By Dr Lee Pheng Soon, SMA President

All Creatures, Great and Small

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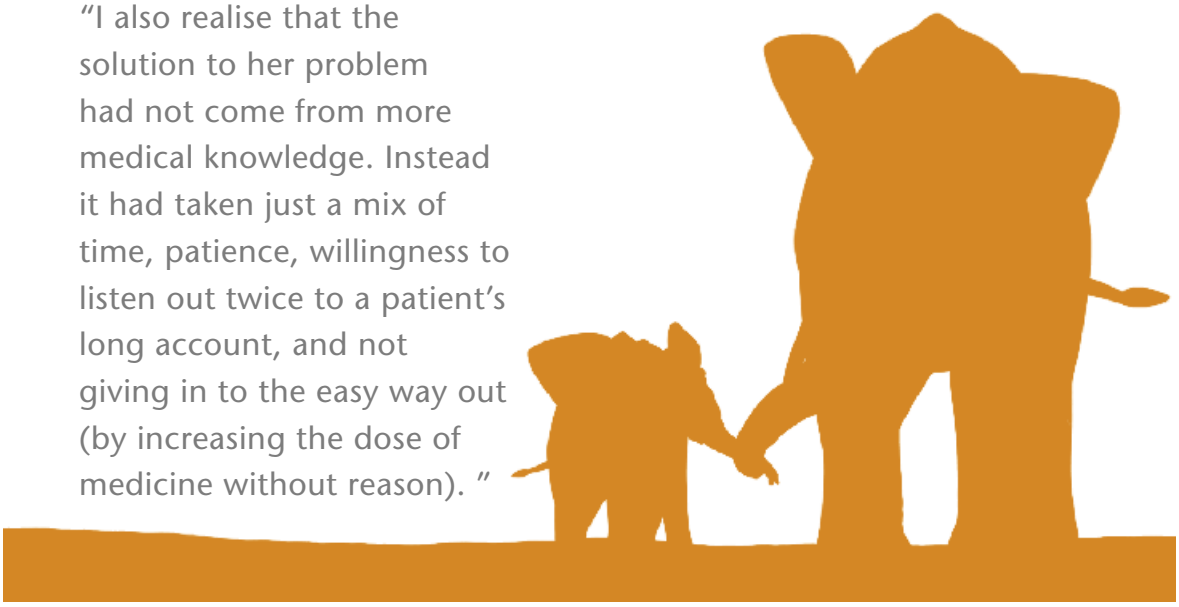

Dr Lee Pheng Soon, BSc (Hons), MBBS (1982), FFPM, MBA, has worked full-time as a pharmaceutical physician and part-time as a GP since 1985. He is Honorary Fellow in Human Nutrition at the University of Otago, New Zealand. The main weakness that he will confess to, relates to moderate amounts of the beautiful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

Much of this *SMA News* is devoted to an interview with, arguably, the most influential doctor ever to have graduated from our medical school. I had tried to be a part of the interview team, but a last-minute change in plans resulted in one of the bigger disappointments in my life. Though controversial (probably also because of it), Tun Dr Mahathir is one of the doctors I have huge respect for. Sadly, I am therefore restricted to discussing other topics in this month's President's Forum, leaving the interview to the two colleagues with the great fortune to have made it.

In the past few months, several important changes have come to the medical profession. Let us think a little about just two of these: the proposed establishment of the Family Physician's (FP) Register, and a new breed of doctors who are devoting significant amounts (even all, in a few instances) of their practice time to "Aesthetic Medicine".

The proposed FP Register is now at the stage of public discussion. Your Council supports the concept in principle, although acknowledging that implementation so as to maximise benefit to patients will not be straightforward. Of course the more complex patients, especially those with multiple conditions, can be better managed at the community level by Family Physicians in conjunction with Specialists. But how this advance can be made economically viable (because these patients need a lot more time with their doctors) is uncertain. How to keep ordinary GPs (who for a variety of reasons have not yet, or will not, qualify to be FPs) from feeling even more marginalised by this process, is equally unsure.

I had a patient who illustrated that point two weeks ago. A 65-year-old lady with diabetes, well-stabilised on oral medication and a single injection of 16U of insulin at night, told me that her fasting blood glucose had gone up "from about 7 to about 14, without reason", and had remained at "12 to 14 for about two weeks". I reviewed her diet and activity level – they had not changed – and neither had she confused her medication. The brand of insulin had not changed, either. After a time, she mentioned that she had started on a new box of test-strips for her glucometer, wherein lay the problem. Her meter was turned on by inserting a strip – and the batch code that then flashed on the screen reflected the code previously set, rather than the code of the strip inserted (as she had mistakenly thought). My patient had therefore been checking her fasting blood glucose

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without "re-zero-ing" her meter for these two weeks. I asked for her new box of strips so I could teach her to re-set the code using the number printed. When I remarked that it was exactly the same as that already registered in her meter, she sheepishly told me that she had always re-loaded new strips into the original container that came with the meter, mixing new and old strips of different batches indiscriminately. Her box, and her code, was about two years old.

One week after I had settled all that, she came back to tell me that nothing had changed, and her fasting blood glucose was still "12 to 14". I began from scratch, reviewing everything to see what I had missed. The problem turned out to be a new bottle of insulin she had started on a month ago, which for some reason had not controlled her diabetes as well as earlier bottles had. The blood sugar returned to normal immediately when she changed once again, to a brand new bottle the next day. (Writing this reminds me that I must check that this frugal lady had indeed thrown away the partially used bottle as I had instructed.)

Looking back, I realise that it had taken me two 30-minute consultations to solve the problem. As older, more complex patients who need this type of long consultations will fall into the same socio-economic mix as the present GP patients now do, it is a mystery to me how an FP practice in the future, specialising in such cases but charging much the same as now, will be able to cover operating costs. But encouragingly, I also realise that the solution to her problem had not come from more medical knowledge. Instead it had taken just a mix of time, patience, willingness to listen out twice to a patient's long account, and not giving in to the easy way out (by increasing the dose of medicine without reason). In other words, those GPs who have said to me that they worry about inability to acquire the additional knowledge needed to make the FP Register, need not despair that they will become irrelevant. They will be, just as they are even now relevant to their patients, more so than they think.

At the other end of the spectrum are the bright young doctors (GPs and some specialists) who are devoting more and more of their time to aesthetic practice. They have said that since society now demands beauty at any cost, surely it would be better for the more extreme measures to be delivered by a medically trained person who can spot if the condition represented an underlying pathology, or recognise early a treatment "starting to go wrong". Others who have been saving lives and limbs for decades, have despaired how this is about "treatment of patients without an illness". I personally can appreciate both views expressed, and can see how the demands of a modern environment change the practice of doctors.

I can draw parallels with a bird featured on a *National Geographic* TV programme two years ago. This bird, which ordinarily lived deep in the woods, could mimic any other bird's call. As they filmed this wonderful creature, it launched forth into an outstanding mimicry of a chainsaw starting up, including the crunch when the clutch bit. I suppose it will not be long before such birds in closer contact with humans, perhaps those that spend time in the botanic gardens, would start repeating the polyphonic ring-tones of cellular phones. So change will also come to Medicine, which responds to changes in the environment. My personal concern about "Aesthetic Medicine", is that practitioners do not inadvertently find themselves in conflict with the Singapore Medical Council's Ethical Code (for example, regarding evidence-based medicine), or practise without adequate insurance cover (for example, regarding Mesotheraphy), or experience other issues that arise because we are used to viewing Medicine as a largely fiduciary contract, rather than a largely commercial contract, between patient and doctor.

My email tells me that the SMA's 1st Vice President, Dr Wong Chiang Yin, is soon going to lead a 15-mixed-doctor delegation from Singapore to the earthquake-hit areas of Pakistan and Kashmir. This is quite soon after many others of our profession had volunteered their own time serving as volunteers after the recent tsunami. It reminds me that all things should be taken into context. The controversy of some of us exploring new fields like aesthetic practice – controversial in this case because the patient's need is not defined in the traditional sense by a pathology – is small, when compared to our unchanged willingness to respond as a unified profession, when society calls out for help in a crisis, whether it be SARS, a tsunami, an earthquake, or in the near future, a mutation of Avian Flu. Responding to such calls we will always do, however we change in small ways, and for this, society can always count on us. ■