MEDICAL

SINGAPORE MEDICAL ASSOCIATION

Newsletter

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SMA - NOT AN OLD PEOPLE'S CLUB - PRESIDENT

Prof. W.O. Phoon President of the SMA at the annual dinner held at the Cathay restaurant on 30.3.74 said, "It gives me particular delight to welcome our guest of honour, Professor Khoo Oon Teik, and Mrs. Khoo. Professor Khoo, our Lecturer for 1974, is, of course, one of the most eminent doctors in our country. Not only is he Chairman of the Department of Medicine at the University of Singapore, a leading pioneer of Nephrology in this part of the world, and Master of King Edward VII Hall, but he has a long list of achievements to his credit and has held with great distinction a large number of top medical positions in our Republic, including the Mastership of the Academy of Medicine. I am particularly pleased tonight because Professor Khoo has been, at different stages of my career, my teacher, mentor and superior and is now both my personal friend and colleague. I don't know whether Professor Khoo will be angry with me for letting out a little secret – today is his birthday and therefore I would like, on your behalf, to wish him a Very Happy Birthday as well.

Mrs. Khoo is the woman "behind the throne", so to speak, though, of course, we don't have any throne as such in our Republic. Several generations of medical students and young doctors have known Mrs. Khoo as a most charming, gracious and hospitable hostess at either her own home or the King Edward VII Hall. It is therefore a great pleasure for me to acknowledge our deep indebtedness to her for gracing the occasion tonight.

I am sure that our many other distinguished guests would forgive me if I do not mention them name by name. I wish, however, to bid them a very warm welcome and thank them for their presence with us tonight. Together with us we have also tonight Miss Teo Peck Hoon who has been our Senior Executive Secretary for the last few years. It is my duty tonight to thank her for her past services. Despite her very dainty exterior, she has been a veritable pillar of strength to successive Councils of the S.M.A. We are sad to lose her but wish her every success in her future career.

Tomorrow I shall be retiring for the second (and last) time as President of the Singapore Medical Association. I hope, therefore, that I shall be forgiven if I sing my swan-song by indulging a few personal reminiscences and observations. It is seven years ago since I first had the honour of serving on the Council of our Association. Thanks to the selfless dedication and vision of the several members who served in the various Councils and Committees and the loyal service of the Secretariat, those seven years have seen many fluctuations in our fortunes, but the progress of our Association has been every year from strength to strength – despite momentary setbacks and many anxious moments! Our financial assets and membership strength have never been as strong before as they are today. On the international scene, we have more contacts and established co-operation with more overseas national medical associations and international medical bodies than previously. On the national plane, we can boast of a strong Secretariat and vastly improved premises. The Association has also been midwife to the smooth birth of the College of General Practice, as well as the progenitor of a brood of lusty affiliated academic societies. It is with great satisfaction

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Medical Care - A Despised Cliche

Prof. O.T. Khoo

The Guest of Honour at the Annual SMA Dinner, Prof. O.T. Khoo said in his speech, "In the past few weeks we have been concerned about the changes and trends in Medicine in Singapore, particularly as it affects the practising doctor.

Perhaps I should preface my remarks with the observation that as a profession we are rather proud of our conservative and traditional approach to Medicine. As a result, our ideas of health and disease tend to be stereotyped and I venture to hypothesize that our concretized concepts more than anything else militate against any major breakthrough in the delivery of health care. For example our dominant concept of the healing process falls heavily on disease eradication and disease management particularly in specialised institutions. This is best exemplified by surgery which views disease as 'focal lesion' in an inappropriate context and therefore must be eradicated by excision or destruction. This leads me to say that we are in danger of narrowing our very concept of health. What is required for today's needs is a total view of health lest some parameters are ignored in health planning.

The crux of the problem in many countries is that so much energy and resources are expended in curing and managing the patient that other services suffer to the detriment of the total health of society. As a profession we are increasingly aware that medicine comprises not only health care but health education and health delivery. As we have been mainly concerned with health care these past weeks I thought it fitting to focus our attention on our understanding of health and care in the few minutes available. Having had to reorientate my own ideas not so long ago I thought this is an opportune occasion to share my thoughts on these two partners of health care which figure and will continue to figure so much in medicine. First, what is health? Rene Dubos said, "The real measure of health is not the Utopian absence of disease but the ability to function effectively within a given environment". And the environment would not only include the fast polluted planet called earth but also our socio-economic milieu. Health as an active ongoing process cannot be isolated from the socio-economic constituents or policy of the country. Ill health means low productivity. The progress of a country is slowed down by a growing residue of unsolved health problems. Especially with fast technological advances medicine must walk in step with industrial progress if the quality of life is to improve. In U.S.A., medicine is one of the largest industries spending 50 billion dollars a year on health care, medical research, education and hospital construction and 4½ million professionals and technicians. As you well know, American health care delivery has many failings despite these enormous efforts and expenditure. One major reason is that curative and institutionalised medicine is expensive and individualised, particularly for those who can afford. In a conference on health in Hong Kong, an attempt was made to define health broadly in 3 statements which challenge our usual concept of it:–

(1) Health implies the full development of one's faculties and gifts to the full.
(2) Health is a continuing process with ever advancing goals or concepts of maturity.
(3) Health depends on achieving a fruitful relationship with one's environment.

These ideas apply equally to individual, family and community health.

The conference also defined sub-health as a failure or distortion in the development of our faculties. The causes of the failure are physical, mental or moral and may be in one's fellowmen or in oneself. In a developing country, these causes include ignorance, superstition, apathy (of the person or family or community), overcrowding, noise, lack of re-

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Postponed Annual General Meeting

As there was a lack of quorum of 50 members the President of the Association, acting in accordance with the Constitution, postponed the 14th Annual General Meeting of the S.M.A., scheduled to be held on 31st March, to:

Sunday, 21st April 1974

At: The Pathology Lecture Theatre
Outram Road General Hospital

At: 2.00 p.m.

The Agenda are the same as circularised on 14th March.

Lunch will be served free to Members attending the Meeting, at the Alumni Medical Centre from 12.30 p.m. onwards. Members who wish to attend this are kindly requested to telephone the Secretariat (981264) for catering purposes.

Assoc. Prof. Chew Beng Keng
Hon. Secretary

VIEW POINT

Reaching for the Stars

There must be few doctors, if at all any, in Singapore who feel that our present system of medical care is perfect and need not be improved upon.

It is good that we in the medical profession are not easily satisfied, nor readily lulled into a state of complacency. Because of this "divine discontent", there has been much progress on the local medical scene, and thanks to it, more will likely follow.

Medical progress however is not measured by the amount of electronic sophistory in hospitals alone, but also by the amount and quality of patient care which we are able to give.

Prof. O.T. Khoo in his speech at the annual S.M.A. dinner laments that the word medical care is "almost a despised cliche these days." Too many clinicians feel that care is what we substitute for cure when we can do no more for a patient.

This is not a medical phenomenon only seen locally. When hospitals get bigger, or a GP's crowd gets larger, medical care tends to be depersonalised. "I would rather have some humble medical attention to the most distinguished neglect", ran a comment in an editorial in the Practitioner some years ago.

How can we raise the quality of medical care? Knowledge can be computable, but can care be assessed by any form of examination? Medical care and medical knowledge are not one and the same thing. Good medical care is based on sound medical knowledge, but sound medical knowledge alone does not always ensure good medical care.

Dr. Wong Kum Hoong believes that by keeping our medical knowledge sound, our patients would get better care, and that both doctors and their patients would benefit if there was a periodic re-certification of all doctors.

The idea that we should periodically up-date our knowledge was called "quinquinial braindusting" by Osler, but he did not say anything about tests at periodic intervals. Tests are unreliable because so many things of value cannot be evaluated by examinations.

This is not to decry the need for post-graduate degrees but even here the emphasis in recent years has been more on apprenticeship and training rather than examinations.

In fact at the last Sir James Mackenzie lecture of the Royal College of General Practitioners Dr. John Stevens went on to say, "No logic exists for the institution of an examination for a generalist working in an open system using heuristic procedures to solve problems. To do so in authoritarian fashion, will in the long term, be counterproductive and inhibiting to the true learning process." Dr. Stevens is an outspoken young doctor. He reminded his College that "in 1815 our forebears the apothecaries were the first profession in this Kingdom to introduce a written examination system. They did so, for political, status and fiscal reasons.... I hope such reasons will never influence us."

Medical care can be raised if our doctors have the right attitudes, and have access to the right facilities. This is not something that can be tackled alone by some post-graduate board. It is something that involves the whole community.

Like all things good medical care costs money. There must be some form of medical insurance so that expensive investigatory procedures will be made more readily available to all who need them. There must be opportunities for post-grad study and doctors in the private sector should plan for this.

The quality of medical care could be improved at the primary level too if there were local community hospitals. We advocated the setting up of inexpensive "mini-hospitals" run by the local GPs some years ago in our columns.

This would mean that cases which were not ill enough to need a precious hospital bed, could still be tended to and cared for by their family physicians.

Bringing the GPs back to the hospitals would be one way of up-grading primary medical care.

A doctor who works from nine in the morning to nine at night is often too tired to do much about postgrad study. No-one works that hard if he had the choice. Young doctors seeking to go into private practice should receive financial assistance to tide over the early years so that they need not work such long hours nor have to resort to questionable practices to earn a living.

A tired doctor is not a good doctor, and putting more obstacles in his way is even less likely to raise the quality of medical care. Few perhaps realise the very long hours some doctors have to work. A houseman who works 24 hours at a stretch, works over a time span that is filled in by 4 shifts of nurses. Air-line pilots would long ago have gone on strike if made to do such long spells of duty. The cardio-vascular surgical team works for seven or eight hours without rest during an operation, snatching only ten minutes or so for a meal during this time.

It is not difficult to see why so many are beginning to be disenchanted with the profession. The fact that there are still so many doctors around carrying on shows that **many still do care** how their patients fare, and this in itself augurs well for quality of medical care in this country.

There are so many ways in which medical care could be improved upon. Do we really have to inflict more exams upon our doctors, rather than encourage them to strive for the stars by doing research, or recording their observations on local variants of known medical disorders? The present O.P.D. laboratory facilities could be made available to GPS.

If we want the best from our doctors, we must motivate them in the correct fashion. Punitive measures like a threat of de-registration is but an admission of failure to inspire and motivate the profession. It would be a sad day for the doctors in this country when we have to kick people in the pants to keep them moving along the line.

E.K.

(Not to be quoted in the Press)

Quotable Quote

MARRIAGE – THE NO MONEY BACK CONTRACT!

Do you realise that every day the unwary and the unready leap into an arrangement that has no guarantee, no warranty, no money back?

Even with the present divorce rate most people still marry with the conviction that they will remain together until death do them part.

And, in this enlightened era, that could be one very long time. During the Middle Ages, when whole villages expired early, due to the prevalence of plague and the misuse of leeches, this was not such an awesome prospect.

But nowadays people who marry in their early 20s have every reason to believe they'll still be kicking in their 70s. In other words, that marriage could last 50 years.

What else in the world lasts 50 years – washers, cars, radios, governments?

Think of the innocents who make this staggering commitment for reasons no more coherent than they feel icy fingers up and down their spine, and, what is more curious, hear music when there's no one there.

Have you faced up to the fact that it is harder to get a driver's licence than to get married? It would be harder, I know, to arrange a road test for marriage that would duplicate the actual traffic conditions. But it could be done.

Jean Kerr.

"Marriage: It simply isn't safe!"

Medical Care - A Despised Cliche

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creational space, poverty, shortage of medical facilities, pollution of air, land and water and industrial practice without considering health needs. As a profession we are particularly concerned with medical problems as a cause of failure or distortion of development but should we not be aware of other, often more important and relevant causes and institute measures to remedy them.

Secondly, an integral part of the concept of health is the concept of care itself in so far as health care is the expression of health itself. **As a caring profession, doctors have been perhaps as guilty as the more permissive section of the business sector in relegating this concept of care to the realm of condescending charity perhaps even as an expression of weak mindedness and impracticability. Because care takes time, energy and money, the account book may suffer. Care is almost a despised cliche in medical concepts and is subconsciously equated with a second-rate type of profession for nurses and nursing aids.** The late Dr. Lambourne said, "So the least prestige, the least money, the least self satisfaction goes to the person who cares for those who cannot be cured. In fact care nowadays tend to be validated only by its efficiency to cure. So caring in itself is a virtue under attack these days". When the professional image is built up in curing people and disease eradication becomes the sole objective, the act of caring is often depreciated as a good thing. I can still remember the long rows of sick and dying labourers in the bamboo hospitals at the river Kwai during the last war; they were supposedly past caring and the main idea was to isolate them; caring was secondary and often non-existent. My observation after 30 years of practice would seem to support the contention that **the quality of care shown in the wards, surgery or sick room differentiates the physician from the technician in our ranks.**

If health care is a potent force for good, then the medical profession has unlimited opportunities to foster and practise this dynamic as an expression of the philosophy and ethic of medicine.

I promised to be brief and I must end by congratulating the SMA Council for their efforts to awaken fresh concepts of healing among the members of the profession and I would encourage the SMA to carry on the good-work for a large section of the profession is still unaware of the necessity of continuing education and assessment of their work ethic. Unless we move on from the dominant concepts of disease eradication and management to caring and development of new strength in the community, we shall be alone in our efforts. The community must be brought in to join us in the promotion of health as the highest quality of life possible and not merely the absence of disease. As we have learnt only too well in the present fuel crisis both the consumer and producer of health must agree on the price to be paid for health care and this relationship must continue even when optimum health is reached."

Shock Tactics in Medicine

By Dr Un Hon Hing

If confession is good for the soul, then Dr Wong Kum Hoong's amazing feat of self-critism ought to be good for his conscience. As is often the case with religious zealots at revival meetings, the sins are luridly exaggerated and the short-comings deliberately distorted in order to shock and startle. In this, Dr Wong has certainly succeeded beyond all expectations.

It is about time we try to restore a somewhat volatile situation back to normal, by allaying fears and calming down passions.

To start with, the charge that private practitioners prefer to see only acute cases because these will get well anyway with or without treatment, is too ridiculous to be treated seriously. Even laymen will know that many acute cases like appendicitis, pneumonias and gastro-enteritis would have died without the timely intervention of doctors.

The charge that private practitioners prefer to abandon chronic cases at the steps of government clinics is obviously meant to shock. Chronic cases like Diabetes require expensive laboratory investigations and equally expensive treatment for life.

Considering that even a skilled labourer like a bus driver gets only twelve dollars a day on which to support his whole family, it must be obvious that private management of chronic cases is a luxury which no average worker in Singapore can afford. Hence, the referral or 'abandonment' of these cases to government clinics.

This is surely not the fault of the doctors, but the fault of our social system where the rich with frivolous complaints can have the fullest access to the best medical skill of the land and the most sophisticated laboratory investigations available while poor workers with suspected cancer of the stomach have to wait more than six months to get a free barium meal to confirm his dangerous condition.

In modern medicine, laboratory investigations are as important if not even more so, than the clinical skill of the doctor himself. Unfortunately even the most basic and essential tests like a Barium Meal, at forty five dollars, can cost more than ten times the fee of a doctor's consultation inclusive of drugs.

Thus, as long as our Singapore worker can only afford to pay four to five dollars for a visit to his doctor, so long will he get only the most basic form of medical treatment, without the benefit of essential laboratory tests or the best drug available.

This is a highly unsatisfactory situation which no amount of vocational training or up-grading of skill, or threats, can hope to eradicate.

Dr Wong's talk would have been much more balanced had he coupled his call for self improvement with a similar call for some form of Health insurance which will bring to the Singapore worker the full benefits of modern medical science. In the absence of such a health insurance scheme, it is idle for us doctors to kid ourselves and to mislead the public by regularly boasting that we have the best medical service in the region. Even if such a claim is technically true, it is without any merit and is in very bad taste.

For the present, the only way in which doctors can offer something more than the most basic form of medical service to the worker is for him to subsidise the poor by overcharging the rich.

In a materialistic society, Robin Hoods are hard to come by. It will be much simpler for society to take over their role.

Meanwhile, the writing is on the wall. The threat of de-registration has been wielded. Just as hawkers will be de-licensed for digging their fingers into their noses, so may doctors be struck off the register for not attending night school after a hard day's work from 9 a.m. to 10 p.m. every day except Sunday.

And all these have happened inspite of or probably because of our strenuous efforts to put up an improved image of the medical profession by voluntarily decapitating our once spirited Singapore Medical Journal and censuring controversial articles in the Newsletter. Unless the medical profession strives to regain its voice and actively defend its rights whenever threatened, doctors will only have themselves to blame if what is a threat today becomes a reality tomorrow.

If Dr. Wong's controversial talk has shocked the medical profession out of its smugness and made doctors realise that both professional and human rights must never be taken for granted but have to be defended all the time, then the storm that he created will not have been in vain.

Singapore Cardiac Society Office Bearers

President: Associate Professor Charles Toh Chai Soon
President-Elect: Mr. Tan Ngoh Chuan
Secretary: Dr. Lim Chin Hock
Treasurer: Dr. Lenny Tan
Council Members: Dr. Chia Boon Lock
Dr. Johan Abdullah
Dr. Low Lip Ping

Changing Trends in Medical Practice

by Dr. Gwee Ah Leng

We publish in this issue two of the four lectures delivered at the **Seminar Week** in March. The other two by Mr. Yahya Cohen and Dr. Colin Marcus will be published in the next issue. The theme of the Seminar was "Changes and Trends in Medicine in Singapore".

Traditionally, the doctor came on the scene as a person who interposed between illness and man. Depending on the viewpoints regarding the aetiological factors of diseases whether divine or mundane, the doctor's function was at once either an agent or intercession – a priest, magician, witch-doctor or even a devil's advocate – or a knowledgeable person who could utilise his skill to remove or ameliorate the sufferings of the sick. His role must vary in the eye of patients in accordance with change of their sophistication, and the factors that determined whether he should be a witch or a philosopher would be originated more from the patients than from him. Hence, in a primitive society where a plague was a visitation from an angry god or devil, the doctor would have to be an interceder or exorcisor. On the other hand, in a society of materialistic rationalism such as ours, he is a scientist with skill and knowledge to counter the ravages of germs, toxins, new growth and degeneration. Whatever his stance maybe however, his relationship with the patients is one of individual contract between two parties – one professing the ability to cure illnesses and relieve discomfort, and the other seeking to be freed of suffering and resorted to health.

Embodiment of the spirit of a code of ethics is in the avowal that a doctor will never do harm (primum non nocere), will always respect life (sanctity of life) and will always respect the patients' confidence (professional secrecy). With such an avowal of intent, the patients accept the doctor as an advisor, a confidant and a healer. This is medical practice at its beginning – an individual contract between the weak and the strong, and its operation has been beneficial to the former, the spirit of dedication to compassion, love of life, and self-restraint exemplified in the Code of Hippocratis. The single-minded doctor devoted to the art of healing to cure or ameliorate without discrimination, and abstained from causing harm to life and person of his patients.

With the development of society, changes occur, for development implies change. In the profession the aim of medical practice has been enlarged from the mere one of amelioration of suffering or cure of the illness of an individual to prophylaxis, social medicine, para-medical science, research and education. Some doctors now see his role not in the cure or relief of a single person but in the control of an illness or in the promotion of an environment for health. They lose interest and may even lose their knowledge and skill to treat patients in their pursuit after other objectives. Medical practice for them ceases to be an individual contract with the original spirit of dedication, which at times would indeed not apply. They are at times "doctors" with the society as their patient, and in ensuring the vigour and life of the society, they may see less of the individual contract where a conflict of interest exists. Hence, a doctor dedicated to individual contract would find his obligation to **respect life from the time of conception** easy to accept and apply, but another dedicated to population control would have to seek other moral support and justifications to terminate foetal existence.

Similarly, devotion to paramedical sciences, gradually isolates the doctor concerned from the patient, and the individual contractual relationship loses its significance. This can also occur to pure researchers and educationists, where the passion for knowledge and teaching may outweigh the interest of the care of single person. At times, there is a total break, and instead of modifying medical practice, a new profession arises. We have then categories like non-medically-trained health workers, paramedical scientists like bacteriologists, anatomists or physiologists, and pure researchers like doctor of philosophy candidates of non-medical origin doing a medical topic, and professional medical educators with no medical qualifications. However, most of the times, there exists a mixed role where the severance is not complete, and a doctor with dual or multiple loyalties emerge. The Code of Geneva as such show a change in that whereas in the original Hippocratic Code, the doctor owes his **entire** loyalty to his patient and will respect his life and person against all comers, the Geneva Code has the doctor respecting also the laws of the country, and the interest of the community. Further change is reflected in the pronouncement by the World Medical Assembly on Human Experimentation under which a doctor may experiment on a human being with his consent even though such an experiment is not likely to be in his interest of being cured or relieved of suffering, and in recent years, experiments on living foetus and mentally disabled cases in the interest of advancement of knowledge have shown further the subtle and yet major basic change in medical practice.

Changes occur too in the society, for whereas the old position was one of a sick man seeking aid in an individual contract, changes in social structure have brought about other considerations. The coming of contract practice and health insurance has introduced a third party into this individual contract to make it now a tripartite one of doctor offering service, patients seeking cure, and a third party interested in the cost-efficiency performance, keen to see no over-charging by the doctors and no unnecessary waste or misuse of medical facilities. Such a presence must in time affect the single-mindedness of individual contract type of medical practice. The problem of compensation brings about a new dimension in that the estimation of loss of capacity and its social values becomes a part of medical practice, and in the doctor's mind, the value for life is now given a concrete basis in terms of dollars and cents, which can mean that some life is worth more than others – a concept not acceptable under the Hippocratic Code, but long recognised as an established legal practice, for example, an unborn child has little value in the computation of material compensation, and a death rated lower in terms of compensation than a severe loss of capacity.

Finally, the intrusion of the State into the picture further alters the medical practice. Quite apart from its power to direct the aims of policy of medical education

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The Views in the articles are not necessarily those of the Singapore Medical Association

SMA Memorandum on Rise in Government Out-Patient and Third Class Ward Charges Submited to the Minister for Health on 15th March 1974

The S.M.A. is concerned with the effects of the rise in out-patient and third class ward charges on the poor in S'pore. We are fully cognisant that the health services are already largely subsidized.

In an inflationary situation, money is spent only on the basic necessities of life such as rent, food and transport. In Singapore, many still do not regard medical care as a basic necessity. While the latest charges in government medical services may not mean much to the well-off, they may be prohibitive to those trying to make both ends meet.

We are aware of the existence of the scheme whereby charges can be waived in cases of a genuine inability to pay, but in the first place it isour experience that the average Singaporean is unwilling to accept charity and secondly it might surprise the authorities how few people realise the existence of the above-mentioned scheme.

Thus it is not surprising that as the government medical charges keep on rising, more and more Singaporeans may resort to self-cures and quacks for treatment until the patients have become almost moribund. Delay in seeking proper medical treatment can often result in permanent invalidism and even death.

The invalidism or death of a worker is an economic loss to society and a tragic disaster to the family.

In the context of an inflation with shrinking wages, a strong case can be made out for a return to free out-patient services and free hospital care in the third class wards.

Firstly, such free medical services will be a welcome boon to the poor in an area that means most to them, namely the health and safety of their families.

Secondly, provision of these basic medical services freely to the poor will encourage them to seek medical care as early as possible, thus cutting down the rate of morbidity and death from delay in seeking treatment because of the rise in medical charges. This will benefit society in the long run.

Thirdly, a healthy and socially secure population will mean greater productivity in work. This will more than justify the extra expenditure involved in financing such free medical services to the poor. These services should be regarded as a sound investment in the health and productivity of our hard working population.

For all these reasons, the S.M.A. feels that it will be cheaper in the long run for government to restore free out patient services and free hospital care in the third class wards in order to safeguard the health and economic productivity of our society.

Yours sincerely,
Assoc. Prof. Chew Beng Keng
Hon. Secretary
(not to be quoted in the press)

News about People

Dr. Cheah Jin Seng	FRACP
Dr. Chia Boon Lock	FRACP
Dr. Lee Liang Hin	FRCPath.
Dr. Emmanuel Shanta Christina	M.Sc. (Public Health)
Dr. Winston Ee Kwong Hong	M.Sc. (" ")
Dr. Bernard Goh Men Tee	M.Sc. (" ")
Dr. Theresa Yoong Ai Len	M.Sc. (" ")

Dr. Yahya Cohen – Elected Corresponding Fellow by the Association of Surgeons of Great Britain & Ireland.

(Not to be quoted by the Press).

7th CMA Meeting

The Seventh Council Meeting of the Commonwealth Medical Association will be held in Kingston, Jamaica, from 16th – 19th April 1974.

Among the various items tabled on the Agenda for the Meeting will include–

- Distribution of Medical Manpower and Ancillary Workers in the Developing World.
- The Role of the Physician in Primary Health Care, with Special reference to the Developing World.
- Standards of Medical Ethics and Standards of Practice.

Associate Professor Chew Beng Keng, Honorary Secretary of the Association was appointed by Council to represent the Singapore Medical Association at the Meeting. This is the second time in succession that he will be attending the Meeting, the last one was in September 1972 when it was held in Accra, Ghana.

Dr. Gwee Ah Leng will also attend the Meeting, in his capacity as regional Vice-President of the C.M.A.

New Office Bearers of:

Society for Neurology, Neurosurgery & Psychiatry

President:	Dr. Gwee Ah Leng
Vice-Presidents:	Mr. Tham Cheok Fai
	Dr. Tsoi Wing Foo
Hon. Secretary:	Dr. Teo Seng Hock
Hon. Treasurer:	Dr. P. Nagulendren
Committee Members:	Dr. Loong Si Chin
	Dr. Michael Yap

Society of Private Practice

Chairman:	Dr. Colin Marcus
Chairman-Elect:	Dr. Ng Kong Kai
Hon. Secretary:	Dr. Goh Soon Chye
Hon Treasurer:	Dr. Teo Chew Seng
Committee Members:	Dr. Foo Chee Guan
	Dr. Leong Vie Chung
	Dr. F. Samuel
	Dr. C.B. Wilson
Auditor:	Dr. A. Aaron

The Future Role of the Family Physician

by Dr Wong Kum Hoong

General Practice although the oldest branch of Medicine, is paradoxically, the most neglected, ignored and sometimes ridiculed. Starting from the 1950's through the 60's and the 70's Medical Specialisation in the narrow segments became the fashion. But history has come one full round and specialization in Family Practice and Family Medicine is now the current emphasis. The Family Physician is the key doctor in the health team.

There are many vague ideas of what a Family Physician is. In Singapore this idea has not yet crystallised and because of this, there is much misunderstanding, confusion and frustration, even among practitioners themselves.

Job Definition

(1) 'The Family Physician is a doctor who provides personal, primary and continuing medical care to individuals and families.

He accepts responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists where and when he thinks it appropriate.

His diagnoses will be composed in physical, psychological and social terms.

He will intervene educationally, preventively and therapeutically to promote health."

(2) "The Family Physician is a personal physician orientated to the whole patient who practises both scientific and humanistic medicine."

(3) "The Family Physician is the doctor of first contact who evaluates the patient's total health needs, provides personal care and refers him to the appropriate specialists when necessary and assumes continuing responsibility for the patient's total health care within the context of his family, his environment and his community."

(4) "The Family Physician provides personal primary medical care. This care is continuing, comprehensive and competent.

He must possess a basic core of medical knowledge which is kept current through constant use and continuing education.

He pays specific attention to the family which is the basic social unit of man. He must have a new attitude of being responsible not only for the sick, but also for the healthy.

The Family Physician is a specialist in terms of function.

These functions, attributes and characteristics are now crystallised into a new concept of medical specialisation.

The quality of medical care is largely determined by the quality of the doctor. This is fundamental.

The doctor leaving medical school is not qualified to start practice as a Family Physician as he is a basic undifferentiated doctor who lacks the necessary training.

The training that is needed for Family Medicine must not only include the clinical sciences and the basic medical science, but also psychology and sociology, the theory and practice of Health Education.

Learning in Family Medicine does not mean just doing the job. There must be a constant interplay between theory and practice and some form of theoretical guidance and supervision by doctors who have had greater experience and knowledge is invaluable.

Continuing Care

Traditionally, general practice has been that of acute episodic care. This is largely the pattern of the out-patient departments and a large proportion of general practices today.

Good family medicine is much more than just acute episodic care. Continuing medical care is best illustrated in the management of chronic illness.

Chronic illness is no more confined to the elderly. Over 75% of all protracted illness occurs between the ages of 15-64 years. 80% of these people will die of a chronic illness. In Singapore, the three major causes of death – cancer, hypertension and coronary heart disease are chronic illnesses. The management of long term illness, or illness that never resolves completely, requires guidelines, skills and techniques that are quite different from those of the common episodic illness.

The quality of medical care is here limited by only two factors:

(i) the existing medical knowledge about the disease process, and

(ii) the physician's level of competence.

Good continuing care needs good case notes. Usually notes are written very scantily, and sometimes not at all. Whatever notes are written are usually limited to a few physical signs and such a method of record-keeping is not good enough.

A better way is the so called problem oriented record system, which requires the doctor not only to record a brief history and important findings but in addition to record:

1) diagnosis, differential diagnoses, clinical impressions, or a retrospective diagnosis;

2) succinct statements of the patient's problems – physical, social, psychological – subjectively as the patient states them and objectively as the doctor evaluates them at every visit.

Comprehensive Care

Comprehensive care means total patient care. To be able to do this the Family Physician must be able to make his diagnosis simultaneously in physical, social and psychological terms, e.g. diagnosis of myocardial infact in a man of 37 years alone is not complete. The doctor must think in the two other dimensions as well. It would be more complete to say that this man is a manual labourer and depends on his job to support his family and he is very depressed as a result of his illness.

To be able to give comprehensive care, the doctor must have an understanding of the patients' reactions to illness and more important, I think, is an understanding of himself and his own reactions to his patients' and their

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Fund for Advancement of Cardiology

"There is available a fund for the Advancement of Cardiology administered by the Academy of Medicine in Singapore.

This fund can be made available for travel expenses, research grants and any other projects that will contribute to the Advancement of Cardiology in Singapore.

Applications should be directed to: The Scribe, Academy of Medicine, 4A College Road, Singapore 3."

Yours sincerely,
N. C. TAN,
Hon. Secretary,
Advisory Committee
Fund for Advancement of Cardiology.

The Future Role of the Family Physician

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problems.

The able use of the doctor-patient relationship is an all important and powerful tool.

Physician's Attitude

A doctor prefers to treat acute illnesses with a short term favourable response. Sometimes he is given credit where credit is not due, (as when a doctor attends a patient on the verge of recovery from an illness) but he will seldom disclaim it!

What we need now is a similar attitude towards chronic illnesses – illnesses that do not resolve completely or satisfactorily. If managed properly the supportive and rehabilitative aspects are a challenge and a source of satisfaction. Otherwise the physician not attuned to the problems of comprehensive care will abandon the patient with a chronic illness or incurable illness, like Rheumatoid Arthritis; peripheral arterial disease, or cancer, leaving the sufferer even more despondent than before.

The abandoned patient is not an uncommon problem in Singapore. It is a problem that is left for the Family Physician to manage in conjunction with the family of the afflicted person.

The Physician must know himself. His personality type, and his behaviourial responses. If he relates poorly to some of his patients because of his own deficiency, he must be honest and call in another colleague to help, before he becomes irritated, irrational, and loses grip of his patient's problems and correct management.

Health Maintenance

The Family Physician not only looks after the sick, but also those that are well and must strive to keep them well, or where this is not possible, to cut down long term risks.

This is termed health maintenance or prospective medicine. Prospective Medicine is:

1) Comprehensive in its concern for the individual's total risk.

ii) Continuous in its search for new risks.

iii) To initiate treatment before disease or injury occurs.

Prospective Medicine is concerned with people who are not sick. It is concerned with people and their prognostic characteristics. It appraises health hazards so as to extend useful life expectancy. Prospective Medicine deals with evidence in terms of numbers and not individual medical opinions, e.g.

i) risk factors in terms of illness and accident proneness in those who are obese.

ii) potential and actual risk involved in occupational hazards, viz. noise, atmosphere, chemical pollution.

iii) environmental health hazards in terms of sanitation, water supply, disposal of excrements, and in this aspect enchroaches on public health.

Competent Care

The quality of medical care is as good as the quality of the doctor.

The selection of medical students, the training of the basic doctor, the post graduate or vocational training of the Family Physician; all these if ideally carried out will go a long way to raise the quality of primary medical care in this country.

Students are selected on the basis of academic merit and no attention is paid to attitudes or aptitudes suited for a career as a doctor. I have heard medical students tell me they did not care whether their patients lived or died as long as they could practice medicine in the way they saw fit – at their own convenience and in the style they considered most profitable.

The training of medical undergraduates at present needs a long hard look. Are we training basic undifferentiated doctor or are we training mini-specialists? What we need is a clear-out, detailed statement about the knowledge, skills and attitudes that are required to pass the M.B., B.S. examinations and a valid, and reliable method of assessment of these requirements.

Postgraduate or vocational training of the Family Physician is virtually non-existent in Singapore. The College of General Practitioners in Singapore has for the past two to three years been trying to do some post-graduate teaching, but this has had a very poor response. There is no motivation among Family Physicians to participate in any continuing education. There are no incentives nor disincentives.

Some doctors are more conversant and up to date with stock exchange prices than with their patients and their problems.

General practice in the private sector to-day is a free for all. Anybody with a registrable M.B. can set up as a principal in general practice. For example, we have doctors who have graduated 30 years ago, and have not picked up a medical book or gone to a post-graduate lecture, engaged in General Practice. That he is completely out of date with contemporary medicine, is an obvious understatement.

Or the retired surgeon or pathologist or medical administrator who all their lives have been functioning in their chosen fields; suddenly turn Family Physicians. That he may not know the difference between the appropriate choice of insulin, tolbutamide or phenflormin in the treatment of a diabetic patient is a tragedy.

Or the young uninitiated who goes into General Practice immediately after his house job (after being posted to Orthopaedics or K.K. Maternity Hospital, Hospital without any post-graduate experience in internal medicine or paediatrics) can he practise Family Medicine unsupervised. Within the four walls of his consulting room he is god and king – what if his subjects?

These factors do not make for a high standard of primary medical care and are not in the public interest.

After all surgeons, obstetricians, psychiatrists and a host of other specialities need a period of vocational training before they can be allowed to practise in their chosen fields.

Family Medicine is now recognised as a speciality in its own right, in America, Canada, Great Britain, Australia, and why not in Singapore?

To remedy these defects in our present set up I propose the following:

1 Intending Family Physicians be required to go through a period of vocational training before they are allowed to practise unsupervised.

2 All practising doctors be required to show evidence of continuing post-graduate education. The half life of our knowledge is only about ten years which means fifty per cent of our knowledge is out of date in ten years if we do not continually up-date it.

3 All practising doctors submit themselves to continuous practice audit. It is one thing to have knowledge and know what to do, but who is to know whether one really practises good acceptable medicine? It is not patients who are qualified to judge a doctor's performance, but his peers.

4 All practising doctors be submitted to a periodic evaluation and assessment. Attending post-graduate courses alone is no guarantee that one has mastered the recent advances of medicine, e.g. seeing ten cases of heart block and attending two lectures on it with cases does not guarantee that one can make a diagnosis of heart block in one's own consultation room. The only way to make sure that one knows it is to satisfy an independent assessment and evaluation team.

5. And last of all, all practising doctors be periodically re-certified that they

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Trends in Medical Practice

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and practice, and its ability to make laws and regulations to affect medical behaviour eg. the assault on professional secrecy by compulsory notification and court orders at times in the interest of health and disease statistics and at others in the interest of justice, it can and in fact seems to be doing, cease medicine to be used against the interest of the 'patients'. The doctor for example is called upon to certify that a person is fit to be flogged, and some have been alleged to have assisted in political persecutions by treating political prisoners as mentally sick patients. Clearly, here the respect for the laws of the country has superseded the respect for the life of his patient, and the doctors concerned maybe said to have a single-minded individual contract with the State to the extent that the patient ceases to be a part of his loyalty.

There are, too, lesser change of medical behaviour as a result of the development of society, and we may obtain an insight of the changes if we examine the position in three separate situations:- medical practice in developing countries, in developed countries, and in highly developed countries. We may scrutinise medical practice under specific headings:-

a. Patient-doctor relationship
b. Doctor's professional responsibility
c. Doctor's categorisation
d. Doctor's activity

a. Patient-doctor relationship

In developing countries where the economic structure is poorly established, the traditional individual contract still applies in medical practice. In developed countries however, there is also third party contracts represented as employers, Government agencies, and insurance. They exist in various degrees, but in highly developed countries like United States and United Kingdom, third party contract exists almost to the exclusion of individual contracts.

b. Doctor's professional responsibility

As a corollary to the above, the doctor's loyalty is to the patient solely in developing countries, but in developed countries, there is more and more evidence of a change of loyalty to include employers, Government agencies and such third party that may apply. The trend however is unhealthy in that there seems to be increasing indication that the secondary loyalties are assuming more and more importance, and in certain cases have in fact already outstripped the primary loyalty eg. human experimentation where it is regarded as ethical to experiment on a patient as long as he agrees, and the harm likely to result is not prohibitive. Even then, some medical scientists deem the provision too severe, and interfering with their activities.

c. Doctor's categorisation

Normally, doctors are in general practice looking after the patient on demand, or in consulting practice being called in to assist the general practitioners whenever the needs arise.

Changes in the complexities of medicine have led to a third category — the specialised doctor, who may look after a special type of patient on demand eg. cardiologist, psychiatrist, surgeon, gynaecologist etc. or who is devoted to other disciplines where the care of an individual case does not arise eg. bacteriologist, pathologist, anatomist, public health, and community physicians. The practising specialists fall between general practice and consultation, and it is gaining strength in many countries. It may ultimately replace consulting practice completely, in which case, there will be a loss of relationship between doctors existing through the referral system, or it may replace general practice to a large extent in which case general practice as such would involve much simpler problems and may be replaced by a rung of less trained personnel such as medical orderlies. There is however an attempt to elevate general practice into a specialty such as advocated by Lord Todd of England, the impact and implication of which measure remain to be seen and assessed.

d. Doctor's activity

As was stated in the beginning; the primary activity is one of treating illness as in general practice. With changes of directions however, a doctor may become health orientated, society orientated, or even State orientated. These changes of direction would have to bring about some changes in attitude, and finally the profession may split as the original apothecary splitted into doctor and pharmacist, into diverse disciplines each with its ethics suitable to its own activity and loyalty, or a very mixed ethical code will result to accommodate the changes resulting in many conflicts.

At present, the conflicts are emerging and becoming more apparent, but insufficient to result in any serious basic difference. However, it seems reasonable to advocate for the time being that irrespective of whatever development of medicine and the human society together with the accompanying changes in attitude, as long as diseases exist, and there is the need for individual care, the medical profession does best to reaffirm its primary sense of orientation, namely that of loyalty to the patient.

Family Physician

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are competent to practise. The principle is not new, e.g. pilots are recertified periodically to see that they are fit to fly. It is a principle intended to safe guard the public. What I have said is nothing new or original. These are the trends and future roles of the Family Physician. It remains to be seen whether doctors in Singapore have the vitality, the capacity and most of all the intellectual honesty and moral courage to shape themselves to meet the future.

SMA-Not an Old People's Club

● From Page 1

that the Association views the coming of manhood (or is it womanhood?) to half a dozen of these lusty infants, who have grown up and left the maternal home, so to speak. Singapore as a centre of medical excellence has certainly thrived as a result of the flowering of so many academic societies, catering to a variety of different disciplines in Medicine. In the old days, a medical lecture held once a week was deemed often enough. Nowadays, there is sometimes no less than three different medical functions for doctors being held during the evening within half a mile radius of each other. I myself have seen doctors who stumble into the wrong lecture by mistake, and who spend the remainder of the evening wondering why the lecturer was speaking even more irrelevantly than his usual self! Although the number of people attending each individual lecture may seen small, I have no doubt that far greater numbers attend our academic functions in aggregate.

It is, perhaps, rather easy therefore to succumb to the error of thinking that the various doctors, belonging to the different disciplines of Medicine, could now go their own way in their scores or hundreds without any close relationship to our Association. It must be remembered that the Singapore Medical Association still remains the only pan-Singapore Association of all doctors, irrespective of whether they are in the government or private sector, irrespective of whether they are housemen or senior consultants, or irrespective of what specialty or "generality" they belong to. More than ever before, we need the Association to coordinate and promote the multi-faceted activities of Medicine in Singapore. More than ever before, we need to have a body to look after the legitimate nterests and aspirations of medical men in our nation and to keep the public fully informed about matters which will help them to lead a more healthy and richer life.

By all means let's meet in our own circles with others in the same medical specialty, but let us not forget also to support the Singapore Medical Association at the same time. **May I extend a sincere invitation to our younger members to come forward and dispel the unwarranted image of the S.M.A. as an old People's Club.** May I, at the same time, urge our senior members not to retire from active participation and leadership of our Association. The times ahead — I have no doubt — are challenging times. There are ample opportunities for us to serve the community and the profession through the S.M.A. Let us rise to the challenge and help our Association to grow from strength to strength as it has done in the past.

THEY LIKE THEIR FAMILY DOCTOR HOSPITAL

by Wendy Robinson

A new type of hospital, the "community hospital", which could bridge the gap between the large district general hospital and caring for a patient in his own home, is being tried out in Britain.

The first purpose built community hospital has been established at Wallingford, a small town on the river Thames in Berkshire, southern England, and was formally opened by Sir Keith Joseph, Secretary of State for the Social Services, at the end of 1973. It has already taken its first patients.

The scheme had its origin a few years ago in proposals from the Oxford Regional Hospital Board, which suggested it might be a good thing to decentralise certain hospital facilities. The concept has since been approved by the Department of Health and Social Security.

Health Centre

To begin with the Wallingford hospital will provide a health centre, a geriatric day hospital, 17 general beds and 17 maternity beds. There will also be provision for the treatment of outpatients.

But the most interesting aspect is that day-to-day care will be provided by the local family doctors who will have the assistance of an integrated nursing team (it is hoped to recruit some married nurses living in the area on a part-time basis) and a band of voluntary workers.

In the second phase of the scheme further wards and supporting services will be added.

Replaces "Cottage" Hospitals

The new hospital has been designed to replace the existing small local hospitals, often referred to as "cottage" hospitals, which are renowned in many areas for their traditional warmth and friendliness. But the new Community hospitals will not replace the work or in any way become small replicas of the district general hospital. The beds they provide will be part of the hospital group complement – with joint policies agreed between the consultants and the family doctors.

Under this arrangement many family doctors will play a much bigger part in hospital work than they have done in recent years by actually being able to look after their patients when they have to be admitted for treatment.

Reassures Them

The elderly patients particularly dislike long stays at the larger hospitals – often situated some distance from their homes and relatives. Many of these patients are anxious and confused when they become ill and admission to a local community hospital, close at hand, reassures them.

"Preliminary estimates suggest that probably 25% of all hospital beds could be provided on community hospital sites," says Dr John Hasler.

Referring to a pilot scheme which has already been carried out within the Oxford region, he said that an analysis of the 1970 figures of ward admissions suggested that community hospitals would make a significant contribution to relieving pressure on beds in the specialist hospitals.

The kind of patients likely to be treated in the new hospitals were those acute medical cases which did not need intensive care and people recovering from operations carried out in the larger units.

The entrance to a section of the Wallingford community hospital, southern England, a hospital where family doctors will play a big part in caring for the patients.

In addition, certain geriatric, psychiatric and handicapped patients could be admitted. Low risk maternity cases could also be dealt with and provision made for certain people needing terminal care.

"Most Logical Development"

Dr Eustace Evans, a family doctor feels that the community hospital concept is important. He believes that as far as the family doctors' participation in hospital work in the future is concerned this development could have far reaching effects.

"Not only is it likely to prove very popular with doctors themselves," he adds, "but it is the most logical development – because it is an extension of general practice." But in Dr Evans' view, the design of the new hospital must be flexible enough to meet the various local needs.

The basic principle, as Dr Evans sees it, is to provide relatively simple care in a building inexpensive to construct and economical to maintain. He suggests that such a building might house anything from 25 to 75 beds.

An Evaluation

One of the aims of the community hospital is to rehabilitate and discharge patients as soon as possible, although certain facilities for long-stay patients will be available. In the pilot scheme a reasonable success rate was achieved, with more than threequarters of the patients returning home after a relatively short time in hospital.

It has taken four years to develop, design and build Wallingford. Now further community hospitals are planned for two other English towns, Corby and Witney, and some existing buildings are being used and adapted in accordance with the new principles.

(from the British Information Service).

Singapore Radiological Society
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President	:	Dr. B. C. Tan
Hon. Secretary cum Treasurer	:	Dr. Grace Tan
Committee Members	:	Dr. K. M. Kho
		Dr. K. P. Tan

Volunteer Judges

The Association has been approached to get 30 of its Members to act as judges at the 1974 Baby Shows at Community Centres during the week-ends of June to August. The shows are being organized by the People's Association, to promote better health consciousness, understanding of childcare and motherhood.

Members of the S.M.A. who are interested are kindly requested to submit their names to the Secretariat (981264) as soon as possible.

Ah Wun, He say,
much strange,
more clothes, girl she take off,
more hot, girl she become.

Medical Protection Society Annual General Meeting

The Medical Protection Society will hold its general meeting at 50 Hallam Street, London, W.1. at 3 p.m. on 9th October 1974.

Members of the S.M.A. who are also members of the M.P.S. are welcome to attend if in London at the time.

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