Context and Finesse

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Let's go straight to the hottest topic of the day – the Singapore Medical Council (SMC). SMC, in its letter to the *Straits Times* (ST) on 9 January 2013,[1] clearly thinks there is no potential conflict of interest in the system and SMA thinks otherwise in its reply on 11 January 2013.[2] We will have to see how this plays out.

However, there are some important points to note. Chief of which is nothing much has changed in the system for decades. The Director of Medical Services (DMS) has always been the Registrar and a member of the SMC. The Ministry of Health (MOH) has always been a user of SMC's services and the regulatory arm of MOH reports to the DMS. The SMC secretariat has always had several staff seconded from MOH. The terminology may have changed somewhat, from Preliminary Proceedings Committee to Complaints Committee, from Disciplinary Committee to Disciplinary Tribunal, etc, but the system really hasn't changed a lot. Defendant doctors have always had good legal representation at SMC hearings, so the excuse that doctors today employ more legal resources to defend themselves is a limited consideration at best.

In other words, whether potential conflicts of interest exist or not, we have lived satisfactorily with this set of conditions for a long time. So why the discomfort and discontent now? The answer lies in context.

The practice of Medicine is contextual. We learn in the wards here, how a jaundiced neonate looks red, rather than what is described in textbooks written in the West – yellow. GPs here do not practice much Obstetrics, even though those elsewhere often do. These are contextual considerations.

Therefore, since Medicine is contextual, the regulation of Medicine is also contextual. But policymakers and regulators sometimes do not see this point. Take this case in point – which can occur in any GP practice – a middle-aged male patient has been seeing the same GP for 20 years. He consults the GP regularly, and so does his family. Occasionally, before he goes for his year-end holiday, he would ask for a few tablets of low-dose short-acting benzodiazepine. The GP would give him five days of medication each time. The GP has never given him more than five days' medication a year and he has never asked for them, except when he goes for a trip to Europe or America, to cope with jet lag. In fact, there are several years when the GP never gave him any because the patient never asked for them. On two or three occasions in the last 20 years, the GP has also given him a few tablets of Librax (which contains chlordiazepoxide) for dyspepsia.

You would think the above seems innocuous enough and probably practised all over the island in many GP clinics. The patient, a well-mannered family man with a good job, is probably not a benzodiazepine addict. However, if you look at the relevant guidelines, this GP is already in big trouble.

Let's refer to the Administrative Guidelines on the Prescribing of Benzodiazepines and Other Hypnotics issued by MOH on 14 October 2008. It states that "patients who require or have been prescribed benzodiazepines or other hypnotics beyond a cumulative period of 8 weeks (…) should not be further prescribed with benzodiazepines or other hypnotics and must be referred to the appropriate specialist for further management".[3] If you think you have any professional liberty to vary from this "guideline", rest assured that you DO NOT. In the covering note to these guidelines, signed off by the DMS himself, it is further stated that "all medical practitioners are requested to comply with the administrative guidelines with immediate effect (…) Your strict cooperation is appreciated."[3]

A reasonable student of the English language may think that a guideline is only a guideline, and one can sometimes vary from it. But for all intents and purposes, once you read the strongly worded covering note, you will know you have no leeway and any variance from the guidelines will render you exposed to the distinct possibility of punitive action by the authorities. A GP giving a patient only three days of benzodiazepine medication a year, over 20 years, would mean he has not complied with these guidelines.

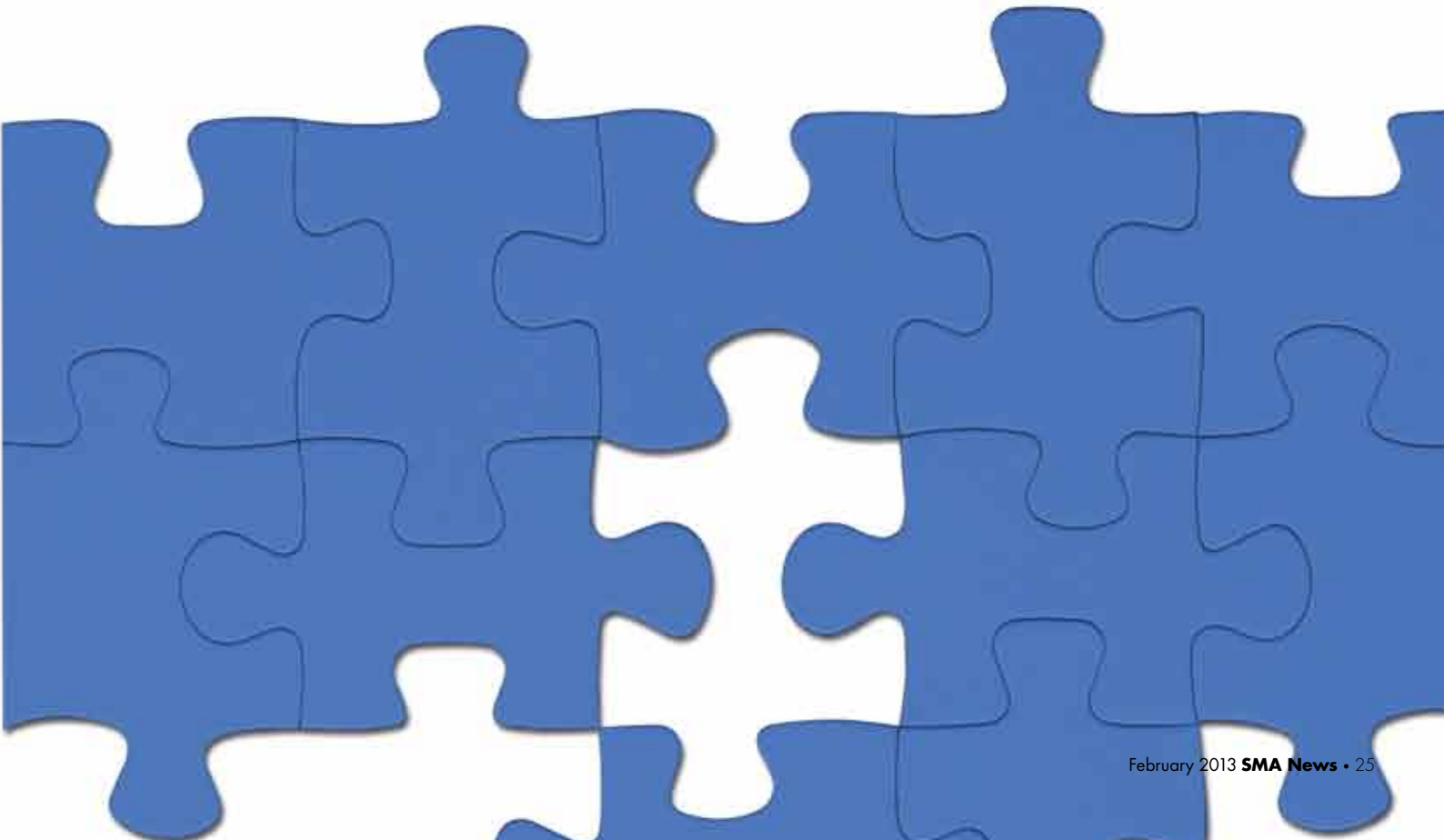
We have no doubt that the said guidelines are well meaning and are targeted at the scourge of benzodiazepine abuse. The problem is that they ignore contextual factors. The condition of "beyond a cumulative period of 8 weeks" over a short time appears reasonable, but once you extend this condition to long term patients who have been seeing the same GP for ten years, even 20 years or longer, then the condition of cumulative period of eight weeks is most difficult to comply with.

Another example of context is our American-based residency. By adopting the American-based residency system almost lock, stock and barrel, we again ignore the context of how the American residency system operates. The residency system in America operates against the backdrop of healthcare spending of 17.9% of gross domestic product (GDP), of which more than half comes from public spending (about 9.5% of GDP). How much is approximately 18% of the economy? Let this Hobbit put things in perspective. According to the Ministry of Finance's (MOF) website, the **entire** Singapore Government lived on a revenue budget of 15% GDP and expenditure budget of 14.2% GDP in 2012, the difference between the two being our surplus.

The entire Singapore Government means literally **everything**, including defence, home affairs, housing, health and the Prime Minister's Office. In other words, Americans (in the public and private sectors) spent more on healthcare than Singapore's government spent on **everything**. Residency training, whether in America or Singapore, is largely public funded. America's public spending amounted to 9.5% GDP. 9.5% as a fraction of the American economy is more than what Singapore government spent on its top four (budget-wise) ministries **combined** in 2012: Defence (3.5%), Education (3%), Transport (1.5%) and Health (1.3%).

So once you take these numbers into context, it's easy to realise Singapore can never, ever adopt the American residency system without experiencing either great pain or great increase in training costs. The other more insidious corollary is that doctors are really one of the biggest drivers of healthcare costs. How they practise has a big effect on healthcare costs. The American doctor is trained to operate in an environment that is dependent on a national healthcare expenditure of 18% GDP. We were trained to live within 3% to 4% GDP, of which only 1.3% GDP is government spending. Our residents will take almost the same exams as their American counterparts (some sources say it is 80% similar in content). Guess where are our healthcare costs heading if our residents are trained to think and dispense care in almost the same way as their American peers?

Don't get this Hobbit wrong, we should spend more on healthcare, and public spending of only 1.3% GDP is clearly unsustainable, given an ageing population. However, when we adopted the American residency system, we ignored the vast differences in funding context that the two countries' healthcare sectors operate in, all in the name of providing more "structured training" that our old system seemingly did not have. Let's hope the money from MOF is there when the full implications of this policy takes effect years down the road.



Now, let's move back to the issue of SMC. Singapore is a small Asian country with a limited talent pool. People holding multiple appointments are not an uncommon phenomenon. Hence, it is not unexpected that potential conflicts of interest may exist. But these can be managed, as it was in the past. Some ambiguity in the Asian context is also sometimes not undesirable. From a Machiavellian point of view, power, backed by the law and buffed by ambiguity, can be a potent deterrent.

But here's the catch, for this sort of milieu to work, you need leaders who are deeply discerning about context, as well as being discrete and precise in the exercise of power. You need people who are reflective and above all, masters of finesse. Finesse is what separates those who can thrive and extract the most, and the rest who bungle and mess up in an environment where some ambiguity and potential conflicts of interest exist. Finesse requires insight, precision and a deep appreciation of context. Finesse is even beautiful.

If you look at the Permanent Secretaries and DMSes of old, you cannot but appreciate that they were men of finesse – how they managed to "outsource" the problem of overcharging to SMA, by getting SMA to come up with the Guideline on Fees (GOF). Since the SMA GOF had no direct legal bite, it was really quite an ambiguous thing in terms of addressing the issue of overcharging. But it was effective for the 20 years it existed and MOH didn't even have to do the heavy lifting. Now, that's finesse!

Now, witness SMC's letter in ST on 9 January 2013 and you decide independently for yourself if it is a work of finesse. Fixing potential conflicts of interest (if any exist at all) may not actually solve the more difficult underlying problems. SMA

References

1. Lau HC. Disciplinary cases fairly heard: SMC. The Straits Times 9 January 2013.

2. Thirumoorthy T, Wong CY. Doctors' concerns not frivolous: SMA. The Straits Times 11 January 2013.

3. Ministry of Health Singapore. Administrative Guidelines on the Prescribing of Benzodiazepines and Other Hypnotics. Available at: https://www.moh-ela.gov.sg/ela/content/TC_2008_Admininistrative_guidelines_on_the_prescribing_of_Benzo.pdf. Accessed 1 February 2013.