MORTALITIES IN A PRIVATE CONSULTING PRACTICE

By A. L. Gwee

There has been a great deal of interest in private practice everywhere in the world, and in recent years, private practice has attracted attention in being elevated to the status of a specialty, especially with the formation of its own Colleges and examination boards. However, very little is known of private practice regarding its pattern of illness, the mode of work of its practitioners, and their successes and failures, and very little in the way of these types of information have been published.

In Singapore, the nature of practice varies widely from district to district and from practitioner to practitioner, and hence, it would be extremely difficult to get an overall view of private practice as such. In situation such as this, study of individual practitioner is likely to be more informative and reliable, and such information may constitute a baseline for a temporary comparison and more wide-spread research in the future.

The activities of any practice can be gauged by a study of the case pattern and its mortalities. The latter is an easier undertaking, because the size of the population involved would be smaller provided there is adequate follow up to make sure that the material is reasonably complete. This is possible over only a limited period of time, as patients in local private practice tend to move more than institutional cases making long term follow up extremely difficult if not impossible.

A survey of a selected period of a private consulting practice was made and between the period of March 1971 to July 1973, a total of 2700 new cases were seen. The study was concluded in December 1973, so that the shortest period of attention for any patient would be six months. Out of these, a mortality of 99 cases was recorded. Some of these occurred while still under the care of the consultant, and others occurred between 6 months to 1½ years after they were sent back to their family doctors for further treatment. These cases were analysed and now reported.

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TABLE I

RACE AND SEX DISTRIBUTION

Race	Male	Female
Chinese	59 (60%)	26 (26%)
Indian	0	0
Malay	0	0
Others	8	6
TOTAL	67 (68%)	32 (32%)

From Table I, it can be seen that in this particular practice under study, no case of Indian or Malay mortalities was encountered. This is due principally to the reason that there were fewer Indian and Malay cases than expected suggesting that utilisation of this practice has been low from the point of these two races. This illustrates in fact the statement made at the beginning of this article that the nature of practice varies.

Although the population of Singapore is a young one with more than half under the age of 18 years, and the sex ratio is about 1:1 of male and female, Table II shows a greater number of male cases (M:F = 2:1) and also the majority of the cases are above 40 years of age. This difference in sex ratio is an interesting one, as it has been noted also in hospital admissions. The most likely explanation would seem to be

TABLE II

AGE AND SEX DISTRIBUTION
(CHINESE ONLY -85 CASES)

Age	Male	Female
0—10	0	0
11—20	0	2
21—30	3	0
31—40	3	2
41—50	12	3
51—60	15	6
61—70	17	6
71 onwards	9	7
TOTAL /99	59 (60%)	26 (26%)

that female patients tend to play down their illness, and utilise medical services less. This is a more likely explanation than the alternative conclusion of lesser incidence of illness among the female, or selection bias of the patients on a sexual basis in the choice of a consultant.

On the other hand, the scarcity of patients below the age 40 years (M 10%, F 15·4%) would have to be explained on the selection bias, and also the relatively healthy state of the younger age group so that illnesses warranting consulting assistance beyond the normal range of general practitioner care are few. The paediatric group besides is being looked after by paediatricians, whose activity in Singapore has for the last 15 years or so been extended from aged 4 to age 10 in the Government hospitals, and this must also affect the distribution of cases in private practice. The higher distribution in the ages above 40 years is due in part also to the fact that illnesses in this age group tend to be more protracted and complex, and economically important to the patients. These factors would increase the call for consultants.

Table III shows that more than 80% of these cases have seen more than one doctor, and more than half had specialist attention before. And yet, it is interesting to note that in just over half of them (51%), the diagnosis was made for the first time, and in another 11%, the diagnosis remained in doubt till after further investigation or at death. This further confirms the observation that the problems encountered were complex and difficult ones. In 38% of the cases, the diagnosis was already made correctly, but the patients still sought second opinion, which must be regarded as an unnecessary wastage economically. The reasons for this course of action by the patients were many, but the most important of which would appear to be firstly a lack of faith in the doctors treating them, and secondly a lack of rapport between the patients and their doctors. A good percentage of the patients expressed open incredibility about their doctors: "They are so brusque and young," "The experienced ones have all left on retirement or resignation," "They refuse to tell you anything" or "The senior man saw me once at the beginning only, and later the younger doctors alone looked after me."

Clearly, most of the complaints were not justified, but they reflected a lack of understanding of the doctor's methodology of work in institutions, and an absence of approachment. Quite a number of these were suffering from malignant diseases, but only a very small number knew exactly what the diseases were, and even less told of the prognosis. This ignorance would appear not to be confined to the patients from whom some doctors may prefer to withold information likely to upset the patient, but the presence of ignorance even in the relatives must mean a communication block which is causing anxiety.

Tables IV and V show the breakdown of the diseases causing death, and the associated diseases present. The scarcity of associated diseases reflected the general health care among these patients as being of a good standard. They had, as was seen, been seeing doctors and in this sense had been receiving medical care continuously. The major causes of death are as expected coronary heart disease, cancers and cerebrovascular disease. Cancers were unusually large in number, and the reason had been partially discussed.

TABLE III

TYPES OF SERVICE RENDERED

Service	Chinese M	Chinese F	Others M	Others F	Total %
Diag. already made but wants opinion	30	6	2	0	38%
Diag. not made till seen	27	15	5	4	51%
Diag. made in retrospect	5	3	1	2	11%
Seen specialist before	38	14	4	4	60%
In hospital before	36	12	7	5	60%
Seen 4 or more doctors before	26	5	2	3	36%
Seen 2 to 3 doctors before	23	16	6	2	47%
Seen 1 doctor only	12	3	0	1	16%

TABLE IV
CAUSES OF DEATH

Causal Disease	Chinese M	Chinese F	Others M	Others F
Cardiac — coronary 11%	8	2	1	0
— valvular	3	0	1	0
— others	3	0	0	0
Respiratory				
— infective	4	1	0	0
— others	0	0	0	0
Neurologic				
— C.V.A.	8	3	4	1
(21%) — tumour	1	2	0	0
— infective	1	0	0	0
— others	1	0	0	0
Alimentary				
— liver	1	0	1	0
— G.I.	0	1	0	0
— others + renal	2	2	0	1
Endocrine				
— diabetes	0	2	1	0
— others	0	0	0	0
Cancers (38%)	23	13	1	1
Miscellaneous (L.E. etc)	1	0	1	3
TOTAL	56	26	11	6

TABLE V
ASSOCIATED DISEASES

Causal Diseases	Chinese M	Chinese F	Others M	Others F
Cardiac — coronary	5	1	0	0
— valvular	0	0	0	0
— others	0	0	0	0
Respiratory				
— infective	3	0	0	0
— others	0	0	0	0
Neurologic				
— C.V.A.	3	1	1	0
— tumour	1	0	0	0
— infective	0	0	0	0
— others	3	0	0	0
Alimentary				
— liver	0	0	0	0
— G.I.	0	0	0	0
— others + renal	3	0	0	0
Endocrine				
— diabetes	3	0	0	1
— others	0	1	0	0
Cancers	1	1	1	1
Miscellaneous	3	2	2	1

In conclusion, from the mortalities in private consulting practice, it can be seen that more than one-third are malignant diseases, and these still showed inadequate rapport with their doctors so that a good deal of unnecessary second opinions were sought. The distribution pattern shows that age wise, those under ten years of age are infrequently seen, and also there is a strong patient selection bias with regard to sex and race.