

THE ROLE OF PHYSICIANS TOWARDS THE YEAR 2000 AND BEYOND

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Einstein said "True science is about reconciling the irreconcilable".

1. The role of physicians in the year 2000 is likely to be characterized by elements both of continuity and of change.

Continuity with the past will find expression in the basic values and attributes for which physicians have been known since the days of Hippocrates. But new responsibilities which physicians will be called upon to assume will reflect the rapidly changing social and technological context within which health care is being delivered.

2. We believe that in the future, as in the past, physicians will be caring, sympathetic and dedicated to their patients - to maintaining them in good health and, when they are ill, to providing comprehensive care that considers the total needs of the individual.

Physicians will continue to act with moral integrity and ethical sensitivity. Contemporary medical codes such as the Declaration of Geneva in 1948 preserve these traditions and impose specific obligations to provide competent and compassionate care by putting the interests of patients above self-interest.

3. Historically, however, there is a notable lack of recognition in earlier codes that the duties of physicians transcend those to the individual patient.

Only relatively recently have physicians assumed a broader responsibility - to the health of society and to humanity in general. How can the basic values which have been applied in the care of individual patients be adapted and extended in the quest for equity in health at the community level? This dimension is becoming of critical importance as new social imperatives throughout the world give rise to the most exciting challenges physicians will face in the decades ahead.

Some of the main social determinants of the changing role of physicians as we approach the year 2000 are reflected in a historic milestone in this regard, namely, the declaration of the World Health Assembly in May 1977, stating that:

4. "The main social target of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life".

This declaration constitutes the corner-stone upon which the "health for all" approach has been developed and spread to all parts of the world.

5. Health for All implies equity.

According to this sacred principle of social policy all human beings have a fundamental right to health. It is not the privilege of any particular group but is the right of all humankind - a right intimately linked to freedom and democracy.

6. Physicians will be expected to be in the forefront of efforts to ensure accessibility to health care.

In addition to providing personal health care, members of the medical profession will be increasingly called upon to play an active role in the political processes which determine how health resources are allocated. This includes acting as advocates for measures to bring adequate health care to disadvantaged segments of the population for whom it is currently unavailable. Knowledge of the economics of health care will then be required as physicians collaborate in deciding how the budget cake for health can be distributed most equitably. Skills in mobilizing political will and commitment will also be needed if plans for ensuring equal access to health coverage are to be translated into reality.

7. In this perspective the quest for health involves initiative and self-reliance on the part of individuals and communities.

People have the right to active involvement. They need to ensure, that this right is given practical expression, that satisfactory prerequisites for health exist for all, that the environment in which they live is healthy, and provides conditions which facilitate a healthy life style, and that the health care system is responsive to their felt needs. The community itself will thus be transformed into a key resource.

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8. Physicians can play a critical role in nurturing the attitude of personal responsibility which enables informed choices concerning health to be made.
These choices will increasingly involve options for selecting health enhancing life-styles in addition to discouraging health-damaging forms of behaviour. Nutrition, physical activity and stress management are emerging as major determinants of health. Establishing a behavioural diagnosis, providing counsel to individuals, families and communities on health promotion and disease prevention will call for the development by medical practitioners of counselling and pedagogic skills which have historically received scant attention in the curriculum of medical schools.
9. Health for All does not imply that by any arbitrary point in time no one will be sick or disabled, or that everyone will be provided with medical care for their existing ailments.
Rather, it refers to a process leading to progressive improvement in health among all segments of the population. It therefore means that people will use better approaches than they do now to promote health, to preserve health, to cure and alleviate unavoidable disease and disability. It implies that essential health care will be accessible to all individuals, families and communities in an acceptable and affordable way. All this requires a positive social climate in which to be born, to grow up, to work, to grow old and to die.
Having embraced the vision of health for all, representatives of the nations of the world came together for an International Conference on Primary Health Care in 1978 in Alma-Ata to consider how it might be attained.
10. The Conference declared "Health for All by the year 2000" to be a main social goal and that "primary health care is the key to attaining this target as a part of development in the spirit of social justice".
11. In defining primary care and its essential elements as a completely different, new approach to health development, the Alma-Ata Conference rejected the notion that health for all can be achieved by providing "more of the same" in health care.
It certainly cannot be envisaged in purely technocratic terms, such as more doctors, nurses, hospitals, drugs and so forth. It evokes a different vision; one in which it is firmly recognized that health for all begins at home, in schools and at work places. It is in this environment in which people live and work and care that health is either enhanced or impaired. And it is there that the first level of contact of individuals, the family and the community with the health system should begin.
12. Medicine, preventive or curative, cannot hope to attack the causes of ill health that lie in the economic, social or political fields.
Medicine alone cannot expect to improve chances for productive employment and incomes sufficient to meet basic household needs; or to control an economic system that turns out with vehemence cigarettes and other consumer goods that are sources of morbidity and mortality.
13. Strategies for Health for All, therefore, rely heavily on action in sectors other than health, for example water supply, education, agriculture.
Close collaboration with other sectors of society is essential if the broader goals implicit in primary health care are to be realized. The health sector must certainly take a lead in promoting co-operation, although effective action may require direction from the outside as well.
14. Health services should be effective, efficient and affordable. Community participation can be an efficacious means of ensuring that these conditions are met.
Active community involvement, with the sharing of perceptions and insight between citizens and professionals, on an equal basis, increases the probability that the health services both reflect societal needs and are responsive to them. The positive value of community participation is now widely recognized but in practice much remains to be done.
15. Secondary and tertiary care are oriented towards, and have as a major priority, helping and reinforcing the first contact level services.
They should be seen in a supporting role, fulfilling those preventive diagnostic and therapeutic functions that are too specialized or too costly to be implemented by the primary health care sector. The goal is a balanced and integrated health care system in which linkages among the different levels of care are functionally effective and in which allocation of resources among levels is equitable. This will generally involve rationalization of the use of resources permitting a strengthening of the first contact and its supporting level. In the eighties about 80% of expenditure within the health sector was in most industrialized countries spent on secondary and tertiary health care, while only about 20% was spent in the field of primary health care.
And so we see that support for primary care poses many challenges. The support of individuals, communities, political and social leaders and health workers, must be mobilized to initiate new directions in health development. But these new directions will also require changes in the structure and the functional organization of health services, and will entail a substantial shift in priorities.
16. This means a health system in which all other echelons are geared to support the level closest to communities; equity in the distribution of health resources so that entire populations are covered; communities actively participating in the planning, implementation and evaluation of health services; and active interaction between health and other sectors.
What impact is this likely to have on the role of physicians? At least two significant consequences may be anticipated.
17. Firstly, larger numbers of physicians will be involved in the delivery of primary health care. Secondly, all physicians, whatever their area of speciality, will have the competencies and resources needed to provide appropriate support for services delivered at first contact level.

18. The precise role of physicians engaged in primary care will depend, of course, on the context within which the care is delivered.

Practitioners working as members of a broadly based primary health care team are likely to undertake many tasks that differ from those of a general practitioner working alone.

In such a team the best use of manpower is generally made when the least-trained person able to perform a specific task adequately is the one actually assigned to perform that task. The role of the physician then involves providing technical support and guidance, assuring referral services and consultations, supervision in the form of continuing education, and elements of management of primary health care teams. But despite variability, there are several basic primary health care functions which physicians in most settings will have in common.

19. Providing diagnostic and therapeutic services is the traditional clinical role of the physician and no doubt will continue to account for a substantial segment of professional practice. But patterns are changing.

The scope of ambulatory medical care is rapidly expanding, as recognition grows that many of the services currently available only at secondary and tertiary care facilities could be offered with equal safety, at greater cost-effectiveness and more acceptability outside hospitals. Included here are minor surgery, physiotherapy, psychological counselling, terminal care, as well as many screening and laboratory tests. It is likely that the potential for intervention at the symptomatic stage of disease in primary health care settings, will continue to grow in the years ahead. For the physician this means developing competencies in primary care settings to perform a much wider range of diagnostic and therapeutic practices, notably so among the elderly.

20. Little emphasis has generally been accorded by medical practitioners to providing promotive and preventive personal health care in clinical practice.

Advances in knowledge and rapid strides in technology, however, are opening bright new vistas for health promotion and disease prevention. In the developed world elimination of specific diseases such as indigenous measles, poliomyelitis, neonatal tetanus, congenital rubella and diphtheria can be envisaged by the year 2000. Primary prevention of accidents and violence, cardiovascular disease, lifestyle-related cancers as well as alcoholism and drug abuse is now possible as spelled out in the thirty seven targets for health for all adopted by the European Region of the World Health Organization in 1984.

21. As pointed out by the Advisory Committee on Medical Research to WHO in 1985 - "Disease is not an inescapable attribute of the human condition; except when determined at or soon after fertilization, it results essentially from unhealthy ways of life and can be prevented if those ways can be changed".

For physicians to play a key role, a change of attitude will be sorely needed, as well as the

acquisition of skills in clinical health maintenance. These include assessing health and risk status, and supporting patients in their efforts to adopt health-enhancing patterns of behaviour. Let me, en passant, mention what a director of one of the leading medical centres in the USA considers the twenty main problems for today's health care: family planning, genetic manipulation, euthanasia, physical mobility, poverty, nutrition, psychic traumas, narcotics, alcohol, sexually transmitted diseases, accidents, violence, suicide, boredom, sex, divorce, juvenile delinquency, mental deficiencies, transplantation, resuscitation.

22. Fragmentation of health care is characteristic of many health care systems, particularly in industrialized countries.

The problem is aggravated, as the level of specialization, and the number of facilities providing preventive, therapeutic and rehabilitative care increases. The primary care physician is in a unique position to coordinate services received by a patient throughout the various phases of illness and to ensure continuous and comprehensive care. In this role the physician may often be called upon to act as the patient's advocate, particularly in weighing the benefits and risks of high technology interventions that may be proposed. Protection of the patient against the unnecessary use of expensive or potentially hazardous procedures or pharmaceuticals may often be needed. This entails making complex clinical and managerial decisions. The ethical dimension of such decision-making, in particular, is likely to increase both in importance and complexity as increasingly sophisticated technology combined with relatively limited resources confront the physician with new and difficult moral dilemmas if such technology is to be applied in the spirit of equity.

Until now I have considered the clinical role of practitioners in its therapeutic and preventive dimensions.

23. But physician responsibilities for primary care in the "health for all" perspective go well beyond encounters with individual patients.

Working in partnership with communities to identify and solve community health problems will constitute the second major facet of physician performance. The knowledge base is different, relying more on the social and behavioural than the biological sciences. Another set of competencies is involved: mastery of epidemiologic techniques to identify and quantify health problems in a defined population; communication skills in conveying technical information so that it is readily understood, and its implications comprehended; developing insights and sensitivities to cultural and social priorities within communities, and their impact on health; negotiating aptitudes in sharing decision-making with community representatives, and encouraging their active involvement in health programmes and health activities; managerial capabilities in implementing community-based programmes and assessing their outcomes; the capacity to function effectively in multi-disciplinary teams as a member as well as a

leader. This is a tall order, particularly if viewed in the light of current physician performance in these areas.

24. In addition to these specific capabilities, physicians will need to be able to cope with the rapidly changing social and scientific basis of medical practices, and to solve unfamiliar problems that are bound to arise.

This means keeping abreast of new developments in the health sciences, and critically assessing technological advances in terms of safety, cost-effectiveness, efficiency and acceptability.

25. What role will specialists play in the emerging configurations of health care delivery?

High quality primary health care requires the participation of both medical specialists and primary care physicians, with both contributing to both prevention and treatment. The function of the specialties is to support primary health care, not to dominate it, or detract from the status and resources which primary health care should have. It is unfortunate that a terminology has grown up of "levels" of health care, with the implication of a hierarchy starting from the bottom of the general practitioner and reaching its pinnacle with the super specialist. In relative importance for health care there is no such hierarchy.

26. In the light of these considerations, it is clear that the role of the physician in the year 2000, as it is perceived today, is subject to change. Circumstances as yet unforeseen may have major consequences for the expected performance of medical practitioners.

Hence the importance of health systems research. Through continuous and systematic study of how physician performance can respond most effectively to the exigencies of health for all, research which is practical in its orientation, and timely in its application, can contribute significantly to informed decision-making in the planning, training and deployment of physicians.

These then are some of the ways, in which the future might unfold as far as the physician's role in the delivery of health care is concerned.

27. It is a future full of promise for the betterment of mankind as the benefits of modern science and technology are harnessed through social equity for the good of all.

But how likely is it that the potential of health for all will actually be realized? Is it a dream without foundation, or does its vision of health care in the future rest on a valid assessment of realistic options?

28. What of the physicians? Will they play a leadership role in shaping the future pattern of care to the exigencies of health for all in the context of country-specific strategies or will they by default fail to make the contribution of which they are capable?

Their expert knowledge and the influence they have vis-a-vis politicians and the general public make them an important potential force for mobilizing and initiating change for health for all.

In my discussion of the more significant new roles and responsibilities, physicians will be called upon

to assume, I underscored the importance of developing new attitudes, and acquiring new skills.

29. Physicians may prepare for their new roles at various stages of professional education.

For those already in practice, opportunities to reorient and broaden skills from the mainly personal, specially-oriented and therapeutic, to include those which are community-oriented, promotive and preventive, that surely can be provided through continuing education in our age of informatics. Practitioners can progressively acquire competencies that were neglected in earlier professional education, and keep abreast of technological advances and developments in social policy. Continuing education can also play a substantial role in overcoming attitudinal problems in resistance to change.

30. For the medical student - revision and enrichment of the undergraduate programme of medical studies is needed.

It is crucial that medical students learn to function effectively within the social health problematique in which they are most likely to practice. Certainly there are generic capabilities required of all physicians, wherever they may practice, such as basic diagnostic, preventive and therapeutic competencies. Others, however, including the ability to cope with specific health problems at the clinical or community level may reflect local and regional needs, and the way in which health care has to be organized to meet these needs.

31. More than this, medical education, in addition to responding to national priorities, can also have a significant impact on shaping the future.

Education has the potential both to respond to and to stimulate change. Realization of this potential involves intimate interaction between the services responsible for delivering health care, and medical schools responsible for training the doctors of tomorrow.

32. Of prime importance is expanding the range of learning settings to include all facets of the health care system rather than the prevalent educational pattern with its heavy emphasis on tertiary care.

The issue of relevance is at the heart of the concept of integrated health systems and manpower development, which links the development of health manpower, including physicians, to identified needs in the evolving health services. It is not sufficient that a major segment of the curriculum be community-oriented. It must also be community-based, and enable students to learn for themselves, from within the community, relevant knowledge and skills in areas such as clinical epidemiology, behavioural sciences and the management of interdisciplinary health teams which genuinely prepare them for their future roles in primary health care. Undergraduate medical education should also reflect feedback from graduates working in primary care, and from experience with continuing education.

33. Learning through a balanced study of all phases of the natural history of disease reflects more realistically the physician's responsibilities in

providing comprehensive care than does the traditional focus on the hospital.

This perspective emphasizes the acquisition of competencies in health promotion, primary and secondary disease prevention and limitation of chronic disability through rehabilitation, as well as in the provision of acute care. It underscores the responsibility of the physician to participate in community health programmes, in addition to providing personal health care.

34. Certainly, progress has been made since Alma-Ata in the reorientation of both continuing education and undergraduate medical studies to reflect changing priorities in health care.

But the resistance to change has been considerable. Professional and institutional inertia, and the perception of change as a threat rather than as an opportunity, are formidable impediments which must be overcome. This is happening, but slowly - far too slowly. As a result the medical profession is today often ill-prepared to assume its natural leadership role in the health for all movement.

35. It is heartening to note that the commitment of today's medical students, who will be the doctors of tomorrow, to the ideals of health for all through primary health care goes far beyond that of their elders.

In its declaration on primary health care and medical education in 1979, the International Federation of Medical Student Associations took the stand that "..... practical teaching in primary health care must be central to medical curricula. This should concentrate on the principles of prevention and therapy in the community with an increasing emphasis on the emotional, psychological and social factors of human health and disease".

36. In its Policy Platform on Medical Education of 1985 the Federation observes that "..... medical education produces doctors who are ideologically committed to the institutional status quo rather than oriented towards promoting and producing the health of society and are thus inadequately equipped to deal with the complicated health care problems of modern society".

The many steps taken by medical students to translate these declarations into action augurs well for the future. It is to be hoped that teachers will have the courage to learn from their students and work together to enhance the relevance of medical education at all stages to the needs and the expectations of society.

To a certain extent, this is already happening.

37. In 1979, a Network of Community-Oriented Educational Institutions for Health Sciences was established.

Among its objectives are the development of technologies, approaches and methodologies appropriate to a community-oriented and problem-based educational system. It is concerned with strengthening educational programmes which help students to acquire competencies which relate to the solution of health problems of individuals and families in a community context. This is an example of an integrated approach to health systems and

health manpower development. At the time it was founded the Network consisted of about 20 medical schools. Today there are some 80 institutional members and another 60 schools have shown interest in possible affiliation. Many are relatively new and enjoy the advantage of being able to explore innovative approaches to preparing future physicians without first having to discard educational patterns which constitute a venerable but confining tradition. But there are early signs of stirring even within the older schools. Several have already introduced an alternate track within the curriculum which offers students an opportunity to focus their studies on community-oriented primary health care. These trends are encouraging, particularly since there is mounting evidence of continuing momentum in this direction.

38. I hope I have been able to project the image of the new medical profession, and its role in the global perspective. The profile of a member of this profession is incomparably richer than ever before in its long and venerable history.

In addition to being the well-known figure of cure, comfort and relief of suffering, the physician will be a prominent community leader, a fighter for health for all. This medical profession is itself a community of fighters without whom there can be and will be no health for all, either by the year 2000 or later. But I am sure that the medical profession will fulfil expectations, and will really become one of the leaders and main protagonists for the most momentous and noble social goal humanity ever set for itself - health for all. Nothing short of that will enable us to carry our share of historic responsibility. I am pleased that a few weeks ago the political world decided to upstage Health for All with Education for All.

39. To assume this new role the medical profession will have to learn new skills and attitudes and the underlying knowledge in fields where in the past it has not ventured. It will also have to learn to put searching questions to itself such as:

- Are we ready to exert efforts to ensure the necessary political commitment for health for all and to win over sometimes rather reluctant professionals?

- Are we ready to lead the way and participate in the reorientation of health services?

- Are we ready to manage, support and provide primary health care, to work in teams, and to be team leaders when necessary?

- Are we ready to enlarge the scope of our usual activities and to include promotive, preventive and rehabilitative actions, as well as the identification and solution of community problems?

40. - Are we ready to work for the mobilization of the community and of the other development sectors interested in health?

- Are we ready to participate in the training and continuing education of other health workers?

- Are we ready to reorient the education and training of the future generations of medical doctors?

- Are we ready to reorient our research work?
- And finally, can we do all this keeping in mind the main social goal and its achievement?

Until the reply to all these questions is in the affirmative, we need urgent action to rectify the situation. Very often, I fear, this action will have to be taken against fierce resistance. However, I am confident we will overcome it, and all other difficulties inherent in all radical change.

We will finally welcome the new roles that are

being offered to us as a continuation and extension of our best humanitarian and technical traditions. To fulfil these roles we will require a combination of sagacity, scientific and technical knowledge, social understanding, managerial acumen, and political persuasiveness. And we will acquire all that! And in so doing we shall remove any unnecessary fragmentation, conflicts and contradictions in the continuum of personal care and public health. We shall indeed reconcile what often appears irreconcilable.

MEETING ANNOUNCEMENT

11TH ANNUAL SCIENTIFIC MEETING CHAPTER OF PHYSICIANS ACADEMY OF MEDICINE, SINGAPORE

*Theme: Current Views on Prophylaxis
and Prevention in Medicine*

*Saturday, 26 January 1991 & Sunday, 27 January 1991
Sheraton Town, Scotts Road, Singapore*

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