THE CHALLENGE OF MODERN DAY MEDICAL PRACTICE

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Twenty years ago I was invited to give the SMA lecture and my topics was "Good Medicine" – wherein I concentrated on the role of a physician in the delivery of good medicine. Twenty years has now lapsed. Much of what I had said then is still relevant today, but perhaps not quite enough to deal with the many changes that medicine has gone through as a result of technological advances and the socialisation of medicine. All these changes in medicine, medical practice and as a result the establishment of various health systems in developed countries are now being mirrored or duplicated in developing countries. This is happening in Singapore and it is important that we, as doctors, realise this and be prepared for such changes. We must anticipate them and try to avoid the many pitfalls ahead. As a profession we must realise the importance of restoring the trust and respect that the community had placed on us in the past. Trust and respect are essential if we, as doctors, wish to contribute, through our profession, our part towards community development not only like every other responsible citizen, eg as volunteers, but also as doctors in the practice of good medicine and making medicine more accessible to all. There are many examples and role models to follow – the late Dr Sheares, Dr Yeoh Ghim Seng, Dr Monteiro and others. I am aware that a significant number of doctors are doing this in their own quiet way.

Medicine is both Science and Art

In its early years of medical history – more than 2000 years ago – medicine was more an art form than a science. It was ancillary to nature. The physician was subservient to nature and his practice was guided by the need not to impede nature – but to assist it and thereby not to hurt his client. There was very little science in the practice of medicine. The physician, however, was trusted. He had a paternalistic role in the community. His authority was hardly challenged, his advice seldom questioned. Since the turn of the century, science has shaped the development and practice of medicine. The physician was not aware of the importance of sociology and the economics of medicine. With great rapidity science supplied the means for the surgeon to perform surgical wonders and the physician was armed with vaccines, antitoxins, serums and chemotherapy, etc. Doctors could come to grips with disease and could take the initiative to manipulate rather than subserve nature. Science later drove medicine into a position where medical care was perceived to foster well-being, ie it offered something that was significant and valuable, and that it was desirable and good. As a result, medicine gained in prestige and the demand for medical service grew in volume.

Another important fact was the growing awareness that many more people required more medical care and service than they were receiving. This resulted in an increasing demand for medical care. Thus the growth of medicine was tremendous just before and more so after World War II. This was part of the increasing social awareness and expectation of that era. Three problems arose out of this:

1. Access to medical care
2. Unequal distribution of medical services
3. Increasing cost of medical care

Thus came about the increasing influence of sociology and economics on the practice of medicine. The term 'socialization of medicine' was coined to denote the pressures upon the governments, medical associations, individual doctors and insurance companies to render medical services available to all. In the US – as a result of draft examination and the resultant health surveys – it was realised that about 30% of the nation were not receiving adequate medical care. Various attempts were made by some countries to overcome these problems. These include:

1. Compulsory health insurance – UK/Sweden
2. Voluntary health insurance
3. Group practice
4. Managed health care system
5. Individual taxation
6. Contract medicine
7. Introduction of Medicare/Medicaid in the US

Many of these schemes were opposed by the medical profession itself although it was essential for the success of any scheme or combination of schemes to have the agreement if not the compliance of doctors and for doctors to play a significant role.

As countries became more affluent the growth of voluntary health insurance continued but not without its opponents who found that health insurance became rigid with vested interest and became largely profit motivated.

In Sweden and in the UK the health service provided by the governments to the public which are funded by taxes had to undergo significant modifications. Because of increasing expectation and increasing demand, costs to maintain an adequate health service have shot up astronomically. In Canada, the government has recently (April 9, 1995), decided that their health service was costing too much and has introduced further cost

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containment measures.

The expanding economy of countries have contributed and can contribute further to the welfare of individuals and their families directly through increased private earnings and through gains in health, welfare and retirement and other programmes developed by government, private institutions and employers and employees which have as their objective the improvement of human well-being.

Any health system must have these 3 principles:

- accessibility
- fair distribution
- containment of costs

Not forgetting the very important part physicians have to play in all these three principles, I will come to that more specifically later.

Increasing costs

Medicine enjoys a rich history starting with the Hippocratic tradition over 2000 years ago. At the turn of the century, medical care for the poor was considered to be a moral obligation of the physician and the hospital. Physicians, as well as hospitals, were not motivated strictly by profit but were governed by the moral dictates of the principle of beneficence which carried an implied obligation to care for the patients who were unable to pay. Physicians were expected to make their living from treating patients who were able to pay. The general hospitals of those days were run by the government which accorded free treatment to those who could not pay - supported to some extent by the paying class patients. Other hospitals run by various community boards, church bodies, were largely supported by philanthropists. Then again much of the treatment of patients was done in the patients' home. However, the emergence of technology in medicine, which became increasingly housed in hospitals and in physicians' offices, made the shift of patient care from home to hospitals and physicians' clinics. Growth of health services was seen in the growth of hospitals. In Singapore this is seen largely in the case of:

- private practitioners
- restructured hospitals
- privatization of Government hospitals
- establishment of clinics within a hospital precinct or as a complement to hospitals.

Home visits – which formed more than 50% of my father's practice before the war – became less frequent. Patients with any ailment of whatever seriousness requiring a doctor's attention daily would now be sent to hospital. Doctors succumbed to patients' expectation and demands. This gradually developed into a personal health service as we know today – the voluntary (private) hospital and the private physician. This model was further expanded by the emergence of a third party to pay for the day-to-day physician and hospital expenses. These developments while occurring in developed countries are being duplicated here.

In America, prepayment schemes, eg Blue Cross, Blue Shield, exist.

In the Blue Cross schemes, the prepayment plan is established by the hospital for the public. In the Blue Shield scheme, the prepayment is for physician services in the hospital. It was not long before private insurance companies, realising the great profits to be made from this growing enterprise (business) of health, entered the picture.

In America, the health insurance paid by the employer became a fringe benefit. The number of persons with hospital insurance jumped from 32m at the end of World War II to 122m in 1960. Physician services in hospital soared from 5m to 83m.

There is no doubt that the growth of wealth and new technology (also fueled by increased expectation and demand) created a new mind set in both the public and the health care deliverers, namely the infallibility of technology and the concept of healthcare being furnished on demand. The right to health became an expectation of the public. But with increasing demand, access to private health care and private physicians became increasingly difficult.

In the U.S., the coincidence of social awakening in the 1960's led to the introduction of the Medicare Act and Medicaid Act which became a means to medically enfranchise the poor. However, neither had provided serious measures for cost containment.

It is ironic that the insurance programme, or prepaid medical health schemes, significantly contributed to the increasing demand for health services which then made access to these services more difficult even for those who could afford them. Hospitals and doctors saw their income doubled. Between 1965-1987 the % amount of GNP spent on health care increased from 5.9% to 11%. (US$ 498 billion in 1987 compared to US$ 12.7 billion in 1950).

Despite the institution of a series of cost containment policies, all attempts to manage the rising costs proved futile (HMO, DRG or Diagnostic Related Groups)

Such schemes shifted cost containment from taxpayer to the provider of health care services – primarily the hospitals. Prior to this, containment for health costs was largely the responsibility of the taxpayer. Neither physician nor hospital possessed any real incentive to control costs. Costs were paid by Government – so why bother?

In DRG systems prospective payment was based on a predetermined rate corresponding to one of 470 diagnosis related groups – regardless of actual cost, the provider receiving a flat rate based on the patients' primary diagnosis. As a result - doctors surrendered their beneficent role and the beneficent autonomy model of physician - patient relationship became the economic autonomy model. Decisions to admit, transfer, discharge, were affected by this new method. It eroded the power and influence, and moral role of the physician. What these cost containment policies achieved were:

1. Reduction in health care programme for the marginalised section of the community – aged, disabled, the poor.
2. Reduced the influence and moral role of the doctor. When the physician of yesteryear played a dominant role in the caring of the poor, there appear to be now an increasing reluctance by physicians and hospitals to care for them if they cannot demonstrate their ability to pay. There is a growing depersonalisation of medical care that comes with the loss of 'caring' role of a doctor.

Cost containment

All cost containment programmes in the U.S. and less so in the UK have failed. While not achieving their desired results, what actually has come about is:

1. Diminished accessibility to health care (not equal access)
2. A threat to the quality of health care
3. A reduction in the moral and beneficent role of the doctor.
4. The inadequate distribution of health care resources.

Health care has been turned into a commodity – something to be bought and sold. Health care is presented to the public as a commodity to be purchased and that people have a right to buy it at a price. The programme promoted a sense of adversarialism. The message given was that if one doesn't get the health care one wants, some sort of compensation is needed in return. An attitude of health care on demand developed. Unfortunately, when

health care is viewed as a product to be bought and sold, it loses any unique moral status it once had and enjoyed by those involved in its delivery.

Those who purchased health care, ie corporations, insurance companies and health management organisations, will always look towards saving money and this is usually achieved by restricting access to basic health services. For those who sell health care, ie hospitals, cost effectiveness often becomes cost savings at the expense of quality care. Their resort to advertising as a result of a higher competitive market leads to the creation of greater demand – even unnecessary demand. Thus market solutions appear to take over control from the physician who rightly should have complete control over the allocation of health care resources. Physicians must never allow this to happen to the detriment of their patients' health.

Role of government in cost containment

Government's economic strategy in Singapore is well known. Essentially, it is to create and increase wealth of the country and of its community by increasing the individual's assets. This we all understand is absolutely vital for our economic survival but the negative aspects of this objective are fully understood by Government, eg inflation, consequential materialistic philosophy of the community which may result in a less caring society with higher and higher expectations and demands, a more litigious society and social discontent due to inequitable distribution of wealth generated. More wealth, as I've said, leads to higher expectation and demands – resulting in 'more' medical care, ie:

- greater use of technology
- 'more' medication
- more laboratory tests and investigations
- more hospitalisation
- poor media responsibility giving rise to false hopes, expectation, eg new drugs and new technology being demanded and tried even more if its reliability has been proven
- more litigious society, leading to defensive medicine being adopted by doctors.

Thus a vicious cycle of 'more' medical care (or medicine) and not necessarily good medicine is created.

The Singapore Government has started the Medisave and Medishield schemes through the CPF compulsory savings policy. Government hospitals – whilst a number have been restructured and privatised – do continue to provide subsidised hospitalisation to those who cannot afford and I am sure it will continue to provide this support. Meanwhile, many public health programmes with health education and preventive health measures have been undertaken with Government playing the lead role.

In anticipation of the demographic changes which will result in an increasingly larger percentage of the population over the age of 65, the Government is also taking some action on the creation of the 'living will' or 'advanced directive'. While public sentiment suggest health care should be made accessible, there is a growing awareness that certain sections of the population may be receiving more than their 'fair' share of health care resources, namely the elderly and the new born. In the US, 12% of the population are over 65, but they are receiving over 60% of health benefits. In the treatment of low birth weight infants, miracles are being performed but at a tremendous cost. Nearly US$71,000 is spent on an average in the treatment of each defective and premature neonate.

Another area of great importance is that of the dying patients and the higher costs associated with dying. In US 10% of all Medicare beneficiaries who are terminally ill account for over 75% of all Medicare spending.

Hospitals' role

There are some Government hospitals available in Singapore which continue to provide adequate care for the needy. But private hospitals are perceived to provide for that sector of the public that can afford what it expects. Not all private hospitals are completely profit motivated, although it must form part of their corporate objectives. Moreover, labour costs are high and skilled labour is in short supply. Competition between private hospitals inevitably lead to the use of high tech equipment even though some of these equipment have yet to obtain complete FDA approval and its restricted use in USA is presently confined to designated hospitals only. Poor management with poor cost efficiency and cost effectiveness leads to increasing costs. It would appear that some part of the answer is to expect hospitals to exercise some restraint and control and improve on their management as well. In a market-driven society, this may be difficult and perhaps Government-managed hospitals must continue to set the lead.

Medical insurance and managed health care systems

Existing insurance, managed health care systems, health management organisations and others whether voluntary, compulsory or combination of both, including those where there is a combination of fee for service and third party paying, have encouraged inflation in medical costs. Medical insurance schemes are usually designed to cover those who are healthy and not really the sick – odd as this may seem. It stands to reason that any insurance schemes designed must be profit – oriented. Also, such schemes are working in a situation where the patient (consumer) is not cost-conscious and the physician (supplier) is trained only to take care of the "consumers' needs". The costs are not generated by the physicians themselves. In fact, consultation fees comprise only about 20% of costs – the larger portion of costs is spent on investigation (CAT, MRI), laboratory tests and the prescription of expensive drugs.

For any managed health system to succeed, it is important that:

1. it provides coverage for those who can't afford, ie there must be equity in access to adequate medical care;
2. co-payment – to curb excessive demands by the patients; capping, however, must be worked into the system;
3. the scheme must be completely cost driven; in other words, health care should not be a commodity but a service.
4. cooperation between the 3 main components in any scheme, doctors, insurance agency and hospital, which includes pharmacy and laboratory tests (including investigation). It should be a medical health care system based on implementing incentives for the health care providers to be efficient and cost effective.
5. government may have to step in, eg introducing a national insurance scheme.
6. finally and most important of all, the part played by the doctors in any managed health system must preserve his authority and autonomy. The doctor also on his part must be conscious about the cost-effectiveness of what he does.

Earlier this year BG Yeo said in his speech to AA (Automobile Association): "At the system level, we must make sure that such schemes do not lead to a 'buffet syndrome' and the enrichment of third parties. By third parties I mean those not directly connected with health care – insurance companies, lawyers, drug suppliers and medical equipment."

About health, SM Lee had this to say at a recent interview:

"We have got ourselves onto sound long term policies – high expenditure on key factors which determines a people's future – health, education, infrastructure, technology." (Straits Times 4 Feb 1995 pg. 3)

Thus the importance of health and good health management has long been realised and in Singapore, our Government has had a long hard look and decided to limit comprehensive national insurance to catastrophic illnesses, eg kidney, cancer, radiotherapy, chemotherapy and intensive care treatment. The Government's policy is that the first line of defense is that each person takes care of his own family needs. The safety net is Medisave. If long-term high cost care for chronic illnesses is needed, then there is Medishield insurance scheme. It isn't a perfect formula. The Medishield component can be strengthened (Dr Phua LH – Straits Times 22 January 95). But as countries become wealthy, they must anticipate problems that come with aging, the explosion of high technology and increasing consumer demands.

Doctors' role

Unfortunately, developments in medicine have taken a turn – such that the profession is no longer regarded with the respect it used to enjoy The profession also is no longer thought of as a highly prestigious one and has lost a good deal of its moral authority and public trust.

In the final analysis, in the delivery of health care and in the distribution of health resources, the doctor must have control because it is the doctor who has to manage the patient and has the ultimate responsibility of ensuring his total well-being. It was Oliver Wendell Holmes who said "Lawyers are the cleverest of men, Men of the cloth (ministers) are the most learned, Doctors are the most sensible."

Let us go back to the basics if we as doctors want to regain our position of respect in the community and our responsibility to the community. The declining level of public trust in medicine may be associated with the diminishing degree of altruistic behaviour and sense of social mission in the profession.

In the undergraduate years, the objective of medical education should be 'to produce a physician who is prepared to practise as a well-rounded, competent, safe and conscientious doctor, appreciative of the socio-economic, psychological as well as the medical needs of the individual, or a physician who will go forward into advanced work in a specialised field of clinical medicine'.

In other words medical practitioners will be divided in 2 groups:

1. Those trained to deal with serious types of episodic and emergency disorders
2. Those trained to be good at maintenance medicine, ie the "day to day health care" – family doctors.

And in our practice of medicine – whether as family physicians or as specialists – there are several points to remember:

1. Application of clinical acumen and judgment
2. Use of good common sense
3. Be aware of costs to the patient
4. Humanitarian approach must always be maintained – ie accessibility
5. Whatever we do must be cost effective and cost efficient and not driven by economy alone because it is difficult for medicine to remain moral if it is purely profit-motivated.
6. Holistic
7. Less defensive

Let us remember an old saying – If it is not necessary to do it, it is necessary not to do it.

The present erosion of trust of physicians can be reversed only if medicine returns to its roots as outlined above.

Only with the restoration of public trust can the physician resume the physician-patient relationship that is important in the physician's role in cost containment. And in today's context, the doctor has to interface with the health management system and/ or medical insurance scheme and the patient. Thus the physician-patient relationship must be of great importance and the physician must be in control (delivery of health care, distribution of health resources) as he is ultimately responsible for the patient's well-being.

Today's doctors practise in an increasingly litigious society. In the phenomenon of defensive medicine, ie the management of patients' care is not only with an eye to his welfare but with an awareness of possible future malpractice litigation or a blending of patients' interest and the physicians' economic interests, these two competing values may not be entirely in the patients' or public interest for they lead to an extension of care far beyond the patients' need. Such practices further erode public trust.

What measures can we take?

1. Physicians must be willing to stake their judgment – although it may be imprudent at times.
2. A less litigious environment should be encouraged by Government, media, legal profession and by education.

In March 11 1995, The Times reported headline "Cancer girl loses appeal for treatment". In a day of drama at the High Court in London, a judge first ruled that the Cambridge Health Authority had been wrong in refusing to pay for the treatment (through the NHS) of patient B, a girl, with acute myeloid leukemia. Two consultants with the Cambridge Health Authority felt that there was only a 2.5% chance of survival with treatment and that such expensive treatment requiring chemotherapy and bone marrow transplant would induce more suffering than good. The Cambridge Health Authority immediately appealed $2^1/_2$ hours later, 3 Court of Appeal Judges sat and after a 4 hour hearing a decision was rendered and the Chairman of the Court of Appeal stated: "While I have every possible sympathy with the patient, I feel bound to regard this as an attempt, wholly understandable, but nevertheless misguided, to involve the Court in a field of activity which it is not fitted to make any decision favourable to the patient."

Thus the Court of Appeal had stated definitively that it was not for the Courts to interfere with the way health authorities make medical judgments on funding. The tragedy of a child's grave illness with possible death presented doctors and health administrators with decisions whose moral burden was almost intolerable.

Simons Jenkins in his leading article, "Life and Death is not for lawyers" said that in the old days, these matters were for doctors only and if a second opinion was needed it was obtained from another doctor and not from a judge or Prime Minister. He concluded that doctors must be allowed to have the courage of their convictions. "I want to be kept alive because I have a better doctor, not a better lawyer and a richer newspaper and a more strident politician in support". Medical decisions must take into account financial resources, but should at all costs be kept out of the Courts.

Clinical judgment

With the appearance of medical insurance, MHS, HMO, etc, hospitals have enlisted physicians as gatekeepers to control costs of care by setting up certain norms relating to admission, length

of stay, specialists' referrals and the utilisation of diagnostic and therapeutic resources. The traditional notion of "clinical freedom" thus becomes cramped.

With the diminution in the role of clinical decision and the rise of corporate medicine, physicians may well be on the way to becoming little more than employees of health care institutions and the practice of good medicine is severely put to the test. That this has already become a reality is evident in developed countries where costs continue to spiral instead of being controlled and increasing number of citizens are being denied access to medicine. As I said before, in the past physicians and hospitals had a mission and were prepared to treat the poor and those denied access to health care. This moral obligation and a sense of mission was in the fore front.

Can the physician in fact be a gatekeeper and also remember his moral duty and mission? This is the moral dilemma. The physician as a gatekeeper must not allow himself nor his patients to be used as a tool for economic interests of the hospital. There is nothing in the term "health care provider" that carries a notion of professionalism. More likely it connotes that health is a commodity for sale. We must be careful that this connotation does not become fixated, eg by subtle or even less subtle advertising. Then the physician must resist all policy deliberations that have impact on the quality of medical care when they arise solely from the economic perspective rather than from a moral principle. Physicians will require considerable courage and endurance. But it must be done in order that public trust can be restored. With this trust well-entrenched, the practice of good medicine will play a significant role in cost containment.

More money is increasingly being spent in health care. In its recent 1996 US budget, more than $716 billion has been assigned for health care and human services. This will happen to us too. Physicians must accept a significant portion of responsibility for controlling costs and this can be done by allowing the principle of beneficence to play a central role in a doctor-patient relationship. Beneficience is nothing more than the practice of good medicine and it seeks to promote a person's welfare and the prevention of harm. The basic tenet of the medical ethic "primum non secrere" tells physician first to do no harm.

The physical harms of medicine are now impinging on our awareness. It may come to pass that patients will live literally in fear of the hospital, not because they fear death, but they fear dying in an intensive care unit. To see friends spend their last days tied to a bed, force fed with no privacy and with no recourse to complain because they are gagged by various machines does not paint a pretty picture of doctors and what they represent. And worse of all, there appears to be a increasing lack of humanity in our management.

In a recent exchange of letters in the BMJ (Dec 17 1994) we are reminded of the Royal College of General Practitioners motto "cum scientia caritas" which emphasises the need to promote good knowledge and compassion. In BMJ, 24 Oct 1994, there was a letter to the journal noting the death of a doctor in the UK after 5 months of illness from leukemia and the diary of the events that took place which gives us food for thought. I commend you all to read it. When Jeffrey (the surgeon and patient) entered hospital to discuss options, he did not know who the consultants were. On hindsight, a question that needed to be asked was: if there was no real hope of chemotherapy working, why was it given with its side effects when palliative treatment of blood transfusion would have reduced his suffering? The writer also complained that when Jeffrey was starving nobody seemed to care. When he had ulcers in the mouth, the writer was told nothing more could be done. The writer ended by saying "what a terrible reflection of medicine today". Essentially, it was a complaint of far too many doctors dealing with one patient, no one doctor would take responsibility, and the lack of personal care for the patient.

Until a few decades ago there was little solace a doctor with his black bag could offer a dying patient other than analgesic medication and moral comfort. Compassion for the dying did not save them but it could care for them and made their dying easier. The patient did not die alone. Now there is much more available and herein lies another dilemma. Do we continue to prolong life when death is inevitable and to what cost in human suffering and in economic terms as well.

If all costs of health care were direct out of pocket expenses very few can afford it.

It is established that inappropriate prescribing is by far the most common complaint heard by medical review boards in the developed countries. Why does this happen?

1. Firstly, many or even most patients want drugs when they are ill. They visit a doctor because they think they need prescription drugs and they expect the physician to prescribe them.
2. Secondly, the placebo effect is widespread. Patients assume that prescriptive drugs are more effective than over-the-counter ones. This is not always true. Again, advance and untimely media stories encourage this belief.
3. Thirdly, the physicians' own ignorance about drugs. They learn about drugs they prescribe from sales people who themselves know little about the products they are promoting.

Horace Walpole once said "A physician is one who pours drugs of which he knows little into a body of which he knows less."

Another interesting fact noted in the US is that doctors in large practices write more prescriptions for their patients, per patient, than doctors in small practices. It would seem that patients who visit large practices are more sick than those who visit small practices.

The same economic and health harm also result from the misuse of medical tests. It has been reported in the US in 1985 that half of the total health cost was for medical tests and investigations. Most of medical tests are 80% accurate only (The minimum acceptable limit is 85%). Eighty percent of physicians are using more tests than are necessary. The reason given is the fear of malpractice suits. Could it be that doctors submit too easily to patients' demand for further tests?

The best interest of patients are supposed to guide clinical judgment. The most important component in diagnosis is listening to the patient's history. The next most important is physical examination. Medical tests and investigations should account for only 10% of the process of diagnosis. Yet in the US it amounts to 50% of costs for health care.

Cost containment measures in health care is the responsibility of all – Government, Hospitals, Public, and finally the Doctors. It must be assessed not only in terms of their economic efficiency but also in their effectiveness in bringing about the well-being of the community, individually and as a whole.

And so in order for us, doctors, to be effective in cost containment measures, we must regain the trust and respect of those we look after, and reaffirm that medicine is a noble profession in our practice. Therefore let us remember that the profession has a mission that includes making medicine accessible to all around us.