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EDITORIAL

A TIME FOR CHANGE AND A TIME TO REMAIN THE SAME

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Editor

First I would like to thank the Singapore Medical Association for permitting me to serve as Editor of the Singapore Medical Journal for the past 9 years. As I pass the torch to a new Editor in 1987, it is perhaps time to reflect on some of the momentous changes in the medical scene in the past decade and the new challenges we all have to face in the coming years.

There are perhaps some of you who having read the title, wonder what it is all about. Rapid changing trends in the provision of health care are taking place and this eventually will determine our own way of health care delivery. The recent introduction of medisave and privatisation of hospitals are examples of this. However amidst all these changes, doctors must reaffirm our faith and commitment to the fundamental values of our profession. In other words, the medical profession in Singapore is poised at the brink of A TIME FOR CHANGE AND A TIME TO REMAIN THE SAME.

This may sound contradictory but really it isn't so. Look around you and you will find many examples. A tree sheds its leaves (time for change) in winter but its roots are deeply embedded in the earth (remaining the same). Similarly a person's appearance may change with age but the same thoughts, feelings and desires remain. Hence the medical profession must be like a tree — changing in response to the environment but its roots must be preserved. So what are the values that need preservation and what needs change.

Preserve Quality Care

Providing quality care is the physician's foremost ethical obligation and it is the basis of the public's trust in doctors. Quality however is difficult to measure. At the 1984 Annual Meeting of the American Medical Association, the delegates conceptually defined care of high quality as care "which consistently contributes to improvement or maintenance of the quality and/or duration of life." To provide this quality, the profession must work to provide our patients with the care they really need in a more cost-effective and efficient manner. We must continue to support undergraduate and postgraduate training and education and most important the profession must maintain the highest degree of professional self-regulation. Doctors are already engaging in self-policing in a most basic and important way — they do not refer patients to questionable colleagues. However much more needs to be done. In a clarion call to its members, the President of the American Medical Association in 1986 asked its members to report professional misconduct and rid the profession of the incompetent, the arrogant, the fraudulent, the impaired and the greedy. On the other hand, the profession must protect its members from an increasingly litigious (or greedy) society in which financial compensation is expected for any hurt or injury or imperfect result, physical or emotional, real or imagined.

Preserve Medicine as a Profession Not as a Trade

The word profession comes from the Latin root profiteor meaning a public statement which might be an avowal, promise, announcement, confession or commitment. On the other hand, the word trade means business and business under the profit motive tries to create needs and to sell more and more goods and services. Medicine as a true profession tries to discern the real needs of the patient and satisfy them in the interests of the patient. Unfortunately in an attempt to promote medicine as a trade or industry, patients become consumers and doctors become providers or worse still "vendors"! Under this marketplace atmosphere, patients resented the rising cost of health care and attributed them often mistakenly to greedy physicians. Miraculous cures come to be regularly expected and patients attribute any result less than satisfactory (to the patient) to physician incompetence. This further erodes the doctor-patient relationship which is so essential in proper doctoring. Because the health care industry is now a billion dollar business, the field now abounds with consumer groups, health care managers, system analysts and computer experts. It is ironic that doctors who were in charge of the health care vehicle when it was a plodding oxcart have now abdicated control when the vehicle became a 747!

Preserve Research

Medical research has been with us since the dawn of medicine. Research and development are the life blood of any profession. Disease and sickness will always be with us simply because being sick and well are part of the natural cycle of life. However to be of any meaning, the profession must act to preserve this research endeavour rather then rhetorically proclaim that doctors must do more research. In this respect we must provide protected time and place to nurture the research fellow and young investigator. Although researchers no longer yearn for the ivory towers of remote universities, it cannot be denied that scholarship first rose in the Middle Ages in the sequestered cloisters of monastories away from the hustle of the marketplace. It is just not possible for a young specialist/research worker to do any research after spending a whole day in the "specialist" clinic looking at cases which by right should be in the province of the primary care physician. The heavy load in our hospitals is because our primary care sector has not developed its full potential.

Promote Public Education

The days when a doctor dictates and the patient follows are over. The traditional doctor-patient relationship has undergone major changes in the past decade. With improvement in education and literacy, the public has become more discerning and critical. The once docile patient has now become an active, effective team member working with the physician to restore and optimize his or her well-being. The profession must welcome such a change and support whole-heartedly this movement by supplying the public with the relevant printed and visual resource material. In the more developed countries in the West this movement has gone one step further — towards self-care. This has been described as self-initiated and self-controlled application of knowledge necessary for the promotion of health, reduction of undesired risk, self-diagnosis and treatment of disease resulting in optimal use of professional health and medical resources. Self-care in fact is not new. Examples range from everybody behaviour like brushing one's teeth to recent innovations like self-monitoring of blood sugar, blood pressure and now-a-days even intravenous injections of antibiotics via a heparin plug. With proper guidance, self-care can improve the doctor-patient relationship, increase efficiency of physicians' services and greater job satisfaction for the practitioner. It leads to an increase sense of control for patients and reduce medical costs. Some studies in fact have shown that 70-80% of all doctor visits are unnecessary because the problems that generated the visit are self-limiting and amenable to effective self-care. In a randomized, controlled, blinded clinical trial of a common-cold self-care programme using an algorithm there was a 44% reduction in the number of unnecessary visits related to upper respiratory tract infection.

The Doctor as Patient's Advocate

These days economics and medicine are not only interdependent, they are inseparable. In the U.S. 20 years ago the rallying cry was that "every person, regardless of any circumstances is to have immediately available the very best in health care. No one is to be denied care for any reason, most especially for lack of funds." In such a system payment will be provided by the state or society. The bubble soon burst, as it must. Now ominously the emphasis on good care is only quietly voiced; some whisper about imposing limitations euphemistically called "resource allocation" or "cost-containment". The primary creed of the profession "Primum non nocere — first do no harm" appear to have changed to "primum pecuniae parcere — first save money"!

Cost of medical care can actually come down without sacrificing quality. There is not an organisation in the world that cannot be made more efficient and hospitals are no exceptions. The inappropriate use of expensive drugs like the newer antibiotics and excessive use of laboratory and radiological facilities are all glaring examples. However there is a line beyond which we cannot go on cutting costs — a line beyond which the quality of care has to begin to deteriorate and beyond which availability of care becomes limited. Doctors must recognise such a limit and ensure no organisation or government crosses such a line. On the other hand, the profession must co-operate fully in enhancing efficiency and cutting down waste.

In this regard the American Medical Association has initiated "economic grand rounds" in over 80 hospitals in the U.S. showing how medical staff and hospital administrators can work together to reduce costs like assessing usefulness and efficiency of procedures and techniques and deleting those that can be replaced by better and more cost-efficient innovations. The real issue is not dollars and cents. It is our relationship with our patients and the public. As long as the public believes that we are their advocates and that no one is being denied care on the basis of ability to pay we have no fear. If we fail to do this, both the public and doctors will be losers and no one can really afford that.

Encourage Academic-Industrial Relationship

The most fundamental question facing the health care system in the next decade is the funding of patient care, teaching and research. Traditionally, Singapore doctors have given industry a wide berth. Nevertheless, we know that no medical congress can be successful now-a-days without the financial support of the drug industry. Industry and academia has a long and honourable history of association in the U.S. Some of the best U.S. universities receive funding and support from industrial giants like banks, computer firms, drug firms, motor-car manufacturers and oil companies. This is one of the changes we have to accept and indeed make it work for us. Singapore is too small and its talent pool too limited to engage in any meaningful basic medical research. Yet we have no lack of clinical materials. Clinical research funded by industry and properly supervised by clinical heads can do much to enhance Singapore as a R & D centre. It is also obvious that the delivery system for medical care is changing much faster than anticipated. Technology is the agent in this process , and economics is both the driving and the limiting force. As we move into the future, it is obvious that both medicine and industry should be complementary in this process. To do so successfully requires an understanding of the mission each seeks to pursue and of what each can do for the other.

Finally I feel it is my duty to thank all the contributors to the Singapore Medical Journal and the SMA Secretariat during the tenure of my editorship. Although the journal has not achieved as much as we would have wished, it nevertheless has provided an important forum for our young research workers locally and regionally. I am confident my successor will receive the same support and bring the journal to greater heights. The basic philosopy however must remain the same — a written record of our local research efforts. As I take my leave I like to wish all our readers the best for 1987 and the coming years.

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