SINGAPORE MEDICAL ASSOCIATION
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Fads and fancies about drugs*

by
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*delivered at
Dinner Meeting, Lions Club of Singapore, North

In 1894, a doctor named William Osler said "Man has an inborn craving for medicine ... the desire to take medicine is one feature which distinguishes man the animal, from his fellow creatures".

Since then, three-quarters of a century have passed. Medicine has been transformed into various drugs and appeared in various forms. It is now given in the form of a tablet, capsule, mixture, aerosol or injection. It is used in the diagnosis, treatment and prevention of disease. Unfortunately, some have been abused in the belief that they will give psychedelic effects, improver physical energy, enhance virility and prolong longevity.

The study of drugs on living tissues is called Pharmacology. It began as a study of the effect of plant extracts and chemicals on man, on animals and also on tissues isolated from the body. Pharmacology thus became an offshoot of Physiology and Biochemistry. Physiology is concerned with how the body works. Biochemistry is concerned with how substances are made and how they are broken down in the body.

Pharmacology, on the other hand, considers how a drug affects the functions of the body and how the drug modifies the behaviour of substances in the body. Pharmacology is not Pharmacy. Because the names are almost similar, these two professions often create confusions in the minds of the public. Pharmacology is the science devoted to the discovery and testing of drugs and the ways in which they act in health and in disease. Pharmacy is the science and art of compounding, preparing and dispensing drugs.

Pharmacology is a relatively new science discipline. Formal teaching in Pharmacology to medical, dental and pharmacy students in the University of Singapore began in 1959. For the last two years, my colleagues and I have conducted several courses of instruction on "What you should know about drugs". The course was offered to the laymen free of charge and held under the auspices of the Department of Extramural Studies of the University of Singapore. Each course comprised a series of 8 lectures spread over a period of 4 weeks. The topics included (1) How do drugs act? (2) Harmful drug effects (3) Non-prescription drugs, e.g. vitamins, cough and cold remedies, stomach medicines, purgatives and antiseptics (4) Birth control drugs (5) Drugs and pregnancy (6) Drugs of addiction. At the end of each course, a questionnaire was given to the participants. The aim was to find out the attitudes of the participants to drugs. Some of the questions asked were: (1) What drugs do you usually take for:

headache, common cold, cough, stomach upset, constipation, diarrhoea, fever, body aches/pains, vomiting, itch and rash.

(2) Have you requested drugs from your doctor for the following conditions:

1. Unable to sleep
2. Mental anxiety
3. Underweight
4. Overweight
5. Feeling tired

160 questionnaires were handed out and of these, only 100 were returned. Those who returned the questionnaires were business executives, teachers, nurses, housewives, medical representatives and medical orderlies from the Singapore armed forces.

Analysis of the questionnaires revealed several interesting points. First, there is a general desire to know how drugs work. Almost all the participants found the course useful and informative. **Second, there is a tendency to self-medication in the event of common ailments such as headaches, common cold, cough, stomach upset, constipation, diarrhoea, fever, bodyaches, vomitting, itch and rash.** Those who have no medical knowledge tend to take herbal medicine and non-prescription drugs. **Those who have some medical knowledge tend to medicate themselves with prescription drugs.** Third, 46% of the participants expected their doctors to give a drug for every complaint. 37% of the participants would be unhappy if their doctors did not prescribe a drug but only gave advice. Fourth, 57% would prefer a drug to be given by injection. However, only 13% of the participants had their injections on request while 84% received injections at the discretion of their doctors.

Self-medication has been practised by mankind from time immemorial. There is no legitimate objection to the use of non-prescription drugs if they were harmless and effective. However, many non-prescription drugs and herbal/medicines are noted for their exaggerated and unsubstantiated claims. Here is an example taken from one label. "Cream of olives: the household remedy for the cure of all inflammation, colds in the head, chest, lungs, catarrh, mumps, croup, burns, insect bites, sun, wind and water chaps, bruises, pimples and all eruptions, safe and sure remedy for piles". Not so long ago, I investigated the antidiarrhoea property of a certain herbal preparation. It contained thirteen ingredients and was claimed to be effective for diarrhoea, vomiting, fever, over-eating, overintoxication and other gastrointestinal diseases. After a series of investigations, **I found that the effect of 100 pills from two containers could not even match the potency of one tablet that is normally prescribed in modern medical practice.**

True, modern drugs are potent chemical substances. Where modern drugs and medical services are available, people tend to live longer than ever before. Many of the infectious diseases can now be prevented by vaccination; many can be cured by drugs. Progress in drugs acting on the brain has now almost revolutionised the method of treatment of mental disorders. Even the degenerative disease that affect the heart and blood vessels can now be alleviated by drugs.

The problem of drug addiction is well known to most of us. Another 'drug problem' today is that we have too much drugs in the market. There are, for example, more than 2,500 different Proprietary drugs now being sold in Singapore. An average of about 2 new brands is added to the armamentarium at monthly intervals. Ta ke penicillin for exam ple, there are no less than thirty different preparations. A drug like paracetamol commonly used for fever and body aches has about 40 different brands. The proliferation of new drugs poses troublesome problems for the practising doctors. Not only is he faced with new names of the same chemical, but also new drugs for the wellknown diseases. The "drug explosion" in recent times makes it even more difficult for a doctor to keep track of scientific literature on the properties, uses and side effects of all new drugs. A number of drugs is now considered to be obsolete in medical practice. Obsolete because of its severe side effects. Obsolete because of its low potency. Obsolete because of its non-specific action. A number of these obsolete drugs have been deleted from the drug-literature and withdrawn by the pharmaceutical manufacturers. Unfortunately, a few of these drugs are still being advertised

● See Page 3

15th ANNUAL GENERAL MEETING OF THE SMA

Members of the S.M.A. are reminded that the Association's Annual General Meeting will be held –

on: Sunday, 23rd March 1975
at: 2.30 pm sharp
at: The Pathology Lecture Theatre
Outram Road General Hospital

and they are requested to make every effort to attend the Meeting.

MEDICAL SINGAPORE MEDICAL ASSOCIATION Newsletter

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VIEWPOINT

Plugging the drain

The Minister for Foreign Affairs Mr. S. Rajaratnam spoke on the brain drain from the Republic at the recent dinner held by the International Alumni Association and provided much food for thought for those who were listening to him.

A small country like ours with only professional expertise to offer and no natural resources of our own must view any brain drain with some seriousness. From the standpoint of the medical profession it seems a great waste if doctors who have been trained at great public expense do not after graduation continue to serve the people of this country. All medical students whether they are fee-paying or scholarship students are heavily subsidised in their medical training from public funds, and our people have a right to expect some form of service in return.

Not all our medical students however are citizens of this country. In fact only a few years back the majority of the students were non-Singaporeans. It is only natural to assume that these non-Singaporean students would want to return to their own countries after graduation. The reason for the low enrolment of Singapore students was presumed to be the greater interest of our students towards engineering and the other technological sciences during those years. Happily more of our own students are now coming forward to do medicine within recent years.

The entrance requirements into the local medical faculty have always been high and aspirants are required to pass chemistry, physics and biology at Higher School certificate levels at one sitting. This requirement to do so at the same sitting is not needed by many of the universities overseas. There is no reason to believe that the standards in these universities have been affected by this more liberal approach towards the admission of medical students.

Medicine is not a pure technological science, it is a humanitarian science as well, and it would be useful to have students with a background of the humanities take up the medical course. These students are often not the type with a forte in the scientific or mathematical subjects at school. In medicine we need both types of students, the scientific "bod" and the "arts" student. One will become the medical scientist so essential to medical work these days, and the other can serve the community in roles where good patient care is of paramount importance.

If the Singapore University adopts a more liberal approach towards the admission into the medical course, more of our local students can be admitted to fill the places in our medical school, and fewer doctors will then leave our shores upon graduation.

Besides those doctors who have returned to their own homeland upon graduation there has been unfortunately an exodus recently of locally-born doctors. Thankfully this has not reached alarming proportions, but the fact that some of our doctors have gone overseas rather than work here must cause us to seek the reasons why.

The reasons are many and varied, not all are truly cogent. Some of our young doctors feel that the medical service in this country is saturated with people at the top, and that prospects for rapid rise are bleak. Others leave because they dislike the "rat-race" in our society. They seek places where they feel the need to be successful is not as urgent or as compelling as in Singapore. A few doctors leave because they are unhappy with the educational system in this country. They think their children are subjected to too much pressures in our local schools.

In the East where family ties are very strong parents often go to considerable lengths of inconvenience to give their children what they consider a 'better' start in life. Mr. Rajaratnam feels those Singaporeans who seek fresh pastures overseas are mendicants and not stayers. He thinks they have no faith in the future of Singapore. In some cases Mr. Rajaratnam's observations hold true, but others have emigrated overseas not because they were afraid of Singapore's future, but perhaps because they were afraid of their own future. These people appear to lack faith in their ability, or their children's ability to ride the crest in our fiercely competitive society.

Can we stop the slow haemorrhage of medical personnel from this country? There are many things we can and should do. Firstly, we must take in as many local boys as we can into our own faculty of medicine. Secondly we have to brighten job prospects for our young doctors. This is not going to be easy in the midst of the economic recession but with pay packets shrinking in purchasing power, our young doctors must be convinced that patience would in time be rewarded, and that prospects in both the public and private sectors in the profession are not as bleak as they look.

Not all who leave do so for financial reasons. Some have been vexed by what they regard as "frustrating" conditions in the Government medical service. A few for example, are unhappy that their applications for no pay leave to proceed overseas for further training have been refused. We should listen to all grouses and if these are legitimate, we should try to redress them.

Thirdly our educational system has to evolve into one that would show more flexibility. There are already signs that this is in fact already being done. No one has suggested, least of all the Education Ministry, that the recent changes in our educational system would be the complete answer to all our problems. The fact that the need for flexibility has been recognised will go far to allay the anxieties of many parents.

Some doctors have gone overseas for these reasons, others have gone away for personal reasons. Some have preferred flight rather than fight in a competitive society. These we cannot help. In all urban societies the going is always rough for the faint-hearted.

The problem of stayers and quitters is not a new one. In 1969 Mr. Lee Kuan Yew said, "After independence, the political leaders have to face pressures to level down and narrow the differentials in rewards between people with unequal qualifications and ability, people who make unequal contributions to the economy. This can result in a brains drain.

Because we are a new society, largely of immigrant stock, with a short history, the future will be decided by whether this 1 to 2% consists of "stayers" or "quitters"."

Whatever we do there will of course be those who are ready to pack and pitch their tents elsewhere. But there are steps we can and must take to plug the brain drain so that the exodus if not altogether stemmed is at least reduced to a mere trickle. It is only when we have a hard core of people who refuse to quit that the future of this country can be assured. E.K.

FADS AND FANCIES ABOUT DRUGS

● From Page 1

sold and used in Singapore.

Two different panels of experts, one in London and one in Edinburgh, recently assessed the therapeutic efficacy of proprietary preparations listed in the Monthly Index of Medical Specialties (M.I.M.S.) of the United Kingdom. From a list of 2657 preparations they categorised, they came to the following conclusions:

(1) therapeutically effective drugs – 50%

(2) undesirable preparations – 35%

(3) rational combinations – 8%

(4) not yet classifiable – 7%

The undesirable preparations included irrational combinations, superseded or obsolete drugs or preparations, ineffective drugs or preparations (including effective drugs in ineffective doses or for administration by ineffective routes).

What about drugs for the future? We have already witnessed the conquest of shock resulting from excessive blood loss with blood transfusions. We have also witnessed the conquest of infection with antibiotics and with vaccines. Two areas remain to be explored. These are the degenerative disease and cancer. Generally, doctors of today still are puzzled as to what process in these conditions is at fault. There is a large variety of drugs available for the treatment of various degenerative disease. Degenerative disease is a condition characterised by the body's inability to repair its tissues. There is also a wealth of drugs available for the treatment of cancer. Cancer is a condition characterised by the growth of abnormal cells. The current practice of drug therapy for these conditions, however, are not specific enough for the disorders. Because they interfere also with normal tissues in the body, they are given like the pellets of a shotgun aimed at a killer in a crowd of innocent bystanders.

If man could control these processes by drugs, he will triumph over the ultimate disease of mankind: old age. Perhaps he is also in a position to manipulate his physical and intellectual capacities with drugs. Already there is an experimental drug which is said to be able to speed up learning and improve memory. It is therefore likely that in future men will be able to use drugs to step up their intelligence.

Another aspect of drugs in the future is related to "genetic engineering". It is possible that drugs may be developed which could suppress harmful traits, emphasise desirable ones and perhaps, make genes to order. If this were possible, parents might then be able to "design" their children according to their own plans. This may perhaps bring forth a generation of man whose hereditary defences against diseases are so strong that drugs might be considered to be things of the past. At that time, man may truly live in a healthy rather than a medicated society.

However, as we project into the future with the knowledge of the past and of the present, we have to consider the likely emergence of new diseases and the likely development of new drugs. Heavy tobacco-smoking and excessive alcohol consumption have already taken the tolls of many lives. Environmental pollution will no doubt claim many more victims. Herein lies a challenge for the search of new drugs for the future. It is conceivable that drugs may be developed that help the body tolerate toxic chemicals or pollutants. Or drugs may be used to induce chemical changes in the cells so that a new breed of man may emerge in the man-made environment. I hope that these drugs will never be prescribed. If they are, God help us. ■

THROUGH THE FLUOROSCOPE

So the Consumers Association of Singapore (CASE) has been looking into our method of dispensing drugs. While I do not wish to be drawn into this controversy, I may perhaps be permitted to add a footnote to the CASE story.

It concerns subscriptions one pays to join CASE. It costs $100 to be a life member whereas the yearly subscription is $6 only. Close scrutiny will show that this does not quite make economic sense.

For, instead of enrolling as a life member and paying $100 outright to CASE, a prospective member can put his sum of $100 in fixed deposit in any bank (current interest rate fluctuating around 9 per cent) and use the interest to pay his recurring subscription. A case of having the cake and eating it!

One wonders how many life members CASE has recruited. If there are many such members, the formation of consumers' association is well justified, if only to look after the interest of these members.

I am happy to note the publicity given in the press to a genetics research worker, Dr. Ann Chandley. She found, as reported, that sperm samples from rabbits and gorillas were 98 per cent effective whereas no human sperm sample tested was more than 75 per cent effective. She believed that tight underpants could adversely affect men's fertility.

This is a new slant to an old issue. As early as 1957, Erhenberg and his co-workers made a report in *Nature* on the effects of temperature on genetic mutation. Based on data from fruit flies and the fact that wearing of clothes raised male gonad temperature by as much as 3°C, they felt that wearing clothes might cause almost half the present load of spontaneous mutations.

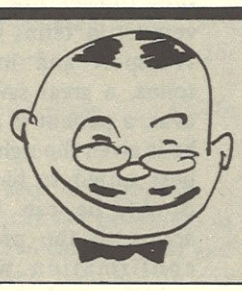
These Swedish workers indeed recommended that the design of male clothing be reformed, "for example, in the direction of the Scottish kilt or of trousers fitted with a codpiece as used in medieval Europe". They thought that garments that tended to press the scrotum against the abdominal skin "specially hazardous". They were also against having frequent hot baths.

It is a curious fact that learned professors of paediatrics have never failed to incriminate diagnostic X-rays as a cause of congenital abnormalities. The late Dr. Virginia Apgar in her book for the lay public *"Is My Baby All Right?"* made the same point. For reasons unknown, tight underwear worn by males has not been mentioned.

Persistent incrimination of diagnostic radiation as a potential genetic hazard has probably created a subconscious dread for X-ray examination. The situation is particularly bad in the United States where Dr. Paul Bishop ventured that "we are passing through an era of radiation hysteria".

He told an interesting story which perhaps has a little moral to it. A 60-year old woman living in Philadelphia adamantly refused a radiological study which she needed. She had read that x-ray damage to the reproductive organs caused genetic mutations in succeeding generations, and she did not want to put her grandchildren who lived in another city, in danger. ■

O.C.L.



ECONOMIC CRISIS

Ah Wun He say,
When neighbour lose job, that call recession,
When oneself lose job, that call depression.

A NEW BREED OF

This letter is addressed to a new breed of "Patients" who would rather be known as "consumers". They are more interested in the names and quantitative particulars of drugs rather than medicines to get well. They are more interested in cost-itemising rather than payment of a professional fee.

The Consensual Contract

Consulting a medical practitioner is a private professional affair governed by the laws relating to consensual contract. The respective rights of the two parties concerned are clearly defined.

A patient seeks a doctor for medical attention and in exchange for this gives a consideration.

The two parties are the **patient** and the **doctor.** The objective or purpose is **medical attention.** The **consideration** is the payment of a fee from the patient to the doctor. The contract is sealed when the doctor accepts the **responsibility** of giving medical attention on receipt of payment. The receipt of payment is, however, not the important factor, as the doctor may decide to waive the fee. Even then, the doctor is bound by the contract the moment he accepts the responsibility.

The important points attached to the contract are:—

1) The contract is by mutual consent (consensual).

2) The parties are not under duress or compulsion to enter into the contract.

3) It is the patient who seeks a particular doctor, given the freedom of choice to firstly, avail himself of subsidised medical attention from publicly maintained institutions and secondly, select any of the total number of practising registered medical practitioners available in the private sector.

4) The doctor is free either to accept or reject the patient.

Terms and Conditions

In Singapore, by custom and tradition, and most certainly within the law, doctors in the private sector do their own dispensing and in the dispensing of medicines, no obligation is placed to label completely i.e. to name the ingredients and to state their quantitative particulars.

A patient who seeks medical attention from doctor in Singapore is presumed to be aware and has accepted the terms and conditions of the contract, which custom and tradition have dictated and which is respected by the law. The terms and conditions of the contract are:-

1. The patient will obtain his medicines from the doctor he seeks for medical attention.

2. That the medicines dispensed will not be completely labelled.

3. That in the professional fee he pays, there will be no hair-splitting of items.

The Rights of the Patient or "Consumer"

A consumer who feels that the conditions imposed on him are unfair or not equitable can do one of the following things:—

1) He can refuse to be a party to the contract.

2) He can negotiate on the terms and conditions of the contract to his own satisfaction.

However, before he does this, he should examine very carefully the premises on which the conditions and terms are erected.

Obtaining Medicines from Doctors

This is certainly no hardship. Indeed, this is very convenient in terms of time and transport and in monetary terms, a great savings. Moreover, a patient is assured that he is given the right medicines best suited to him. When in doubt, he can have direct access to the prescriber for confirmation without the need for further travel. Most, if not all, patients are extremely pleased with this arrangement. Even foreigners are delighted with this convenience and have highly commended it.

Labels carrying no Complete Itemisation

This is done in the interests of the patient. When a doctor undertakes the responsibility of treating his patient, he respects the latter's right to absolute privacy. Every word uttered, every physical finding, every laboratory report, every X-ray finding, the diagnosis, the method of treatment and the drugs used in his treatment are all treated in absolute confidence. No one is allowed to know unless the patient decides otherwise.

On many occasions, it is possible to tell what a patient is suffering from just by the names of the drugs used. Thus, if PAS/INH are prescribed and labelled, any third party can tell at once that the recipient is ill with Tuberculosis or when DAPSONE is written on the label, Leprosy is the most likely diagnosis. In Medicine, many drugs have specific uses and it is this specificity which gives away the diagnosis. This, the doctor is not prepared to do for he may be sued for not observing professional secrecy. Writing down the name and dosage of the drug would constitute an OBLIQUE WAY of revealing the diagnosis. Therefore, it is certainly in the interests of the patient that his medicines should not be labelled by name and dosage.

There are other reasons of commercial, social and economic importance with immediate and distant impact against complete labelling. They are related to advertisement, self-medication, encouragement of medical quackery, growth of illicit drug markets, drug experimentation and drug abuse. Countries which have hitherto practised complete labelling are now reaping some of the ill-effects of this practice. Again, all these are taken into consideration against complete labelling.

The paramount concern of patients is whether non-labelling has any dangers? The answer is a categorical NO. This is attested to by doctors both in Government Hospitals and in private practice.

The Lethal Dose of modern drugs or in lay terms, the safety margin of drugs is such that even if a patient consumes all his dispensed medicines (usually between 8 to 12 doses) at one go, there is no fear of immediate death. Resuscitation of such a patient is by a thorough stomach washout and observation.

Overdosage by deliberation. As stated above, the lethal dose of modern drugs is a built in safety measure against deliberate overdosage. However, if a person is hell-bent to commit suicide, it is very likely that he will not leave any tell-tale evidence of the drug he has taken. Even if a label were completely itemised, it would not help as the person would have taken the precaution to have it removed before hand. Moreover, the assumption that the label will reveal what he has taken is ten times wrong out of ten. This means that no assumption can be made as to the nature of the drug ingested from the label. The stomach contents and

PATIENTS

still have to be analysed. Resuscitation again depends on stomach washout and safeguarding the vital functions.

Drug Allergies are of two main types. The alarming anaphylactic reaction and the delayed drug reaction Treatment of the first is basically the same irrespective of the drug involved. The treatment of delayed drug reaction should be from the prescriber. Only in this way can an entry be made in the patient's clinical history relating to adverse drug reaction from the unsuitable drug.

Legal Protection. The law requires all scheduled drugs used in the treatment of all patients to be entered into specific books kept solely for the purpose. This enables an audit to be made by the relevant authorities.

Medical Protection. Ethical drugs are used in the treatment of patients. This means that the drug has gone through prior investigation and evaluation before it is used therapeutically. Most of the ill-effects of ethical drugs have been worked out and known to the practising doctors. Even before the prescription is written out, the doctor is already evaluating from the history of the patient whether he is likely to be allergic to the drug he intends to use. Potent drugs are given with adequate verbal and written instructions against self-medication with any drug (Western or Chinese) or food which might react adversely with the prescribed drugs. All patients with congenital deficiency of certain enzyme systems e.g. G&PD deficiency are provided with letters of clear instruction and warning. All patients with drug allergies are provided with warning cards and in certain cases registered with the S.M.A. Medic Awas Scheme formulated many years ago in the interests of patients.

Spurious Advice. "Consumers" may like to listen to alarmist advice pertaining to the non-labelling of medicines; patients generally don't. On medical matters, "consumers" may want to heed the advice of Consumers' Associations rather than Medical Associations; patients certainly don't. "Consumers" may be impressed with the advice of only two pharmacologists rather than the physicians who treat human beings; patients are not.

Cost Accounting in a Professional Fee

A professional fee normally carries no itemisation on cost. Itemisation in a professional fee insults the intelligence of the patient. No surgeon will add the cost of cat-gut in his bill. Only badminton racket stringers do. No radiologist will charge for the development of the X-ray film. Only photo-studios do. No G.P. will add the fractional cost of tablets and mixture to his bill. Only druggists do. A professional fee is a fee for "medical attention" or "medical services" and everything else is incidental. Thus, "medical attention" or "medical services" may take the form of a medical checkup or simply medical advice without the need to hand over anything physically to the patient.

Even a can of curry-chicken from our local manufactory carries no itemisation of costs. It is sold at a fixed price. Perhaps, "consumers" would like to see the following theoretical cost-accounting in every can of curry-chicken:-

Chicken	$1.80c
Curry, salt, oil	.11c
Can	.10c
Label (advertisement)	.08c
Fuel for cooking	.03c
Profit	.28c
Total retail price:	$2.40c

Patients and "Consumers"

Patients are interested in getting medical attention and to get well and not in the quantitative particulars of their medicines. Patients pay a fee and do not want their intelligence insulted. The relationship between a genuine patient and his doctor is more than a consensual contract. It has its roots in history. The bonds are forged in the spirit and in deep abiding respect. The relationship between a "consumer" and doctor is, however, calculated on "quantitative particulars of named ingredients" and in "itemisation of costs".

■ L.V.C.

THE LATE DR. CHONG SOON LIAT L.M.S.

Born....23rd Mar. 1916
Graduated....Dec, 1946
Died....15th Nov. 1974

An Appreciation

He ne'er has cause to be rude.
Pushing, climbing is not his creed.
He lived his life as few men would,
Ever thoughtful of others' need.

Just as he lived, so did he die,
Without regrets, only a sigh
That just by leaving he should cause
Sorrow to those who feel his loss.

H.H. Un

Life Membership of SMA

For the information of Ordinary Members of S.M.A., I wish to draw your attention to Article III of the Constitution of Singapore Medical Association:

Membership

Life Membership may be granted to:–

(a) Ordinary Members who have been in continuous membership for at least FIVE years, who have reached the age of 55 years and who have retired from active professional practice in Singapore; and
(b) Ordinary Members who have been in continuous membership for at least TEN years, on payment of a sum equivalent to ten years' annual subscription at Ordinary rate.

Professor Loh Tee Fun,
Chairman,
Membership Drive Committee

NEWS ABOUT PEOPLE

Assoc. Prof. Loh Tee Fun – **Elected Fellow of the American Academy of Paediatricians**

Dr. Goh Siew Teong – **Diploma MCGP (S'pore)**

Dignity without Designation

Many of the points raised by OCL in his article "The Medical Specialeast" require comment in spite of the fact that they were made with the best intention.

On Specialisation and Superspecialisation

These have their places in Medical Science. Indeed, they are essential in opening up new vistas of knowledge and have made Medical Science an intensive as well as an extensive subject.

The trouble is not with specialisation and superspecialisation but with the proper utilisation of the special knowledge and expertise of the specialist and superspecialist.

The fault lies in the failure of those requiring medical care to appreciate that good medical care is essentially a two-tier system. Primarily, there are the physicians of initial contact, the General Practitioners in the private sector and the Medical-officers, in the Out-patient Services, in the public sector. When a patient is in need of secondary medical care or expert specialist opinion, he is accordingly referred to the second tier of medical care where the expertise and opinion of the specialist or superspecialist are obtained and put to optimum and appropriate use.

If specialists and superspecialists are consulted as doctors of primary contact, then a lot of their expertise is unnecessarily wasted. In terms of dollars and cents, patients who seek primary medical care from specialists and superspecialists have to pay very much more, even if all they have is the "common cold".

On Macro-Medical Knowledge

The growth of General Practitioners' Colleges all over the world is not really a COUNTER-MOVE against specialisation and superspecialisation. OCL's proposal has, I am afraid, the dubious distinction of being somewhat behind time in terms of what already has taken place over the past few years. As Medical Science becomes more and more minutely segmented into specific fields, there is an obvious need to correlate each specific field to other specific fields so that in the final correlation, a composite picture can emerge from the divergently specific fields. Of what good are jig-saw puzzle pieces if they cannot fit in with each other into a composite picture? The expertise expected of a G.P. is therefore to know sufficiently of each specific field of medical knowledge to correlate all of them together into a composite whole or unity and to apply this integrated knowledge for the benefit of his patients. The specialist and the G.P. thus, work on a mutually complementary or supplementary basis rather than on a mutually exclusive basis.

ON Designation, Medical Centres and Logos

A special nomenclatural label such as "The Medical Specialeast" is certainly superfluous and not required to enhance the status, importance and dignity of the G.P. His history of existence is much longer than that of the specialist or superspecialist and his place in the future is never in fear of being supplanted. He is a generalist and the physician of primary contact and as such requires no special designation.

His place is with his patients and within the environment where they live. A grandiose, multi-storey building with logo and large signboard even if accepted by the Ethics Committee defeats the very concept of his function. He should be within easy access to his patients who depend on him for primary medical care. If his patients live in attap huts, he will probably operate from one of these structures. If his patients live in H.D.B. flats, he will probably operate from one of these premises on the ground floor. The important thing is that he identifies himself with his patients. He is the one who will be called to hold the hand of the patient awaiting to answer the grim-reaper when he calls.

On Political, Social or Economic Pressures

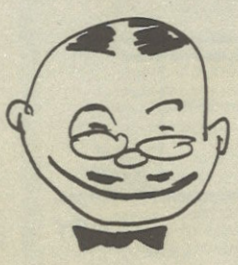
It is surely as much the duty of the G.P. as well as the Specialist to speak up on any issue whether political, social or economic, affecting the practice of medicine be it on a macroscopical or microscopical scale. Each can only contribute in the light of his experience and expertise. The specialist can go into the minutiae and the General Practitioner can present the overall view. Their views are complementary, with different emphasis but essentially in the same direction.

For these reasons and others, associations like the Society of Private Practice and the Singapore Medical Association are formed and should enjoy wholehearted support. Within the cloistered association meetings, everyone can voice his private views and opinions however strident and divergent. But publicly and collectively, the official view should represent the majority opinion. Executive committees are elected into office to carry out the mandate of the proposals made at the Annual General Meetings or Extra General Meetings. It is necessary to stress that proposals at these meetings are only passed with a majority vote.

Finally, erudition is a matter of discipline and practice. Anyone who cares sufficiently to seek and think is capable of "seeing a world in a grain of sand" ■

L. V. C.

TACKLING MALE COW



Ah Wun He say,
Man who say he can tackle any problem by the horns,
Him usually have only two points but plenty bull in between.

CAN WE PREVENT KIDNEY DISEASE?

— Minister for Health

Mr. Chua Sian Chin, the Minister for Health & Home Affairs at the opening of the Colloquium in Nephrology held recently said, "In the face of the global problems of over-population, pollution, precarious food supplies, dwindling natural resources, the problems posed by kidney diseases would to some, appear to pale into insignificance. Detractors can easily point to the relatively small number of persons who die from kidney diseases. On a global scale there are many more deaths from chronic malnutrition and starvation than from kidney diseases.

In Singapore, deaths from kidney diseases have numbered between 155 to 185 a year in the last 10 years. This works out to a death rate of 10 to 8.5 per 100,000 population. It ranks 8th in causes of deaths in Singapore.

It can also be pointed out that the treatment irreversible kidney failure either by dialysis or by kidney transplants is very costly. The costs for maintaining each patient on dialysis a year amount to $6,000/-. And this is exclusive of the cost of the kidney machines or that of staff. The inevitable question posed is: Is it worth all the effort and cost? Could not such expenditure be used for the benefit of a larger number of persons and on other more common types of cases?

This is an example par excellence of medical technology having advanced so far ahead that it has outstripped the ability of the medical services in almost all countries to be able to afford, either in terms of funds for equipment and running expenses or in trained staff, to treat every person suffering from kidney failure. So the debate continues as to the priority to be assigned in the provision of such costly facilities for a particular speciality against providing for a wider range of services.

Pertinent as these arguments are, we in Singapore as an open plural society have decided on a position which can be summarised as follows. We are to provide as wide a range of services which are comprehensive enough for most needs, and with tertiary specialities as the ability becomes available. Development of either does not exclude the other.

Thus, besides extending the range and comprehensiveness of our general medical services together with a hospital development programme, we have embarked upon a priority development of 5 selected specialities. One of these 5 specialities as recommended by the Committee on Medical Specialisation is Nephrology.

We have already established in Singapore a conventional dialysis unit. The unit is being expanded into a Renal Unit which will be eventually housed in the new Singapore General Hospital to be built in Outram Road. This Unit including the dialysis centre in the new hospital will cost $2.56 million.

It is unfortunate that at this stage of our knowledge, our doctors only become involved with kidney diseases invariably at their end stages when they are manifest. In many cases they have reached a stage when they cannot be reversed. Worse still, in some cases the progress of the diseases cannot be halted. Thus the kidney machine had to be used to give a lease of life to the unfortunate victims. This is costly both in terms of money as well as manpower. Further, however improved and wondrous the kidney machines are, they cannot replace the natural organ in its numerous and other vital functions.

Kidney transplant is therefore the best method of treatment in such cases. Unfortunately there are never enough donors nor have the problems of rejection been adequately surmounted. We have had only 14 kidney transplants in Singapore since 1970. Despite a vigorous publicity campaign few have volunteered to will their kidneys, and thus we are not able to obtain many which now "go to waste" at death.

Faced with such intractable problems, the obvious question is whether it is possible for us to halt kidney diseases from its progression and reverse the pathology to effect cures. Better still, can we prevent kidney disease from ever occurring? This is indeed the greatest challenge facing us today.

Should screening of urines for the presence of blood or abnormal numbers of cells or albumen be undertaken? If the latent disease in its various forms is discovered early, could these conditions be halted and even reversed so that kidney failure does not result?

I am of course aware that there are no simple answers to these questions. Nor can a short meeting cover the entire range of problems pertaining to kidney diseases. I hope nevertheless that you will in this colloquium make an attempt to touch on some of these basic problems. It is on the work of experts like you and the serious deliberations in such meeting that would eventually point a way to new directions in the prevention and care of kidney diseases.

In the meantime, medical services such as ours will have to strive at great costs to meet the demands for better care facilities for kidney patients and to obtain adequate numbers of donated kidneys." ■

1975 Combined College's Meeting - Sydney

The Combined College's Meeting of the Colleges of General Practitioners of Australia, Singapore, Malaysia and New Zealand will be held in Sydney from August 24-29, '75.

The Singapore College hopes to send as many members as possible and arrangements have been made for an all-in excursion fare with 2 weeks hotel accommodation and return fare for about S$2,100. Where possible breakfasts and local excursion trips will be put on without extra charge.

As the success of the scheme will depend upon the numbers of participants, the more who join the more attractive will the package deal be possible.

Please ring 70606 Mr. F.B. Vaz, Admin. Secretary, College of General Practitioners, Singapore, for more details.

SNOOPY (With apologies)

LETTERS — Not to be quoted in the Press

Specialists doing General Practice

Dear Sir,

The Singapore Medical Association allows for a small fee Specialists who are leaving Government or University service, the privilege of sending out circulars to all other practitioners, announcing the place and style of their practice. Whilst this announcing or advertising is questionable, by itself, it is not the problem to which an answer is sought.

Having utilised this facility and whatever advantages it provides, some specialists then proceed, either from the outset, or somewhere along his career, to do general practice as well. For example, the Specialist then acts as doctor for some company or perform pre-employment or insurance medical examinations, etc. This work is by no means specialist practice. Whilst the Specialist could do general practice too if he wishes, it seems rather unfair, first to inform his General Practitioner colleagues of his intention of practicing his speciality and thereby canvessing referrals from them and having achieved this goal to then grab a piece of the general practice as well.

The rebuttal that sooner or later the news will leak to his general practitioner supporters thus ending referrals or general knowledge of the Specialist being no longer doing specialist work only is not true as the Singapore Medical Association has already indirectly supported his announcement to all practitioners of his intention to specialist work and the general practitioner must individually, by hearsay or whatever means discover that the person whom he has been referring cases to when the occasion arises has been quietly nibbling away at his field.

What, if any, is the stand of the Singapore Medical Association's ruling on this?

One suggestion for all Specialists wanting to make announcements of this nature is to have an undertaking that this service provided by S.M.A. to them stipulates that they should practise their speciality and nothing else. Should this be discovered otherwise the S.M.A. should inform all practitioners via the same cyclostyled circulars that the Specialist concerned is no longer practising as a Specialist. The S.M.A. owes that to its general practitioner members.

Alternatively, the S.M.A. should keep a Specialist roster and a Specialist can then be removed from the list should he or she do general practice and members of the profession duly informed of this.

Yours sincerely,
S. L.

(This letter is published to generate further comments from S.M.A. members. However, the proposal to maintain a specialist roster is not within the hands of the SMA. – Ed.)

Park & Ride-Doctors should pay like everyone else

Dear Sir,

I refer to the correspondence between the SMA and the government on the Park and Ride Scheme. I am shocked by the arguments advanced by the SMA to support its plea for exemption.

Firstly, the restricted period into the city is only between 7.30 a.m. to 9.30 a.m. This is the period when the city is just beginning to come to life. If a medical emergency is to strike a patient during this period, it is more likely to strike him when he is at home rather than when he is already inside the city. The chances therefore of a doctor having to dash into the city during the restricted period to save life and limb must be very remote indeed.

Secondly, every doctor knows that the occasions when he is desperately involved in the 'saving of life and limb' are rare and far in-between. Except for these rare and dramatic occasions, the work of a doctor is quite mundane and routine. Therefore, by and large, the entry of a doctor into the city in the morning is no more urgent than that of an architect or a lawyer.

Such being the case, the comparison of a doctor going into the city in the morning with an ambulance or a fire engine is both irrelevant and misleading. Every time an ambulance or a fire engine dashes into the city, it is on a desperate mission to save lives. The same cannot be said of a doctor, everytime he enters the city to his work. Why then try to create the impression that the two cases are identical, and to claim that the car carrying the doctor to his work every morning should be exempted from payment like the ambulance?

The SMA is a responsible body of doctors. The concept that its members are involved in the saving of life and limb is widely acknowledged and well deserved.

We should never debase this noble concept by thoughtlessly invoking it to support causes that are mean and miserly.

I am all in favour of the SMA taking up causes involving the rights of Man and the dignity of the Individual such as the abolition of flogging for non-violent crimes or the modification of the Disincentive scheme for multipara.

I cannot support the undignified attempt by the SMA to beg for exemption from a fee which everyone else has to pay, on the strength of arguments that are pompous and pretentious, spurious and misleading.

Yours sincerely,
Dr. Un Hon Hing