" Nothing Endures but Change."
– (Heraclitus, 540-480 BC)

In this year, the 100th anniversary of medical education in Singapore, it seems good to look at a couple of recent changes in what we consider to be "Medicine", and what constitutes the work of the doctor. This issue of the News has articles that examine aspects about two new "kinds" of medical practice: the clinically-trained administrator and the practitioner of aesthetic medicine, and suggests that times have really changed.

Decades ago, it was fairly simple. Doctors helped the sick and dealt with illness. Most of their working hours revolved around patients, and whether to offer cure or comfort. The remedies available – whether drugs or surgical technique – were far fewer than now, and required less sub-specialised training to apply satisfactorily. Dare we say, the expectations of patients were also different then – doctors simply helped the sick in whatever way they could, with whatever skills they had, and patients were grateful.

In the 70's and 80's, the idea of "business units" came to hospitals and institutions, and with it the concept that skilled administrators could help the hospital or its individual departments run better. ("Better" meant "more efficiently", and the meaning of this was also time-dependent.) Some of these were expert administrators "from outside", while others were already well-respected clinical experts, often Heads of Departments, asked to take on an additional role. In the last 10 years or so, a few doctors have even elected to study Administration and to practise it as an occupation. They help patients not by exercising clinical skills, but by facilitating the effectiveness of the work of their clinical colleagues.

In this edition of the News, the Hobbit takes a tongue-in-cheek look at the role and necessary qualities of Administrators. Comparing the knowledge, attitudes and practices necessary for excellence in clinical service versus administration, the Hobbit contrasts the criteria that define excellence in job performance between the two different roles, and muses whether the instincts and skill-sets that result from decades of medical study and mentorship, are those that make for the finest administrators. And embedded in these thoughts is a wider question: how do clinicians see medically-qualified persons who no longer directly deal with disease, and who no longer "see patients"?

Those of us who had attended the SMA's Annual Medical Convention recently, would have been introduced to Aesthetic Medicine – a recent development that also begs the last question above. Arguably, aesthetic medicine has nothing to do with medicine, insofar as the "patient" almost always has no "illness". It is "medical practice" only because the law restricts many of the procedures involved (for example, injections and use of lasers), to medically-trained people – correctly so, because of the risks involved.

But these three points (no illness, not patients, and treatment that is not risk-free) by themselves open a new Pandora's box. The social contract under which a doctor used to practise medicine was based on a patient with a pathology, the doctor being able to ameliorate or cure the disease, and the patient choosing the risk of treatment over the suffering he would have to face untreated. The risk-benefit equation for aesthetic medicine is clearly very different, and perhaps not all "patients" understand it. In addition, the less charitable among us would say that the social contract involved has deteriorated to something no more than the sale and purchase of more beauty. As a direct result, traditionally-derived mores of ethical boundaries – of appropriateness of fees, of the profession self-regulating its members, and even of the role of the Bolam test in legal suits – are no longer as easily applied as before. Dr T Thirumoorthy's article reflects on some of the ethical difficulties when looking at this new world.

Are there easier answers?

For example, need we always insist that at least some of our hospital Administrators be clinically-trained? Yes, because nobody else would champion the safety of the patient, when compromises are proposed in the name of economy or efficiency. For example, a clinically-trained person will be fully aware of the additional risks from delays that occur when an A&E department, administered for cost-efficiency at a level appropriate for "ordinary days", is almost overwhelmed when ambulances are diverted from another hospital "further up the highway" when *their* A&E closes.

Similarly, should we accept that some of our youngest and brightest doctors elect not to heal disease, but to "do aesthetic medicine" full-time instead? Yes, because so long as society demands incremental beauty from invasive methods, it is best that this is delivered in the safest possible way, by doctors.

So long as both the clinical administrators and aesthetic medicine practitioners do their very best with the interest of their patients at heart, they have reason to be proud of their contributions to medicine and to society. And although the more traditional doctors among us look upon them with some alarm, the profession should not dismiss them as mavericks who can contribute nothing to medicine.

It is frequently said that condemning a new entity is easier than trying to understand it. These two articles will not tell us everything about medical administration or aesthetic medicine, but they will help us better understand some of the issues that such colleagues face. Read, I urge you, with an open mind – and try to understand the issues better.

About the author:
Dr Lee Pheng Soon (BSc(Hons), MBBS (1982), FFPM, MBA) has worked full-time as a pharmaceutical physician and part-time as a GP since 1985. He is Honorary Fellow in Human Nutrition at the University of Otago, New Zealand. The main weakness that he will confess to, relates to moderate amounts of the beautiful Central Otago Pinot Noirs.