SINGAPORE MEDICAL ASSOCIATION

NEWSLETTER

FOR PRIVATE CIRCULATION ONLY

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COMMENTS FROM A VISITING CONSULTANT ...

"I feel the success of the scheme depends,a lot on the relationship and understanding (of each others weakness and strength) of the institutional head and his visiting consultants.

Any suspicion that the visiting consultant is seeking to exploit his position would destroy this relationship. As the scheme is in its infancy, I feel it is crucial for the visiting consultant to be aware of this sensitivity. To blatantly flaunt the designation 'visiting consultant' or 'visiting specialist' on calling cards, letterheads etc appear rather obvious (especially when attached to 'such and such' a hospital). Similarly, to transfer difficult cases in or to transfer cases that are unable to pay to continue their management inside will also be viewed with suspicion.

There is no doubt that the visiting consultant does accrue a lot of advantages in terms of stimulation by his peers and junior staff, the advancement of his knowledge by discussion and his technique by the vast amount of patient material seen. Above all, he re-establishes a comaderie developed while he was in an institution. In return, he must be ready to sacrifice his time. To turn up 'as he feels like it' is unworthy.

On the other hand, to impose a visiting consultant on a unit whose head is not quite happy or where staff is more than adequate is unrealistic. The decision must rest with the head of unit. Imposition can be subtle but similarly if the head does not want to accept a visiting consultant, rejection can also be subtle.

I personally have enjoyed myself tremendously and really feels that (hopefully) I am welcome. More important is that I feel the staff at registrar and senior registrar level have benefited a bit from what I can offer. I think a good assessment would be to get opinions from the staff at this level as to the usefulness of the visiting consultant.

I feel the visiting consultant must integrate himself into the unit he is in – not only for the few hours he is there, but also on a social level.

Student teaching to a great extent is dependent on the arrangements in NUS departments. As the staffing appear more than adequate (at least in orthopaedics), I have not been involved much in student teaching. Again the visiting consultant must be conscious of sensitivities. Criticism of management, intentional or otherwise would lead to unhappiness.

I feel the scheme is young and it behaves both institutional and private practitioners to nurture it though for the sake of future medical development. However, the final decision of the usefulness of this scheme must rest with the institutional staff. If having a visiting consultant causes disruption or unhappiness in a unit, it would be better off wihout one !"

**The President, Council,
Editorial Board & Secretariat
Staff wishes our readers**

KONG XI FA CAI

THE HONORARY & VISITING CONSULTANTS SCHEME

— An Opinion Survey

The utilisation by the Ministry of Health of sepcialised skill in private practice was implemented as early as 1973. Initially, only Honorary Consultants were appointed. Then in 1979, the category of Visiting Consultant was created followed by a new category of Visiting Specialist since 1981.

How do specialists appointed to this scheme perceive their role? Do they find acceptance by their institutional colleagues of their presence and services? Answers to these and related questions will provide an insight into how the scheme is faring and point to future directions of improvement in the scheme. It is with these objectives in mind that the Editorial Board conducted a questionaire survey amongst the private specialists appointed to the Ministry's consultant scheme. From the latest available statistics 56 specialists are in this scheme consisting of 3 Honorary Consultants, 49 Visiting Consultants and 4 Visiting Specialists. Of these 23 replied to our questionaire (1 Honorary Consultant, 19 Visiting Consultants and 3 Visiting Specialists).

The replies have been collated and are presented below:

Role of Visiting Consultant/ Specialist

Specialists were asked to list the priority of the following of their perceived roles: (a) transfer of medical knowledge by teaching of staff; (b) transfer of medical technology by teaching of medical students; (c) consultation for an opinion on the management of difficult cases; (e) any other perceived roles.

(a) Teaching of Staff

4 (out of 23) agreed to the 4 listed roles but did not score them by priority; 1 considered all of the listed items to be important with the exception of teaching medical students. 12 (out of 23) gave transfer of medical knowledge by teaching of staff first place, 2 gave it second placeand 1 third priority.

(b) Teaching of Medical Students

6 (out of 23) placed priority of transfer of medical technology by teaching of medical students as second and 7 as third. Only 1 regarded it as not important.

(c) Consultation

6 (out of 23) considered consultation for an opinion on the management of difficult cases to be 2nd priority, 9 third in priority and 4 fourth in priority.

(d) Helping out

10 (out of 23) gave helping out the specialist medical outpatient/surgical list fourth place in priority and 3 specifically regard this role as unimportant. Only 1 gave it first priority and only 1 gave it second priority.

(d) Research

2 Visiting consultants mentioned research. One of these felt that junior staff needs guidance in this area and full-time hospital staff may be too busy to provide the necessary guidance. 1 Consultant felt that the stimulation of specialists towards medical excellence to be one of the roles of a Visiting Consultant.

From these results, it would appear that the transfer of medical knowledge to staff occupies first priority, followed by teaching of medical students and being consulted on difficult management problems while helping out the medical outpatinet/surgical list is regarded of low importance.

Extent of Influence

Respondents were asked the extent to which they were able to do what they thought important. 5 out of 23 felt they were able to do all what they had thought important well; 3 moderately well; 5 satisfactory, of which 2 felt there was room

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ANNOUNCEMENT

JOINT 15TH SINGAPORE MEDICAL ASSOCIATION (SMA) NATIONAL MEDICAL CONVENTION/2ND MEDICAL ASSOCIATION OF SOUTH EAST ASIAN NATIONS (MASEAN) CONFERENCE.

Theme : "Towards Medical Excellence"
Dates : 14 April, 1984 – 15 April, 1984
Venue : Shangri-La Hotel

Please Keep These Dates Free.

INSIDE

PRESIDENT'S COLUMN

We have been talking for some time about the future direction the Association should take. Inherent in and vital to that discussion is the structure of the Association. It is an issue we must examine and discuss urgently so that our Association may further grow in strength and effectiveness.

The Association was formed in 1959 as a logical development of the Singapore branch of the British Medical Association (B.M.A.). With its formation, the Alumni Association of the King Edward College of Medicine relinquished its professional, scientific and medico-political roles to the S.M.A. and thereafter confined itself to social and re-union activities. At the time the S.M.A. was formed, the private sector in Singapore consisted almost entirely of general practitioners. Nearly 100% of the specialists then were in Government service. For a long time most of the officers and Council members of the S.M.A. came from the public sector, both Government and University. To meet the special needs of the General Practitioners, the Society for Private was formed in 1965 and this in turn was transformed into the autonomous Association for Private Medical Practitioners of Singapore in 1981.

This very historical resume is necessary in order that we may be able to view the present structure of the S.M.A. with the correct perspective. As provided in the present constitution, the officers and Council members are elected from the members present at the A.G.M., i.e. from the floor. There is no built-in provision to allow for the election of a Council that is representative of the profession at large.

A quick look at the medical scene in Singapore today shows it to be strikingly different from the scene 25 years ago. There are as many specialists in private practice as there are in the public sector. The general practitioner population is also not only larger but much more active and better trained. Within the public sector itself, the proportion of specialists to general duty officers has increased strikingly, and finally the number of University clinical specialists is now by no means small.

The present Council consists of 5 private specialists, 2 public sector specialists, and 4 general practitioners. The spread between the various sections of our medical community is not too bad but this is in large part due to the care that was taken during the nominations at the last A.G.M. And this care was due to the fact that some of us deliberately set out to see that a sufficiently representative Council was elected. This may not necessarily happen the next time around.

The message is quite clear, at least to those of us who have been involved in these discussions.

The present structure and therefore the Constitution of the S.M.A. are not designed to provide adequate and equitable representation of the various and different sections within our medical community. None of us in the present Council would pretend, even with the best will in the world, to be able to comprehend and therefore be able to present the views and needs of the other sections of our profession. What we do need urgently is a Council in which there will be by Constitution at least one representative of each section of the profession as well as members elected to represent the profession as a whole. The instrument we need for this must be the Constitution, hence the need to review, revise and update the Constitution.

Some of us have been studying the Constitutions of other Medical Associations and the one that appears to provide a stuitable model is that of the B.M.A.

The B.M.A. is divided up into sections by geography and crafts. The following are some of the "Crafts" committees.

Hospital Junior Staff Committee

Joint Consultants Committee

Medical Academic Staff Committee

Thus every section of the medical community if of sufficient size has its own committee, whose functions are obvious.

We do not need such a complicated structure but we should seriously consider restructuring the S.M.A. along

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MEDICAL PRACTICE

MALPRACTICE OR JUST BAD MANNERS?

Dr Tan Hooi Hwa's article on the etiquette of medical practice in: A doctor and a gentleman (Oct 1983) has prompted Dr. G.Y. Caldwell to send us this article from his dosier. We wish to thank Dr. G.Y. Caldwell for his contribution to the Newsletter and his kind remarks — Ed.

In the final year of a Northern Medical School, the students used to be introduced to a genial general practitioner with some years of experience behind him. One of the subjects he would enlarge upon was the etiquette that existed and was practised between a general practitioner and a consultant in consultation on a case. He spoke of how on a domiciliary visit the general practitioner would always be there on time and waiting for the arrival of his learned colleague. Introductions would be made to the spouse or relative and then the doctor would lead the way into the bedroom to meet the patient; he would then stand back, observing and listening. At the end of the examination the visitor would be led out to the hallway or another room set aside for the actual consultation, discussion and opinion of the case. Back to the bedroom, and the consultant then would lead the way and the patient's doctor would follow. The former would announce to the patient his views in a gentle way and let it be known that anything further would come through the hands of his own doctor. And so he would say goodbye and lead the way out to the front door, collecting his fee as he went. Note the order of precedence on each occasion. The patient was still in the hands of his own doctor and a second opinion had been obtained for the benefit of all.

Etiquette is a good old-fashioned word with a practical meaning. It is therefore heartening to read that in that country of Singapore, where courtesy is being underlined, a fresh approach is being made to teach students to be nice to their patients, and to treat them as human beings rather than a number on the case notes or just another disease.

In the above-mentioned Northern Medical School, a roar of anger would be brought forth from the monocled senior surgeon if a callow student failed to learn as a habit the gentle routine of saying first "Good morning" to his patient. And worse, if he further omitted to ask his full name, address, marital status, domestic environment, description of job and place of work, etc., before proceeding to the query: "And what was it that first took you to your doctor?"

So much for the beginning of good manners and courtesy.

The consultant first mentioned would be a specialist in a certain field of medicine or surgery or might even be a neighbouring general practioner with no more letters after his name than those of his degree, but with many years of general experience behind him.

The 'Third Estate'

It is therefore, strange today to have in certain Asian countries this Third Estate of Medical Practice which calls itself Specialist. Outside his rooms he does not constrain himself to a discreet and mall brass place that gives his name, nor does he aim to be consulted by his colleagues, It is apparent he seeks more the itinerant patient of no fixed abode and who of his own accord diagnoses his own sickness or at least decides in which organ it lies.

Such misplaced self-diagnosis can very often lead to an extravagant morning round of the Asian Harley Streets.

Again, there does not seem to be any code of ethics to control the often blatant advertising of a Specialist on his hoarding. Its indecent size leaves no doubt that one is dealing with a circus-man attracting an ignorant peasant, if not exactly illiterate then one whose visual acuity is minimal, if one takes note of some eye clinic notice boards.

Can one blame the patient for shopping around if doctors thus make shop-fronts, and behind them sell merchandise expensively?

The old-fashioned etiquette of a specialist returning a referred patient back to his own doctor seems to have been forgotten, or was it never taught? One is aware that the itinerant Asian patient rarely has a regular family doctor, he is always on the move, shopping around, but it is felt that the Specialist should try and find him one near his home so that some follow-up or continuity can be achieved. And, it should not be forgotten that the specialist/consultant should always be giving a second opinion, not the first.

Consultancy – then and now

Recalling more of the old etiquette, it used to be the practice of the consultant to meet and examine the patient and, without mentioning his opinion to the patient, send him away with the message that his doctor would be informed, by letter or by phone.

How different then is the practice of medicine today. It is not impossible for the patient referred for a consultation never to be seen again by his general practitioner. And never heard of either. The specialist accepts the patient gratefully as a lucrative addition to his own source of income, for ever. In some cases there is neither acknowledgement nor a note nor a word of thanks. There is certainly no opinion given.

It must be said here, in fairness, that this is not by any means the total picture. Those who have learnt manners, whether in Asia or abroad, do not usually forget them when they decide to go into private consultant practice. They make a point of being wholly a consultant and will always behave impeccably both to the patient and to his doctor.

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THE REMEDY FOR GROWING PAINS.

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EDITORIAL

Systems Approach To Medical Care

The systems approach is being widely used in current management thinking and action. Likewise, it can be usefully applied to the planning and provision of medical care services. Such an approach takes its development from biology, the origin and elaboration of which may be credited chiefly to the biologists Paul Weiss and Ludwig von Bertalanffy. Basically, such an approach looks at things as parts of a system. In turn such a system is part of a larger system and so on.

There are three key concepts in the systems approach, namely : first, the parts must together function as a whole for harmony of action; the default of this is a sub-system optimisation and the system as a whole cannot perform well and may even collapse. Second, communication amongst the various parts is essential for unified action and sense of purpose. Third, feedback serves to close the loop between action and results and provides an objective basis for improvement.

Our health care system is made up structurally of subsystems of health care providers namely, general practitioners, specialists, clinics, polyclinics and hospitals. Each must function in a related way if the health care system is to achieve optimum results. It is not so much as whether the GP, the specialist, the private sector, the Govt sector, primary health care, secondary or tertiary care is more important, but rather all are equally important as parts of the system. These various parts must function as a continuous whole with as little unnecessary duplication of services as possible.

Better communication is a cornerstone of better health care. To achieve this, there must be acceptance amongst all health care provides that good communication is important, and all must try to get it going.

Feedback provides us with an objective means of evaluation of the services we provide, be it from a private clinic, from a Government polyclinic or from a hospital ward. The subjective feeling of being satisfactory is not enough. Answers to objective yardsticks must be sought to provide us the directions for improving the services that we provide: Does the patient wait unduly long to be served? Is he happy with the services provided? Has he got his money's worth?

There is much for the profession and the Ministry of Health to explore along these logical lines of thinking in our efforts to maintain and provide a better health service.

GLG

ASSOCIATION NEWS

Business Section

The SMA intends to go full force into exploring ways and means of generating income to meet with the ever increasing costs of maintaining the Secretariat which is due mainly to inflationary factors.

A full-time staff who would be responsible to the Executive Secretary for the business activities of the Association, will be employed to supplement the present staff and to assist Council to look into new avenues of generating income.

With the appointment of this additional staff, the SMA hopes to be able to serve our members even more efficiently.

SMA 1984 Campaign

Council, at its last Council Meeting, decided that it would sponsor candidates to be represented on the Singapore Medical Council at its next elections scheduled for May 1984. Full details regarding the May 1984 Elections will be released at a later stage nearer to the date of election. Meanwhile, SMA members who are interested to be considered for SMA sponsorship are requested to write to the Hon. Secretary.

WELCOME

SMA welcomes the following new members:

Ang Ah Ling
Chantharakulpongsa, Chumpon
Chong Hoi Leong
Das De, Shamal
Lai Sioe Moy
Shrestha, Kokila Devi
Tan Ee Ling
Tan Gee Hwa
Tong G. On
Vijiaratnam, Rajini
Wong Kai Cheong
Wong Leun Heng, Daniel
Wong Wai, Eric
Wong Yew Wui
Zakowich, Paul Edward
Cooke, David Miller

Credit Card Companies – Cardmember Directory

Members are reminded that listing of doctors' names and particulars in any directories other than the Telecoms Yellow Pages and the Singapore Professional Centre Directory, would be viewed as being in contravention of the SMA Code of Ethics.

Therefore, members who are utilising the services or who accept payments through any of the credit card companies must ensure that their names are not included in their Cardmember Directories.

All doctors who have already allowed themselves to be listed in the current issues of any of these Directories are requested to take necessary steps to remove their listing from the next issue.

Commonwealth Medical Association (CMA)

The SMA has successfully bidded to host the 21th CMA Council Meeting which is scheduled to be held from 16 to 19 November 1984. This will be the second time that SMA will be hosting such a meeting; the first time was in 1970 when the 5th CMA Council Meeting was held here. Representatives and delegates from the various member-countries of CMA will be attending the Meeting. A CMA Scientific Clinical Meeting is usually held in conjunction with the Council Meeting. This year's scientific session has been arranged for Sunday, 18 November 1984 and the theme is "Freedoms in Medicine". Participation in the scientific session will be open to official delegates as well as observers. ■

PRESIDENT'S COLUMN

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similar sectional lines which will then provide the basis for sectional representation at the Council level. We have in recent history had the unpleasant and disturbing experience of decisions at A.G.M. being influenced by the heavy voting power of one section of the membership, without due regard for and therefore adequate safeguarding of the needs and rights of other less strongly represented sections. This imbalance of voting power makes it very difficult to arrive at equitable decisions or resolutions. The Association represents the entire profession. Whatever decisions, policies and views it presents to the public or to the Ministry, it must ensure that that they are balanced and do not advantage one section to the disadvantage of other sections.

It may be necessary when the issue demands it that more than one view or opinion will have to be presented, if one single opinion cannot represent the views of all sections, as has happened before and undoubtedly will happen again. This inability to present one single unanimous opinion should not be seen to mean a split within the profession but rather as acceptance of the complexities of the issue at stake. Basic ethical and professional principles remain the same throughout the profession but there are issues where may be no blacks and whites but shades of grey.

All these representation will only be possible if there is a sectional structure, and sectional representation for at both A.G.M. and Council levels.

These are only preliminary thoughts on how best can we make the S.M.A. more effective and more representative of the whole profession. I hope they will stimulate you to give some thought to this issue and provide for some feedback from our members. ■

NEWS & VIEWS

HEPATITIS B

Notifications of Hepatitis B Carriers and Hepatitis B Vaccination

The Joint Coordinating Committee on Epidemic Diseases in Singapore has made it necessary that every medical practitioner and the person in charge of a clinical laboratory (with facilities for the diagnosis of viral hepatitis) should notify any person who is a carrier of HBs Ag irrespective of the clinical diagnosis (including chronic hepatic liver disease and hepatocellular carcinoma).

The notification of a carrier of a notifiable disease is required under Section 6 (1) of the Infectious Diseases Act, 1976. The usual notification form (Form D) should be used for the reporting of Hepatitis B carriers.

Such notifications will provide a record of hepatitis B carriers in the country and enable thorough epidemiological investigations to be conducted. These include tracing the source of infection and elucidating the mode of transmission, identification of persons at risk and immunoprophylaxis of the susceptibles.

The Joint Coordinating Committee of Epidemic Diseases has also made it necessary that Hepatitis B Vaccination be made notifiable. General practitioners (and specialists) are requested to notify all hepatitis B vaccination procedures carried out. Hepatitis B Vaccination notification forms are obtainable from the Quarantine & Epidemiology Department, Princess House, Alexandra Road, Singapore 0315 (Tel: 636534 or 645111 Ext 266).

The main objective of such notification is to monitor the outcome of the hepatitis B vaccination programme over the short-term (first five years), intermediate (5-10 years) and long-term (over 10 years) time spans. In the short-term evaluation, the reduction in incidence of acute hepatitis B and reduction in prevalence of carriers in infancy and adults will be examined. In the intermediate and long-term evaluation all the short term indicators plus reduction in chronic liver diseases such as chronic active hepatitis, cirrhosis and primary hepatocellular carcinoma, will be carried out. *(Epidemiological News Bulletin, Oct. 1983).*

The Singapore Immunisation Programme for Hepatitis B

Prof C J Oon, Associate Prof of Medicine & principal investigator (National University of Singapore and Ministry of Health, Singapore) on Hepatitis B, writing in the Family Physician (Sept/Dec 1983) outlined the Singapore Immunisation Programme for Hepatitis B, he said:

Until large quantities of vaccine become available and at a lower cost than presently available, the vaccine is now only offered to those at high risk. These are neonates born to Hepatitis B carrier mothers, hospital staff (all grades) who are in contact with blood products or patients, servicemen and family contacts of acute and chronic hepatitis B carriers.

It is envisaged that by 1986, vaccine produced from the Singapore plant will be locally available to extend the immunisation coverage to other persons. Meanwhile, bulk vaccine manufactured by MSD, and licensed by FDA will be packaged in Singapore. Such multidose vials would be available in mid 1984 to further implement the recommendations of our Immunisation Committee.

Dose

The dose used is 10ug given at 0, 1 month and 6 months has been shown in other studies to be as effective as the 20ug and 40ug for adults and children. Locally, the 10ug dose is being evaluated in adult population in the hospital at-risk group. In children born to carrier mothers, it is important to know the 'e' Ag status of the mother. Children born to such mothers become carriers and follow up of such children (including liver biopsies) have shown changes of chronic persistent hepatitis. Some children have also shown spider naevi and isolated case reports of primary hepatocellular carcinoma have been documented in childhood carriers, (though this disease is rare in this age group even in endemic countries). Table 1 show the immunisation scheme for neonates.

Register

A vaccination register (which in the interim period is in the Department of Medicine I, Singapore General Hospital) would eventually be transferred to the Epidemiology Department of the Ministry of the Environment, once computerisation has taken place.

A monitor is being kept too of side effects related to any of the vaccines. Any adverse effect requiring hospitalisation or absence from work for at least 48 hours should be documented and reported to the Coordinating Centre for the Hepatitis B Vaccine Programme, Department of Medicine I, Singapore General Hospital. These cases will be investigated to determine whether the adverse reaction event was genuinely related to the vaccination.

Screening Before Vaccination

Since 80% of young adults aged 20 and below have not been exposed it is important to identify those who need vaccine.

It is hoped that in the near future a centralised screening laboratory could be set, with trained technicians to tackle the load of large population screening programmes. The two routine screening tests done now are HBsAg and anti-HBs. Only those who are negative for both require the vaccine.
(The Singapore Family Physician -- 1983, Vol. IX, No. 4)

Table 1: Immunisation Scheme for neonates

(a) Neonates born to 'e' Ag positive mothers:–

BHIG	MSD vaccine
(0.06ml per kg bw)	(10ug)
i.m. at birth (one limb)	(other limb)

Subsequently 10 ug at 1 month and 6 months

(b) Neonates born to 'e' Ag negative mothers:-

MSD Vaccine – 10 ug i.m. at birth, then 1 month and 6 months.

Cont'd form page 5

for improvement; and 4 felt that they could do little of what they thought important. Thus, there appears to be a spectrum of perception ranging from well to poor. The response of the head of unit to the scheme was regarded a factor in the extent the Visiting specialist/Consultant attached could or otherwise carry out what he thought important by at least 1 visiting Consultant.

Specialist Staffingin Hospitals

Visiting Staff were asked their perception of staffing in the units they worked. 13 (out of 23) felt it was adequate whilst 9 felt it was not. I said he did not look into this aspect.

Perception of Hospital Staff's Reception

Visiting Staff were asked what were their perception of the Hospital Staff's reception. 17 (out of 23) felt they were accepted; 3 felt they were tolerated and 2 felt they were both accepted and tolerated. One commented: "the Government staff has been excellent in their acceptance of me. In fact, I also go over there to consult them on my difficult cases. This two way traffic is excellent. Another said: "In my case, I have an excellent working relationship with the head of the Department. In fact, I am practically accepted as a staff of the Unit."

That the working relationship with the Head of Department is an important factor was explicitly stated by 2 of the respondents. One said, "This largely depends on the relationship of the Visiting Consultant and the Head in particular."

Some were not so well received by the senior staff. This created a dilemma in relationship. One consultant observed: "Acceptance and welcome by all junior staff. Tolerance by some senior staff – because of this, junior staff is fearful of consulting the visiting consultant."

Is the scheme effective

Visiting staff were asked if they thought the scheme effective. 14 felt it was effective. 4 felt it was partially effective and there was room for improvement. One Consultant commented: "It can only be effective if both parties, that is, the unit staff and the visiting consultant have the right attitudes."

Motivation To Stay

The respondents were also asked this question: "In what ways do you think the Government Hospital can motivate the specialists to stay in Government service." The replies were interesting. Better working conditions were suggested by 6. This included more room facilities. Better pay was suggested by 2; housing subsidy was suggested by one and limited private practice by another. Time for research, attending conferences and study leave were suggested by 3. Correction of staff shortage was suggested by one and one suggested more staff so that time for research and study leave can be made available. One commented:: "GEt senior staff to remove their selfish and self-serving attitudes and ways." Postgraduate training, structured prospects for advancement was suggested by one. 2 had nothing to comment and one felt that there is no way that the Government doctors can be induced to stay.

A Private Consultant As Head

Respondents were asked to comment if a private consultant should head a Government unit. 11 gave an explicit no; reasons like no time, conflict of interests, not practical were given in support of their opinions. 9 gave a conditional yes, conditional to the availability of time. The following is representative of those who said no: "No successful private specialists have the time to run a Government Unit and their own practice." Another said:" No. The head should be a full-time head. Only then can be hope to inspire (by his example) the medical students and trainees."

Would this apply even when there is "no choice"? One replied: "Even when there is no choice, I think someone in service should be made acting head. Have the private consultant act as an advicer."

A Government specialist's view

We also asked Dr Chee to write about the history of the Consultant's scheme as well as contribute his viewpoint of the Scheme from the standpoint of a Government specialist. His response is given on page 6.

Acknowledgements: The Editorial Board wishes to thank all the respondents to our questionaire survey.

– Editor

A VIEWPOINT:

PRIVATE SPECIALISTS IN GOVERNMENT HOSPITALS

Introduction

The Singapore health scene is governed by the clear-cut division of private versus public service doctors. You are either a doctor in the public service or in the private sector and you cannot be part-time in one and full-time in the other or part-time in both. Looking back over the past decade, this dichotomy remained so in principle with only a very few highly qualified and respected doctors appointed as Honorary Consultants. They are usually in private practice and are appointed by the Ministry of Health to provide consultant and teaching services in government hospitals. Over the years their numbers have been very small and in 1982 there were three Honorary Consultants. No one grudges them their honour and such doctors deserve this accolade. All three are surgeons – in general surgery, ophtalmology and otolaryngology.

Evolution of Privatisation of Public Hospitals

The utilisation by the Ministry of Health of the Specialised Skill in private practice is not new. In 1971-2, a committee under the chairmanship of Dr Yeoh Kean Seng was formed in the SMA to consider whether specialists in private practice should be allowed to practise in government medical institutions. The gist of that report follows:

Highly skilled doctors in the government hospitals are not as numerous as abroad, so that specialised skills of private doctors should be utilised in the public sector. As more specialists form the private sector, there is now a large body of specialist doctors in private practice whose skills could be profitably utilised by the Government.

Private specialists are not prompted by selfish motives to want to work in government hospitals but do so as a measure of public service more for professional satisfaction than for monetary advantage. Their contributions could be in-

(a) The setting up and running of special clinics

(b) The teaching of both undergraduates and postgraduates

(c) The carrying out of research in conjunction with hospital staff

(d) The integration of private and government doctors encouraging exchange of ideas and leading to a higher standard of patient care.

The Committee recommended advertising the particular posts in various hospitals in the local press, selection by a Committee of Ministry of Health officials, a three-year term in the first instance and remuneration to the tune of $50/- for morning/afternoon session of 2 hours duration or $100/- for a full day subject to a maximum of $800/- per month (this was 1972).

The doctors' union strongly objected to the government appointing paid part-time staff to the hospitals arguing that if private doctors were appointed, there would be fewer full-time government staff appointed. The Committee pointed out that these specialists are over and above the number of gazetted posts, and are therefore supernumerary once there are sufficient full-time doctors in the government hospitals (which will never be?)

Following this report, the original scheme to appoint consultants was introduced in 1973.

In 1979, Dr Yeoh Kean Seng was again appointed chairman of the SMA Committee on Hospital Scheme for Honorary and Visiting Consultants. This was necessary in view of the government's latest ruling to allow private beds for the visiting consultant's private patients implying that the occupancy rate of public hospital 'A' class wards was low. This Committee recommended that Visiting Consultants should not be paid $50/- per hour honorarium or have the privilege of admitting private pateints into government hospitals but instead be appointed to perform work schedules (clinical teaching, treatment of public patients etc) in the government hospitals entirely in the honorary capacity.

As regards the possibility of excess private (paying Class A) beds in the government hospitals, the Committee recommended that these beds be run on the basis of a private hospital with public patients benefitting from the participation of private specialists in government hospitals and private patients benefitting from the use of facilities in the government hospitals.

Consultants

So two categories of consultants were created in 1979.

(1) An Honorary Consultant is appointed in recognition of his distinguished contributions to the field of medicine as a clinical teacher or research worker. No specific duties are assigned to him but he may be called upon by Government Medical Consultants to advise on on the diagnosis and management of patients, perform surgical operations or teach.

(2) The Visiting Consultant should normally be 45 years old and above and have served at least ten years in the government service or University of Singapore from the date of first appointment. He will have a set schedule of work in any of the duties of a similarly qualified government consultant, subject to a minimum of three hours per week. They serve to complement the existing full-time staff.

The Honorary Consultant serves three years and the Visiting Consultants two years, subject to renewal or termination.

This Decade

In October 1980 there was the press announcement that the Ministry of Health had appointed 25 private specialists as Honorary or Visiting Consultants to government hospitals to help maintain and extend its services. Six were Honorary Consultants given the privilege of admitting their private patients to Class A wards in government hospitals, subject to a maximum of six patients each at any time. The nineteen Visiting Consultants could opt for payment of $50/- an hour or the privilege of admitting their patients to government hospitals.

From the Health Ministry's 1980 Annual Report, it was mentioned that fourteen Visiting Consultants were newly appointed and a quick glance at the list showed that all six Honorary Consultants are over 50 years old and the nineteen Visiting Consultants are in their forties if not older.

On 12 September 1981, our Prime Minister officially opened the new Singapore General Hospital. And in the 1981 Ministry of Health Annual Report, eighteen new Visiting Consultants were appointed in the year making a total of 37 (from 19 the previous year). In the 1982 Annual Report, twelve new Visiting Consultants were appointed and the total was now 49. In addition a new category – Visiting Specialists – was created and four were appointed as such. This last category consists of specialists with more than five and less than ten years of specialist experience and holding less than a consultant status at the time of resignation from government service. Another glance at the list of Visiting Consultants shows that even those in their mid-thirties now qualify. So you recall the Prime Minister's speech?

Comment

This whole scheme excludes the Visiting Consultants and Specialists from departments of the National University of Singapore which are physically at the present time, in government hospital buildings. The implication is that these departments are well staffed and can cope without complementary aid in terms of manpower and expertise. Is this true? While numbers of senior staff are in some cases more than double the total staff in the same specialty in certain government departments no institution senior staff does at present function without the help of junior staff members i.e. house officers, medical officers and trainees. So a potential bottleneck exists and those harassed will be the junior staff who are Ministry of Health employees. A simple example is when surgeons depend on government anaesthetists before they can operate and thereafter on the house staff for postoperative care. Can an upside-down pyramid stand without falling to pieces? The poor house-officer is the final common-pathway in health care. It would be beneficial to patient care if the senior staff be prepared to do the more simple and mundane procedures of the ward and even step down a grade or two to help in doing calls and duties.

The Visiting Consultants are assessed by their government colleagues but more often than not, the latter are junior to the visitors. How objective can their report and assessment be? If, even in assessing junior staff, few assessors are willing to give a bad report when the situation warrants it, can we expect this trend to be reversed when someone more senior has to be commented upon? What are the repercussions to the assessor himself if in being objective a bad report is the only conslusion for the visitor? It is all very well to have nice forms and list virtues like teaching ability, service rendered and the quality of second opinions given but human tendency being what it is, more will give an average assessment and few if any "dare" to give a poor report.

How do the Visiting Consultants look upon the conferment of such a status? With pride? As a waste of valuable time? Is it another chore each week to go to a worse environment (compared to their own posh clinics) and see patients who cannot speak English, who cannot give a proper history, who are "problem cases" and so demand more time and patience? There are some consultants who appear to act this way. By their very nature and attitude, one can conclude that the courtesy campaigns over four years have done them no good. Why should the government doctors stomach this kind of humiliation? Perhaps these visitors are so senior that they cannot change and become polite and courteous. Must they behave like they used to when they were all-powerful in their own departments? I can well remember my student days in the local medical school. It was unpleasant (to put mildly) to meet some of

Cont'd on page 7

BOOK REVIEWS

DIGESTIVE DISEASES
by **Galambos Hersh**
Butterworth Publishers
(1983)

701 pages Price £ 57.00

This readable and highly informative book deserves a place in the library of the practising clinician. It covers an extensive field and deals with the more common digestive disorders in a well-balanced and practical manner. It follows a patient management approach in which symptoms and signs are evaluated, diagnostic processes featured and diseases discussed. Unlike most other gastroenterological textbooks, it is the disturbed function rather than anatomical structure that is emphasized.

The book is organized into two main parts: the first deals with "low level resolution" symptoms and laboratory findings which suggest but do not confirm a diagnosis and the second with "high level resolution" defining diagnostic criteria and treatment for specific digestive diseases.

Another interesting feature is that each topic is provided with three planes of criteria for diagnosis probable and circumstantial) according to the degree of certainty needed. In some situations the clinician can accept a diagnosis with reasonable suspicion but in others certainty may be required particularly when the specific treatment involves some risks to the patients.

Specific curative therapy including those which need to be administered urgently is dealt with weparately from management programme that aim at alleviating identifiable abnormalities due directly to the disease. Under supportive care, measures which help patients accept and deal effectively with their disease are discussed.

Dr Lim Kian Peng

ILLUSTRATED MANUAL OF ORTHOPAEDIC MEDICINE by **JH Cyriax** and **PJ Cyriax**
Butterworth Publishers
(1983)

246 pages Price £ 25.00

This is an excellent book as it correlates surface anatomy with clinical symptoms and signs. The books is well illustrated with beautifully coloured parts of the body anatomy. This is a good book for those who would like to know more about the soft tissue affections of the human body. All sports medicine doctor should read this book. Soft tissue affections is a topic that not many doctors is familiar with. Most doctors would not object to the many non-invasive techniques used in this book to treat these cases. However the frequent and repeated injections of steroids into soft tissues and joints may warrant some deep consideration by the doctor in view of the associated complications of steroids. Such complications like degenerative tearing of ligaments and a vascular necrosis of bones are seen now and then. The manipulation of the spine in the presence of neurological deficit is something most orthopaedic surgeon would not like to do as this procedure may aggravate the neurological deficit.

In conclusion this is an excellent book that illustrates soft tissue affections concisely and precisely.

Dr Chan Heng Thye

Private Specialists in Govt Hospitals
Cont'd from page 6

our teachers and today it is no less unpleasant to have to come in contact with them again in the course of patient care.

How do the Visiting Consultants feel about the work given them to do? Is their expertise being utilised as it should be or are they just another pair of hands – a pair of glamorous hands doing mundane, bread and butter stuff? If you were a Visiting Consultant and your expertise were not utilised, would you protest? Or would you continue doing this just for the honour of being classed as a Visiting Consultant? I know of some departments where the visitors are so good that just on their sessions, the junior staff have been motivated to want to do their speciality.

Finally how do the recipient department consultants feel? Is an inferiority complex created?

Conclusion

I have looked at this topic from the historical point of view. I have also given my impressions and queries on the scheme but this may well be biased. It is hoped that more in-depth case studies of the visitors will reveal just how well or how badly this scheme is faring to the end that improvements will be forthcoming, benefitting firstly patients, then government doctors and medical students.

ANNOUNCEMENT

1984/85 ASEAN SCHOLARSHIPS PROGRAMME FOR APPLIED TROPICAL MEDICINE AND PUBLIC HEALTH (ASP-ATMPH)

The National University of Singapore invites applications for two scholarships under the ASP-ATMPH from nationals or permanents residents of Singapore who are qualified medical practitioners. The award of a scholarship is conditional on the scholar gaining admission to the postgraduate course of study leading to one the following degrees:

MASTER OF SCIENCE IN OCCUPATIONAL MEDICINE OR MASTER OF SCIENCE IN PUBLIC HEALTH

Further information and application forms may be obtained from the Secretary, School of Postgraduate Medical Studies, Faculty of Medicine Building, College Road, Singapore 0316, by sending a stamped and self-addressed envelope together with the request for information and/or forms.

The closing date for applications is Saturday, 3 March 1984.

CHECKLIST

About Day To Day Management

1 Delegate responsibly – know the rules.

2 Cut the fire-fighting with good planning.

3 Heroes don't last.

4 Centralise the intellectual process – decentralise the work.

5 The most important things you do are designing and describing the jobs and finding the right people to fill them.

6 Let everybody in on what's going on.

Sir Kenneth Corfield

Chairman and Chief Executive: Standard Telephones and Cables

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But it is surely not only malpractice but also bad manners to treat the streets of our cities as a common hunting-ground for patients.

Is there then any need in medical practice for this Third Estate of medicine? Is it not better for the patient, the sick person, to have as a general control a general practitioner? And also have the second opinion when it is required or desired? The suitable consultant for the case will be consulted, an opinion obtained, and the patient referred back for continuing care. Both the consultant and the general practitioner should ideally act as a team, each to his own ability, for the benefit of the patient.

It is good to know that this still is the practice in certain areas of Asia. It is unfortunate that, through ignorance or negligence, it is not the rule.

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CONGRATULATIONS

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
PART I F.R.A.C.S. EXAMINATION
NOVEMBER 1983

CHONG Tze Shing **LEE Yew Chung, Peter**
HENG Lee Kwang **TAN Seang Beng**

Medical Meetings 1984

Feb 9 – 12, 1984 : Singapore
Workshop on Osteosynthesis
Info: University Dept of Orthopaedic Surgery, Singapore Central Hospital, Singapore 0316.

Mar 27 – Apr 2, 1984 : Singapore
2nd Forum on Scoliosis
Info: Singapore Orthopaedic Association, c/o Dept of Orthopaedic Surgery, Singapore General Hospital, Outram Road, Singapore 0316.

Mar 26 – 30, 1984 : Sydney, Australia
17th Clinical Congress, Pan-Pacific Surgical Association
Info: Pan-Pacific Surgical Association, c/o Royal Australiasian College of Surgeons, 147 Macquarie Street, Sydney, N.S.W. 2000 Australia Tel: (02) 27-6451.

Apr 14 – 15, 1984 : Singapore
Joint 15th Singapore Medical Association National Medical Convention/2nd Medical Association of South East Asia Nations Conference
Info: Singapore Medical Association, 4A College Road, Singapore 0316. Tel: 2231264

April 14 – 17, 1984 : Genting Highlands, Malaysia
2nd Asean ORL/Head & Neck Congress
Info: Prof Madya Imran Gurbachar, Head, Dept of ORL/Head & Neck Surgery, Faculty of Medicine, National University of Malaysia P.O. Box 2418, Jalan Raja Muda, Kuala Lumpur, Malaysia

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