for preventive care and early intervention services, to avoid the crisis hospital care that’s ongoing.

It takes great minds to pull this together. We have many great minds. I’m not in that area. But there are leaders who could be brought together to really rethink what we can do for children, and change this health and social policy for children and ensure, because of the political, bipartisan approach to health care and the escalating cost of health care, ensure that children have something that’s solvent.

DR. STRAIN: Right now, insurance is covered by employers. Medicaid covers a group of children. The SCHIP [State Children’s Health Insurance Program] program covers a group of children. All of that is somewhat voluntary. Do you think for it to become effective that there’s going to have to be some kind of action taken where children’s insurance is required, that it has to be mandated? Not voluntary; as long as it’s voluntary, there’s going to be people who aren’t going to take advantage of it.

DR. SIA: That’s right. All children. Families can’t afford this unless it’s part of a package, and the package needs to be a comprehensive package. Now, this is dreaming. That’s ideal. But why can’t we set the ideal for the uninsured, under-insured at this stage and work from there, incrementally? It looks as though the last ten-year efforts for universal coverage are not politically feasible at this stage. Let’s work on the under-insured and uninsured. It’s not an easy job.

DR. STRAIN: No, and the Academy has been at this, you know, for ten years.

DR. SIA: And nobody wants to change what we’re comfortable with. Every state has certain things. And whether this is feasible—but it then gets back to a social consciousness. If healthcare access and costs are escalating, something’s got to be done. It’s going to be done for the elderly. Kids are going to be left out. Can we come up with a proposal, or thinking at this stage, that will counteract what’s going to be obviously “kids are last?” That’s what I’m saying. And you got models now to move that with the medical home.

DR. STRAIN: Cal, I think we’ve covered the things that I wanted to ask you about. Are there any last-minute statements you want to make?

DR. SIA: I think, Jim, that in terms of work, it’s really a matter of support by many, many people. The fortunate thing is to have mentors who give you ideas. I could name a number of mentors who have helped me in pulling it together. And the second thought is, never give up, to have perseverance. [Laughs] Keep trying, because down the road, someone will
listen. And the third probably is mentorship. I think the beauty about my age today is mentoring the younger ones and having them move and perform even better than I do, which is really the gratifying thing.

DR. STRAIN: Sure. Thank you very much, Cal. I appreciate your comments. It’s great, and we’ll see that you get a copy of the transcribed version, and you can go from there.

DR. SIA: Thank you, Jim.

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CALVIN C.J. SIA, MD FAAP

Calvin C.J. Sia graduated from Dartmouth College, Western Reserve University, School of Medicine, and did his pediatric residency training at Kauikeolani Children’s Hospital in Honolulu, Hawaii. A primary care pediatrician in Honolulu for 38 years, he retired in 1996 from practice to devote his time as Principal Investigator on various early childhood grant projects promoting the medical home and integrated system of care. A Clinical Professor of Pediatrics at the University Of Hawaii School Of Medicine, he has continued his association with the Department of Pediatrics since retirement as a part time Professor of Pediatrics.

Dr. Sia has been a tireless child advocate in Hawaii, nationally and internationally. In partnership with staunch advocates like himself, Dr. Sia has been actively involved in Hawaii since the ‘60s with establishing child protection services center, a statewide home visiting program to prevent child abuse and neglect, statewide school health system and support for special education services in public schools through his legislative efforts. He privately founded the Variety School for Learning Disabilities in 1967. He also conceived a bill with Senator Inouye’s support in Congress that established Emergency Medical Services for Children as a system of care nationally in 1984 that is now in all 50 states and territories.

Beginning in the early ‘80s, he promoted statewide the concept that “every child deserves a medical home” and advanced the medical home and integrated community based system of care for children with special health care needs in Hawaii. Through support of Maternal Child Health Bureau grants, this was subsequently promoted nationally and transferred to American Academy of Pediatrics as the National Center for Medical Home in 1995. He has Chaired this Professional Advisory Committee since 1995-date.

Since February 2003, Dr. Sia has convened selected pediatric leaders from Asia and USA to translate the science of early childhood in primary care. Four successful conferences were held with leaders from Beijing, Shanghai, and Hong Kong China, Philippines, Singapore, and Thailand.

Dr. Sia has been Chief of Staff Kauikeolani Children’s Hospital 1963-67 and its Board of Trustees 1967-82; Kapiolani Medical Center for Women and Children Board 1982-90; Kapiolani Health Care System Board and subsequently Hawaii Pacific Health from 1990 to date, Emeritus since 2005; President of the Hawaii Chapter American Academy of Pediatrics from 1968-1976; President of Hawaii Medical Association 1976-77; Chairman, American Medical Association Section on Pediatrics 1983-2007. He has served nationally on the Advisory Council Child Health and Human Development, NICHD, NIH and Advisory Commission on Childhood Vaccines, HRSA, HHS.

He has been recognized as Physician of the Year in Hawaii by the Hawaii Medical Association in 1979. Dartmouth Class of 1950 “Outstanding Contributions to Society” Award in 1981, Distinguished Alumnus Award for 1992 from Medical Alumni Association, Case Western Reserve University, Honorary Doctor of Humane Letters,
CURRICULUM VITAE

CALVIN CHIA JUNG SIA, M.D.
656 Paikau Street,
Honolulu, Hawaii 96816-4406
Phone - (808) 737-4770

PERSONAL HISTORY

Date of Birth                        June 3, 1927
Place of Birth                      Beijing, China
Citizenship                         U.S.A.
Wife                                Katherine Wai Quin Li Sia
Children                            Richard H.P. Sia
                                     Jeffrey H.K. Sia
                                     Michael H.T. Sia

EDUCATION

1945                                High School Diploma, Punahou School, Honolulu, HI
1947-50                             A.B. Dartmouth College, Hanover, NH
1950-51                             Columbia University, N.Y.
1051-55                             M.D. Western Reserve University, School of Medicine,
                                     Cleveland OH

PROFESSIONAL TRAINING

                                     Beaumont Army Hospital, El Paso, TX
1956-58                             Pediatrics Residency, Kauikeolani Childrens Hospital
                                     Honolulu, HI (under Dr. Irvine McQuarrie)

CERTIFICATION

1955                                Ohio License to Practice Medicine
1958                                Hawaii License to Practice Medicine
1960                                Fellow, American Board of Pediatrics
1961                                Fellow, American Academy of Pediatrics
1987                                Recertification, American Board of Pediatrics

MILITARY SERVICE RECORD

1945-47                             U.S. Army, S/Sgt., U.S. Armed Forces Institute
1955-56                             U.S. Army, 1st Lt., Medical Corps

POSITIONS HELD

1958-1996                           In full time primary care pediatric practice - solo,
                                     2-3 person group, Calvin C.J. Sia, M.D. Inc.
                                     Retired from active practice Sept. 1996.
1958-67                             Lecturer, School of Nursing, Univ. of Hawaii
1964-69                             Lecturer, Newborn Psychological Research Project,
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POSITIONS HELD (continued)

University of Hawaii
1966-75 Clinical Associate Professor of Pediatrics, School of Medicine, Univ. of Hawaii
1975-99 Clinical Professor of Pediatrics, School of Medicine, Univ. of Hawaii
1999-Date Professor of Pediatrics, School of Medicine, Univ. of Hawaii
1960-64 Chief of Newborn Services, Kapiolani Maternity Hospital, Honolulu, HI
1963-67 Chief of Staff, Kauikeolani Childrens Hospital, Honolulu, HI
1962-96 School Physician, Pediatric Consultant, Hawaii School for Deaf and Blind/Statewide Center for Sensory Impaired (Department of Education)
State of Hawaii

MEDICAL COMMUNITY SERVICES

Pediatrics
1960-61 Secretary/Treasurer, Honolulu Pediatrics Society
1966-67 Executive Committee, Hawaii Chapter, American Academy of Pediatrics
1967-68 Chairman, Pediatrics Practice Committee, Hawaii Chapter AAP
1968-71 Chapter Chairman, Hawaii Chapter, AAP
1971-74 Re-elected, Chapter Chairman, Hawaii Chapter, AAP
1974-76 Re-elected, Chapter Chairman, Hawaii Chapter, AAP
1968-72 Pediatric Consultant, Project Head Start, Maui and Molokai, American Academy of Pediatrics,
1973-75 Pediatric Consultant, Project Head Start, Oahu, American Academy of Pediatrics

Honolulu County Medical Society
1968-75 Delegate to Hawaii Medical Association
1972-74 Membership Committee
1974-76 Medical Practice Committee
1985-88 Nominating Committee

Hawaii Medical Association
1961-68 Chairman, School Health Committee, also served on Crippled Children’s.
Maternal & Infant Mortality, Medical Indigent, & Legislative Committees
1969-75 Commissioner of Public Health (10 Committees relating to public health)
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MEDICAL COMMUNITY SERVICES (continued)
Hawaii Medical Association

1975-76  President-Elect
1976-77  President
1978-97  Services on Legislative, School Health, Medicaid,
         and other Committees, also on Council
1978-79  Chairman, Ad Hoc Child Health Planning Committee
1985-86  Chairman, Ad Hoc Infant Care Review Committee

Community Service

1963-69  Board Member, Child & Family Service Agency
         1968-69, Executive Committee, Vice Pres.
1965-68  Board Member, Booth Memorial Home, Salvation Army
1966-94  Founding Board Member, Variety Club School for
         Learning Disabilities
         1966-68 Vice Chair; 1969-76 Chair; 1986-93 Chair
1971-76  Board of Directors, Easter Seal Society for
         Crippled Children and Adults
         1972-76 Chairman, Professional Advisory Council
1965-70  Committeeman, Boy Scout Troop, 109
1968-69  Chairman, Adoptions Committee, Hawaii State
         Commission on Children and Youth
1969-70  Chairman, Committee to Study Legal Aspect of Child
         Abuse, State Commission on Children and Youth
1969-71  Member, Advisory Board, Social Welfare Division,
         Health and Community Services Council of Hawaii
1969-70  Member, Advisory Board, School Health Committee,
         Health and Community Services Council of Hawaii
1973-75  Advisory Council, Infant Stimulation Project,
         School of Public Health, Univ. of Hawaii
1970-87  Member, Advisory Committee, Children's Protective
         Services Center of Oahu, Dept. of Social Services
         and Housing, State of Hawaii
         1970-71 Vice Chairman
         1971-72 Chairman
         1971 - Chaired Program Seminar on Child Abuse and
         Neglect for State of Hawaii with Dr. Henry Kempe
         1974 - Chaired Dr. Ray Helfer's consultation for
         child abuse prevention
1976-79  Member, Hawaii State Council on Child Abuse and
         Neglect
1975-Date  Founding Member & Executive Committee, Hawaii
         Family Stress (Support) Center, (initiated Demo
         Grant for Child Abuse and Neglect Prevention for
         State with 3 years grant from Office of Child
         Development, HEW of $1 million, 1975-78; Hawaii's
         Healthy Start home visitors program 1985-date)
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Community Service (continued)

1970-89  Chairman, Interagency School Health Planning Group
         Dept. of Health & Education, State of Hawaii
         (oversee initiation, development, and planning for
         total school health program in statewide public
         school system: health education, services, special
         education needs as volunteer chairman)

1972-76  Member, Advisory Council, Special Education, Dept.
         of Education, State of Hawaii. Chair, 1975-76

1977-80  Governor's Appointment as Member, State Health
         Coordinating Council (PL 94-641)

1976-78  Member, Advisory Committee, White House Conference
         on Families in Hawaii, Honolulu Junior League

1979-80  Chairman, Advisory Committee, White House
         Conference on Families, State of Hawaii,
         Governor's appointment as Member

1980     Delegate, White House Conference on Families, Los
         Angeles Conference, HEW

1977-81  Advisor, Honolulu Junior League

1984-87  Member, Advisory Committee, Queen Lilioukalani
         Trust for Hawaiian Orphans

1986-1996 Governor's Appointment, founding member, Hawaii
         Zero to Three Project, PL 99-457, Education for
         Handicapped Infants & Toddlers, Hawaii Early

Hospital Community Service

1967-82  Member, Board of Trustees, Kauikeolani Childrens
         Hospital, Honolulu, HI

1982-90  Member, Board of Trustees, Kapiolani Medical
         Center for Women and Children (merger with
         maternity hospital)

1990-Date Member, Kapiolani Health Care Systems (corporation
         for Kapiolani Medical Center for Women and
         Children and Medical Center (medical/surgical
         hospital) at Pali Momi); now known as Kapiolani
         Health.

1993-94  Member, Advisory Board, Queen's Health Care Plan

NATIONAL SERVICES

American Academy of Pediatrics

1968-74  Member, School Health Committee
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American Academy of Pediatrics (continued)

1969; 1975  Chairman, Nominating Committee, District VIII
1969-Date  Member, Section on Community Pediatrics
1971-75  Elected Member, Nominating Committee for president-elect, AAP, 1 yr. term, re-elected 3 yrs. Chairman 1974-75.
1975-76  Member, Task Force on Pediatric Research, Informed Consent and Medical Ethics
1976-78  Member, Committee on Pediatric Research, Informed Consent
1980-81  Member, Ad Hoc Committee to Study PL 94-142, Education for all Handicapped Children
1981-2002  Member, Section on Pediatric Emergency Medicine
           1981-83 Founding member of executive council
           1983-85 Member, Task Force on Pediatric Emergency Medicine
           1985-87 Member, Provisional Committee on Pediatric Emergency Medicine
           1987-94 Member, Committee on Pediatric Emergency Medicine
1993-2000  Regional/District CATCH (Community Access to Child Health Care) Facilitator
1995-Date  Chair, Project Advisory Committee for the Medical Home Program for Children with Special Health Care Needs (National Medical Home Initiatives for CSHCN)
1995-96  Selected as one of two candidates to run for President-elect of Academy by Nominating Committee.
1997-98  Chair, Task Force for Newborn Infant Hearing Screening, Detection, Treatment.
1998-99  Selected as one of two candidates to run for President-elect of Academy by Nominating Committee

U.S. Department of Health and Human Services (formerly HEW)

1970-71  Member, Advisory Board, Southwestern Region Deaf-Blind Project
1971-75  Sec. HEW Appointment, Member, National Advisory Council Child Health and Human Development, National Institutes of Child Health
1975-79  Consultant, National Institute of Child Health and Human Development, Director’s appointment
1994-96  Sec. HHS Appointment, Member, Advisory Commission on Childhood Vaccines, Health Resources Services Administration. Chair - 1996

Institute of Medicine

1991-93  Member, Committee on Pediatric Emergency Medicine
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NATIONAL SERVICES (continued)

American Board of Pediatrics

1974-89    Oral Board Examiner; Observer, 1974-75
1974-98    Member, Board of Pediatrics

American Medical Association

1978-Date    Member, Section Council on Pediatrics
1981-83    Alternate Delegate for American Academy of Pediatrics
1983-Date    Chair, AMA Section Council on Pediatrics
1983-Date    Delegate and Chair of American Academy of Pediatrics delegation

Family Support America

1999-2002    National Board Member, Family Support America, Chicago, IL

Dyson Foundation, New York

2000-2007    Member Professional Advisory Committee to Annie E. Dyson Initiatives to train pediatric residents in community pediatrics; Chair of PAC Dyson Initiatives 2001 to date. New Community Pediatric Institute - AAP. (Oversight of five years grants given for pediatric residency training in community pediatrics to Univ. Rochester, Columbia, Childrens Hospital of Philadelphia, Wisconsin, Univ. of California at San Diego, Univ. of Hawaii, Miami Univ., Univ. of Florida, Univ. of Indiana, and Univ. of California at Davis)
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AWARDS AND HONORS


2. Special Certificate of Appreciation, The American Academy of Pediatrics for valuable and devoted services to Head Start children and their families, 1973 (5 years service)


4. Wyeth Outstanding Small Chapter Award, American Academy of Pediatrics, October, 1976. (Chapter Chairman)


7. Special Recognition Award, Kauikeolani Children's Hospital, for fifteen years service on Board of Trustees, September, 1982.

8. Citation, American Academy of Pediatrics, for Outstanding Services Rendered as a Faculty Member for the Inservice Training Project for Physicians Serving Children with Handicaps, September, 1982.


AWARDS AND HONORS (continued)

13. Special Achievement Award, American Academy of Pediatrics, for Distinguished Service and Dedication to the Mission and Goals of the Academy, Advocacy for Child Health, April, 1989.

14. Children's Advocacy Award, Contemporary Pediatrics, accomplishments of pediatricians who have gone beyond the scope of daily practice or academic responsibilities to better the lives of children, October 8, 1990, Boston, Mass. (Biography appeared Contemporary Pediatrics, June, 1990).


20. Sir James Carreras Award, Variety Clubs International, New York City, N.Y. May 19, 1992 ("Recognize the Physician who has done Outstanding Work in the Field of Pediatrics Medicine during the Previous Year and whose Dedication and Skill in the Field of Pediatrics is Exceptional")


22. Organization of Women Leaders 1992 Private Sector Award to Individual whose Contributions have Enhanced Family Life and have Broadly Impacted Hawaii's Community. September 14, 1992, Honolulu, Hawaii.
AWARDS AND HONORS (continued)

23. Hawaii Association for the Education of Young Children, Nona
Beamer Community Service Award for Exceptional Leadership in
the Provision of Services to Young Children in the State of
Hawaii, June, 1993

24. National Association of the Deaf, Golden Hand Award, State of
Hawaii, July 3, 1993

25. Donna J. Stone Award, National Committee to Prevent Child
Abuse, Chicago, Illinois, November 29, 1993 at Pittsburgh,
Pennsylvania

26. Hawaii Family Stress Center Award, in Honor of Sustained
Advocacy & Support of the Hawaii Family Stress Center and the
Healthy Start Statewide Program, at 20th Anniversary
Celebration, Honolulu, Hawaii, March 12, 1996

27. Honored by the Senate of the State of Hawaii, the 18th
Legislature, in "Expressing Appreciation to Doctor Calvin Sia
for his Lifetime Commitment to Helping the Children of our
Community", Honolulu, Hawaii March 27, 1996

28. "Ohana" Award, "To a Pediatrician Who Has Done So Much for
Families in Hawaii, Congratulations upon Retirement", Hawaii
Chapter American Academy of Pediatrics, Honolulu, Hawaii
October 17, 1996

29. March of Dimes, Jonas Salk Memorial Award 1966, for Achievement
in Maternal and Child Health, Honolulu, Hawaii October 18, 1996

30. Honored by Kapi'olani Health Foundation (Kapi'olani Medical
Center for Women and Children) at Crystal Ball,"to
acknowledge the great work and community involvement of Dr.
Calvin C.J. Sia" Honolulu, Hawaii November 2, 1996

31. Federal Interagency Coordinating Council Achievement Award, for
Outstanding Contribution to Improving Services to Children and
Families through Interagency Collaboration, Washington, D.C.
November 7, 1996

32. Outstanding Physician of Kapiolani Medical Center for Women and
Children Award, Honolulu, Hawaii December 2, 1996
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Award and Honors (continued)

33. Private Citizen Award, National Governors Association for Distinguished Service to State Government in support of his work with “family-centered, preventive approaches to health care to ensure a child’s healthy development.” Las Vegas, Nevada, July 28, 1997.

34. Dr. Calvin Sia Day in Hawaii, proclaimed by Governor Benjamin Cayetano for his outstanding service to his profession and to the people of our state and nation, July 28, 1997.

35. Certificate of Appreciation for Contributions to the enhancement of the Health and Well-being of Mothers, Children and Families, through Support of the Programs Implemented under the Title V of the Social Security Act, by Director of Maternal Child Health Bureau, Dr. Audrey Nora, August 8, 1997 at National Medical Association, Section Council on Pediatrics meeting, Honolulu, Hawaii.

36. The First EMS-C National Heroes Lifetime Achievement Award, for “an individual who has dedicated himself to transforming the way emergency medical care is provided for children throughout the United States. He serves as a model to be emulated by others.” Presented at the National Congress on Childhood Emergencies, Washington, D.C., March 23, 1998 by The Health Resources and Services Administration’s (HRSA) Maternal and Child Health Bureau (MCHB), the National Highway Traffic Safety Administration (NHTSA), and the EMSC National Resource Center.

37. The 1998 American Medical Association Benjamin Rush Award, given to an individual who has made an outstanding contribution to the community for citizenship and public service above and beyond the call of duty as a practicing physician. Presented December 6, 1998 at AMA Interim House of Delegates meeting.

38. American Academy of Pediatrics, Job Lewis Smith Award in Community Pediatrics – to an individual who has demonstrated outstanding leadership in community pediatrics. Oct. 20, 2001, Chicago, IL


40. Professional “Friend of Family Voices” Award – March 2002, Washington, DC
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41. Young at Heart Award – The American Medical Association Young Physician Section – in recognition of his invaluable support and guidance to the Section and Young physicians. June 15, 2002, Chicago, IL.


43. The 2006 Hilopa’a Lifetime Legacy Award given to Dr. Calvin Sia in Recognition for the legacy of inspiration, leadership and service provided to our Children, families and professional partners of Hawaii, December 2006.

GRANTS

1. Co-Principal Investigator, Grant MCJ-152887, 10/1/86-10/1/89; Principal Investigator, 10/1/89-10/1/90: Facilitation of Primary Care Physician in Preventive Health Care of Children Age 0-5 from Underserved, Diverse, Cultural Populations. Maternal Child Health Bureau, HHS, $125,000/yr.

2. Co-Principal Investigator, Grant MCJ-154001-01-3, 10/1/87-10/1/89 with extension to 10/1/90: Plan, Develop and Implement Emergency Medical Services System for Children. Maternal Child Health Bureau, HHS, $500,000 for 2 yrs.

3. Principal Investigator, Grant MCJ-155078-01-0, 10/1/90-10/1/93: The Medical Home Project. Maternal Child Health Bureau, HHS, $180,000/yr.

4. Principal Investigator, Alger Foundation Grant in collaboration with Hawaii Medical Association, Kapiolani Medical Center for Women and Children, Child and Family Services: Healthy and Ready to Learn Project, 1/1/93- 6/31/97, $400,000/yr. (Additional Building for Healthy and Ready to Learn - $1 million.)

5. Principal Investigator, Grant MCJ-157962-01-0, 10/1/93-10/1/96: Kids in Sports, Access to Care. Maternal Child Health Bureau, HHS, $125,000/yr.


8. Co-Principal Investigator with Governor's Office of Children and Youth, 1/14/96-1/14/98: Planning Grant for Development of Integrated Services for Early Childhood based on Starting Points. Carnegie Corporation of New York $300,000/2 yrs.

9. Principal Investigator, Grant ISC 97-06, 10/1/97-9/30/01: Malama Pono (To Take Care)-Family Professional Partnership in the Medical Home. Maternal Child Health Bureau, HHS, $150,000/yr.

10. Co-Principal Investigator with Good Beginnings Alliance, 4/15/98 – 4/15/00: Implementation Grant for Development of Integrated Services for Early Childhood based on Starting Points. Carnegie Corporation of New York $300,000/2yrs.
PUBLICATIONS


15. Sia, C: “Promoting a Medical Home for all Children” AAP Healthy Child Care America page 3, summer, 1999.


