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FAMILY MEDICINE

Dr. Marti Taba specializes in the care of all family members. Her special interests include adolescent health, women's health and preventive medicine. Received Doctorate of Medicine from University of Hawaii, John A. Burns School of Medicine. Residency at Riverside Methodist Family Practice Residency Program, Columbus, OH. Member of the American Academy of Family Physicians. Dr. Taba will be seeing patients at the Straub Kailua Family Health Center.

INTERNAL MEDICINE

Dr. Edward Silver is Board Certified in Internal Medicine. Special interests include cardiology, diabetes and hypertension. Received Doctorate of Medicine from University of Tennessee. Residency at Wilford Hall USAF Medical Center, San Antonio, TX. Dr. Silver will be seeing patients at the Straub Pali Momi Clinic.

NEUROSURGERY

Dr. Todd Thompson's special interests include minimally invasive neurosurgery, functional and stereotactic neurosurgery, spine surgery and endoscopic pituitary surgery. Received Doctorate of Medicine from Temple University School of Medicine. Residency at University of Pittsburgh, PA. Fellowship in Gamma Knife Radiosurgery at the University of Pittsburgh, PA.

ORTHOPEDIC SURGERY

Dr. John Wright is Board Certified in Orthopedic Surgery. Special interests include arthroscopy surgery, sports medicine and total joint replacement. Received Doctorate of Medicine from University of Connecticut Medical School. Integrated Surgical Residency at University of Hawaii and Orthopedic Surgery Residency at The Hospital for Special Surgery, New York, NY. Fellowship in total joint arthroplasty at the New England Baptist Hospital, Boston, MA. Sports Medicine and Shoulder Surgery Fellowship at the Steadman Hawkins Clinic, Vail, CO. Assistant team physician for the U.S. ski team and recipient of the 2001 Otto Aufranc Award for outstanding research.

UROLOGY

Dr. David Wei's special interests include urologic oncology and reconstructive urology. Received Doctorate of Medicine from the University of Southern California School of Medicine. Residency at the University of Miami, Jackson Memorial Hospital. Fellowship in Urologic Oncology at the Sloan-Kettering Cancer Center, New York, NY.

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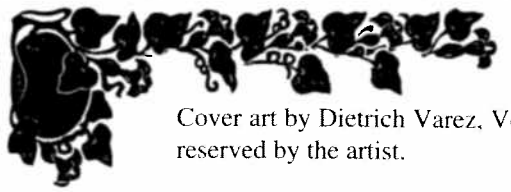


Cover art by Dietrich Varez, Volcano, Hawaii. All rights reserved by the artist.

Ahi

"Ahi" meaning "fire" refers to the speed with which the giant tuna pulls the line over the side of the canoe. The friction causing the line to "smoke".

Editorial

Norman Goldstein MD
Editor, Hawaii Medical Journal

Happy Birthday, Hawaii Medical Journal

This issue marks 60 years of continuous publication of the Journal. Volume 1, No. 1 appeared in September 1941. The Hawaii Medical Association was then the Hawaii Territorial Medical Society, "incorporated in 1856 under the Monarchy."

The first Journal contained the following manuscripts:
- Rheumatic Heart Disease in Hawaii - S.E. Doolittle and I.L. Tilden
- Specific Therapy of Lobar Pneumonia - M.A. Blackenhorn
- The Sulfonamides in Gonorrhea - Lt. Cmdr. F.R. Moore
- Dermatologic Lesions vs. Syphilis - H.M. Johnson

Our first two editorials by Harry L. Arnold, Jr. were:
- The Bulletin is dead - long live the Journal
- The proposed Plantation Health "Cooperative Plan"

The Journal also included "Progress in Internal Medicine", "The Latest Advances in Surgery", "Plantation News", and "Leprosy in Hawaii" by Edwin Chung-Hoon. The first issue cover had a drawing of the Mabel L. Smythe Memorial Building which housed the administrative office of the Territorial Medical Association. The Mabel Smythe Building, located next to the Hawaii Medical Library at the corner of Punchbowl and Beretania Streets, had recently been restored.

A copy of the first issue of the Journal is available in the Hawaii Medical Library. The Table of Contents as well as the Index by Title, Subject and Author of Volume One, September 1941 -July 1942 may be found on the Web at http://hml.org/contents/hmj01.html. Mahalo to the staff of the Hawaii Medical Library for providing this service.

"Knowledge is a source of power, and the dissemination of knowledge is one task to which the Journal is dedicated - not especially generalized knowledge of the sort which can be gained from perusal of the old established national medical journals, or more particularly knowledge pertaining to medicine in Hawaii, that all in our profession here and others who may care to read may know what are our problems and what is being done to solve them."
- editorial comment by Harry L. Arnold, Jr., M.D.

Editorial, HMJ Vol.1, No. 1

"The Bulletin is dead. Long Live the Journal."

Establishment of the Hawaii Medical Journal signalized by the appearance of this Number 1 issue of Volume 1, should not be considered an end in itself-even though it represents the fulfillment of an aspiration which certain members of the profession have long kept alive.

This is a beginning, rather than an end attained, and it behooves the staff and the rest of the profession to pause to consider of what it is the beginning-what is the task to which the career of the Journal must be dedicated if it is to justify its existence.

Our medical friends from the Mainland, who from time to time have visited Hawaii, have been with a reassuring degree of unanimity, most complimentary in their estimation of the quality of medicine practiced in the Islands, and of the standards maintained by the profession of Hawaii as compared with those of similar sized population groups elsewhere in the United States. With justifiable pride, the profession here can point to items of individual and group accomplishment which have contributed to the well-being and progress of the community. More often than not, however, it has been individual rather than collective effort which has won results-and seldom if ever has the full force of the whole, united medical profession of Hawaii been exerted to the full measure of its capabilities.

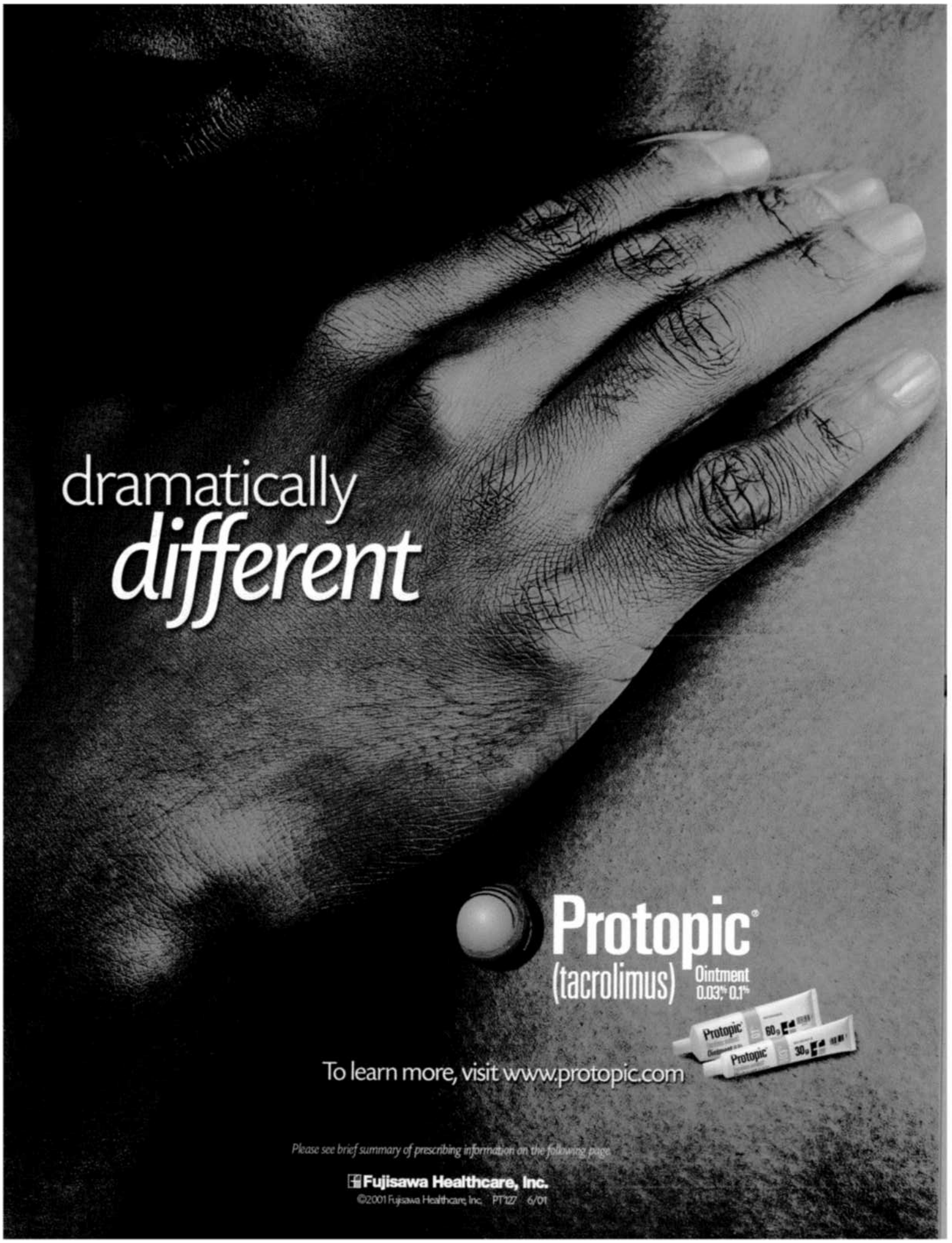
Any factor which tends to marshal and direct this power of a united profession is to be welcomed, and such a factor for good in Hawaii, the Journal well may be.

Knowledge is a source of power, and the dissemination of knowledge is one task to which the Journal is dedicated,-not especially generalized knowledge of the sort which can be gained from perusal of the old established national medical journals, but more particularly knowledge pertaining to medicine in Hawaii, that all in our profession here and others who may care to read may know what are our problems and what is being done to solve them. There is something about words put down in black and white on paper which crystallizes thought and makes usable and effective ideas which conveyed by spoken work, escape from mind and memory all too soon.

The Journal should be a medium by which the minds of our confreres may be brought into focus on problems which concern us all, -problems having to do with better standards, better practice, better health regulations, better laws. Too much of the thinking for the profession in the past has been done by too few. More enlightenment, more interest, more opinions should improve the quality of our thought, and augment the effectiveness of our influence.

The Journal should also be a means through which the effective participation of the profession in community tasks, such as the defense programs, public health education, and communicable disease control, may be improved. In such matters, through lack of information, the efforts of doctors fully willing to put their shoulders to the wheel have not been fully utilized.

If to the betterment of the profession, and to the betterment of Hawaii, the efforts of the present and future editorial staffs are dedicated, the success of the Journal is assured.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BRIEF SUMMARY

47002/Issued: December 2000

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INDICATIONS AND USAGE:
PROTOPIC Ointment, both 0.03% and 0.1% for adults, and only 0.03% for children aged 2 to 15 years, is indicated for short-term and intermittent long-term therapy in the treatment of patients with moderate to severe atopic dermatitis in whom the use of alternative, conventional therapies are deemed inadvisable because of potential risks, or in the treatment of patients who are not adequately responsive to or are intolerant of alternative, conventional therapies.

CONTRAINDICATIONS:
PROTOPIC Ointment is contraindicated in patients with a history of hypersensitivity to tacrolimus or any other component of the preparation.

PRECAUTIONS:
General

Studies have not evaluated the safety and efficacy of PROTOPIC Ointment in the treatment of clinically infected atopic dermatitis. Before commencing treatment with PROTOPIC Ointment, clinical infections at treatment sites should be cleared.

While patients with atopic dermatitis are predisposed to superficial skin infections including eczema herpeticum (Kaposi's varicelliform eruption), treatment with PROTOPIC Ointment may be associated with an increased risk of varicella zoster virus infection (chicken pox or shingles), herpes simplex virus infection, or eczema herpeticum. In the presence of these infections, the balance of risks and benefits associated with PROTOPIC Ointment use should be evaluated.

In clinical studies, 33 cases of lymphadenopathy (0.8%) were reported and were usually related to infections (particularly of the skin) and noted to resolve upon appropriate antibiotic therapy. Of these 33 cases, the majority had either a clear etiology or were known to resolve. Transplant patients receiving immunosuppressive regimens (e.g., systemic tacrolimus) are at increased risk for developing lymphoma; therefore, patients who receive PROTOPIC Ointment and who develop lymphadenopathy should have the etiology of their lymphadenopathy investigated. In the absence of a clear etiology for the lymphadenopathy, or in the presence of acute infectious mononucleosis, discontinuation of PROTOPIC Ointment should be considered. Patients who develop lymphadenopathy should be monitored to ensure that the lymphadenopathy resolves.

The enhancement of ultraviolet carcinogenicity is not necessarily dependent on phototoxic mechanisms. Despite the absence of observed phototoxicity in humans (see **ADVERSE REACTIONS**), PROTOPIC Ointment shortened the time to skin tumor formation in an animal photocarcinogenicity study (see **Carcinogenesis, Mutagenesis, Impairment of Fertility**). Therefore, it is prudent for patients to minimize or avoid natural or artificial sunlight exposure.

The use of PROTOPIC Ointment may cause local symptoms such as skin burning (burning sensation, stinging, soreness) or pruritus. Localized symptoms are most common during the first few days of PROTOPIC Ointment application and typically improve as the lesions of atopic dermatitis heal. With PROTOPIC Ointment 0.1%, 90% of the skin burning events had a duration between 2 minutes and 3 hours (median 15 minutes). Ninety percent of the pruritus events had a duration between 3 minutes and 10 hours (median 20 minutes). The use of PROTOPIC Ointment in patients with Netherton's Syndrome is not recommended due to the potential for increased systemic absorption of tacrolimus. The safety of PROTOPIC Ointment has not been established in patients with generalized erythroderma.

Information for Patients
(See patient package insert)
Patients using PROTOPIC Ointment should receive the following information and instructions:

1. Patients should use PROTOPIC Ointment as directed by the physician. PROTOPIC Ointment is for external use only. As with any topical medication, patients or caregivers should wash hands after application if hands are not an area for treatment.
2. Patients should minimize or avoid exposure to natural or artificial sunlight (tanning beds or UVA/B treatment) while using PROTOPIC Ointment.
3. Patients should not use this medication for any disorder other than that for which it was prescribed.
4. Patients should report any signs of adverse reactions to their physician.
5. Before applying PROTOPIC Ointment after a bath or shower, be sure your skin is completely dry.

Drug Interactions
Formal topical drug interaction studies with PROTOPIC Ointment have not been conducted. Based on its minimal extent of absorption, interactions of PROTOPIC Ointment with systemically administered drugs are unlikely to occur but cannot be ruled out. The concomitant administration of known CYP3A4 inhibitors in patients with widespread and/or erythrodermic disease should be done with caution. Some examples of such drugs are erythromycin, itraconazole, ketoconazole, fluconazole, calcium channel blockers and cimetidine.

Carcinogenesis, Mutagenesis, Impairment of Fertility
No evidence of genotoxicity was seen in bacterial (*Salmonella* and *E. coli*) or mammalian (Chinese hamster lung-derived cells) *in vitro* assays of mutagenicity, the *in vitro* CHO/HGPRT assay of mutagenicity, or *in vivo* clastogenicity assays performed in mice. Tacrolimus did not cause unscheduled DNA synthesis in rodent hepatocytes.

Reproductive toxicology studies were not performed with topical tacrolimus.

Pregnancy:
Teratogenic Effects: Pregnancy Category C
There are no adequate and well-controlled studies of topically administered tacrolimus in pregnant women. The experience with PROTOPIC Ointment when used by pregnant women is too limited to permit assessment of the safety of its use during pregnancy.

There are no adequate and well-controlled studies of systemically administered tacrolimus in pregnant women. Tacrolimus is transferred across the placenta. The use of systemically administered tacrolimus during pregnancy has been associated with neonatal hyperkalemia and renal dysfunction. PROTOPIC Ointment should be used during pregnancy only if the potential benefit to the mother justifies a potential risk to the fetus.

Nursing Mothers
Although systemic absorption of tacrolimus following topical applications of PROTOPIC Ointment is minimal relative to systemic administration, it is known that tacrolimus is excreted in human milk. Because of the potential for serious adverse reactions in nursing infants from tacrolimus, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use
PROTOPIC Ointment 0.03% may be used in pediatric patients 2 years of age and older. Two phase 3 pediatric studies were conducted involving 606 patients 2-15 years of age: one 12-week randomized vehicle-controlled study and one open-label, 1 year, long-term safety study. Three hundred and thirty (330) of these patients were 2 to 6 years of age.

The most common adverse events associated with PROTOPIC Ointment application in pediatric patients were skin burning and pruritus (see **ADVERSE REACTIONS**). In addition to skin burning and pruritus, the less common events (< 5%) of varicella zoster (mostly chicken pox), and vesiculobullous rash were more frequent in patients treated with PROTOPIC Ointment 0.03% compared to vehicle. In the long-term 1 year safety study involving 255 pediatric patients using PROTOPIC Ointment, the incidence of adverse events, including infections, did not increase with increased duration of study drug exposure or amount of ointment used. In 491 pediatric patients treated with PROTOPIC Ointment, 3(0.6%) developed eczema herpeticum. Since the safety and efficacy of PROTOPIC Ointment have not been established in pediatric patients below 2 years of age, its use in this age group is not recommended.

Geriatric Use
Twenty-five (25) patients ≥ 65 years old received PROTOPIC Ointment in phase 3 studies. The adverse event profile for these patients was consistent with that for other adult patients.

ADVERSE REACTIONS:

No phototoxicity and no photoallergenicity was detected in clinical studies of 12 and 216 normal volunteers, respectively. One out of 198 normal volunteers showed evidence of sensitization in a contact sensitization study.

In three randomized vehicle-controlled studies and two long-term safety studies, 655 and 571 patients respectively, were treated with PROTOPIC Ointment.

The following table depicts the adjusted incidence of adverse events pooled across the 3 identically designed 12- week studies for patients in vehicle, PROTOPIC Ointment 0.03%, and PROTOPIC Ointment 0.1% treatment groups, and the unadjusted incidence of adverse events in two one year long-term safety studies, regardless of relationship to study drug.

Incidence Of Treatment Emergent Adverse Events

	12-Week, Randomized, Double-Blind, Phase 3 Studies 12-Week Adjusted Incidence Rate (%)					Open-Label Studies (up to 1 year) 0.1% Tacrolimus Ointment Incidence(%)	
	Adult			Pediatric		Adult	Pediatric
	Vehicle n=212	0.03% Tacrolimus Ointment n=210	0.1% Tacrolimus Ointment n=209	Vehicle n=116	0.03% Tacrolimus Ointment n=118	n=316	n=255
Skin Burning[†]	26	46	58	29	43	47	26
Pruritus[‡]	37	46	46	27	41	25	25
Flu-like symptoms[†]	19	23	31	25	28	22	35
Allergic Reaction	8	12	6	8	4	22	15
Skin Erythema	20	25	28	13	12	12	9
Headache[†]	11	20	19	8	5	10	18
Skin Infection	11	12	5	14	10	11	11
Fever	4	4	1	13	21	2	18
Infection	1	1	2	9	7	14	8
Cough Increased	2	1	1	14	18	3	15
Asthma	4	6	4	6	6	5	16
Herpes Simplex	4	4	4	2	0	12	5
Eczema Herpeticum	0	1	1	0	2	2	0
Pharyngitis	3	3	4	11	6	5	10
Accidental Injury	4	3	6	3	6	4	12
Pustular Rash	2	3	4	3	2	6	8
Folliculitis[†]	1	6	4	0	2	11	2
Rhinitis	4	3	2	2	6	5	5
Otitis Media	4	0	1	6	12	1	7
Sinusitis[†]	1	4	2	8	3	3	7
Diarrhea	3	3	4	2	5	4	6
Urticaria	3	3	6	1	1	5	5
Lack of Drug Effect	1	1	0	1	1	10	2
Bronchitis	0	2	2	3	3	3	6
Vomiting	0	1	1	7	6	1	5
Maculopapular Rash	2	2	2	3	0	4	3
Rash[†]	1	5	2	4	2	2	5
Abdominal Pain	3	1	1	2	3	1	5
Fungal Dermatitis	0	2	1	3	0	2	6
Gastroenteritis	1	2	2	3	0	4	2
Alcohol Intolerance[†]	0	3	7	0	0	6	0
Acne[†]	2	4	7	1	0	2	4
Sunburn	1	2	1	0	0	4	4
Skin Disorder	2	2	1	1	4	1	4
Conjunctivitis	0	2	2	2	1	4	2
Pain	1	2	1	0	1	4	3
Vesiculobullous Rash[‡]	3	3	2	0	4	2	2
Lymphadenopathy	2	2	1	0	3	2	3
Nausea	4	3	2	0	1	1	2
Skin Tingling[†]	2	3	8	1	2	2	1
Face Edema	2	2	1	2	1	3	1
Dyspepsia[†]	1	1	4	0	0	1	4
Dry Skin	7	3	3	0	1	0	1
Hyperesthesia[†]	1	3	7	0	0	3	0
Skin Neoplasm Benign[##]	1	1	1	0	0	2	3
Back Pain[†]	0	2	2	1	1	3	1
Peripheral Edema	2	4	3	0	0	2	1
Varicella Zoster/ Herpes Zoster[‡§]	0	1	0	0	5	1	3
Contact Dermatitis	1	3	3	3	4	1	1
Asthenia	1	2	3	0	0	2	1
Pneumonia	0	1	1	2	0	1	2
Eczema	2	2	2	0	0	3	0
Insomnia	3	4	3	1	1	1	0
Exfoliative Dermatitis	3	3	1	0	0	0	2
Dysmenorrhea	2	4	4	0	0	0	2
Periodontal Abscess	1	0	1	0	0	3	0
Myalgia[†]	0	3	2	0	0	1	0
Cyst[†]	0	1	3	0	0	0	0

[†] May be reasonably associated with the use of this drug product

[‡] Four cases of chicken pox in the pediatric 12-week study; 1 case of "zoster of the lip" in the adult 12-week study; 7 cases of chicken pox and 1 case of shingles in the open-label pediatric study; 2 cases of herpes zoster in the open-label adult study.

[##] Generally "warts".

Other adverse events which occurred at an incidence greater than or equal to 1% in any clinical study include: alopecia, ALT or AST increased, anaphylactoid reaction, angina pectoris, angioedema, anorexia, anxiety, arrhythmia, arthralgia, arthritis, bilirubinemia, breast pain, cellulitis, cerebrovascular accident, cheilitis, chills, constipation, creatinine increased, dehydration, depression, dizziness, dyspnea, ear pain, ecchymosis, edema, epistaxis, exacerbation of untreated area, eye disorder, eye pain, furunculosis, gastritis, hernia, hyperglycemia, hypertension, hypoglycemia, hypoxia, laryngitis, leukocytosis, leukopenia, liver function tests abnormal, lung disorder, malaise, migraine, neck pain, neuritis, palpitations, paresthesia, peripheral vascular disorder, photosensitivity reaction, procedural complication, routine procedure, skin discoloration, sweating, taste perversion, tooth disorder, unintended pregnancy, vaginal moniliasis, vasodilatation, and vertigo.

OVERDOSAGE:
PROTOPIC Ointment is not for oral use. Oral ingestion of PROTOPIC Ointment may lead to adverse effects associated with systemic administration of tacrolimus. If oral ingestion occurs, medical advice should be sought.

DOSAGE AND ADMINISTRATION:
ADULT
PROTOPIC Ointment 0.03% and 0.1%

Apply a thin layer of PROTOPIC Ointment 0.03% or 0.1% to the affected skin areas twice daily and rub in gently and completely. Treatment should be continued for one week after clearing of signs and symptoms of atopic dermatitis.

The safety of PROTOPIC Ointment under occlusion which may promote systemic exposure, has not been evaluated. **PROTOPIC Ointment 0.03% and 0.1% should not be used with occlusive dressings.**

PEDIATRIC
PROTOPIC Ointment 0.03%

Apply a thin layer of PROTOPIC Ointment 0.03% to the affected skin areas twice daily and rub in gently and completely. Treatment should be continued for one week after clearing of signs and symptoms of atopic dermatitis. The safety of PROTOPIC Ointment under occlusion, which may promote systemic exposure, has not been evaluated. **PROTOPIC Ointment 0.03% should not be used with occlusive dressings.**

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Fujisawa Healthcare, Inc.

The Kulia Program: Psychiatric Rehabilitation in Hawaii

F.M. Baker MD, MPH and Patricia Nakasukasa RN

Abstract

The Kulia Program was a culturally oriented, psychiatric rehabilitation program. It was developed in the only in-patient psychiatric hospital serving the 2 million multi-ethnic residents of the island state of Hawaii. From 1992-1999 the Kulia program was implemented on the only open, 36-bed unit of the Hawaii State Hospital with the mission of facilitating the reintegration of the chronically mentally ill into the community by encouraged its patients "to strive for the highest." Of the 238 patients discharged between 1992 and 1999 only 7% were re-hospitalized. Comparisons with other four treatment units during this period were not appropriate because of the difference in patient populations. These units provided long-term institutionalization of the criminally mentally ill, the behaviorally disoriented, mentally retarded and/or traumatically brain injured, and the behaviorally disoriented demented elderly. Their lengths of stay varied from 8 years to over 20 years in the hospital during this time period.

Introduction

Psychiatric rehabilitation began with Lamb.[1] He characterized moral treatment as the first organized psychiatric rehabilitation in the United States. The work of Adolf Meyer[2] emphasized the need to understand the role of social environment and biological factors in determining psychopathology and supported Clifford Beers[3] in establishing the mental hygiene movement. The goals of the mental hygiene movement of the 1900s included rehabilitation.

The discovery and use of antipsychotic medication in 1950 increased the number of psychiatric patients able to live in the community, and with the federal funding of community mental health centers in the 1960s, a precipitous decline in the number of patients in psychiatric hospitals occurred. The work of Anthony,[4] Anthony et al.,[5] Liberman et al.,[6-8] Wing and Morris,[9] and Lamb and Lamb et al.[1,10-11] helped to define the field of psychiatric rehabilitation.

In reviewing the historical development of psychiatric rehabilitation Anthony and Liberman[12] noted the importance of the 1943 amendments to the United States Rehabilitation Act that extended financial support and vocational rehabilitation services to the psychiatrically disabled. This legitimized the idea of training and rehabilitation of psychiatrically disabled individuals and grounded psychiatric rehabilitation in vocational rehabilitation.[12]

Anthony, Kennard, O'Brien, and Forbess[13] defined the "mission" of psychiatric rehabilitation as "to ensure that the person with the psychiatric disability can perform those physical, emotional, and intellectual skills needed to live, learn, and work in his or her own particular community, given the least amount of intervention necessary from agents of the helping professions." Most recently, Bachrach[14] defined the central goal of psychiatric rehabilitation as enabling patients with long-term mental illness to develop their capacities to the fullest extent possible.

In the 1960s-1980s period the field of psychiatric rehabilitation grew and developed. In contrast to prior treatment approaches, psychiatric rehabilitation emphasized the evaluation of observable outcomes and the utilization of the evaluation.[15] The outcomes being measured included: 1) client behavioral change (mastery of skills and activities) and 2) client and society benefits because of the psychiatric rehabilitation intervention. These authors provided critiques of existing measurement instruments.

Anthony et al.[13] emphasized 25 myths that needed to be eliminated to prevent them from hindering the development of psychiatric rehabilitation. These included the beliefs that: increasing treatment compliance could singularly effect rehabilitation outcome; community based treatment setting were well utilized by persons who were psychiatrically disabled, where a person was treated was more important than how the person was treated, and a person's rehabilitative outcome was a function of the credentials of the mental health professional with whom the person interacted.

Anthony, Cohen, and Farkas[15] specified the ten essential ingredients of a psychiatric rehabilitation treatment program that differentiated this program from program that were "rehabilitation" in name only (Table 1, *see next page*). These authors acknowledged the synonymous use of the terms psychosocial rehabilitation and psychiatric rehabilitation. Programs functioning as psychiatric rehabilitation programs "were designed to remove or reduce those residual handicaps which interfere with psychiatrically disabled person's abilities to function in their own communities." Anthony and Lieberman[12] noted that multiple types of skills were required to implement patient-specific treatment plans targeted to maximize the strengths, to develop the skills, to decrease problematic behaviors, and to teach the behaviors needed by the patient to function in the patient's discharge environment.

The initial failure of mental health professionals to address the psychosocial needs and rehabilitation of the chronically mentally ill resulted in non-professionals and patients establishing psychosocial self-help clubs, such as Fountain House.[16,17] The focus of Fountain House was: 1) to develop strategies to help people cope with the environment rather than succumb to it, 2) to achieve health induction rather than symptoms reduction, and 3) to foster a belief in the potential productivity of the most severely, psychiatrically disabled

Table 1.— Essential Ingredients of a Rehabiliation Program

(A* = Present in the Kulia Program)

1. Functional Assessment in Relation to Environment Demands (identification of the patient's strengths and deficits in relation to skill demands in the particular environment in which the patient plans to function)*
2. Patient Involvement in the Assessment and Intervention Phase Rehabilitation (patient communications his or her plans, experiences, feelings, ideas, and goals)*
3. Systematic Individual Client Rehabilitation Plans (sequential behaviors to be completed by the patient in order to achieve the rehabilitation goal)*
4. *Direct Teaching of Skills to Clients (developing a plan of* what *is to be taught and* how *it will be taught to the patient)**
5. *Environmental Assessment and Modification (environmental modification involving* assessment of the strengths and deficits of resources in particular client environments and the development of programs to address each)*
6. Follow-Up of Clients in the Real-Life Environment (monitoring the patient's progress in his or her real-life environment maybe done through the report of significant others)*
7. Rehabilitation Team Approach (team approach enables all learning, living, and working skills needed to achieve rehabilitation/return to the community to be comprehensively assessed)*
8. Rehabilitation Referrals (psychiatric rehabilitation referrals are made as goal directed, not activity oriented, for a specific patient behavioral outcomes related to a specific functional deficit with a timeline for achieving the results)*
9. Evaluation of Observable Outcome and Utilization of Evaluation Results (accomplished by follow-up of clients in their real-life environments provides a foundation for the evaluation of accomplishments of practitioner and agency)*
10. Consumer Involvement in Policy and Planning (involvement of consumers, i.e. patients, in planning meetings and satisfaction ratings) * *(Begun in 1998)*

Modified from Anthony WA, Cohen M, Farkas M. A psychiatric treatment program: can I recognize one if I see one? Community Mental Health Journal *1982,18:83-96.*

patients.[16] Peterson[17] spoke movingly of a change in his self-perception from "chronic patient" to "member" of the Fountain House community. He stressed the importance of an accepting, supportive environment in maximizing change and underscoring the importance of enabling each member to have his or her own apartment and to have meaningful activity in the person's life.

Background

In contrast to many mainland states, Hawaii is comprised of seven habitable islands. There is no majority population. Thirty-four percent of the Hawaiian population is Asian [Japanese (20%), Chinese (3%), Filipino (10%), Korean (1%)], 21% are Native Hawaiian or part Hawaiian, 22% are Caucasian, 21% are Other Mixed Ancestry (not including part-Hawaiian), and 2% are Other [African American (1%), Samoan/Togan (0.8%), Puerto Rican (0.1%).[18] The ethnic composition of the Hawaii State Hospital Staff is reflective of the state and that fact facilitates an understanding of the cultural expectations and mores of Hawaiian, Filipino, South Pacific Islanders (Samoan and Tongan), Japanese, Caucasian, Chinese, African American, and Korean patients.

The Hawaii State Hospital (HSH), built in 1944 to provide psychiatric services to Hawaii residents, has had a checkered history. Overcrowding, excessive length of stay (years), and minimal quality of life standards for patients resulted in a federal consent degree in 1989 that mandated specific changes in patient-staff ratios, resources available to patients (food, clothing, personal space), type of treatment provided, and mandated the development of out-patient services for the least restrictive alternatives of care. The establishment of an affiliation with the Department of Psychiatry of the John A. Burns School of Medicine in 1991 brought medical school faculty to the HSH, as clinical psychiatrists, to improve the assessment, care, and treatment provided to the patient population. The collaboration between the Adult Division of Mental Health of the Department of Health of the State of Hawaii and the Department of Psychiatry of the John A. Burns School of Medicine resulted in the HSH obtaining accreditation by the Joint Commission of Hospitals in 1996 and, again, in 1999.

The patient population was initially referred mainly from the acute emergency rooms of the islands of Oahu, Maui, and Hawaii as well as patients from the Department of Correction facilities on those islands that required in-patient psychiatric treatment. In 1991 in order to facilitate improved patient flow and to target treatment to specific patient populations, the HSH was reorganized into an acute admission unit, a transitional step-down unit, and five treatment units which focused upon specific populations: the elderly, the mentally retarded and persons with traumatic brain injury, patients with personality disorders who committed "high profile" crimes of murder and/or sexual assault, and chronically, mentally ill (one locked and one open unit). In several mainland states (e.g.New York state) each of these HSH units would be a separate state hospital housing a specific population, e.g., a hospital for the institutionalized mentally retarded, a forensic hospital for the criminally insane, and a hospital caring for the chronically, mentally ill with an acute admission unit.

This paper describes the development of the Kulia Program on the 36-bed, open treatment unit of the HSH Focusing upon the chronically mentally ill; this psychosocial program was developed within a single unit of a state hospital to address the needs of its changing patient population.

Kulia Program

The Kulia I Ka Nu'u Program's name in Hawaiian means, "striving for the highest." Patients admitted to this unit were more likely to have a diagnosis of schizophrenia (75% of patients) and to have arrived at the hospital as being Unfit to Proceed from their court hearing because of mental illness, because of revocation of a Conditional Release, or because of misdemeanor charges caused by psychotic behavior. A small subsection of the patients were sexual offenders who had sexually assaulted or repeatedly exposed their genitalia. These patients were moved to the unit with the closing of beds in an older section of the HSH in 1992 and were believed to be able to participate in the Kulia Program and ready to move toward discharge from the hospital. Patients earned Patient Incentive Points (PIP) by maintaining a minimal level of personal hygiene and grooming, keeping their personal space organized with beds made, and participation in a scheduled program of activities as determined by the patient and staff observations reviewed in the patient's treatment team meetings.

Specific one hour educational, skills training, and interpersonal skills groups were held Monday through Friday from 9:30-10:30 followed by a 30-minute break before lunch (11:00-11:30) and from 13:30-13:30 following a 60-mminute break. Patients had unscheduled time between 15:30-17:30. Patient could go to the gym for exercise, go for a community walk, read or watch educational television program or video on the units, or use the time for personal grooming. Patients who were unable to successfully utilize "free time" met with the patient's treatment team and target goals were

established. Some patients were placed in leisure time skills building module implemented by the Recreational Therapy Department to aid them in the development of leisure time interests. Dinner occurred daily from 17:30-18:00. Evening activities focused upon social, recreational activities such as word games, table tennis, pool, reading, and crafts. Alcoholics Anonymous (AA) meetings (twice per week) and Narcotics Anonymous (NA) meetings (twice a week) were part of the evening Kulia Program for those patients requiring substance abuse treatment.

The cultural basis of the Kulia Program was reflected in the incorporation of Hawaiian culture into every component of the program. The educational program including Hawaiian language and customs. Recreational activities included games indigenous to the islands (balancing a specially rounded stone). Crafts activities included making flower necklaces (leis). Fund raising activities featured Hawaiian foods including poi (pounded taro), a local delicacy - Spam musubi (a slice of fried Spam wrapped in rice circled by dried sea weed), and Portuguese malasadas (fried donuts). Patients from other cultures were encouraged to share their language, stories of creation, special foods, and societal organization in a class focused on the various cultures comprising Hawaii. Patients were encouraged to identify their unique history in a group focused on development through the life cycle. Recreational trips to important historical sites in Hawaiian culture and history on the island of Oahu were planned and implemented by the patient community. The Hawaiian Cultural Heritage component of the Kulia program, also, included a bi-weekly group, called Malama Na Ike I and II. One group focused upon beautification of the grounds around the open unit with Native Hawaiian plants and an understanding of their significance in Hawaiian culture. The second group focused upon the history, culture, and language of the Hawaiian people. Patients from other cultural groups (African American, Caucasian, Japanese) participated in both groups depending upon their interest in these areas. Only on the open usnit was this cultural focus incorporated throughout the treatment program. The presence of the HSH multicultural staff facilitated patient engagement and effective communication with the patient's treatment team.

Individual treatment sessions were held with members of the treatment team from 9:00-9:30 and 13:30-16:30 for 30 minutes to 60 minutes depending upon the focus of the session. Group psychotherapy sessions occurred in the afternoon time period, also. Table 2 summarizes one schedule of groups (educational, social skills, substance abuse treatment and prevention, prevocational and vocational rehabilitation, and community reintegration for one patient during one nine-week cycle of the Kulia Program. In the eighth week of each cycle, a treatment plan meeting was held. Patients and members of the patient's treatment team developed the individual schedule for the next 9-week cycle.

Patients had the opportunity to have input into the programming and the development of specific activities, such as fund-raisers. The monies raised were used for a specific patient community activity determined by the patients such as a cookout or trip to a location of

Table 2.— Kulia Schedule

KULIA SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8-8:30	Patient Rounds		Patient Rounds	Patient Rounds	
8:30-9:00	Community Meeting	Community Meeting	Community Meeting	Community Meeting	Community Meeting
9-9:20	Nursing Team Mtgs/Work Individual Session	Nsg Team Mtgs/Work Individual Session	Nsg Team Mtgs/Work Individual Session	Nsg Team Mtgs/Work Individual Session	Nsg Team Mtgs/Work Individual Session
9:20-9:30	Patients' Break	Patients' Break	Patients' Break	Patients' Break	Patients' Break
9:30	Substance Abuse Education Group (SW, Nursing - Activity room) Talk Story Group (Psychology -E Conf. Room) Substance Abuse Process Group "B" (SW, Nursing - Classroom 2) Living Skills (Ward OT, Nursing - Classroom 1) What's News? (Nursing - Lobby or Day room)	*8-30-10:30 Sex Offenders' Group (Psychology - Guensberg) Spiritual Journey (Psychology, Chaplain) Coping Skills (Ward OT, Nursing - Classroom 1) Library World (Nursing - Village Green Library) *10:30-11:15 Neuropsych Training Neuropsychology - Building L	Anger Management (Social Work, Nursing - Classrm 2) Beautification Activity (Nursing - Day area, courtyard grounds around E) Communication Skills (Nursing, Ward OT) Discharge Readiness I (SW, Nursing - Activity Room)	Computer Skills (OT Skills Center) *9-10a / *9-11a Basic Conversational Skills Grp (Nsg, MD - Activity Room) Feelings Through Music Group (RMT, Psychology - Auditorium) Remotivation Group (Ward OT, Msg - Classroom 1) Stress-Ease II Group (RT, Nursing - Classroom 2) Relapse Prevention (Psychology, Dr. Wood, Dr. Zodrow Guensberg Bldg) *10-11a / *11a-12p	Job Skills (OT - Skills Center) *8-9a *9:30-10:30a Skills Expolration (OT-Skills Ctr) *8-9a *8:30-10a Malama Na Ike Activity (Nsg - Community Cultural Sites & E) Kulia Brain Gym Group (Nursing - Activity Room) Crafts 'n Arts Group (RT, Nursing - Classroom 2)
10:30	TPs/Individual Contacts	TPs/Individual Contacts	TPs/Individual Contacts	TPs/Individual Contacts	TPs/Individual Contacts
11-11:30	Patients' Lunch	Patients' Lunch	Patients' Lunch	Patients' Lunch	Patients' Lunch
11:30-12:30	Patients' Rest Time	Patients' Rest Time	Patients' Rest Time	Patients' Rest Time	Patients' Rest Time
12:30	WORK Health Education Group (Nursing - Activity Room) Treatment Planning Group Psychology, Nsg - E Conference Rm Money Management (Ward OT, Nursing - Classroom 1) *1:30-2:30 Adult Education (DOE - Village Green Library)	*11:45-1:30 Escorted AA Community Meeting (RT, Nsg - Aikahi Church Site) WORK Gym with Unit E Staff Nursing - Gymnasium) Personal Effectiveness (Ward OT, Nsg - Classroom 1) Symptom Management (Nursing, MD - Activity Room)	WORK Pass Prep Group (Nursing, Ward O.T. - Classroom 1) Medication Management (Nursing, MD - Activity room) Wellness Group (Nursing - Classroom 2) *1:15-7:00p: Community Reintergration Bus Module (RT - Community Sites)	WORK Substance Abuse Process Group "A" - (SW,Nsg-Classroom 2) Men's Activity (Nursing - Activity Room) Getting Along Group (RT, Nursing - Day room) Hygiene/ADL s/Etiquette Group (Nursing, Ward OT- Classroom 1)	WORK Polynesian Story-telling Activity (Nursing - E Conference Room) Cognitive Games (Nursing - Activity Room) Self-Esteem / Awareness (O.T., Nursing - Classroom 1)
1:30-2:00	Team Wrap-Up Meetings	Team Wrap-Up Meetings	Team Wrap-Up Meetings	Team Wrap-Up Meetings	Team Wrap-Up Meetings
2:00-2:30	Pt. Break / Individual Contact Individual Session	Pt. Break / Individual Contact Individual Session	Pt. Break / Individual Contact Individual Session	Pt. Break / Individual Contact Individual Session	Pt. Break / Individual Contact Individual Session
2:30-3:15	Educational Video (Nursing - dayroom) Open Gym Activities (Gymnasium) Individual Session	Educational Video (Nursing - dayroom) Open Gym Activities (Gymnasium) Individual Session Model Making Group (R.T. - Day area) Percussion Group (RMT - Auditorium)	Educational Video (Nursing - Dayroom) Open Gym Activities (Gymnasium) Individual Session	Educational Video (Nursing - dayroom) Open Gym Activities (Gymnasium) Individual Session	Educational Video (Nursing - dayroom) Open Gym Activities (Gymnasium) Individual Session Music Session (RMT - Auditorium)

7/6/98 - 9/4/98 CYCLE

Hawaiian historical significance or to a specific cultural festival (Hawaiian Taro Festival, Japanese Bon Dance, Greek Cultural Festival, Native American Pow-Wow). Staff worked with the elected patient leaders to plan these activities.

A diabetic, Hawaiian-Chinese patient admitted with a diagnosis of Schizophrenia Paranoid Type and Crystal Methamphetamine Dependence, and Cannabis Abuse may be assigned to the following groups for her first 9 weeks on the unit: Understanding Mental Illness Group, Medication Education Group, Substance Abuse Education Group, Personal Effectiveness Group, Hawaiian Culture Group, Anger Management Group, Personal Grooming Group, an Adult Development Group, and a Spiritual Journey Group. These groups would enable the patient to improve her understanding of her mental illness, the role of medication in its treatment, the effect of substance abuse upon her mental illness, facilitate an identification of her bi-cultural heritage, improve her interpersonal interactions and ability to manage anger as well as personal grooming, and to aid the patient to compare her current life course with the usual tasks, goals, and relationship of persons of her age. The Spiritual Journey Group focused upon the role of religious belief in each person's life and encouraged the patient to identify it in her life. Recreational activities focused upon the development of alternative activities for remaining physically fit and identified specific patterns of leisure time activities, frequently a deficit for these chronically mentally ill. A special Recreational Therapy module helped patients to use public transportation with a structured program which established a destination, planned the buses to be taken, made the trip accompanied by a recreational therapist, and reviewed the extent to which each patient had met his or her goals in travel, behavior, and resource utilization. When indicated, neuropsychological and nutritional consultation were requested to address the specific goals of improving the patient's information processing and to improve diet planning and food choice for the diabetic patient.

The Patient Incentive Points (PIPs) that were earned could be used in the community reintegration activities on weekends that included traveling by van to participate in a local beach cleanup, attendance at a cultural festival (e.g. Hawaiian Taro Festival, Japanese Bon Dance, celebration of the Chinese New Year), visiting the local library to obtain a library card and to take out books and videos. PIP points were also used to go Wiki Wiki (fast and cheap) shopping to pick up items that were not provided by the hospital including special foods (siamen noodle soup), batteries for Walkman radios, and personal clothing. Wiki Wiki shopping provided an opportunity to emphasize the skills of budgeting and managing finances. These ommunity reintegration outings served as an on-going monitor o patient's ability to mange their finances and to plan leisure tie activities.

As patients improved in their level of appropriate behavior, each patient and patient's treatment team could elect to complete a vocational assessment during the in-patient hospitalization. Upon completion of the assessment, the patient working with the occupational therapist, identified work assignments within the HSH for which the patient could earn monies while demonstrating work readiness skills.

All group assignments for the Kulia Program resulted from the initial comprehensive evaluation of each patients involved in assessment by psychiatry, psychology, social work, nursing, recreational therapy, and occupational therapy. Each patient's individual strengths and weaknesses were established in an interview with the patient's team's social worker. In treatment planning sessions the patient's goals for the hospitalization were identified and in monthly treatment planning meetings the attainment of these treatment goals was assessed and new goals established with the patient. The Kulia Program group assignments were for a 9-week cycle. In the eighth week of the current cycle the patient met with his or her treatment team and reviewed the patient's progress and established the patient's groups for the next cycle.

Outcomes

The HSH in the 1990s continued as a unique institution. Its various in-patient units housed very different patient population. Because 50% of its population came as forensic admissions, the average length of stay was over 18 months, including an additional 3-6 months to complete the court-ordered evaluation for conditional release and the receipt of the final judicial determination at the court hearing. In contrast to many mainland, public, in-patient units with length of stays in days or weeks, patients admitted to HSH's only open unit remained in in-patient treatment an average of nine months. Prior to the most recent reorganization of the hospital and an emphasis upon discharge, the annual discharge rate of the Kulia Program was higher than the discharge rate for the other units. The geriatric unit discharged patients only at death, an average of one per 2.5 years. The unit focused upon the treatment of high profile, personality disordered, criminals rarely discharged patients from he hospital resulting in Length of Stays of 6 years to over 20 years. Discharges to the community from the unit treating the developmentally disabled and traumatic brain injured patients, and the closed unit for the chronically mentally ill were difficult because of the limited number of community services and housing existing during this period and the impact of a narrow range of linked community mental health services existent at that time.

Because of the diverse mission of each unit based upon each unit's specific population, a comparison of the treatment programs and resulting readmission rates is an unequal comparison. Given this caveat, of the 238 patients discharged from the Kulia Program between 1992-1999, only 7% were readmitted. The readmission rate was approximately 20% for those few patients who were discharged from the four other treatment units. The lower recidivism rate for the open unit's Kulia Program was one important outcome marker in terms of in-patient costs saved as well as an indicator of the successful modification of the patient's problem behaviors that resulted in the need for in-patient treatment. This is a result similar to a naturalistic study of treatment of the chronically mentally ill that compared the states of Maine (usual treatment) and Vermont (variant of psychiatric rehabilitation program) with Vermont patients doing better in rates of rehospitalization, absence of symptoms, employment, living successfully in the community, and global functioning.[19]

The presence on the grounds of the HSH of a halfway house, privately run, facilitated a physical transfer from the in-patient Kulia Program to outpatient treatment. The proximity of this residence to the former inpatient unit was important for some very fragile patients with chronic mental illness who had significant problems with the transition from the in-patient setting. Although formally

discharged from the hospital, these patients could remain on hospital grounds while making their first initial transition into community care.

Comment

The Kulia Program provides one successful model of incorporating cultural diversity within an in-patient psychiatric rehabilitation program in a state hospital serving a diverse patient population. Although designed originally primarily for chronically, mentally ill, schizophrenic patients, the program evolved to include work with patients with dual diagnoses involving substance abuse as well as patients with psychosexual disorders and offenses. The maintenance of these patients in their discharge communities is a reflection of the success of the program. The importance of the linkages that the Kulia Program established with community services and outpatient treatment teams was recognized and incorporated into a new treatment model currently being implemented at the HSH to facilitate discharges and to decrease the Length of Stay for the total hospital population. Linkages that did not exist effectively before the development of the Kulia mode are being established and institutionalized by the Adult Division of Mental Health of the Department of Health of the State of Hawaii as a new comprehensive network of psychiatric community services are developed. In contrast to most mainland states only in 1999 was an Oahu island-based Assertive Community Team (ACT) established through the initiative of the Adult Division of Mental Health of the Department of Health of the State of Hawaii in its effort to develop a comprehensive range and network of services.

In order to meet the mandates of the Department of Justice to standardize care across all treatment units at the HSH, the Kulia Program model was incorporated into a standardized rehabilitation model developed by the Adult Division of Mental Health of the Department of Health of the State of Hawaii. In order to facilitate the standardization of treatment, the HSH has had a decrease in its bed capacity and its units have been reorganized, again, into one admission and three treatment units. All treatment units now are locked and contain a mixed population of patients: the chronically mentally ill; the dually diagnosed; and the personality disordered, substance abusing, court-committed criminal offenders. Intensive staff training[20] preceded the unit reorganizations and continues as a new, standardized treatment model incorporates a schedule of educational, skills training, anger management, and interpersonal skills groups centrally held on the campus of the HSH.

In the HSH structure of the 1990s the Kulia Program provided an example of what could be accomplished with psychosocial rehabilitation in an increasingly diverse population. Its emphasis upon Hawaiian culture facilitated the sense of history, prior accomplishments, and sense of heritage for Hawaiian and part-Hawaiian patients as well as the diverse culture comprising the state of Hawaii. Although serving a segment of the HSH patient population very well, the majority of HSH patients at that time could not participate in the Kulia Program.

As with any change, there are losses and gains. Although the Kulia Program no longer exists, the model of rotating classes addressing activities of daily living, social functioning, education about medication and treatment, and community reintegration activities comprise the core of classes now centrally offered to all patients on the revised treatment units. Efforts to establish a Fountain House model on the island of Oahu have begun.

Conclusion

The Kulia Program developed on the only open unit of the only public mental health hospital in the state of Hawaii met the 10 essential features of a psychiatric rehabilitation program as articulated by Anthony, Cohen, and Farkas in 1982 (see Table 1). It was unique in providing a psychiatric rehabilitation program that incorporated a culturally sensitive component. In order to standardize care to a redefined and downsized forensic patient population at the HSH the Kulia Program formally ended in 2000 with the reorganization of the HSH into a closed, forensic facility.

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Medical School Hotline

Medical Education Fellowship in the Office of Medical Education at the John A. Burns School of Medicine

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Faculty development is vital to maintain quality education and curricular innovation at academic institutions. Evidence is building that faculty development in instructional skills with select participants improves knowledge of effective teaching, observed teaching behaviors, and teacher evaluations.[1] Despite this fact, clinician-educators are assigned to teach in an ever-evolving academic environment without the benefit of any formal instruction in teaching skills.

Faculty development plays an important role in promotion and retention. In recent years, much attention has been given to the challenge clinician-educators face when seeking advancement in academia. In a survey of medical school promotion committees, those aspects of a clinician-educator's performance deemed most important for promotion from assistant to associate professor levels included teaching skills, clinical skills, academic administration, developing educational programs, and various types of scholarship.[2] Faculty members without specific training in these areas face a steep learning curve before reaching peak efficiency.

In recent years, faculty development fellowships, which may be one or two years in length, have emerged as a model to improve the instructional, professional, and leadership skills of faculty.[3] They offer several advantages over episodic workshops and individual consultations. Fellowships provide a longitudinal learning experience in which participants have the time to conceive, develop, and pilot new educational interventions. They can apply what they are being taught. Fellowships allow time for the continual reinforcement of important principles. Finally, the extended time period allows fellows to develop meaningful relationships with faculty mentors and work with a cohort of peers who become future colleagues and collaborators.

As a response to the need for additional faculty development opportunities, the Office of Medical Education (OME) at the University of Hawaii John A. Burns School of Medicine (JABSOM) developed and piloted a Fellowship in Medical Education in the 2000-2001 academic year. This fellowship was designed to meet the needs of faculty at JABSOM and therefore its curriculum was aligned with the skills needed to serve effectively in the school's unique academic environment.

The content of the fellowship fell into three distinct units:

1)Curriculum Design
2)Teaching
3)Personal Effectiveness and Educational Leadership

1)Curriculum Design: Fellows learned how to develop new educational experiences in a scholarly way by:

A. Beginning to learn how to complete a literature review and curricular need assessment.
B. Learning the principles involved in writing goals that reflect real world performance, defining measurable objectives, and selecting realistic and feasible yet innovative instructional methods.
C. Learning ways to evaluate student performance and overall program effectiveness.

As a fellowship requirement, fellows must apply these principles to create and to pilot a new curriculum benefiting their home department, program, or unit.

2)Teaching: Fellows reviewed educational principles and adult learning theory by:

A. Practicing the application of instructional technology, like the use of presentation software and incorporating video in teaching.
B. Becoming familiar with the use of standardized patients in instruction and evaluation.
C. Learning techniques for teaching in the clinics and hospital wards.
D. Applying these principles in active teaching exercises conducted under the supervision of fellowship faculty who provide feedback and guidance.

In addition, fellows reviewed the theory behind problem-based learning (PBL) and PBL case-design. They served as a PBL tutor for a group of first or second-year students to learn firsthand how to tutor effectively and see how the theory behind PBL is practically applied.

3). **Personal Effectiveness and Educational Leadership**: Fellows learned practical skills in time management and organization, as well as principles of management, effectively facilitating change, and leadership as they apply to medical education.

Miscellaneous topics included, discussing the promotion process, developing teaching portfolios, improving performance through feedback, writing for publication, presenting scholarly projects, planning educational workshops, and learning elements of educational research.

The content was delivered over the course of the year in the form of weekly two-hour seminars. Assignments, including selected readings and the completion of task-specific workbooks and reflective essays, were completed between seminar sessions. Fellows devoted 25% of their time to fellowship activities that was negotiated in advance directly with the fellows' department chairman or unit director.

The response of the fellows in the pilot year of this program has been positive. They reported that the fellowship provided them with a better understanding of curriculum design, the principles underlying effective teaching, problem-based learning, and leadership. They suggested an improved mechanism for protecting their time to complete homework and additional sessions on teaching skills and educational research. The second class of this fellowship program is scheduled to begin this fall.

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Local Studies Address a Previously Hidden SexuallyTransmitted Disease: Human Papillomavirus and Cervical Neoplasia

Marc T. Goodman, PhD, MPH
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Of the many triumphs in our fight against cancer, perhaps the best recognized has been the significant decrease in cervical cancer incidence worldwide through the use of the Papanicolau (Pap) screening test. As with many other public health successes, routine cytological screening and treatment of dysplasia and carcinoma *in situ* were performed without complete knowledge of the cause(s) or natural history of cervical malignancy. Our understanding of cervical neoplasia and the carcinogenic process has come a long way since the introduction of the Pap smear, and we now know that the majority of cervical cancer is caused by a single infectious agent, the human papillomavirus (HPV).[1] What we don't know is why only certain women develop cervical dysplasia or cervical cancer when HPV infection appears relatively common; nor why Asian/Pacific Islanders in Hawaii generally have lower incidence rates of HPV-associated squamous cell carcinomas than whites.[2]

In 1991, prompted by the availability of a new DNA amplifying technique, polymerase chain reaction (PCR), we initiated a case-control study of risk factors for pre-malignant changes in cervical epithelium. The specific aims of this five-year investigation, funded by the National Cancer Institute, were to identify viral and non-viral risk factors for cervical dysplasia, with a special emphasis on the interaction of HPV and diet. Eligible subjects included non-hysterectomized women, from 18 to 84 years of age, who were residents of Honolulu. Women who had been pregnant or lactating within 6 months of enrollment, who had a diagnosis of cervical abnormalities within the past three years, or who were clinic referrals were considered ineligible for study. Eligible cases were identified through the cytology logs of the participating clinics and included all women with a cytological classification of atypical squamous cells of undetermined significance (ASCUS) or squamous intraepithelial lesion (SIL) according to the Bethesda system.[3] Potentially eligible women were contacted by letter, followed by a telephone call, for consent to participate in the study before their return to the clinic for a follow-up examination and cervical smear. As part of the study, a colposcopy was performed and cervical cells were collected for HPV testing. Interview information was obtained from 214 women with biopsy-confirmed SIL and 254 women with a cytological diagnosis of ASCUS. Blood was drawn from 147 of the SIL cases and 185 of the ASCUS cases who completed interviews.

Controls were women with negative cytological smears attending the same clinics as the cases. Eligible women were selected from the admission logs of the participating clinics on a randomly selected day of the month. Potential controls were met at the clinics by one of the interviewers who explained the purpose of the study. An exfoliated cervical cell specimen was obtained at the time of the cervical cytological smear. Of the 271women with negative cytological results who were interviewed, 191further consented to have their blood drawn.

Participants were scheduled for a personal interview at their homes or other convenient location. A standardized questionnaire was used to elicit a detailed sexual and reproductive history, including age at first intercourse, number of sexual partners and methods of contraception, diet, a lifetime history of tobacco and alcohol use, and other demographic and lifestyle information. Fasting blood was used to determine plasma levels of a variety of nutrients. DNA was purified from peripheral blood leukocytes by SDS/proteinase K treatment and phenol/chloroform extraction for genetic analysis. Frozen cervical cell specimens were prepared for HPV-DNA detection by PCR amplification and dot blot hybridization of the amplicons.

Our findings suggest that high plasma concentrations of several antioxidants may reduce the risk of ASCUS[4] and cervical SIL.[5] We found an inverse dose-response of a-cryptoxanthin, total tocopherol, and a-tocopherol to the odds ratios for cervical SIL, after adjustment for HPV, tobacco smoking, and alcohol drinking. The risk of cervical dysplasia was reduced by about 70% among women in the highest compared with the lowest quartile of these micronutrients. We were also interested in the influence of dietary and plasma folate levels and related compounds on the risk of cervical dysplasia. Folate is essential to the synthesis of nucleotides, and low levels of folate have implications for cell replication, DNA excision and repair, and DNA hypomethylation. We found an inverse association of dietary,[6] but not plasma,[7] levels of folate, vitamin B_6, and vitamin B_{12}, on the risk of cervical dysplasia.

Other than diet, we have also explored several genetic hypotheses regarding the etiology of cervical dysplasia. Most recently, we examined the risk associated with a polymorphism in the methylenetetrahydrofolate reductase (*MTHFR*) gene.[6] A common variant of MTHFR, which catalyzes the synthesis of 5-methyltetrahydrofolate, results from a *677C6T* (*ala6val*) substitution in the gene. This variant has been shown to have reduced enzymatic activity and is associated with mild hyperhomocysteinemia. We found a positive, monotonic trend ($p = 0.02$) in the risk of cervical SIL associated with the number of variant *MTHFR T* alleles. Women with the heterozygous *CT* genotype had twice the risk of cervical SIL, and women with the homozygous *TT* genotype had almost three times the risk of SIL, compared to women who were homozygous for the wild type (*CC*) *MTHFR* genotype.

Tobacco smoking has been associated with the risk of cervical malignancy and SIL,[3] and nicotine, cotinine, and tobacco-specific nitrosamines have been detected in the cervical mucus of smokers.[8] Although the significance of these observations is unclear, DNA adducts of bulky aromatic compounds have been found with increased frequency in the cervical epithelium of smokers compared to nonsmokers,[9] providing biochemical evidence that smoking may be a cause of cervical cancer. Based on the significant positive association of tobacco smoking and cervical dysplasia in this investigation, we explored the hypothesis that genetic polymorphisms in

the cytochrome P450 1A1 (*CYP1A1*) and glutathione S-transferase classes mu and theta (*GSTM1* and *GSTT1*) genes promote dysplastic change by moderating the activation and detoxification of polycyclic hydrocarbons and other compounds that influence oxidative stress and DNA adduct formation. Women who were homozygous, but not heterozygous, for the *CYP1A1 MspI* variant allele were at significantly increased risk of cervical SIL compared to women who were homozygous for the wild-type allele.[10] Subjects with the *GSTM1* null genotype were also at (borderline) elevated risk of cervical SIL compared to women with the gene present. No difference in the risk of cervical disease was associated with the *GSTT1* variant genotype. The combination of the *CYP1A1* homozygous variant and the *GSTM1* null genotypes increased the odds ratio for cervical SIL to 5.1 (95% confidence interval: 1.3-20.8). It is possible that both the *CYP1A1 MspI* and *GSTM1* polymorphisms are susceptibility factors for early, premalignant changes in the cervical epithelium.

The recognition that HPV infection may be a necessary cause of cervical cancer has had a major impact on the epidemiological study of this disease. Of critical scientific and public health importance is whether the presently established risk factors for cervical dysplasia, such as tobacco smoking, are HPV cofactors that modify the progression of HPV infection to cancer or are simply correlated with viral infection. In collaboration with several local health care providers, we are presently engaged in another National Cancer Institute-funded project to establish a multiethnic cohort of 1,150 HPV-positive women for long-term follow-up to identify factors that influence the persistence or resolution of HPV infection of the cervix. The project aims are 1) to study the association of the dietary intake of fruits and vegetables and the plasma levels of carotenoids, tocopherols, and vitamin C with HPV persistence, and 2) to examine the role of HPV type, viral quantity, and multiple HPV infections in HPV persistence. The identification of these factors may provide insight into the natural history of HPV infection and may improve the ability to characterize women who are at greatest risk for developing HPV-associated neoplasia. A unique feature of this investigation is the development of a laboratory capability at the Cancer Research Center to perform HPV-testing. This is the only such laboratory in Hawaii and has been used increasingly by local physicians.

At present, we have enrolled over 1,000 local women of whom 210 were HPV-positive on the first or subsequent visits. We are asking for your help in enrolling additional volunteers. Participants in the study will be monitored through quarterly screening during a 3 year follow-up period. At each visit, a Pap smear is obtained, along with a blood specimen and collection of cervical cells for HPV testing. All participants will be reimbursed for their time and travel. Women at least 18 years old, not currently pregnant, and who have no prior history of hysterectomy are eligible for the study. Call Dr. Brenda Hernandez at (808)586-2987 for more information about participation in this study.

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News and Notes Henry N. Yokoyama MD

Potpourri...

Lost in Translation...My six year old grandson called his mother from his friend Charlie's house and confessed he had broken a lamp when he threw a football in their living room.

"But mom", he said, brightening, "You don't have to worry about buying another one. Charlie's mother said it was irreplaceable."

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While working for the U.S. Census, I approached one home where I was greeted by two children. I introduced myself, explaining that I was a census taker and asked to see an adult. The older child ran to the door and shouted to the woman of the house. She hollered back, "Who is it?"
The youngster yelled, "It's the senseless under taker."

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The little boy I was babysitting showed us his family photo album. He pointed out a nice picture of his whole family and I complimented him on how handsome he looked. He shook his head and said, "My mom doesn't like it at all. She wants to have it blown up."

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Six guys were playing poker when Smith loses $500 on a single hand, clutches his chest and falls over dead.

Who's going to tell his wife, they all wonder. They drew straws and Anderson picks the short one. They tell him to be discrete and break it to her gently. "No problem," he says.

So he drives over to the Smith house and knocks on the door. When the wife answers he tells her, "Your husband just lost $500 playing poker." She screams and says, "tell him to drop dead!"

Anderson replies, "Okay, I'll tell him."

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Outhouse Medicine 101...

My neighbor and patient, Greg McAdam called to tell me his friend had a terrible accident and that he was very upset about the situation.

It seems his friend was smoking in his outhouse while doing a "major job". The friend threw his butt into the hole as he sat...a huge explosion occurred when the lit cigarette contacted the methane gas. Now Greg's friend is missing both testicles and most of his penis...

I was laughing so much I forgot to empathize with Greg's friend's loss.

Dr. Erica Golliatt

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Potpourri...

Frantic man on the phone: "My wife is pregnant and the contractions are two minutes apart..."

Doctor: "Is this her first son?"

Man: "No, you idiot! This is her husband."

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Patient: "I've lost my memory."
Doctor: "When did this happen?"
Patient: "When did what happen?"

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Patient: "I think I swallowed a bone."
Doctor: "Are you choking?"
Patient: "No, I really did."

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A vet felt sick and went to see our doctor. When the doctor started to take a history, she interrupted, "Look, I am a vet and I don't need to ask my patients these questions. I can tell what's wrong just by looking at them. Why can't you?"

"I can probably do that too", said the doctor. He looked her up and down, wrote out a prescription, which he handed to her and said, "Take these pills. If they don't work we will have to put you to sleep."

"Nostrum" by Simon Halley
Stitches Editor

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Two women were chatting in the doctor's waiting room.

"I want a baby more than anything in the world," said one. "But I guess it's impossible".

"I used to feel that way," said the other, "but then everything changed. That's why I am here. I am going to have a baby in 3 months."

"You must tell me what you did."

"I went to a faith healer."

"But I've tried that! My husband and I went to a faith healer for a year and nothing happened."

The other woman leaned over and whispered, "Next time go by yourself."

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President Bush and Vice President Cheney are having lunch at a restaurant. Cheney orders the "heart healthy salad". Bush leans over to the waitress and says, "Honey could I have a quickie?"

The waitress is horrified... "Mr. President," she says. "I thought your administration was bringing a new era of moral rectitude to the White House. Now I see what a false promise that was!" And she marches off in a huff.

Cheney leans over and says, "George, it's pronounced quiche."

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Placenta Previa: In the 1970's the presence of a father in the delivery room was a relatively uncommon occurrence. But on this occasion, a young Cockney father was invited to the birth of his first child. Dressed all in greens, he vacillated rushing from the head of the table to the stirrups.

The father was most appreciative of the medical attention accorded his wife, but asked to speak privately with the physician. Taking the senior resident to a corner of the delivery room he asked in all sincerity: "Well Doc, when can me and missus have sex again?"

The resident looked first at the father and then at the mother, still in stirrups and quietly informed him, "Sir we usually wait until the delivery of the placenta."

Dr. Arthur Atkinson

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Ten men and one woman are hanging on to a rope that extends down from a helicopter... The weight of 11 people is too much for the rope so the group decides one person has to jump off.

No one could decide who should let go until the woman volunteers. She gives a touching speech saying she will sacrifice her life to save the others because women are used to giving up things for their husbands and children.

When she finishes speaking, the men all start clapping...

Margaret Pitman

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Live & Learn:

One of my favorite patients was a four foot, 200 pound, hyperchondriac of German extraction. She would present herself with two shopping bags – one for her purse and the other for her meds.

Mrs. B. suffered from every disease in the book. Dr. S., her long-suffering and infinitely patient doctor tried valiantly to keep her out of harms way.

On the occasion of one of Dr. S's absences, Mrs. B. presented me with a request for a refill of the medication Sulfasaxazol. I asked her what exactly was Dr. S. treating.

"My infected prostate gland," came the reply.

"And is the medication working?" I made the mistake of asking.

"Yes, but it's not quite better so I want some more medication," she said. Based on my past medical experience with her, I knew better than to argue.

Mrs. B. was given her prescription refill and became the only woman in

medical history to be diagnosed and successfully treated for acute prostatitis! Oh the things they don't teach us in medical school.

Dr. William Fritz

Medical Tid Bits

Colon Cancer: Colorectal cancer is the third deadliest cancer in the U.S. with 103,000 cases diagnosed each year. Last April, the FDA ruled that CAMPTOSAR (in use since 1988 as a second line treatment) is potent enough in combination with other chemotherapeutic agents and can now be used as a first line therapy even in advanced cases...

CPR: In heart attacks, standard CPR calls for alternative mouth to mouth resuscitation with chest compressions. A study of emergency medical technicians demonstrated that chest compressions alone may be sufficient. Survival rates were the same with or without chest compressions.

Bated Breath: Steroid inhalers are the most common treatment for chronic bronchitis and emphysema. MDs say that steroids improve the shortness of breath and frequency of office visits, but fail to show progression of smoking-induced disease and do not show bone loss.

Roto-Rooter: A study of 63,000 patients confirmed that angioplasties save more lives than clot busting drugs in heart attacks. The odds of dying after emergency angioplasties are 40% lower than after a round of clot busters. Caveat: The finding applies only to centers doing at least 50 or more angioplasties per year.

Sugar Coating: Blood screening in the afternoon may miss half the cases of diabetes because sugar levels are normally below 125 mg/dl...

Problem Pill: Women with a family history of breast cancer should avoid birth control pills manufactured before 1975 (which may increase the likelihood of breast cancer).

Stiff Wind: Dr. Russell Stodd in his February column, "The Weathervane" warns: "If you eat beans with your Viagra you get a stiff wind"...

Plavix and Aspirin: A major study at McMaster University in Ontario, Canada found that clopidogrel (Plavix) taken with aspirin reduced the risk of death, strokes, and new heart attacks by 20%...Experts say the drug will become routine treatment for the one million Americans suffering heart attacks each year...Dr. Christophore Cannon of Brigham and Women's Hospital in Boston says, "It is relatively cheap and has monster benefits"...

Diabetes: The first fully automated monitor which analyzes blood and provides results has been approved by FDA...

Estrogen: Two major studies have shown that taking estrogen long after menopause may not benefit the heart. A long term study may produce definitive answers in five years... Meanwhile women with high cholesterol should be on a low cholesterol diet and take cholesterol lowering drugs...

Fatty Fish: Health experts are interested in a group of good fats (Omega-3 fatty acids) which lower triglycerides and decrease blood clots. The American Heart Association is recommending everyone eat two 3 oz. Servings of fatty fish each week.

AIDS: The first known trials of vaccine against African strains of AIDS was begun in Kenya and England. The FDA has approved a new anti-HIV drug...

Alzheimer's: Testing was begun on drugs to clear plaques (a gamma secretose inhibitor) a compound that blocks the formation of the sticky plaques that gum up the neural connections.

Good Cholesterol: New research shows that people with high HDL have a 47% reduced risk of strokes. In the U.S. each year, 600,000 patients stuffer strokes and is the country's third leading cause of death...

Heart Warming: A team of scientists using high powered microscopes and new techniques has challenged the medical dogma that the heart cannot regenerate new muscle cells after a heart attack.

Girls and Math: Girls seem to do more poorly in math than boys. The answer may be iron. A study of 4,500 children found that those with iron deficiency were twice as likely to score below average in math tests...8.7% of adolescent girls were iron deficient compared to 0.9% of boys...

Less is Better: Menopausal women who find the cure for hot flashes and night sweats worse than the symptoms, take heart. A study has found that low dose hormone replacement therapy (0.3 to 0.45 mg of estrogen) is just as effective and having less side effects. Low dose HRT poses no increased uterine cancer risk and may reduce breast cancer risk.

Herbal Warning: The FDA says Echinacea, ginkgo biloba and St. John's wort do not belong in our food...In the U.S. last year, the market research firm, Frost and Sullivan reported that consumers bought $700 million of drinks spiked with Echinacea, ginseng, and other herbs...

Glowing Report: Angioplasty with stent works 90% of the time for a short term, at least. After six months, the artery closes up in one patient out of four...Now a new idea, blast the treated vessel, stent and all with radiation. Two preliminary studies suggest that the odds of a zapped vessel reclogging is reduced 90%...

Statin Drug Benefits: A Scottish report shows that Pravachol reduces the risk of developing diabetes by 30%...A study of heart attack survivors on Pravachol reduces the odds of stroke 20%...

Prozac Nation: Seventy percent of patients on Prozac do not feel the drug fully alleviates their symptoms. Half of the patients discontinue the drug because of side effects such as diminished sex drive; 1/5th of the patients skip doses and 1/2 stop the pill altogether.

Glucosamine Sulfate: Dr. John Klippel, a medical director of the Arthritis Foundation reports that osteoarthritis strikes one in three Americans over age 63... He feels that the dietary supplement glucosamine sulfate taken regularly shows a 20% to 25% improvement in symptoms in three years.

Tea Party: At a meeting of the American Society for Microbiology, volunteers swished either black tea or lukewarm water in their mouths...Conclusion: green tea and black tea prevent cavities as long as the tea is not sweetened with sugar or honey...

Diabetes Blues: DIABETES CARE reports that diabetics are twice as likely to suffer from depression. Proper treatment of depression may actually improve diabetes. However, antidepressants, especially the older tricyclics may disrupt glucose control...

"Medical School Hotline," continued from p. 235

Faculty development is a symbolic representation of the value an institution places on both the quality of education it provides and the faculty that deliver it. The OME Fellowship in Medical Education is an investment in the future of our medical school, and a way to serve the needs of our faculty and students.

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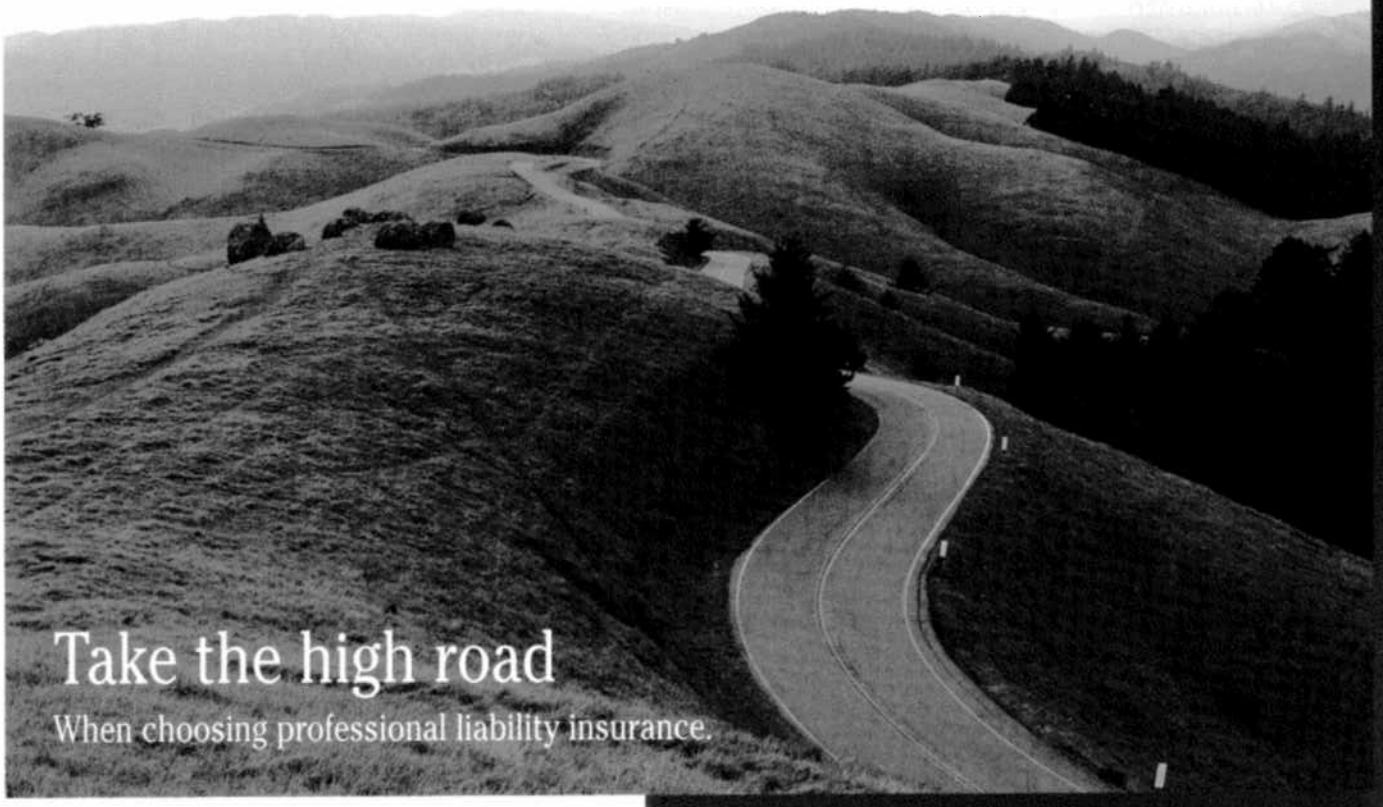

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