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SMA NEWS

Introducing Our New DMS

Interview with Prof K Satkunanantham, Director of Medical Services

Editorial note:
In this issue of the SMA News, Editorial Board Member Dr Jeremy Lim speaks to Prof K Satkunanantham, Director of Medical Services (DMS), and Prof Tan Chorh Chuan, former DMS, and now Provost of the National University of Singapore, on their visions and thoughts on healthcare in Singapore. (Please see page 5 for the interview with Prof Tan.)

JL: What are the key areas in healthcare that you would like to see more attention focused on?

DMS: We actually already have a very good healthcare system. The improvements I would like to see are really about making good better, and not fixing a broken system.

Prof K Satkunanantham, MBBS(S), MMed(Surg)(S), FRCS(Edin), FAMS, graduated from the National University of Singapore (NUS) in 1974.

Prof Satku assumed the post of Director of Medical Services, Ministry of Health, Singapore, on 1 April 2004.

His other current appointments include
1. Professor of Orthopaedic Surgery, NUS
2. Registrar, Singapore Medical Council
3. Chairman, Specialist Accreditation Board

Prof Satku was formerly Head of Orthopaedic Surgery, NUS. He was also Master of the Academy of Medicine, Singapore, from July 2002 to June 2004.

Prof Satku has been married to Dr Rose Bharathi for 28 years, and they have two children, one a practising doctor and the other a medical student.

Primary care is the first area. In this new world, the buzzword is chronic disease, and we must tackle chronic diseases by emphasising prevention and early detection. Unfortunately, tertiary care is the face of modern medicine and technological advances dominate the headlines. The primary health agenda sometimes gets pushed to the background. We need to make a conscious effort to ensure that care at primary health settings constitutes not only acute episodic care but stresses preventive care.

JL: What steps can doctors take then?

DMS: Currently, many patients are seen by their doctors only for the problem at hand, but we do not realise how effective a little nudging by the doctor to lose a little weight, stop smoking, and so on, can be. I would be very glad if all doctors, at all levels of healthcare, regardless of the presenting problem, spent a little time talking to their patients about prevention and early detection of chronic diseases.

The second area of concern to me is nursing. Let us look at Europe and North America for examples of how much more our nurses can do. Nurses can play a bigger role in opportunistic screening, prevention and care in general. Studies have shown that in many situations, patients can be as satisfied with the care provided by nurse practitioners as that by doctors. I hope to encourage our nurses to achieve higher qualifications so that they can take on a variety of roles and new challenges, including functioning as advanced practice nurses to better complement doctors.

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Care of the elderly is another critical area. The population is aging, and we want our people to age well, and remain active and productive well into their sixties and seventies. For that to happen, we must not only stress preventive health but also focus our efforts on developing new ways to allow our elderly to enjoy a good quality of life in their twilight years.

JL: What do you think are the three greatest challenges facing Singapore medicine in the coming years?

DMS: The three challenges are ensuring appropriate training for our doctors, both undergraduate and post-graduate, nurturing academic medicine and controlling healthcare costs. Let me elaborate on training first.

Exclusively, undergraduate and post-graduate training is undertaken by the restructured hospitals. This is increasingly becoming a difficult proposition, as hospitals feel pressured to focus on their bottom line. Training does not yield immediate returns, unlike clinical practice, and the hospital sometimes is not even sure if it is training a doctor for itself or another institution! But unless we invest in our young doctors, the next generation of doctors, those who did not benefit from mentors such as Prof Wong Hock Boon or Prof Bala will not have the same nurturing and guidance. We as a profession and our society, will then pay the price.

JL: But with more and more doctors in training and so many senior staff leaving for the private sector, how can we ensure proper training and supervision?

DMS: Yes, there is more competition for the hours that should be set aside for training but there can be novel solutions. We are actively looking into harnessing talent in the private sector for medical training. This may be especially apt for family practice but even at the tertiary level, hospitals such as Raffles Hospital, which is organised into departments, may have a role in providing the breadth of clinical experience. Your point about senior staff is noted and this brings me to the issue of academic medicine.

Where are the doctors who have that quest for knowledge and are always striving to do better, aiming for excellence? When I was a young doctor, there seemed to be more role models. Prof Wong Hock Boon was one such doctor. He would study a child's presentation very carefully, go back and read about it, and the next day come back with an article and teach all of us. We would see his paper a little while later. Even in his 70s, he never stopped reading, writing and caring for his patients.

I would be very glad if all doctors, at all levels of healthcare, regardless of the presenting problem, spent a little time talking to their patients about prevention and early detection of chronic diseases.

JL: So what is the situation now?

DMS: The situation now is very different. Private practice has grown and continues to grow. I am seeing young doctors in their late 30s or early 40s leaving for private practice. How do we keep such doctors, these potential academic physicians, in service? I think it is not so much about rewarding as it is about recognising. We must send a very clear signal to such doctors that they are valued and appreciated. Job security is another important factor if we are to nurture academic physicians. With the emphasis on service load and an uncertain future, some academic physicians may feel their very livelihood threatened, and hence pursue clinical excellence and leave earlier for private practice while they still can, rather than be forced out later.

Lastly, healthcare costs. We cannot blame the finance guys; the responsibility lies with the doctor to not only be a superb clinician but also an adroit resource manager. Gone are the days when we focus only on our patient and nothing else. Think about our dealings with the BTS MO (Blood Transfusion Service Medical Officer) for a packet of blood. When necessary, we must do everything we can for our patient, but when it is not really necessary, we have to think about the resource limitation and take a larger view. Does my patient really need blood? Or is it better kept for my colleagues' patients? We need to see what resources we have to benefit our patient, and decide which to use, such that we do not overburden the patient financially or the system as a whole. If doctors spent at least some of their time acquiring the skills to be resource managers, this problem would be much easier to solve. The doctor needs to have a greater perception of his context in the overall healthcare system and in managing the State's resources. This is a fine balance that comes with experience.

JL: Do you think education can play a role here?

DMS: The medical school is key, and I hope that resource management concepts are introduced at a very early stage of a doctor's growth and development.

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About the interviewer:
Dr Jeremy Lim, MBBS (1997), MRCS (2002), MPH (2003) is a recent Fulbright/ Shaw Foundation scholar who obtained a Masters in Public Health at the Johns Hopkins University. Dr Lim can be contacted at his email: jeremyfylim@yahoo.com.sg

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JL: How do you keep in touch with the ground?

DMS: I still go back to NUH once a week. I spend the morning in the clinic and the afternoon operating. This keeps me in contact with patients and clinicians, and allows me to see for myself the impact of policies, and that is so important in public policy. I also make it a point to have regular dialogue with the various professional groups, and ever since I became DMS, there has been no shortage of people I meet in the hospital corridor and socially, offering me advice! To these colleagues and others I say, keep it coming!

JL: Who do you look to, to test your ideas?

DMS: I enjoy talking to people, and hearing them out. I bounce my ideas off people who share the same philosophy. It is also important to reflect while learning, and to re-strategise when necessary.

JL: Are you busier now than when you were a full-time clinician?

DMS: I am definitely busier now, but I suppose it is partly because I am finding my feet and learning the ropes. I have a simple guiding policy: if you take on something, you have to do it with excellence, give it everything you have got. If you cannot, then do not do it.

JL: Is your family complaining?

DMS: Oh, both my children are grown up and my wife also works so they do not miss me much. I make it a point to spend time with them and have cut back on other things like golf and trekking.

JL: Thank you for your time, Prof. Any parting advice for our doctors?

DMS: Technology is a big part of medicine now, but remember patient rapport is still essential. Do not be a servant to technology. A doctor who places little emphasis on communication and relies heavily on technology will be in trouble. Although patients have become more sophisticated, they still appreciate simple gestures like listening, touch, and a doctor who comes to see them even on weekends. Tell the patient you will look at the mountain of X-rays and scans later. First, you want to take the history, find out more about him and what is troubling him, examine him, and only then pore through the investigations. The science of medicine is always changing and we must keep abreast, but the art has remained constant. ■