Editorial

Norman Goldstein MD

CHIS—Consumer Health Information Service Hawaii Medical Library

Every medical student at the John A. Burns School of Medicine, as well as most practicing physicians, know of the vast reference material available at the Hawaii Medical Library. The journal and book collections, the computer access programs, and especially the knowledgeable, helpful Library staff enable us to keep right up to date with our practices, our research and teaching curricula.

You may not be aware of another very important section of the Hawaii Medical Library, CHIS.

This service is helping your patients to:

- understand their illnesses and treatment options
- make informed decisions about their health care
- learn about overall health and wellness

In the past year, CHIS averaged 285 questions per month, and sent an average of 62 information packets per month to the inquiring public. Services are increasing exponentially with the CHIS web site (http://hml.org/CHIS/) getting 2,800 hits per month. Amazing!

CHIS also has many excellent models and charts available for classroom and health fair exhibits, and is currently expanding its alternative medicine resources.

In a recent survey of CHIS users, 97% were satisfied with the services provided, 28% were repeat users, and 90% said they used the information provided to make a healthcare decision.

Our legislators, Hawaii hospitals and physicians and, yes, even attorneys, should be encouraged to continue to support the activities of CHIS at the Hawaii Medical Library.

Cancer Pain Guidelines: Are They Being Used?

This excellent manuscript on page 655 by Pat Kalua, RN was to appear in our Special Issue on Pain. This issue has been delayed because of updating manuscripts as well as production problems. It will hopefully be published in January 1999.

The Kalua manuscript is so important, in view of the recently completed Governor's Blue-Ribbon Panel on Living and Dying with Dignity—we publish it at this time. Look forward to the Pain Special Issue.

An Assessment of Hawaii Quest Medical Plans Performance Using Medicaid HEDIS Measures, 1996-1997

Because of initial controversy and questions about the Hawaii QUEST programs, Lynette Honbo, MD Medical Director of the MED-QUEST Division of the State Department of Human Services, was asked to submit this Assessment of QUEST on page 662.

As Director, she supervises 15 healthcare professionals in the Medical Services Branch and helps to clarify the QUEST Medical/Dental/Behavioral Health and Pharmacy benefits of QUEST as well as the Medicaid fee-for-service programs and the QUEST-NET program. Mahalo, Lynette and Matthew Loke, Ph.D.

On a personal note, Lynette is married to OB/GYN Clayton Honbo MD.

President's Message

Where do we go from here?

Leonard Howard MD
President, Hawaii Medical Association

In this, my last message to you as your president, I would like to make some observations about the practice of medicine in Hawaii as seen from the heart of the Hawaii Medical Association. This has been a year of relevancy. Everything that we have done this year has been directed towards being relevant to the practice of medicine. The results have been equivocal. On the plus side, the physicians of Hawaii are now seen by the lay public as speaking more with a single viewpoint than ever before. More points of view are now being represented in the consensus voice of medicine. Our voice is being heard in more task forces, more focus groups, and more socio-political arenas than ever before. This is what we set out to do during this past year.

So what are the results of this course of action? Our membership is roughly what we started with last November, but the rotating door has never stood still. If we could ever figure out how to retain members our dues problems would be solved. The problem is that physicians in a tight economic market do not see an immediate return on the money spent for HMA/AMA membership. I would venture to say that membership in Specialty societies, if judged by the same immediate return on investment, would also come up wanting, but for some reason are given priority over the HMA and AMA. I am a life member in my specialty organization, but do not see how it provides any more immediate return than does the HMA.

In our quest for relevancy we find the need for considerable staff support. In the legislative arena we need four full-time people to maintain our presence in the big square building, in addition to the many physicians who donate many hours each week to present testimony. The committee work necessary to support the legislative process is tremendous, but the cost of this support is never mentioned as an immediate benefit of membership. Ask yourself if you personally have the time to spend in the committee hearings, presenting your own testimony. If you are not there, don't you think there should be someone there representing your interests? To do this costs money. Money comes from members. It is your choice.

I do not see any prospect for any less managed care in the future, since the demand for more and more care will ever increase as the percentage of our population that is in the Medicare age group increases. The whole concept of medical ethics is changing. Many of the injunctions of the original oath of Hippocrates are ignored in current medical practice, and the oath itself has been often rewritten to be more politically correct. Yet one of its legacies is the demand

that a physician, if unable to heal or cure, shall do no harm. To some physicians, this means that they must do everything possible to ensure the physical well-being of their patients, or more problematic, everything that might help their patient. Many patients and policymakers have the same expectations. In economic terms, this means that we are required by medical ethics to devote such resources to the care of our patients that the marginal effect of the last dollar spent approaches zero. If we follow this injunction rigorously, we can easily spend our entire gross national product on health care many times over. Thus the shift of managed care or managed-cost. The new ethic of health care says "Perform procedures until the marginal health benefit is greater than or equal to the marginal monetary cost." This new ethic results in less medical care, but it ensures that whatever we get for the expenditure of the health-care dollar is worth the cost of providing the care. Physicians and healthcare administrators for most of the post-World War II period were encouraged to believe that money should never be a consideration in the medical decisionmaking process. Today, we are being told that money should always be considered. Moreover, the decisionmakers in healthcare financing gravitate towards a cost-benefit standard - a collectivist standard not always in the best interest of individual patients.

It is for this reason that organized medicine must continue to represent the patients in this social equation. This can only be done when organized medicine has the financial and staff assets to be part of the bureaucratic decisionmaking process. If organized medicine is unable to continue to function in our society, the practice of medicine will truly become a service industry rather than a profession, something that many social planners are strongly advocating at the present time. It is only by flexing the muscle that comes through unity that we will ensure our ability to practice our profession. This requires that every physician who wishes to continue to practice as a professional do their part to support organized medicine. If we do not do so, the medical profession as we know it will disappear and we will have only ourselves to blame. The choice is ours. I pray we make the right one.

Medical School Hotline

An Update on the USMLE Performance of Medical Students at the John A. Burns School of Medicine and Computer-Based Testing

Gwen S. Naguwa, MD
Associate Dean, Office of Student Affairs

As reported in this annual update on the United States Medical Licensing Exam (USMLE), the students at the John A. Burns School of Medicine (JABSOM), continue to do well, especially on the Step 1 exam. Also, at its June 1998 meeting, the Composite Committee, which consists of members representing the Federation of State Medical Boards, the National Board of Medical Examiner and Educational Commission for Foreign Medical Graduates, formally voted to implement Computer-Based Testing (CBT) beginning in 1999.

Students in the JABSOM Class of 2000, who challenged the Step 1 exam this past June, achieved a post-Problem-Based Learning curriculum high passing rate of 98%, compared to the national passing rate of 95%. The mean score for JABSOM students was identical to the national mean of 216. The passing rate for our current seniors on the Step 2 exam, taken in August 1997, was 96%, as compared to the national rate of 95%; however, the mean score for JABSOM students was 214, slightly higher than the national mean of 209. As before, although the National Board of Medical Examiners steadfastly states that it is a licensing exam and should not be used as a method of evaluation of curricula, the faculty continues to feel that the students' performance is an indication that they have mastered the skill of learning, or at least solved the problem of how to pass the USMLE.

As a brief review, the USMLE is the only path to licensure in the U.S. and its territories, and a passing score in all three steps is one of the requirements. Step 1 is designed to assess a student's ability to apply knowledge and understand key concepts of basic biomedical science, with an emphasis on principles and mechanisms of health, disease, and modes of therapy. The Step 2 exam is to determine whether a student can apply basic science knowledge and understand the clinical science necessary to care for patients under supervision, and now includes health promotion and disease promotion. Step 3, usually taken near or after completion of one postgraduate year of clinical training, assesses the ability to apply the medical knowledge and understanding of biomedical and clinical science considered essential for the unsupervised practice of medicine with emphasis on patient management in ambulatory setting.[1]

While the purpose and fundamental content of the USMLE will not be affected significantly by the conversion to the computer-based format, the effect of the Composite Committee's