SINGAPORE MEDICAL ASSOCIATION
NEWSLETTER
FOR PRIVATE CIRCULATION ONLY

VOL. 17 NO. 2 MAY 1986 MC(P) – 26/2/86 PP(S) 28/12/85

Dr V K Pillay

1986 SMA LECTURE

TOWARDS EXCELLENCE IN MEDICINE

The President of the Singapore Medical Association, Dr Khoo Chong Yew, the Council of the SMA, distinguished guests, colleagues, ladies and gentlemen:

I would like at the beginning of this lecture to thank most sincerely the President and the Council of the SMA for having conferred on me this most singular honour of delivering the 1986 SMA lecture. By tradition a senior member of the profession has been invited to deliver this prestigious lecture on a topic pertaining to the practice and ethics of medicine. I am mindful of this great honour and I hope that I will do justice to the task of keeping in focus the moral force in the practice of what is still considered to be a noble profession.

The topic I have chosen may need a little explanation. Perhaps all of us feel we know what excellence means. It is the best of something; that it is the highest class in a grading or ranking; that there is nothing better than excellent; it is just first class or first rate. An Indian scientist and educator, Dr Sudarshan, speaking at a recent convocation stated "Excellence is not a zero sum game in which one person's gain is at the cost of another person's loss – Excellence is certainly not restricted to higher education but those who have had the good fortune to undertake higher education have a social contract to seek excellence, to grow in knowledge and to propagate knowlege." It is important to recognise the key concept that the pursuit of excellence should not be regarded as one-**upmanship** or at the expense of anyone but as a driving force for self improvement that in its passage benefits everyone.

THE SINGAPORE MEDICAL SCENE

Medical education began in Singapore in 1905. In 1920 the local diploma was granted recognition by the General Medicl Council of the United. Kingdom indicating that our standards were equivalent to that of medical schools in Great Britain. In 1950 the University of Malaya was incorporated and medical education was on an University level with the MBBS (Malaya) replacing the LMS (Singapore). The medical school became the Faculty of Medicine but the name of the University underwent changes to the University of Malaya

Cont'd on Page 8

GUEST OF HONOUR SPEAKS AT 26TH SMA ANNUAL DINNER

Dr Chew Chin Hin
DDMS (Hospitals)
Ministry of Health

The President of the Singapore Medical Association, ladies and gentlemen:

May I first of all thank the President and the Association for inviting my wife and I to this dinner.

It is indeed a privilege to be given the opportunity to share with you some of my thoughts on the provision of health care, a service in which we are all involved.

With some 1,700 members, the Singapore Medical Association (SMA) represents almost two-thirds of the total doctor population in Singapore. Your President has told me that your membership has increased significantly in recent months. This puts the SMA in a strong position to influence medical practice in Singapore. More important than just numbers, however, full and active participation of the members is required if the SMA is to be recognised as it should be as the national body representing the interests of medical practitioners in this country.

In this regard, I am particularly pleased to note that the SMA in no small way has participated and contributed to the improvement of medical practice in many areas. Thus the Association has taken the initiative in urging its members to comply with a number of new directives such as those relating to drug labelling, answering of emergency calls, having a chaperone when examining female patients and ensuring that medical certificates will not be abused for non-attendance in court.

When it was announced that the Medisave scheme would be extended to private hospitals, the Association met with representatives from the Ministry of Health and private hospitals. SMA paid for the costs of printing the Doctor's Guide to the Medisave Scheme In Private Hospitals and also immediately printed an abridged Version of the International Code of Diseases for doctors. The implementation of Medisave in the private sector has been the result of close co-operation between my Ministry, SMA and the private hospitals. Though there have been some teething problems, I am sure that this same spirit of co-operation will see them resolved and will carry us through.

With its membership on the Health Advisory Council, the SMA will be involved not only in implementing but also in the formulating of policies on major health care issues. The setting up of the Health Advisory Council is Ministry's commitment to participatory planning and problem-solving. The process of involving affected parties in decision making will mean that policies are much more likely to be accepted and thus can be implemented with more expedition.

In recognition of the importance of public health education, SMA has also this year launched several major projects on public health education and community service. This year's National Medical Convention was open, for the first time, to the public in keeping with the objective of promoting public health education. The theme of the Convention "Facts & Fallacies About Your Health" emphasises the need for the public to be given correct knowledge on health matters. As health professionals, the public will look upon us as the major sources of such information. We should take the opportunity to impart such information not just at organised talks and conventions but in daily encounters with patients and the public.

In this regard also, I was exceedingly pleased to learn only recently that the SMA is now running an electronic bulletin board and has thereby taken a bold leap forward into information technology. This, I understand, will serve both the public by providing articles on health education and members of our profession by updating them on latest advances. These are also the areas namely, public health education and continuing medical education in which the Ministry has for a long time been most concerned.

The subject of organ donation and contracting-out legislation has received much publicity in recent weeks. This is a matter of vital health importance. I am sure the public will look forward to

Cont'd on Page 10

PRESIDENT'S COLUMN

OPTING-OUT LEGISLATION

THE PROBLEM

The opting-in system of kidney procurement has been tried over the last fifteen years and has failed. Last year there were 1000 fatal accidents in Singapore, out of whom only one kidney donor was procured. The National Kidney Foundation is to be congratulated for its tireless efforts in trying to make the opting-in system a success.

200 kidney patients die every year. As doctors, we "must always bear in mind the importance of preserving human life". I think the public too have this in mind, as shown by the way the public reacted to the New World Hotel disaster, and the way volunteers risked their lives to save the victims.

THE FEAR

There is a fear that kidneys may be removed from an unwilling donor who has for some reason failed to opt-out. Certainly the under-age and mentally handicapped should be protected.

SAFEGUARDS

The relatives must be informed before organ removal, and due consideration must be given to the wishes of the relatives. The public should be informed that the legislation is not confined to kidney donation only, but also to other organs, and therefore provision should be made for those individuals who wish to opt-out specific organ(s).

PUBLIC EDUCATION

Everyone must be informed and given the chance to opt-out. We suggest that in addition to intensive public education campaigns, those who have their identity-cards renewed (at age 18 years) be given a document to read and sign, regarding the opting-out legislation. The uneducated an d mentally handicapped must be given special consideration.

KCY

WELCOME

SMA welcomes the following new members:

Chan Siew Ling, Pamela
Chee Beng Kiat
Cheong Wei Ling
Choo Hock Leong
Chua Hock Leong, John
Daruwalla, Jimmy Shiavux
Eu Kong Weng
Foo Fung Fong
Fung Mei Keng, Janet
Lee Boon Siong
Lim Choo
Ong Biauw Chi
Ong Choo Khim
Rilly Ray
Sim Wee Peng
Siu Young Tong
Tan How Koon
Tan Sai Tiang
Tan Song Tuen
Tay Yong Kwang
Teh Kwan Geok
Yap Boh Wei
Yii Hee Seng
Wong Fung Chun, Josephine

CONGRATULATIONS

FINAL MASTER OF MEDICINE (ANNAESTHESIA) EDAMINATION – MAY 1986

Dr Agnes Ng Suah Bwee (Miss)

PERSONALLY SPEAKING

WARD ROUNDS

Dr Chee Yam Cheng

An integral part of internship, medical officer, trainee, registrar and senior registrar training is the ward round. Hospital care is reflected in ward care and patients who are hospitalised sense the pulse of the medical profession acutely by a day's stay in the ward. The medical profession prides itself in its high calling and vocation – to serve and to care and occasionally to cure. Every link in the hospital care chain must be up to standard for a hospital to be reputable. Doctors play the pivotal role in the running of the ward. It is they who admit, keep and discharge patients. It is they who order treatment, diet, intravenous drips and restrict mobility of patients. It is they who sign death certificates, medical certificates, make coroner's cases and inform relatives of DIL patients. It is they who inflict pain, do venepunctures, other punctures in the hope of achieving good in the end. No doubt the nursing personnel are just as essential. So too the ancillary staff who wheel patients for x-rays, ECGs, send blood specimens to the laboratory etc.

I would like to concentrate on the responsibilities of the doctor in the ward. Each ward should have a hierarchy of medical staff. One consultant, one senior registrar or registrar, a medical officer and a house officer. Perhaps an acceptable complement of beds is forty under the care of this team. For intensive care patients the ratio may be more doctors and for chronic care, less, for the same bed complement. I am not referring to the number of overall staff in one department for then surgical disciplines may require more staff to run their operating theatres etc. But just consider for a moment an ordinary ward in a government hospital.

Ward staff change. Every four months a new batch of house officers arrive at a department and if they be rostered through wards of male, female patients and through various classes of wards, perhaps the house officer will stay about a month in a ward. Medical officers also change postings – once every six months and they too rotate through various wards. So perhaps they stay six weeks in a ward. Hopefully the registrar and senior registrar are not so exchangeable. They will stay a year or more in a ward. Likewise the consultant. Each time there are staff changes, the ward routine must be made known and standards reset and emphasized. The nursing officer should be part of the briefed party for doctors and nurses must work together. Doctors' orders more often than not are carried out by the nursing staff.

New doctors to a ward are told right at the beginning what is expected of them. For example the ward round daily must begin by 0830 hours. If there is blood to be taken, this must be completed before the ward round. Some doctors have reasoned that it is better to do venepuncture after the ward round as other tests may be ordered. My counterargument to that is that the blood tests should have been ordered the day before or during the night round by the reviewing doctor (registrar or consultant) should the patient have been admitted after the day's morning round. For non-central hospitals where blood specimens have to be despatched to SGH, there are fixed times of transportation and doing blood taking after the round leads to delayed departure of the blood to SGH. Instead of leaving at 1000 hours, the blood is held back till 1400 hours. Arriving in the afternoon rather than the morning in the SGH laboratory means a delay of one day in receiving the results back. Keeping patients for one extra day has its consequences for the patient (increased expenses) and for the ward (short of beds). Patients who get warded during the day will have their venepunctures done immediately rather than wait for the next day. So the first round in the ward in the morning is the venepuncture round. The house officer is responsible and he must take pains not to destroy veins, cause excessive, unsightly and painful hematomas and to protect himself against accidental pricks especially if the blood specimen taken is thought to be infectious (e.g. Hepatitis B). In hospitals where medical students are available, sometimes this responsibility is delegated to them, not without benefits to the house officer but then, not without disadvantages to the patients. Whatever the case, it is the house officer's responsibility to sign the appropriate laboratory forms. Blood specimens without signed laboratory forms have no passport to leave the ward. And in some instances signed forms without adequate information may result in the test ordered not being done. So until the blood specimens have left the ward, the venepuncture round is not completed. While at it, the house officer should also sign the forms for x-rays, ECT etc and get them moving.

Come 0830 hours, the ward round starts, irrespective of whether the more senior staff have arrived. A junior ward round can handle elementary cases and elementary decisions or decisions made the previous day at the afternoon round can still be carried through. It is best to start a round with the complete staff complement. The ward round begins by inspecting the 24 hour ward report which details the happenings to patients for the past 24 hours. Doctors if not on duty go home by 1700 hours. How is he to know what has transpired in the ward from then until 0800 hours the next day, a full 15 hours duration? Some answer is forthcoming by perusing this report. A house officer with the medical officer must know the whereabouts of each of their patients. Who went home, who died, who was admitted etc. You cannot come to a patient's bed e.g. bed 10,

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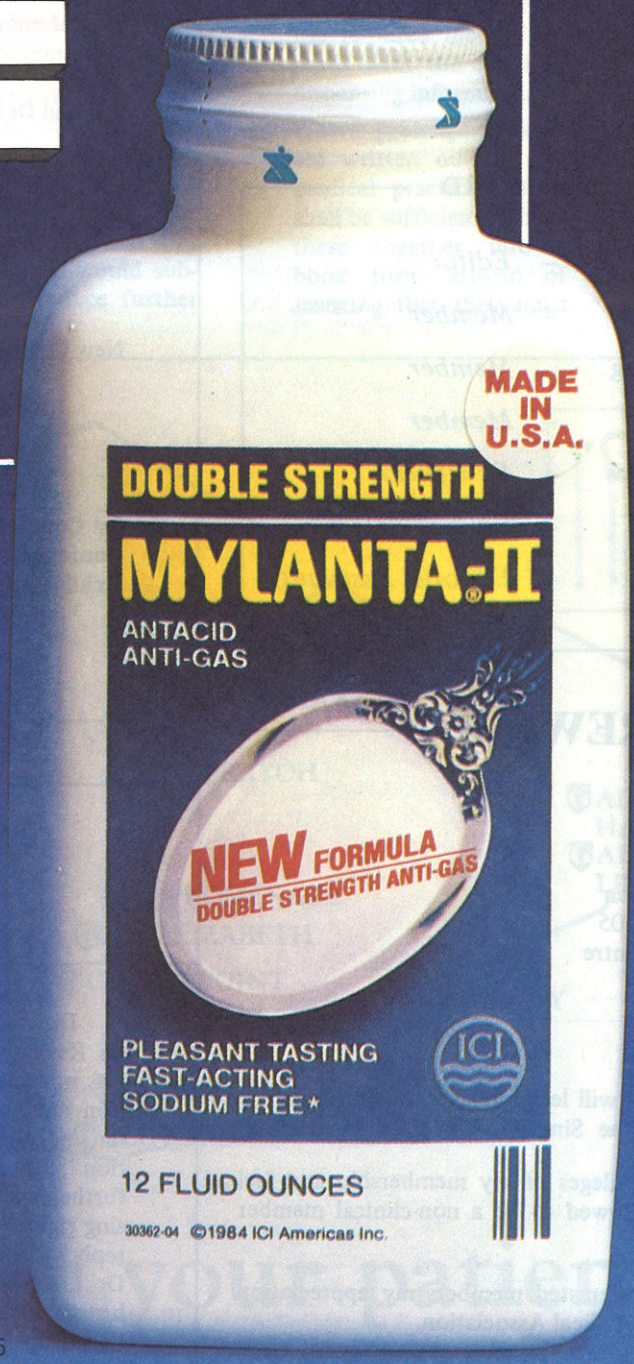

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Sources: *Contemporary Pharmacy Practice 1982; 5:246-249. Physicians Desk Reference® for Non-prescription Drugs 1984; Edition 5.*

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EDITORIAL

EXCELLENCE IN MEDICINE

Privatisation may be seen as a way to excellence. Such thinking may not be without flaw. This was pointed out in the 1986 SMA lecture.

"The Ministry of Health apparently feels that privatisation of these two hospitals (NUH and SGH) will enhance the development of medicine in Singapore. The SGH and the NUH must aim to emerge as the leading hospitals in Singapore and in the region for postgraduate training and education.

The professors and other academicians in medicine are being encouraged to promote medicine as big business. It is not in the management of diseases in the mass that will bring about excellence. The NUH and the SGH should be the places to which all regional hospitals could turn to, to manage the more problematic cases requiring greater skills in management."

This view point may be food for thought for our health administrators and planners.

GLG

FAREWELL

30 April 1986

Dr Khoo Chong Yew
President
Singapore Medical Association
c/o 3 Mount Elizabeth # 06-05
Mount Elizabeth Medical Centre
Singapore 0922

Dear Chong Yew,

It is with regret that I will leave Singapore and resign my Scientific membership of the Singapore Medical Association.

I have enjoyed the privileges of my membership and feel honoured to have been allowed to be a non-clinical member of your fine organisation.

Please pass to other interested members my appreciation to them and the Singapore Medical Association.

I look forward to returning to Singapore from time to time and to visit with my colleagues and friends.

Yours sincerely

FRANK B VORIS, MD

HIGHLIGHTS OF COUNCIL MEETING

held on 20 May 1986 from 9.00 pm to 12.00 midnight

Turkish Medical Association	:	The President of the Turkish Medical Association and six colleagues have been arrested because they signed a petition against capital punishment in Turkey. The World Medical Association has asked for our cooperation to protest against the arrest. Our Ministry of Foreign Affairs has advised us not to do so.
Appointment of Committee Members	:	Council approved the appointment of the various chairmen and members of the many standing and adhoc committees of SMA.
Specialists' Register	:	In response to the Ministry of Health's invitation for views, Council has set up a Committee to work on the establishment of a Specialists' Register.
New Members	:	Another 24 applications for membership were approved. The high number of applications continues.
Medical Defence Union	:	Enquiry is to be made on the long delay in the issuance of membership certificates by MDU.
Organ Donation	:	A press statement was prepared on the proposed opting-out legislation. The President will also be giving the opening address at a seminar organised by the National Kidney Foundation.
New Premises	:	We will have to vacate the old Alumni Centre by July 31. Our temporary home will be at the Housemen's Quarters. A more permanent home is needed. Hopefully we will be able to occupy the Department of Scientific Services Building on Outram Road.
1st Computer Conference and Exhibition	:	The SMA Computer Club is to be congtratulated on a very successful conference on 11 May 1986.

FROM AGM 1986

DISPENSING: DAY BOOK

Dr V C Leong questioned Council as to why a Joint SMA/APMPS Memorandum on Review of Requirements for Dispensing Records sent to the Ministry of Health was not enclosed in the Annual Report. He also was disappointed that the Association did not submit an independent Memorandum as he felt that this issue was by far, more important to the medical profession than a subject like "in vitro fertilisation", the latter of which was reported in full in the previous Annual Report. He further added that the memorandum took no account of the history of the "dispensing rights" issue and the subsequent imposition of the "day book" requirements. In reply, the Hon Secretary reassured Dr Leong that the omission was not deliberate. Dr L G Goh, one of the ad-hoc committee members said the committee had no historical records at hand to refer to and suggested that perhaps some archival system be set up for records of historical value to be kept. In response to Dr Leong's statement regarding verification from the Ministry of Health whether the pasting of prescription slips in a bound book in lieu of manual recording in the Day Book is acceptable, Dr Y C Wong said he will check with Miss Amy Lim of the Drug Inspectorate of the Ministry of Health. The Joint Committee report in question was printed in the May issue of the Private Practitioner. It is reproduced on the next page.

MEMORANDUM ON REVIEW OF REQUIREMENTS FOR DISPENSING RECORDS SUBMITTED TO MOH ON 25 JUNE '85

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1 LEGAL REQUIREMENTS

The present legal requirements for dispensing records are set out in Section 7(3)(a) to (d) of the Poisons Act (Cap 164).

Essentially the law requires certain particulars to be entered in a book (the Day Book – to be kept for 2 years) on the day or the next day to enable the Poisons Inspector to monitor the movement of any poison within the State in general and within the doctor's practice in particular.

2 COMPLYING WITH THE LAW

2.1 Where a prescription slip is not generated by a doctor, the manual recording in the Day Book of the required particulars is mandatory. It has been regarded as highly labour intensive with practically very little if any productivity by many a doctor. As labour is not only costly but also an increasingly rare commodity, many clamour for its abolition, arguing that these particulars are within the medical records and also on the labels and furthermore apparently hardly ever made use of.

However this Association is mindful of its Raison d'etre visually that should the occasion arise where information is required by the Poisons Inspector of the total quantity of a given poison dispensed over a given period of time and to whom, this information is normally readily available from the Day Book.

One possible compromise solution is to reduce the amount of information to be recorded in the Day Book to the minimum, visually the date of consultation and the name of the patient and/or his index number. Both the name of the patient and/or his index number will serve as a call system to retrieve the required medical records and thus enable the Poisons Inspector to be informed of the total quantity of a given poison dispensed over a given period of time and to whom.

2.2 Where a prescription slip is generated by doctors either by a hand write-out or a computer print-out (an increasing experience), the recent relaxation in the interpretation of the Act by the Ministry of Health to allow for the pasting of these prescription slips (up to two per page) in a bound book in lieu of manually recording in the Day Book has been much welcomed by these doctors as it has reduced significantly the labour intensive aspect of recording. An added advantage is that inaccuracies during the transfer from human error are removed.

However this Association is of the view that by a slightly greater relaxation of interpretation to allow for the binding together of these prescription slips into a book would substantially reduce further the labour intensive aspects of recording to a meaningful and acceptable level.

The bulk-generating effect of pasting, leading to problems of storage and the messiness related to pasting will then be done away with.

3 CHANGES SUGGESTED

3.1 Where no prescription slips are generated and the dispensing information is available in the medical records, the reduced Day Book which will contain **at least** the date and the name of patient and/or his index number shall be accepted in lieu of the present Day Book as it can serve as a call system to retrieve in a short time, the required medical records with the requisite dispensing information.

3.2 Where prescription slips are written out by the medical practitioners, it shall be sufficient to bind these together into a book form instead of insisting that they must be pasted in a bound book.

3.3 Where the computer is being used not only to generate medicine labels but also to print out the particulars required of a dispensing record, the sequentially-filed, end-of-day print-outs shall be considered equivalent to the present manually recorded Day Book.

4 AD HOC COMMITTEE ON DISPENSING RECORDS

The above report was prepared by a joint ad-hoc committee of the SMA and APMPS, which met on 14.5.85 and 4.6.85 and has been approved by both the Councils. The members of the Committee are:

Chairman:
Dr Wong Yip Chong

Members:
Dr Alfred Loh
Dr Steven Ong Sin Eng
Dr Goh Lee Gan
Dr Chua Sui Leng
Dr W R Rasanayagam (SMA Representative)

Dr Wong Yip Chong
President
for Association of Private Medical Practitioners, Singapore

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WARD ROUNDS

Cont'd from Page 2

realise there is a new face there and not know where the original patient has gone to. You must be in control of the ward situation. Patients admitted during your absence should be seen first – a quick glance to assess if they are in need of immediate attention or can they wait their turn in the round? Then the round begins with the staff nurse or nursing officer accompanying from bed 1 or bed 40 whichever way you choose.

Greet each patient if they are awake and proceed with the medical aspects of the round. Look at the charts – the temperature, pulse, the antibiotics given, the frequency of bowel motion, the intake, output, diabetic, head charts etc. Are they relevant? If not, take them off. Do not give nurses unnecessary work. Then go through the S.O.A.P. mnemonic for recording in the case sheet. A subjective complaint; an objective sign, an assessment of the condition and a plan, in the short and long term, of action. Every patient in a hospital bed, especially an acute ward, must merit his stay; otherwise out he goes in the quickest possible time. It is wrong to keep a patient there because doctors do not know what to do with him. If a junior doctor is ignorant ask up the hierarchy. Do not waste a hospital bed.

New cases must be hospitalised for a reason – the diagnosis is unclear, the treatment needs intense monitoring, investigations need to be done on an inpatient basis, observations are required and so on. All this must be properly dissected out by the doctor who clerk the case and the medical officer and registrar who subsequently review the case. The house officer, it must be remembered, is under training. His clerking is for his experience and learning. The medical officer being fully medically registered holds responsibility for the case till the registrar has reviewed the patient. Finally, the ward consultant assumes responsibility for every case in the ward. If you agree with this division of responsibility, it is inconceivable that consultants can fail to do a ward round daily on weekdays. What sort of responsibility are they assuming if they have never seen the patient? Each and every new admission should be seen by a consultant within 24 hours of admission. Hence on weekends and public holidays the responsibility is even more acute because only a skeleton staff is on duty.

In the process of the ward round, teaching must be done. Sometimes when the ward is exceptionally busy it is a business-round. But when it can be leisurely, junior staff must be taught. More theory can enter the discussion. How leisurely a ward round can be does not depend entirely on the number of patients in the ward. If the house officer is good and can be trusted, it may not be necessary to go through every point in history taking and examination as he can be trusted. If he is not sure about a sign or symptom, he should say so and the senior staff will check that sign. It is the good senior staff that knows when to check a patient through thoroughly and when to accept at face value the junior staff's assessment. Some cases, the senior staff must take extra care. For example, police cases, patients with no history available and such like, senior staff must ensure that no negligence or potential medicolegal problems will arise for which they cannot answer adequately. At the outset, the house officer's language proficiency must be known. Inability to communicate with patients and relatives is a very serious handicap of present day doctors.

Changes made during the ward round should then be properly understood by the nursing staff and carried out. Orders written by doctors should be legible and no mistake in transferring words into actions ensured by checking with the nurse who serves medicine or does a procedure. Of course a nurse could serve the correct medicine to a wrong patient but nurses have rounds too and if they know their patients well enough this should not happen. During the round, senior staff must ensure availability of beds for new admissions. This has to be estimated from past experience with regard to call days. The overflow phenomenon of patients should be prevented for it is disruptive to the ward round and irritating to the unit's staff into whose ward your patients have overflowed. To the administrator it is a bonus for in computing the daily ward occupancy he will be delighted to find wards over 100% occupied. But to you on the ground it is nothing but a cause for concern, a potential source of trouble. The temporary "centre bed" phenomenon has ceased to exist.

After the ward round, it is useful to return to the nurses' station and with the name list of patients on the round according to their bed numbers, go through each patient and restate what is to happen to each of them today. For example, Miss Lim in bed 1, a case of drug overdose, is going home. Number 10, MC for 2 more days. Inform time of discharge. Mrs Ong in bed 16, for CT scan today at 2 o'clock. Madam Rosario in bed 20 to see relatives regarding discharge and so on. Once such instructions are clear the senior staff can leave the ward to let the junior staff manage until the afternoon round. In between, the senior staff can be summoned should an unforeseen problem arise, or a new ill case gets admitted. If for some reason or other, e.g. OPD, lectures to students, nurses, the senior staff cannot do the round, they should call the ward after the round is over and go through over the phone, if need be, the status of each patient and take corrective steps if indicated. At all times the consultant should be aware of what is going on in his ward. There can be no excuse for it to be otherwise. Patients in a ward are managed by the medical officer and the registrar or senior registrar who supervise the house officer. They themselves are supervised by the consultant and are answerable to him. Private patients referred to a certain doctor should be managed the same way unless that certain doctor wishes to do everything himself. The major decisions must be his to make. However the junior ward staff would be very happy if he could be found when wanted and that he has some feeling of responsibility toward that ward with respect to bed shortages. Senior staff should make ward rounds lively and interesting. It should not be dull and there must not be "shifting dullness' as the dullness shifts from one bed to the next.

By noon all discharges and paper work for the day must be completed and at visiting hours, relatives can take the patients home. In the afternoon doctors should do case summaries, trace results only if absolutely necessary and do some reading around interesting or problematic cases. Sometimes they are off call or they may have to run the outpatients or attend the department's teaching programme, death round etc. In the afternoon at 4 pm, for example, another ward round is in order. This time the nurses are spared. Tests done in the day should have results ready for review. X-rays, ECGs done should be read and necessary changes ordered. Passing each bed, familiar faces must ring a bell in the doctors' minds regarding why they have not been discharged. New faces should cause doctors to have their reasons for admission sorted out and a plan of management instituted. If the bed situation is tight and discharges warranted then the less ill patients will have to go home. But an explanation to relatives must be forthcoming. If the afternoon round becomes one of discharges frequently then administrative steps to increase bed complement or cut down admissions should be worked out. Sending patients home earlier than medical judgement would allow for reasons of shortage of beds will become a vicious cycle with such improperly treated patients coming back to hospital sooner or in the middle of the night. This generates unnecessary paper work and endangers human lives. Patients who may be expected to be unstable through the night must have their cases passed on to the duty staff. That is basic courtesy for you would not want yourself to be saddled with a DIL patient and his anxious relatives in the middle of the night and you do not know what to do, what has been told to them and what to expect.

What of weekends and public holidays? Staff that know the patients should do the round. It is inconceivable that a roster be drawn up rostering doctors who have never seen the patient to do the morning round. At best he will try not to make decisions or do changes. At worst he might actually spend hours pouring through each case sheet and infuriating himself, nurses and the patient. If it is a post call day then the full complement of ward doctors should do the round the usual way. At most it will last till noon. Illness has no respect for weekends and public holidays. Patients are sick when they come so they must be serviced and serviced competently.

There is a category of senior staff called the "any problems" doctors. They for whatever reasons do not do a ward round but at 12 noon when the round is all over, pop in their heads and ask, "Any problems?" After a while the answer must surely be, "no problems". Does that then give them the legitimacy not to do any ward rounds? Is a ward round only for problems? How about teaching? How about showing the right example of patient approach, patient interaction, dealing with relatives? What is a problem? Is it not easy to shelve decisions, sweep under the carpet insoluble tasks, wish away problems? What about follow-up care of patients? Should not the senior staff say, "Mrs Teo to see me", not because she looks good, is my friend or has an easy problem but rather the reverse. She is a problem patient in more aspects than one and therefore needs the senior staff to deal with her. Her diabetes is difficult to control because of indulgence in delectable foods. Should not the senior man give her a talking dow

I fear the days of the ward round are becoming extinct. I say this because wards, for financial reasons, are being shared by departments. There will come the day when a house officer cannot say with pride, "This is my ward and these are my patients" because the ward is now multiuser. He may have one patient here, three patients elsewhere, yet another five somewhere else and one quarter of this ward and one third of that ward. No desk is his. All are shared. Doing a ward round becomes a depressing business. Patients get transferred from one place another. Nobody seems to know who the patient is or where they came from. Doing two rounds a day under such circumstances becomes a trying experience. In multiuser wards of say 36 beds, eleven different units may have patients there. The nurses don't like it, neither the doctors but the administrators favour it. "No paying bed must be empty", they say. And so one day, if you ask me where is my ward, the one I am in charge of, I will just look at you without an answer.

"Is the ward rounds only for problems? How about teaching? How about showing the right example of patient approach, patient interaction, dealing with relatives?"

JOURNAL ROUND-UP

DR CHEE YAM CHENG

BACK TO BASICS IN MEDICAL EDUCATION

This is a summary of the Association of American Medical College's Report – "Physicians for the Twenty-First Century" published in 1984. The dramatic explosion of biomedical science and technology has inevitably led to more and more specialization in medical practice. In order to respond to the patient's personal concerns and problems and to prepare physicians for specialised education in medicine, there must be a general professional education. Every physician should be caring, compassionate and dedicated to keeping patients well and helping them when they are ill.

There is an accelerated continuing erosion of general education for physicians because of:

* the rapid advances in knowledge and technology,
* the increased complexity, effectiveness, and dangers associated with these technologies,
* the likelihood that the principal providers of medical service in the near future will be physicians employed by large corporations or health service organisations covering specific population groups, and
* the likelihood that the environment of medical education will be heavily influenced by the agencies paying for medical care.

To avoid critical and irreversible damage to the medical education and service delivery systems, five recommendations followed the committee's conclusions.

Conclusion 1 addressed the purposes of a general professional education. These purposes are to enable students to acquire the knowledge, skills, values, and attitudes that all physicians should have, and to develop the abilities all physicians need in order to undertake limited responsibility for patient care, under supervision, during the early period of their residency. Values and attitudes should promote caring and concern for the individual and for society. Concepts and principles must be derived from knowledge of the natural sciences, the social sciences, and the humanities. Skills need to include the collection of information from and about patients, the establishment of a rapport with patients to facilitate both diagnosis and therapy, and the application of the scientific method to the analysis, synthesis, and management of problems. Necessary skills also involve the ability to identify and critique relevant literature and clinical evidence, and the continuation of effective learning.

Conclusion 2 declared that a broad and thorough baccalaureate education is an essential component of the general professional education of physicians. The result of the present, narrowly focused undergraduate education is, very often, a premature specialisation and the failure to obtain a broad, rigorous education. An intensive effort by college and medical school faculty members is required if the baccalaureate experience is to resume its original purpose.

Conclusion 3 stated that physicians continually need to acquire new knowledge and learn new skills. A general professional education should prepare medical students to learn throughout their professional lives, rather than simply to master current information and techniques. Students must be more responsible for their own learning. This means that they should become active participants in their intellectual growth and not be passive recipients of information.

Conclusion 4 emphasized the importance of clinical education as an integral part of general professional education. The focus of this learning should be on patients and patients' families. During properly structured clinical clerkships students gain skills in interviewing and examining patients, in correlating information, and in formulating diagnostic hypotheses. They gain knowledge of disease processes through the study of illness. Their sense of responsibility and respect for patients and patients' families, their approach to clinical problems, and their attitudes toward working with other health professionals are moulded during this critical period.

Conclusion 5 focused on the need for an enhanced involvement of the medical faculty in the general professional education of medical students. The discipline and specialty-based administrative structures, which are the prevailing forms of faculty involvement, are not very effective in promoting the interdepartmental and interdisciplinary work necessary for the design and implementation of a programme of general professional education for medical students beginning the study of medicine. Despite frequent assertions that the general professional education of medical students is the basic mission of medical schools, the panel concluded that it often occupies last place in the competition for faculty time and attention.

Medical Journal of Australia 15 April 1985: 464–5

QUESTIONS ABOUT OCCULT-BLOOD SCREENING FOR CANCER

To-date, there is no evidence that screening for occult blood reduces mortality for colorectal cancer. Benefits of screening are uncertain as occult blood tests miss 20–30% of colorectal cancers and 90–95% of persons with a positive test do not have cancer. For those over 50 years with overt rectal bleeding, the positive predictive value for rectal or sigmoid polyps or cancer is only 8%. The false negative rate of 20–30% may give false assurance to those who already have cancer and may lull them into ignoring early symptoms. Causes of false positive results are many. Since the occult blood test is unreliable, the other suggestion that every person over 40 or 50 years should be colourscoped may result in more perforated bowels than cancers cured.

"Any programme designed to make apparently well persons 'healthier' through screening must be able to demonstrate clearly that its benefits outweight any cost or harm." There is an ethical difference between everyday medical practice and screening since the latter implies guaranteed benefit.

Lancet 14 January 1986: 22

EDUCATING THE DOCTOR: POSTGRADUATE, VOCATIONAL & CONTINUING EDUCATION

Doctors must learn throughout the whole of professional life because the rate of accummulation and obsolescence of knowledge and skills is so great. Commitment in this direction is essential especially of consultants and principals in general practice, who are ultimately responsible for maintaining and improving standards of medical practice and for seeing that their juniors follow suit. Many senior doctors understand this commitment but not all shoulder their responsibilities and fully discharge their duties.

In the preregistration year, clinical drill should be emphasized. The raw recruit on graduation is impressionable and hopefully willing to learn about and work with the tools that will transform theoretical knowledge into practicality in the clinical situation. "Registrars in particular and also consultants should supervise housemen, often through proper review of notes, in checking relevant histories, and in ensuring careful complete physical examinations, or at least as complete as warranted."

"The preregistration year is the time par excellence to make sure that housemen know what to do and do it." Not to supervise them because of the excuse of overwhelming service burdens is counterproductive and inefficient. Juniors must be constantly checked to ensure that they can be relied upon to do a good job. The function of senior doctors include service to patients, teaching their staff (medical and others), research (often operational and critical review) and administration / management. It is not enough to overemphasize service to the detriment of other functions.

Intermediate training involves the senior house officer and registrars, who need "general" knowledge and skill in the context that all doctors must be able to make reasonable diagnoses of the problem questions for their patients so that they may be referred to those who know how to make a more exact diagnosis and act technically on that basis. It is wisdom to know where one's own competence runs out so that those more skilled can be called in to help.

"The only assessor of clinical competence can be the consultant with whom a junior doctor works, yet this is still incompletely realised."

Senior registrars and consultants are full of knowledge and are very competent in their skills. Yes, they may be well trained but ill educated. It is not knowledge and skills that seem deficient but inadequate attitudes to and for the task. All consultants and principals have now become the important figures in education, of their juniors and of themselves. (Doctors who take on research and teaching have their attitudes to knowledge and evidence changed drastically and these attributes spill over into all the daily problems, transforming them into lively, interested and enthusiastic professionals whose clinical work becomes more effective and themselves more self-critical). Through teaching and learning, education and training, these seniors are the setters and maintainers of standards of practice.

Professional competence becomes even harder to acquire and maintain and therefore demands more and more effort in education and training. Society demands the best of its doctors in knowledge, skills and attitudes which together constitute education. To this end the leaders must lead, persuading others to do what they otherwise would not have done.

British Medical Journal 15 June 1985: 1808–10

1986 SMA LECTURE

Cont'd from Page 1

(in Singapore) to the University of Singapore and now it has become the National University of Singapore. Each change saw growth but with the Faculty of Medicine finally moving over to Kent Ridge in 1985 and with the establishment of the National University Hospital we should be poised for greater advances in medical education and research. In the Medical School of 1905 the teachers were Government servants but gradually with the establishment of a Faculty of Medicine of the University of Malaya, strong University departments in various broad specialities grew as part of the development of the Faculty.

ADMISSION CRITERIA INTO THE MEDICAL FACULTY:

Our system is based on meritocracy and if this were to be practised fairly then it should breed excellence. Unfortunately there is one notable field where the principle of meritocracy is not practised. Until recently one obtained admission to the Faculty of Medicine solely on the results of the H S C examination. The best students of the science stream usually enrolled in the Medical Faculty. The University administration /Government felt that because of this trend, the other disciplines were not obtaining their fair share of talent and it was presumed that this state of affairs could have serious consequences for the country. As a result of this, the admission criteria have changed. As I understand it only 15% of the cream of the Science stream can get into the medical faculty. Furthermore, to add to the heartbreak for the aspiring student, the selection of this 15% appears to be by an interview which has so far not proven to be able to really select those best suited for a career in Medicine. There are some who feel that perhaps one could merely ballot or draw lots and save a lot of time and heartache. Moreover it is also well known that in spite of having women's rights entrenched in our constitution the maximum number of women that can be admitted into the Medical Faculty is not more than a third of the enrollment. This is because of what is termed a wastage of manpower in that many married women doctors are not as economically productive as their male counterparts and the country cannot afford the luxury of giving women an education in Medicine.

In my view one of the chief factors in the progress of western civilization was the extension of equal rights and equal educational opportunities for women. The benefits of an educated mother are transmitted to the whole family and through the family to society at large. Women interact more intensely in the social milieu in matters concerning the health of the family. The experience of countries with significant female participation in the medical profession has so far been positive and in these countries community health has benefitted greatly. There is therefore much to be said for restoring to women the equal opportunity to study medicine which they enjoyed previously.

To my mind these restrictive practices can only lead to a fall in excellence in the quality of our medical students. The second deputy Prime Minister has rightly remarked that every Singaporean will be given the opportunity to develop his/her potential to the full. Many a bright young man/woman wanting very much to be a doctor may well ask why not review the admission criteria again. The more well to do can still bypass the system and go overseas but the poorer brilliant student must go through life feeling that our society has punished him/her for trying to excel.

WHAT IS EXCELLENCE IN MEDICINE:

When we ask around as to how one defines excellence in Medicine one is bound to get innumerable definitions. To the layman or patient excellence means that whenever he/she falls ill he/she will get the most careful attention from a skillful, informed, intelligient, honest, responsible and compassionate physician whose sole aim would be to get his/her patient well irrespective of the demands on his/her time. In the private sector this must be at a reasonable cost to the patient. In the public sector the doctor is expected to sacrifice his/her other pursuits, be they in research or teaching or administration and forgetting leisure and family, place the welfare of the patient above everything else. Singaporeans should perhaps derive great satisfaction in knowing that we do have a comprehensive health service and have progressed from a position in 1950 when the biggest cause of death was infective and parasitic diseases (21.5%) to a point now when cancer and heart disease are the major causes of death – a pattern seen in the advanced nations of the world. We take much of the excellence in medical care for granted and one has only to travel to other developing countries to be made aware of what we were like a few decades ago.

FAMILY MEDICINE:

The recent sub-committee report on medical services which forms part of the report on "The Singapore Economy: New Directions" classifies medical services as an industry that should receive priority for promotion. What is to be promoted does not appear to be Primary Health Care or Secondary Health Care, for example the provision of Health Centres and better facilities for general practitioners who are the mainstay of the "curative" and to a great extent the "preventive" aspects of medicine. While allowing for private enterprise Government could make available to the general practitioners setting up practices in the housing estates, where most of the Singaporeans reside, specialised ancillaries such as laboratory and x-ray facilities which require high capital cost. It is important for general practitioners to build family practices with closer rapport with their patients and better understanding of their problems and a moderate fee for service will promote this type of practice. Consideration can be given to subsidising the private medical expenses of the unemployed or indigent. If the patient gets a personalised service of this nature there will be less duplication of treatment and better regulated use of laboratory and specialist facilities.

The College of General Practicitioners, since its inception in 1971, has encouraged postgraduate and continuing education among the general practitioners. Its present membership is 430. Ideally all general practitioners should seek admission to the College by taking the prescribed courses of study to continually upgrade their knowledge. Continuing education and the acquisition of new skills is a life-long committment in medical practice be it for the specialist or the general practitioner.

SPECIALISATION IN MEDICINE:

The great advances in Medicine have come from improvement in Science and Technology. The volume of scientific knowledge is so vast that no one can keep up with new developments in every field. Gone are the days of the horse and buggy doctor or the generalist. There is a steady demand for specialist services and the pace of medical development and the advances in medicine inevitably mean that Singapore too will see more and more specialists among the practitioners of medicine. In the near future the number of family practitioners will be equal to or be less than the number of specialists. The present doctor population ratio is 1:987 and the specialist population ratio is 1:2665. The doctor population ratio will also see an improvement though in the forseeable future the number of admissions to the medical faculty now close to 200 per annun may be reviewed.

SUBSPECIALISATION/ SUPERSPECIALISATION:

The development of the institutions of tertiary care has been in the direction of providing more and more specialist services. The key to excellence in medicine is in subspecialisation. As an example if one or two surgeons concentrated on the difficult problems of hip surgery then we will have hip surgeons comparable with those in the developed countries of Europe and North America and Japan. This is because the number of patients with such problems will not be large in Singapore and if all orthopaedic surgeons wanted to tackle such problems then hip surgery cannot be taken to great heights. This is where able leadership and foresight will be needed to pick and train the right people and ensure that they acquire all known skills and knowledge and have the problem cases in their field referred to them. The encouragement of sub-specialisation is a path to excellence.

PRIVATISATION OF PUBLIC HOSPITALS:

Until recently our public medical service was developed in the British mould with the state taking the initiative and providing for basic medical care at all levels. Now we are witnessing a change to the North American model which has developed in the direction of privatisation of medicine. A rapid transition from one to the other is not in the best interest of the public and the development of excellence in medicine. What is perhaps the most striking development recently has been the re-building of the Singapore General Hospital with over 1,650 beds and the erection of a completely new hospital at Kent Ridge – the National University Hospital (with a provision of 767 beds). Recently it has been announced that the Singapore General Hospital will be privatised in the near future and will operate like the National University Hospital. The Ministry of Health apparently feels that privatisation of these two hospitals will enhance the development of Medicine in Singapore. The Singapore General Hospital and the NUH must aim to emerge as the leading hospitals in Singapore and in the region for postgraduate training and education.

Whilst agreeing that millions of the tax-payers money is being channelled into these institutions I must question why only in medical education it is necessary to make money for the institution. In none of the other disciplines, say architecture, engineering, law or even in business administration is it considered necessary to attract business and earn money for the institution. The professors and other academicians in medicine are being encouraged to promote medicine as big business. It is not the management of diseases in the mass that will bring about excellence. The NUH and the SGH should be the places to which all regional hospitals could turn to, to manage the more problematic cases requiring greater skills in management. The doctor in charge of the patient could be encouraged to continue looking after his patient but the superspecialist brought into the picture will perform the more difficult operations or procedures or have the final say in the medical management. The patient could go back to his own doctor even if he is a specialist after the crisis is over as patients are sent back to family physicians for further management after specialist care. This will break down the barriers that exist in medical practice today between public hospitals and between the public and private sectors. The superspecialist could be invited to manage patients with consultants in any hospital in Singapore and similarly consultants in other hospitals should be allowed

Cont'd on Page 9

Cont'd from Page 8

to be part of superspecialist teams at the NUH or SGH for limited or extended periods of time. This cross-fertilization is a vital catalyst to promote excellence. Medical postgraduate training will be enhanced with such team work and the sub-specialities will flourish.

But can medicine advance if most of these beds are filled with ordinary run of the mill patients who can be more cheaply and equally effectively treated in the regional hospitals which term is being used to embrace even the private hospitals and nursing homes? If this system be adopted there will be a wealth of clinical cases for study as it is in the treatment of problem cases that there are true challenges. New methods of management would emerge if there is such pooling of material and concentration of talent.

UNDERGRADUATE CLINICAL INSTRUCTION IN THE NUH & SGH:

How will undergraduate education fare in this context. Private patients will not generally want medical students prodding and probing them. Some may not mind this in the interest of education. It should be part of the conditions of admission to public hospitals that patients in subsidized beds (B2 and even B1) should allow medical students to examine them and perform simple procedures on them such as setting up drips, lumbar punctures, wound dressings, which will not endanger their lives. The National University Hospital must have a sufficient number of such patients but the major clinical teaching could be conducted by University dons and clinical (non University) teachers in all hospitals in Singapore. The administrators of private hospitals could allow medical students under supervision of the clinical teachers in private practice to examine patients in the private hospitals. In this way there will be no dearth of clinical material for teaching. Many a time former University teachers, now in private practice, have regretted not having one or two students around who could be shown the educationally interesting problems encountered in their practice. There should be no problem in getting consent to discuss the patient with students. Most patients would welcome making a contribution to learning if they did not suffer any real inconvenience. Also this open attitude will serve to upgrade the standard of practice, for the doctor who is not afraid to discuss his patients with others even if they are only medical students is practising ethical medicine. There is greater alertness all round whenever students with critical and enquiring minds are around.

SINGAPORE AS A REGIONAL POSTGRADUATE CENTRE:

Though the National University of Singapore awards the higher degree of Master of Medicine in Internal Medicine, Paediatrics, Obstetrics and Gynaecology, Surgery, Anaesthesia and Psychiatry the M Sc in Public Health and in Occupational Medicine are the only ones for which foreign students regularly enrol. Even with local candidates the M. Med is still not popular enough. Often it is easier to become a member or fellow of one of the Royal Colleges (of Medicine, Surgery, or Obstetrics and Gunaecology). The requirements for the Master of Medicine are perhaps stringent and foreign graduates cannot easily qualify to sit for this examination. This is as it should be for to lower the standards would mean that the degree of Master of Medicine, which is now recognised in the Commonwealth as equivalent to a fellowship or membership of one of the Royal Colleges in so far as it allows the holder of such a qualification to proceed further for higher training may cease to have such recognition.

For example the holder of the M. Med (Surgery) can enter the course of study for the postgraduate degree of M Ch Orth of the University of Liverpool which course is normally open only to candidates who are fellows of the RCS. What should be done more, to promote medical excellence, is to have structured courses in various disciplines to which foreign doctors from the region can be invited. Here I would like to mention that for the last 10 years the Academy of Medicine has been offering fellowships in Orthopaedic Surgery for surgeons in the Asian region, particularly from Asean. To-date 35 young surgeons have spent six months in Singapore gaining further experience in orthopaedic surgery under the Lee Foundation and Shaw Foundation Fellowships. In October 1975 the Academy of Medicine with the support of the Ministry of Health and the University of Singapore sponsored the 2nd International Symposium on Orthopaedic Training in Developing Countries as a result of which a new organisation called World Orthopaedic Concern was formed for the promotion of orthopaedic education and care in the developing countries. World Orthopaedic Concern is registered in Singapore as a charity Though there are world-wide activities going on in this organisation the Singapore contribution is the provision of postgraduate orthopaedic education for the surgeons in training at the Hasanuddin University in Ujung Pandang, East Indonesia. This project is funded by the Lee Foundation. From this year the Lee Foundation will be offering further fellowships in orthopaedic surgery, through WOC, in addition to those offered through the Academy of Medicine. The impact of this close contact with young professionals from the region will have an influence on medical progress in Singapore. I note with great interest and quote the relevant part of the subcommittee report of the "Singapore Economy" namely "to establish Singapore as a specialist training centre to which doctors in the region will be invited or attracted for seminars, workshops and training courses. In future they will look to their Alma Mater to refer patients for second opinions or more complicated treatments." The Academy of Medicine has done this for the last 10 years in one discipline. What is needed is public funding for projects such as this and private efforts by institutions such as the Academy of Medicine. This private enterprise of a non-remunerative nature will enhance our stature as a centre for medical excellence.

GREATER ROLE FOR THE ACADEMY OF MEDICINE:

This institution founded in 1957 played a key role in instituting postgraduate degrees in medicine and is

Cont'd on Page 10

GUEST OF HONOUR SPEAKS:

Cont'd from Page 1

receiving your well informed advice and views on this.

We can be justly proud that the standard of medical practice in Singapore has a high degree of approval and respect by the public. But this is not unqualified. Expectations of patients and the public are constantly rising and criticisms will come more frequently with better education and knowledge. Among the criticisms will be those relating to costs of services and receiving value for money. It can be expected that the public will also be particularly cost conscious in these times of recession.

It is worthy of note that the SMA has faced the problem squarely and initiated a scale of fees for general practitioners and specialists. Much time and effort has gone into working out its Guidelines on Fees for the private sector which will be the first of its kind in Singapore. This, indeed, is a commendable step.

While there is no doubt that the doctor deserves reasonable compensation for his services, patients and the public should not be given the impression that our sense of vocation has been overtaken by more material considerations. There is therefore a need to look at our sense of values from time to time and ensure that they are not debased by ambition and worldliness. For it is not only skills and ability, but the commitment of our doctors and the upholding of high ethical standards by which we will be judged.

In its plan to serve the public, Ministry will rebuild its hospitals and provide more sophisticated facilities and equipment. As we strive to maintain high standards, our hospital services will also be improved and expanded by careful selection of specialisation and subspecialisation in fields where we are able to attain the highest standards within economic and manpower constraints.

Finally, ladies and gentlemen, we in the Ministry look forward to maintaining a cordial dialogue with the Association and the other professional bodies representing the interests of medical practitioners and specialists. Let us work together to ensure the smooth implementation of policies that will shape the health of our nation in the years ahead. ■

Footnote:
The President's Dinner speech will be published in the next issue.

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Cont'd from Page 9

linked with the School of Postgraduate Medical Studies of the National University of Singapore. Nearly all specialists from the private and public sectors who have attained the required maturity and experience have sought admission to membership of the Academy. There are now 581 ordinary local members in the 7 chapters of the Academy. The Academy is moving soon with the College of the General Practitioners into the old Faculty of Medicine Building in College Road. The Academy has played a major role in postgraduate and continuing education and can do much more if the membership will rise to the challenge. The Academy

Cont'd on Page 11

Cont'd from Page 10

has established a roll of specialists in various disciplines of Medicine. Today in Singapore anyone who is registered by the Medical Council can call himself/herself anything he/she pleases and practise a specialty and all kinds of abbreviations can be appended to one's name, some reputable, some not so reputable. Only when something goes wrong and the patient sues the doctor or when a colleague who is concerned about medical ethics will report a case of neglience or malpractice can action be taken against the offending doctor. There is nothing better than peer review and it is time the role of the Academy as the best peer review group for specialists be accepted widely. The public may demand of someone calling himself a specialist in something or other to produce a certificate to that effect from his peers in Singapore, in this case the Academy of Medicine. One private hospital has asked the doctors using its facilities to set up a Medical Advisory Board and various committees such as a Credentials Committee, Quality Assurance Committee, Continuing Education Committee and a Tissue Committee have been formed. Doctors seeking privileges in this hospital will first have to pass a peer review. This is a step towards excellence in medicine in the private sector.

IMPORT OF EXCELLENCE:

Much as we would like to welcome top men to practise in Singapore one would not like all and sundry to walk into Singapore and claim expertise in various fields. Short term appointments of top specialists to teach local doctors certainly works to our advantage. What is needed is the development of our own excellence. Bright young doctors seeking to specialise say that they are not being given the full encouragement they deserve. There should be established a manpower training committee directly under the Minister for Health with representation from the Ministry of Health, the National University of Singapore, the Academy of Medicine and the College of the General Practitioners.

FUTURE RESEARCH:

While it might be thought that it is the University that is the seat of learning it must be admitted that many research projects can be undertaken even by those in the private sector. There should be encouragement given to all bright young doctors to produce a thesis leading to a Doctorate in Medicine or a PhD in Medicine. In my own discipline 3 local theses have been produced and it is hoped that many more will be forthcoming. Many excellent papers have been written from Singapore and new techniques have been developed. Even new medical conditions have been described from Sinpore and new techniques have been developed. Even new medical conditions have been described from Singapore. This shows that local talent is not lacking and we should work harder at giving the best opportunity for our own flowers to bloom. Now and then we read about our countrymen/women making brilliant contributions overseas. We would like them to return home and continue with their work here. The Medical Services Sub-Committee Report recommended the setting up of a Medical Research Department. This should be a Foundation with representation from the NUS, the Academy of Medicine, the College of General Practitioners and the Ministry of Health. Doctors too have a vested interest in the development of medicine and all doctors should contribute generously to this Foundation. Perhaps a professional skills development levy can be introduced when the time is right and the money utilised for the futherance of medical research in Singapore. Now that the Medical Faculty has been sited at Kent Ridge the already developing cross fertilisation between various disciplines will progress further. The proximity of the Science Park to the NUS and NUH and its aim of attracting academic participation in industrial and scientific development should have a beneficial influence on medical progress.

THE DEVELOPMENT OF NURSING AND ANCILLARY SERVICES:

Because of a short period of muddled thinking in the recent past when it was insisted that before one is allowed into the SRN programme the nurse-in-training must get an assistant nurses certificate, Singapore is suffering an acute shortage of nurses, especially now when new hospitals are opening up. However hard the School of Nursing may try, it is going to take a while to set this right. Perhaps the time has come to start thinking of a degree in nursing in the National University Hospital. There was resistance in the past to the setting up of a School of Physiotherapy and again we have a shortage of physiotherapists. In fact if our standards are high and the training is good we can attract good candidates from neighbouring countries and not be afraid of over producing physictherapists or nurses. Better nursing and ancillary services are important elements in the excellence of medical care.

CONCLUSION:

In conclusion I must stress that we must however resist the concept that medicine is merely an industry, that doctors are providers of services (products) and that patients are consumers and that we should resort fully to business practices of competition, marketing and advertising. Finally as I grow older and approach the 6th decade of my life I begin to appreciate that just as paediatrics was earlier developed as an important discipline when our population was relatively young, now we have to push to have geriatrics as an important discipline, to be developed rapidly. The senior citizens, which many of us have become, will need adequate and efficient care if we are not to burden our young with sickness and ill health. Just as we have "well-baby clinics" we could have "fitness clinics" with regular medical advice on how to remain holistically well with sound minds in sound bodies not senile minds in decrepit bodies.

It is obvious that excellence in medicine is not a quantifiable entity. It is a multi-faceted problem from the provision of sophisticated hospitals fully supplied with high-tech equipment to personnel able to use the machines and yet retaining the human touch. We are not too far behind in most things and want to be in the forefront, the cutting edge of advancement. We must learn that team work is the essence to good care in many situations. The ability to work in groups with the sharing of experience and expertise is important. Ours is not a profession in which we can reap rich financial rewards nor should this be our aim. In our search for excellence the tangibles and intangibles come into play but ultimately, the performance of the profession as a whole will determine the progress medicine will make in the next few decades. ■

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Published by the Singapore Medical Association, 4A College Road, Singapore 0316. Printed by Jin Jin Printing Industry Pte. Ltd.