SINGAPORE MEDICAL ASSOCIATION
NEWSLETTER
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YOUR PRESIDENT SAYS

SPEECH GIVEN AT 26TH SMA ANNUAL DINNER

"The Guest-of-Honour, the DDMS Dr Chew Chin Hin, distinguished guests, ladies and gentlemen.

Those of you who attended the Convention today will know that it has been a great success. We have, for the first time, opened the whole Convention to the public. This is in line with our goal to promote public health education.

There are many more changes that need to be made, if we want to make progress towards Singapore as a centre of medical excellence. There is nothing wrong with aspiring for progress. As the Japanese philosopher, Konosube Matsushita, propounded so succinctly:

> "The history of man since his emergence on the planet Earth can be summed up by one word – PROGRESS."

There has recently been a great deal of talk about developing Singapore into a centre of medical excellence. All this may have benefitted the specialists. But let us not forget our family physicians and general practitioner colleagues. A closer look at Primary Health Care is also necessary. SMA Council has set up an adhoc committee for general practitioners, under the chairmanship of Dr Patrick Kee. This committee will look into the many problems of the general practitioner.

The economists have a new parameter for measuring your economic worth, called "value-added", that is, the value you have added to whatever "raw materials" you have purchased to run your business. It is a better indicator than profits because a company's profits could be coming "from windfall gains from non-operational items such as investments."

When I looked at the list of value-added indicators of the various businesses and professions, the general practitioner was near the bottom of the list.

There are many changes required to improve on the livelihood of our general practitioners. High HDB rental, clustering of clinics, and excess doctors are all glaring problems. Our general practitioners have been subjected to so-called "free market forces", when market forces are really not free. For free market forces to work, supply should respond to demand. It was Prof Ruderman from Canada, who pointed out to me, when he visited us last year, that in the medical profession, supply is not related to demand. The supply of doctors is regulated by a licensing body. If we are not careful, within 15 years we will reach the critically low level of doctor: population ratio seen in the European countries. In Belgium, there are now doctors who treat only one or two patients a week, which prompted Brearley to write in the British Medical Journal:

> "It seems paradoxical that an excess of doctors now constitutes a major threat to health care."

I am glad to say that the Ministry of Health is already looking into these problems, and I am confident that, under the dynamic leadership of Dr Kwa Soon Bee and Dr Chew Chin Hin, many of these problems will be solved.

These are changes which we would like to see taking place. But there are some changes being implemented which we do not like to see take place. We have had to accept the legalisation of abortion, which according to our Code of Ethics is unethical. We have had to accept the reporting of drug addicts, which to us is violating professional secrecy. And now, we are called to make our stand on advertising by hospitals. It is not easy to make a decision on some of these controversial issues.

I have learnt from one of our members that there are two types of leaders:

1) The leader who is merely a MESSENGER. He carries out the instructions of his voters and is not expected to exercise his own judgement.
2) The leader who is a TRUSTEE. He uses his knowledge and experience to evaluate and judge what the true interests of his voters are. This role is best summed up by Edmund Burke, who wrote:

"Your representative owes you, not only his industry, but also his judgement; and he betrays, instead of serves you, if he sacrifices it to your opinion."

SMA President Dr Khoo Chong Yew

During the year I met with the First Deputy Prime Minister, Mr Goh Chok Tong. This was at a meeting organised by the Singapore Professional Centre for the various professional associations to meet Mr Goh. After a three-hour long meeting, I asked Mr Goh what message he would like me to bring back to the membership. And this is what he said:

> 'As we develop our individual professions, we should think also of the nation.'

May I end by thanking our Guest-of-Honour Dr Chew Chin Hin for gracing this occasion. I would also like to thank the organising committee under the able leadership of Dr Tan Yew Ghee and Dr Yap Boh Seng, all Council members; and you ladies and gentlemen for your support." ■

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PRESIDENT'S COLUMN

MANDATORY CONTINUING MEDICAL EDUCATION

SMA has always actively supported continuing medical education. Proof of this are the many affiliated bodies of SMA, which have regular continuing medical education programmes. The medical profession is the most active of all the professional groups in continuously updating its knowledge. You need only check our calender of events to see that almost everyday there is a talk, seminar or discussion going on. Organisers are now facing the problem of finding a "free" day for their function, so that it will not clash with another medical meeting. The last SMA medical convention clashed with a conference of the Singapore Diabetic Society.

In spite of all this activity, there are some doctors who do not attend seminars or lectures. This may not mean that they do not regularly update their knowledge by other means, such as reading medical journals, listening to medical cassette tapes, or watching an audio-visual presentation. Some people learn more by self-study than by attending lectures or seminars.

The Korean Medical Association has had a mandatory continuing medical education programme for the past three years. The programme is administered on a calender year basis with medical doctors required to complete 15 credits per year. Credit requirements may be fulfilled in a number of ways including:

* Participation in a lecture programme
  (1 credit for each hour of participation)
* Participation in a clinic programme related to a lecture series
  (1 credit for two hours of participation)
* Listening or watching an audio-visual presentation
  (1 credit per topic with a maximum of 3 credits)
* Taking a self-study course
  (1 credit per topic with a maximum of 3 credits)
* Attending a medical symposium at home or abroad
  (1 credit per day of attendance with a maximum of 3 credits)
* Teaching interns or residents
  (1 credit per hour)
* Presenting or publishing a paper
  (5 credits per paper)
* Preparing and exhibiting a medical poster
  (2 credits per piece)

I think a high percentage of doctors in Singapore will be able to complete 15 credits per year. Let us hear what the government's proposal is first.

KCY

WELCOME

SMA welcomes the following new members:

Ang Hwa Cheng
Chia Swee Heong, Daniel
Choo Chih Huei
Heng Joo Teck
Ng Poh Heng
Tan Gek Hua

PERSONALLY SPEAKING

MEDICAL EDUCATION: THE CLINICAL YEARS

Dr Chee Yam Cheng

It is a joy to pass the first professional examination for the MBBS; to escape the drudgery of the basic sciences and to get the feel now of patients. That is what doctoring is all about, about patients and their illnesses, patients in a society, their stresses and adaptations, their failures and successes and how they cope with them. Yes, days of elementary clinics, when you are dressed in white overalls seem to be just the goal you were aiming at when you just began medical school. Days (and nights) in the wards are eagerly looked forward to.

But you are in for a surpise. You are in multiple groups, each sent to different hospitals and different units. The teaching standards are dissimilar, the patients are not the same either. What's more, if lectures have to be held at Kent Ridge in the Faculty of Medicine, that means a lot of travelling for many of you – to the far reaches of the non-central hospitals. How unfair the whole thing seems. You would rather do a final year posting in Surgery A than now. And there are so many points of difference to grouse about.

Are government units up to standard for teaching medical students? Some students would rather opt for government than University departments in certain disciplines. Ask the medical students why! Obtain their feedback. It may be a real eye opener. Posts in clinical departments of the University medical faculty should be plum jobs and they who have secured them should examine themselves to see if they daily live up to the standard required of them. Ask the students for their comments. Are the lecturers punctual? Why are students kept waiting time and again? Can the excuse that an emergency occurred hold water time and time again? Can the lecturers say do not trouble me? I must get on with my papers – it is a matter of life and death. Publish or perish is the motto. Not teach or perish, unfortunately. But what are these doctors employed to do? I think the University must re-emphasize that its role in medical education is firstly to teach by example and precept and not by the latter alone, and secondly to do research, to strive for academic excellence. Not all doctors are cut out to do both equally well. In undergraduate days, there is little exposure to research opportunities and methods. Cramming of masses of information seems the rule. Even if there were research posts, the pragmatic society we live in does little to encourage us along that line.

What about teaching ability? The students ought to know best. Some cannot teach, some do not bother to teach. To them, students may be a waste of time. How are they going to list their teaching abilities and teaching activities in their curriculum vitae at year's end? How much space can a description of such occupy in comparison to papers presented and published which has a cumulative effect from one year to the next. Can the University recognise good teachers? Does it support them in their crucial role of training young doctors or does it prefer the glamour of doctors who publish a lot and neglect their teaching responsibilities. For the good of the University, perhaps in clinical departments, doctors should be employed to mainly teach or to mainly do research. Good, if they can combine both but as of now, the incentive to be a good teacher seems to me self-defeating. If you are a good teacher, more and more students come to you, request tutorials, extra sessions etc. It is not polite to refuse and these poor things, since you feel teaching is so bad overall, no harm giving in to their requests. So you will have more and more teaching to do while their original teacher can well take a holiday.

Some lecturers complain that there is not sufficient teaching material. Paying patients choose to refuse to let students have a go at them. So although the National University Hospital (NUH) may be on the right track as far as economic viability goes, who spares any thought as to whether the medical students are on the right track? Students are posted to clinical departments in NUH. But there is insufficient clinical material, so what do they do? They go to other hospitals. But who assumes the responsibility for teaching them? Should not their assigned lecturer follow them to those other hospitals and conduct proper tutorials and case presentations? The conflict of interests of doctors practising in NUH is well known. Although great medical centres are privately owned and yet teaching centres, the same is not true of NUH (as yet?).

Teaching hospitals perform a critical societal function that is closely linked to medical education – the provision of charity care. In Singapore, the rapid movement to a highly competitive health care system places an overriding emphasis on the price of the medical care product. The administration is promoting this change and private payees are pursuing it. As price competition takes hold, it will grow more difficult for teaching hospitals to incorporate the costs of education within the costs of patient care and to cross subsidise the costs of uncompensated care, and clinical research. The move to privatise has led teaching hospitals to face a difficult period. At a time when a wide variety of interests are being asked by government to tighten their belts, these institutions are being asked not only to do that but also to prepare for an era of price competition as well. As society moves to industrialise its medical care system and thus places a greater emphasis on price and

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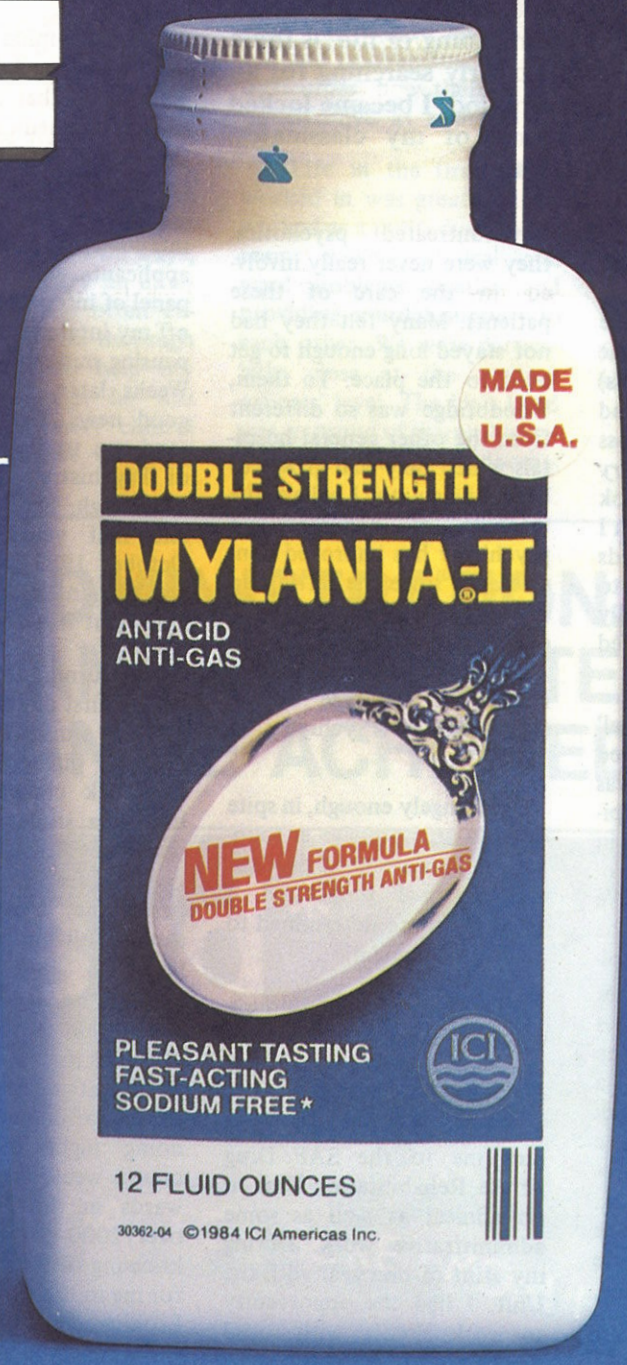

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Sources: *Contemporary Pharmacy Practice 1982; 5:246-249. Physicians Desk Reference® for Non-prescription Drugs 1984; Edition 5.*

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THE MAKING OF A PSYCHIATRIST

My Days in Woodbridge

Cpt (Dr) Ang Yong Guan

I first became interested in psychological matters during my pre-university days. Whilst my classmates were reading paperback novels during their leisure hours, I found myself attracted to books such as Napalean Hill's *Think and Grow Rich* (rich not just in material goods but in manners, grace and personality as well) or Dale Carnegie's series of *How to . . . . .* books. In June 1972. I bought a second-hand Penguin (Anthony Storr's *The Integrity of the Personality*) from a Bras Brasah bookshop. At tha t time, it made little sense to me when the book talked about psychoanalytical psychotherapy but little did I realise that the book was to become part of my reading list for the MRCPsych Examination 13 years later. I remembered enthusiastically collecting some of the key facts I gathered from such books and pinning them up at the back of the classroom in Raffles Institution; hoping that they would stimulate my classmates to think psychologically. Existential issues (who am I; where am I going; what is the meaning of life; is there a God?) fascinated me; I was clearly searching for an identity during that formative period. I became locked in endless dialogues with some of my classmates; Christians, Buddhists and atheists.

On the day of my disruption from National Service to join the Medical Faculty in June 74, I went to the second-hand bookstores (one of my favourite pastimes) opposite Cathay Cinema and was delighted to come across David Clark's *Psychiatry Today*. I finished the book that same evening. Although I knew I was drawn towards Psychiatry, it was too early to make up my mind; especially when I had not even started medical school yet.

My first taste of 'real' Psychiatry finally arrived when my clinical group was posted to Woodbridge Hospital during my fourth year in medical school to do a two-week clinical attachment. We were supposed to spend the working hours in the hospital but we found ourselves attending afternoon lectures in other disciplines at the Medical Faculty as well; as a result, we hardly spent enough time with patients to acquire the relevant skills to do a proper mental state examination. To make matters worse, the whole teaching programme appeared rather unstructured. One classmate confided in me, years later, that throughout the two-week period, he only went to Woodbridge twice. Some of my classmates told me they were wary of the mentally ill and were afraid of being 'attacked' by the untreated psychotics; they were never really involved in the care of these patients. Many felt they had not stayed long enough to get used to the place. To them, Woodbridge was so different from the other general hospitals which they had grown to be familiar with. I believe the teaching of undergraduate psychiatry has improved considerably since the setting up of the University Department of Psychological Medicine in 1978 and the advent of the Master of Medicine Course (M. Med) in Psychiatry in 1983.

Strangely enough, in spite of such unimpressive encounters, my interests in psychiatry remained unaffected. I was even more determined to pursue the subject.

After finishing my housemanship, I was re-enlisted to do National Service. I told my superiors that I was interested in psychiatry. They sent me to the SAF Drug Abuse Rehabilitation Unit to do clinical as well as some administrative work. During my stint of one year with the Unit, I had the opportunity to work closely with social workers, psychologists and rehabilitation officers. It was an eye-opening and enriching experience. My frequent encounters with the myriad of psychological problems faced by drug addicts convinced me that at least I was not tired of listening to their woes although, at the same time, I coul see that the helping profession had a mammoth task of effecting lasting and positive change in the behavior of these drug-offenders. Relapse was not uncommon and sometimes, I wondered, how could positive change ever be possible unless these individuals with deep-rooted personality defects showed some motivation to change their life-styles. I had my first taste of realism in helping people to change; one may lead a horse to the water, but one cannot force it to drink.

In the middle of 1981, the Singapore Armed Forced announced that it was keen to send a medical officer to the United Kingdom for further training in psychiatry. I applied and on the day of the interview, I saw five other applicants. When I faced the panel of interviewers, I rattled off my interests in psychiatry; pausing minimally for breath. Weeks later, I was told the good news. The plan was to send me to the Department of Psychiatry, University of Edinburgh, Scotland for two and half years; starting in October 1983. Meanwhile, I was to gain experience in psychiatry at Woodbridge.

Returning to Woodbridge on the first day of September 1981 as a medical officer was entirely different from the two-week clinical posting I had as a student four years previously. The immediate impact I felt was that for the first time, I was going to assume full clinical responsibility for real psychiatric patients under my care; with supervision provided by my Consultants. The next fact which hit me was that I was going to do be by myself doing night duty at least once a week; covering the 50 wards in the Hospital with over 2000 patients. Without knowing what was in store for me in the two years ahead, I soldiered on.

I was fortunate to have a group of equally enthusiastic medical officers working together with me in the Hospital. The six of us were never lacking in initiatives in our attempts to make our working lives at Woodbridge enjoyable and memorable. It was not surprising at all that all six of us eventually decided a romantic relationship which rapidly culminated in a blissful marriage in July 82. I was the Best-man for the wedding. We were told romances seldom blossomed in Woodbridge; this was one of the very few.

Each of the medical officers during that time had to look after two acute wards (one female and one male) and four to six chronic wards in addition to doing out-patient work in the afternoons at one of the five OPDs (Bedok, Lim Ah Pin, Pegu, Queenstown (later moved to Bukit Merah) and Maxwell). I remembered when I was with my first Unit, I had to cover Ward 32 (male acute), Ward 14 (female acute) and Wards 46 to 50 (the chronic wards) as well as Tampines Home (a Home for the physically handicapped situated near Woodbridge which is run by a charitable organisation) and the Mental Defective Unit (a 60-bedded unit).

The ward nurses knew we were hard-pressed for time. Each morning, they assembled those patients who needed urgent attention in front of the nurses' station. As soon as I walked in, I would assess the mental state or attend to any medical problems presented by these patients. Depending on the amount of time available, I could spend as short as five minutes or as long as half an hour with each patient. After an hour or so, I had to rush off to my other acute ward because the nurses there had similarly gathered a few urgent patients for me to review. So out of the 70 to 80 patients in the two acute wards, I could only see a limited number each day but the nurses would, at regular intervals, keep me up to date with a thumb-nail sketch of each patient.

Leaving the hospital at around lunch time and heading for one of the OPDs was a pleasant break for most of us especially after some exhaustive ward work in the morning. We would eat at one of the hawker centres near the OPD and after our meals, we would either catch up with the latest Woodbridge gossips or do some personal administration such as going to the post-office or the bank.

The Out-patient Clinic was from 2.00 pm to 4.30 pm. In 4 of the 5 OPDs, we were each given a room to see our patients. But in Maxwell, I remembered having to share a room with my colleague; an arrangement which provided no privacy at all for the patients. Between the two of us assigned to a Clinic each afternoon, we had to see as many as 60 to 80 patients. So within a short period of 150 minutes, each of us had to see 30 to 40 patients; that is, 4 to 5 minutes per patient.

We soon developed our own rapid assessment method to ascertain whether the patient was well or not. Some of our standard review questions consisted of: a) Are you eating well? b) Are you working? c) Are you behaving yourself at home? d) Are you sleeping well? e) Do you have any side effects from medication? I could not help feeling that all of these questions were close-ended so that the patients or the relatives would not be given the opportunity to elaborate further because we simply could not afford to give them more time. This was the most unsatisfactory part of the OPD work. Because of the situation then, I remembered commenting to my colleagues: "Our patients deserve more than just a cursory review when they turn up for their outpatient appointment. Psychiatry is not just about asking those few close-ended questions. Neither is it a matter of titrating the patient's medication according to his answers to those questions." But being idealistic and enthusiastic as a trainee is one thing; facing the realities of our everyday practice is yet another. Of course, we did bring these issues up for discussion but the answers given to us had the usual theme: ". . . administrative and manpower contraints beyond the jurisdiction of the Hospital . . .".

"Go and read about the sleep cycle", said the first Registrar I worked with on Ward 32, and come back tomorrow to give a brief summary to the students and nurses on the ward." His voice was friendly and encouraging. I did not feel ordered by him. During the next six months, we developed a close working relationship. Being fresh from UK himself, he was enthusiastically promoting a learning atmosphere in the Hospital. He often cajoled us to take an active interest in research and succeeded in persuading several of us to embark on

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joint projects with him. The findings of several such projects appeared in rapid succession in the Singapore Medical Journal the following year; for instance, prevalence of tardive dyskinesia amongst the in-patient population, review of the diagnosis of mental illness amongst the elderly, and bulimia nervosa.

One day, he came to the ward to hand me an article on *Morbid Jealousy* taken from the British Journal of Hospital Medicine and instructed me to present a summary of it at the Hospital's Journal Club. At that time, it was highly appropriate as we had a patient with the same syndrome on the ward. I decided to give a clinical presentation of the patient as a prelude to the discussion of the topic. I benefited substantially from such a learning experience; linking clinical material with theoretical expositions. This was to become and still is my style of learning paychiatry. Patients are often the best text-books; no two patients are alike. They may share a common psychopathology but their unique life experiences make them different from one another. Besides, psychiatry is still in its infancy and the textbooks may not have exhausted the vast pool of ever-changing clinical material available. Moreover, these textbooks are written by Western authors and may not be entirely applicable to our local context. I learnt to treat every psychiatric patient with utmost respect and I have since, stopped stereotyping people. That was my first lesson in Woodbridge.

Once a week, we would take turn to present new patients under our care at the Unit Ward Round; usually presided by the Unit Head. Also present were social workers, psychologists, occupational therapists, nurses, medical students. We formed a semi-circle behind a rectangular table situated at one end of the patient's dormitory. There was no proper interview room; the designated end of the dormitory was converted into a temporary interview area by the use of several screens. We could see curious-looking patients or their relatives peeping through the spaces in between the screens. After the medical officer had read out the history, the key relatives were called into this designated interview area to face members of the staff. I knew from the facial expressions ofthese relatives that it must be daunting for them, already troubled and bewildered by the illness of their closed ones, to face this semi-circle of professionals. After laboriously checking out the various important aspects of the history, we thanked the relatives and then called for the patient. Some patients were seen alone; others in the presence of their relatives. Then, after the patient and his relatives had left, the medical officer who had presented the history earlier on would give his assessment of the patient. The Consultant of the Unit would then invite other members of the staff to contribute their opinions.

The first Consultant I worked with was also the Head of the Unit. He adopted a philosophical approach to his patients and I could still remember vividly the many profound statements he uttered at Ward Rounds. He expected his staff to treat his Unit's patients with respect and often emphasised to his juniors the need to examine all the three aspects- physical, psychological, spiritual- of each patient. To him, it was not enough to put a diagnostic label to a patient. He wanted us to seek a deeper understanding of the patient's suffering; for instance, why did this patient become ill at this point of his life and not earlier?; what possible explanations could be offered to account for his current breakdown? In his own ways, he made Psychiatry an interesting subject and often encouraged me to be thorough in my efforts to help my patients. Although he was busy with his heavy clinical and administrative work, he always made himself readily accessible; something which has, for many years now, endeared him to his staff.

I remembered spending many half-hourly sessions in his room either discussing a difficult patient under my care or talking about life and its vicissitudes. He would listen attentively before making any comments. I gathered from these sessions that acquiring proper attitudes is as important as gaining knowledge in the training of a psychiatrist. With the help of this Consultant, I had taken my first step towards understanding myself; this process of self-awareness, considered to be a vital part in the training of a psychiatrist, was to feature prominently in my later training. A psychiatrist deals with human emotions and mental sufferings; he seeks incessantly to understand his patients and to empathise with them. If he does not seek to know himself and to overcome his own difficulties, how then can he be effective as a therapist?.

Life in the first Unit I worked in was great fun. We worked as a multi-disciplinary team; solving clinical and ward problems together and providing mutual support to each other. We were particularly close at the medical officers' level. The Unit Head was so proud of this enthusiastic bunch of junior doctors that even up till today, he frequently referred to that period as "the golden era of the Unit".

Shortly after settling down at Woodbridge, we organised for our patients the first Inter-Ward Games. It was held on a Saturday morning and about 100 patients from our Unit and a handful of relatives graced the occasion. The staff morale was high. It was a thrilling sight to see the staff competing in various events (including the most comical gunny-sack race) with the patients. For once, laughter and joy filled the air; dispelling the gloom that had always been assciated with the drab Woodbridge surroundings. If a member of the public were to walk pass Ward 32 that morning, he would find it difficult to believe that he was in a mental asylum. Our objective in organising the Games was to allow patients and their relatives to mingle with staff in a carefree and informal atmosphere, away from that "semi-circle". We wanted, in our own small way, to minimise the stigma often associated with mental illness and psychiatric patients. Because of the success of thefirst Games, we went on to organise two more enlarged versions of the Games within a short space of six months; both these times,

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EDITORIAL

INFORMATION TECHNOLOGY

Information Technology (IT) is a new catchword that will be circulating around us. Already, our National Computer Board has come out with a National IT Plan.

IT embraces the use of computer, telecommunication and office systems technologies for the collection, processing, storing, packing and dissemination of information. The corresponding applications in the medical profession may be termed Medical Information Technology.

Be it the use of computer in business, research, or in the medical context, it is not enough just to computerise, we must see how IT can be strategically and creatively exploited to take us up the high tech road.

The successful exploitation of IT requires seven building blocks, namely (1) Manpower (2) Culture (3) Information Communication Infrastucture (4) Application (5) Supporting IT Industry (computer services, computer hardware manufacturing and telecommunication services (6) Climate for Creativity and Enterpreneurship and (7) Co-ordination and Collaboration Amongst the Various Sectors of Economy and Organisations.

The First Computer Conference has helped to focus our attention on the exploitation of IT in the medical context. Of the seven building blocks, the ones requiring greatest nurturing will be IT culture, IT application and inter and intra organisational collaboration and coordination amongst the various medical bodies. Developing on IT culture is perhaps the most important building block of the seven because successful exploitation of IT depends on the mental disposition of people.

The SMA has an important role to play in helping to create a very positive attitude towards IT in the medical world, to bring to the surface not only the potentials of IT but also the adjustments that will have to be brought about with its extensive use. It must be a catalyst for change.

GLG

HIGHLIGHTS OF COUNCIL MEETING

held on 13 June 1986 from 9.00 pm to 11.30 pm

Review of the last SMA Convention	:	Council recorded a vote of thanks to the Convention Organising Committee for a job well done. It was suggested that personal invitation cards to the Opening Ceremony be sent to all members for the next Convention. A scientific session should also be included.
Press Report	:	Following the Sunday Times report on "The Bad Boys in Medicine", it was decided that we request for a copy of the Report of the Economic Committee's medical services sub-committee.
Guideline on Fees	:	Following the directive of the last AGM, the proposed Guideline on Fees was revised by the Guideline on Fees Committee. Council members will study the revised Guideline and report back at the next Council meeting.
Law Society	:	As Council did not wish to be drawn into the dispute between the Law Society and the Acting Community Development Minister, Mr Wong Kan Seng, no statement was made to the press by Council on the matter.

SMA COMPUTER CLUB COMMITTEE

The SMA Computer Club Committee has done some thinking on how it could best cope with the role of being pathfinders in computer use for the medical profession. There are basically 3 types of activities related to computer use namely (1) running the bulletin board (2) running computer education activities such as courses and the monthly meetings and (3) spearheading the development of useful applications. The Committee has organised itself as follows:

SMA COMPUTER CLUB COMMITTEE

STEERING COMMITTEE

SMABBS COMMITTEE	**COMPUTER EDUCATION COMMITTEE**	**SYSTEMS DEVELOPMENT COMMITTEE**
SysOP	Chairman	Chairman
Asst SysOP	Vice-Chairman	Vice-Chairman
SigOPs		Task Groups
Asst SigOPs		

STEERING COMMITTEE

Chairman	Dr Wong Poi Kwong
Vice-Chairman	Dr Cheong Pak Yean
Hon Secretary	Dr Goh Lee Gan
Chairman – SMABBS	Dr Ronnie Tan
Chairman – Computer Education	Dr Lim Su Min
Chairman – Systems Development	Dr Yeo Khee Quan

SMA-BBS COMMITTEE

Chairman/SysOP	Dr Ronnie Tan
Vice-Chairman/Asst SysOP	Dr Cheong Pak Yean

	SigOP	**Asst SigOP**
Public Health	Dr Lim Su Min	Dr Ong Choo Khim
Computing	Mr Lam Siew Hong	Dr Teo Keng Seng
CME	Dr Yeo Khee Quan	Dr Kenneth Thean
News	Dr Goh Lee Gan	Dr Wong Wee Nam
MIA	Dr Wong Poi Kwong	Dr K C Lun
Meetings	Mr Michael Loh	Miss Elin Chan Miss Emily Tan
Feedback	Dr Ronnie Tan	Dr Cheong Pak Yean

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OVERCHARGING...

The subject of fees and overcharging made its appearance in the Straits Times again recently. This has resulted in murmurs of being unfairly accused by the press.

A Straits Times article (ST 25 May 1986) headlined "The Bad Boys in Medicine" said "when private practice and specialist knowledge converge, the opportunities for abuse are greatest. The medical profession in Singapore is no exception.

By all accounts, there are only a handful of opportunistic doctors, but there are more than enough 'horror stories' of overcharging, excessive referrals between doctors, and unnecessary surgery, to name but a few of the malpractices."

Public Flogging

One of our doctors, Dr Tan Soon Khiam, wrote to the Straits Times (which to-date to our knowledge has not been printed). He said in his letter:

"The medical profession has been flogged once again in public and will be flogged sometime in the future just as it has been flogged in the past. It is a fair game for everybody, especially the newspaper media. I wonder what has it done to warrant such frequent attention by the newspaper media, compared to the other professions like the lawyers, accountants, architects, teachers and others. The journalists have developed the immunity to public flogging. I am sure the medical profession would like to know what preventive measures to take in order to avoid this perennial problem of public flogging. Perhaps the members of the medical profession should consult the journalists. As far as I know they have not done so. Is it because they are afraid of being overcharged, or being given unnecessary surgery, or being referred to other journalists?

'These are a few of the opportunistic habits of some specialists in private practice here.'

It is not difficult to identify 'some specialists in private practice here'. The medical community is so small that the journalists should not have any problem pulling the so called black sheep out of the flock and exposing them for what they are. What is it that is holding the journalists back from taking such actions?

I believe that if the journalists are so bent on taking the medical profession on and sincere in exposing the black sheep they should be the first to cast the stone. If they do not they must have reasons best known to themselves."

A Matter of Opinion

The APMPS Council issued a statement in response to the Straits Times article. It said:

". . . with regards to allegations of overcharging, we would reiterate our recommendations that the public should ask the specialist directly or his family doctor the fee chargeable.

The specialist should also inform the patient beforehand, especially where the fee would be considered high. In this way, a contractural relationship would be established.

We would also like to point out that most specialists' fees are close to the government schedule of fees, and at times even below them.

With regard to the other issues, what may be overcharging, overservicing and overinvestigating may be a matter of opinion. However, the association will look into any serious charges in these areas of private medical practice."

GLG

NOTICE OF REMOVAL

All members are to take note that the SMA Secretariat will be temporarily closed on Monday, 28 July and Tuesday, 29 July 1986 to facilitate the move of its office to its news premises at:

Singapore Medical Association
Ground Floor
Housemen's Quarters
c/o Singapore General Hospital
Outram Road
Singapore 0316

Operations will resume as usual on Wednesday, 30 July 1986 at the new premises. The SMA telephone numbers remain unchanged. We regret for any inconvenience caused.

HAVE YOU PAID YOUR SUBSCRIPTIONS FOR 1986?

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COMPUTER EDUCATION COMMITTEE

Chairman	Dr Lim Su Min
Vice-Chairman	Dr Goh Lee Gan

SYSTEMS DEVELOPMENT COMMITTEE

Chairman	Dr Yeo Khee Quan

PROJECTS

1.	Clinic-Lab Communication	Dr Yeo Khee Quan (Co-ordinator) Dr Ronnie Tan
2.	Drug Labelling Program	Dr Goh Lee Gan (Co-ordinator) Dr Cheong Pak Yean Dr Chin Koi Nam
3.	Drug Toxicology Database	Prof Chao Tze Cheng (Co-ordinator) Dr Clarence Tan Dr Ronnie Tan
4.	Public Health Education Games	Dr Ong Choo Khim (Co-ordinator) Dr Wong Poi Kwong Dr Teo Keng Seng Dr Mohan Chellapa Dr Ronnie Tan Dr Lim Su Min Mr John Toh (Hon Advisor)

Interested doctors please contact the respective project co-ordinator.

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economic returns, we should ensure that there is no lessening of interest in the advancement of medicine and in teaching in medical school.

Consider the plight of the medical students whose lectures must be at Kent Ridge for the Dean so insists and because the facilities to hold such a crowd are there. So be it. 8 am or 2 pm, lecturer (who comes from NUH, a stone's throw away) and students (who have to come from their homes and then from all others hospitals) must meet there. After that, the lecturer walks back to NUH while the students consider if it is worthwhile to return to the other hospitals. Or students may have decided to cut travelling costs and save time, to cut the lectures. Should we blame them? Not every one of them has a car. Many still travel by bus. Distances are long, weather not conducive. So what sort of education process are they being led through? Worse still some consider the lectures irrelevant to their clinical posting at hand. Others may feel that lecturer is not worth the trouble listening to. But students will continue to pass out as doctors, the few will continue to score distinctions and the not so few will continue to sit supplementary examinations.

If you speak to the senior staff of the clinical departments, this picture may emerge. "We cannot control standards. It is up to the individual lecturer, senior lecturer, associate professor or professor. They do as they please. No one can control them", or they may say, "The class is too big – two hundred and more students – how do we get to know them well and train them properly. They are a mass of faces." In enlarging the medical intake no one seemed to bother to increase the number of teachers. So how personal can you get? Therefore the University has part-time clinical teachers. Its list is impressive. Again it is all academic qualifications – long string of degrees but what about the ability to teach? Would not the University enhance the role of the part-time clinical teacher if the latter was chosen for a specific purpose, a task which the University knows he or she can do well and contribute to the higher standards of medical practice? Rather than as at present, bank on quality rather than quantity. Above all there must be proper coordination of the teaching programme.

The government part-time clinical teacher is clearly at a disadvantage when compared to the full-time University staff. Remuneration aside, the audiovisual aids available to them are so inferior, primitive and difficult to come by. Machines that churn out slides, transparencies at the press of buttons; easy availability (which may also mean easy to abuse) and staff to do these teaching aids abound in the University. For us in the government side, even cheap photocopying facilities are hard to come by. Blue slides are difficult to obtain, what more in colour. The department of medical illustration is yet to be born. Yet despite these handicaps we teach. It is possible to refuse the post of part-time clinical teacher but then it causes difficulties in the department when a batch of students gets posted in. Anyway it is good to be able to teach – to pass on skills that reading books cannot impart. But the standards?

We should all know that we teach better by example than by words. Illustration with patients is an art worth learning – how to gain the patient's confidence, to be attentive, to assess rapidly the feelings of the patient, how to comfort, how to be calm amidst anxiety and so on. These sort of things lectures cannot impart. It is the living example that counts. Patients are people! They are not guinea pigs. The professor must insist on the highest standards of patient care. Moral pressure has to be paramount and will be more effective in every day practice than statutory orders. Doctors must learn accountability.

Vertical accountability exists in the relation of the various members of a hospital team – the house officer, medical officer, registrar and consultant. The accountability of junior staff is obvious – efficient and compassionate care of the patient and relatives, correct note-taking and an appropriate relationship with hospital staff and general practitioner. By insisting on this the consultant is seeking good standards of care for the patient and of training of future senior staff. But the obverse is important. The consultant in turn has a moral obligation to offer himself as an acceptable model to his juniors and also take an interest to further their career and act as counsellor.

Seeing vertical accountability in practice will make an impression on the medical students' minds. As they walk the various wards and watch closely what goes on, surely something must rub onto them. Bad habits die hard, good ones are difficult to cultivate. So from the first clinical year it is essential that students learn good ones. The great physicians of yesteryear were a treat to watch – the way they interacted with patients, got a history, elicited clinical signs and managed patients. Today medicine seems to be more and more sophisticated expensive high technology superceding the human touch. The younger set seems fascinated by specialisation and the inflated economic returns to certain specialities. They seem to see past the patient to the dollar sign. This ought to be corrected and three billion dollars spent educating the public will make them, hopefully wiser and more questioning as regards their health and what medicine has to offer.

The academics may be forgiven if he seeks knowledge to know the full truth. The practising physician should involve the patient in deciding the course of investigation and management. Tests are done for a reason and that reason ought to be that the result will influence management. Otherwise there is no doubt that medical costs will rise and with expensive technology, doctors can generate the demand for them until such time when doctors as a profession are deemed to be disgraceful, self-centred and money minded creatures. If through our acts the public views us as such, then we as a profession have lost our credibility. To reverse this increasing trend, the medical students must have before them the correct role models and I believe it is the University's onerous task and responsibility to ensure that their teachers live up to their roles.

In the clinical years more so than in the pre-clinical, and henceforth for the rest of a doctor's life, the medical library plays an important part. It is sad that the University Medical Library has moved out of its central location. While waiting for the Academy of Medicine to fill the gap (and even then, not all doctors may be allowed its use), each major hospital should have its own well stocked medical library. What I teach today may be outdated tomorrow and in some fields, changes are so rapid that even the journals may be out-of-date. However, my point is it is so frustrating not to be able to have resource material easily at hand. The photocopying machine has enabled knowledge to be widely and cheaply disseminated. We should not stifle young inquiring minds who have questions they want answers to by failing to provide a library which is up-to-date. To write papers, to have basic background material before starting a project, to be able to obtain articles found in the references of standard textbooks – these are the necessary pre-requisites to excellence. Otherwise every patient appears to be the same – another stroke, another diabetic. When I was in Australia, the house officer could walk from his ward into the medical library, obtain a photostated copy of the article he wanted and come back into the ward and read it and relate it to the problem case at hand. Here we have to travel miles and yet not obtain the information we want. Several tries of such fruitless endeavours kill the medical curiosity within if we even had such feelings at all.

Finally, a comment from a general practitioner friend. "Our doctors do not know how to communicate with patients. They should learn transactional analysis," he says. I am not exactly sure what that big term means. Medical jargon is confusing to the layman and many are easily frightened when we use them. We need to learn how to communicate with patients in their own language. Many medical students cannot take a proper history. They ask for interpreters. Old people still converse in dialects. Not everyone understands English.

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with participation from the other two Units of the Hospital.

On another occasion, two of us together with a few nurses, with permission from the Hospital Director, brought 40 long-staying patients to the Singapore Zoological Garden in a hired bus. Some of these patients had been in Woodbridge for more than two decades. It was a learning experience for me to see two chronic schizophrenic patients, who rarely talked or smiled on the ward, immersing themselves in an animated conversation about the tigers and lions which they had just seen. They must have been stimulated by the animals to momentarily forget about their schizophrenic state. From this incident, I knew that it is not necessarily true that one loses all of one's mental faculty when one breaks down; islets of normality may lie dormant awaiting to be activated. I came to understand better the importance of optimal stimulation in any rehabilitation programme for chronic mental patients.

Shortly after that enjoyable trip to the Zoo, we organised another trip; this time, to the Tiger Balm Garden (Haw Par Villa). I noted that the patients were not as responsive or as enthusiastic as those who had been to the Zoo. As all the exhibits were static and provided little visual stimulation, I was not surprised to see the patients getting bored easily. Nevertheless, they behaved well and unless one cared to scrutinise their dress or behaviour, it was difficult to tell that they were chronic mental patients from Woodbridge.

Besides organising such activities for patients, we too were equally enthusiastic about our own social activities. We had, to quote one consultant, "rounds and rounds of outings and bungalows". These activities helped to promote a sense of comradeship and Unit identity; factors which are vital to the personal growth and development of the staff. They also served as strong antidotes to the so-called "staff burnt-out" syndrome which is quite prevalent amongst those in the helping profession working in stressful and unpleasant environment. I learnt at this early stage the value of effective interpersonal relationship in the work of a psychiatrist. A surgeon or gynaecologist who pays little attention to the development of his personality or the promotion of interpersonal relationships with his staff may thrive in his work by virtue of his surgical skills alone; a psychiatrist, by nature of the state of his art, has to rely on his multi-disciplinary team for effective functioning. I concluded that there is no room for narcissistic individuals in the psychiatric field.

Whilst we enjoyed ourselves, we never neglected our studies. Since at that time, there was no formal local post-graduate teaching in Psychiatry and the M. Med (Psych) was still unheard of, the six of us launched a Monday lunch-time tutorial group; targeting to finish the syllabus for the Part One MRCPsych Examination (Neuroanatomy, Neurochemistry, Neuropharmacology, Genetics, Psychology, Psychopathology, Statistics and Epidemiology) of the Royal College of Psychiatrists. I got together a bunch of Consultants (psychiatrists and psychologists) to sacrifice their lunch break in order to tutor us. Most were willing; a few were reluctant because they felt "they had to read up to keep pace with us". Our group generated a learning atmosphere which was said to be unprecedented in Woodbridge. Suddenly, there was a flux of learning activities in the wards and lecture rooms. I seized every available free time to teach nurses and students and even medical orderlies from the Army. I remembered one Staff Nurse who had been working for more than a decade in Woodbridge told me one day on the ward: "You lot are like a fresh breeze blowing to clear the stale air in the Hospital".

We combed the Psychiatric section of the Medical Library and enthusiastically (or rather, parasitically) photocopied all the relevant sections. It was not an uncommon sight then to see some of us going round the Hospital to collect orders for the photocopying of books. I am writing this with a tinge of embarrassment. But then, at that time, as trainees, we could not afford expensive originals and most of the times, they were not readily available. Besides, it was a national fever amongst the students to photocopy books and some shopping centres even specialised in this trade.

After one year at Woodbridge, I decided to have some exposure to Neurology and Internal Medicine. In October 1982, I approached the Head of a Medical Unit at Tan Tock Seng Hospital to ask if I could work in his Unit. He was more than delighted to grant me the opportunity. During the following six months, armed with a stethoscope, I was back to the main stream of Medicine; focusing my attention on areas closely related to Psychiatry.

One Medical Consultant of the Unit told me that he had done some Psychiatry at Woodbridge but decided to switch to Medicine because he was disillusioned with the woolliness of the subject. He held the view that one day, psychiatry would be incorporated into Neurology as the causation of more and more of the psychotic illnesses is discovered; quoting General Paralysis of the Insane as an example. He also argued that priests, social workers, psychologists and even lay counsellors are as well-equiped as, if not better than, psychiatrists to deal with the minor psychological problems of daily living. I put forward the view that as the human race progresses, it is inevitable that man diversifies to sub-specialise in various fields in order to keep pace with the rapid scientific advancement. I remained unconvinced by his arguments that Psychiatry will one day die a natural death. On the contrary, it has gained popularity over the years because man, having conquered the scourge of infectious diseases and is now leading longer and healthier life, remains trapped by his own emotional and relationship problems sufficient to impede his functioning and to lead him to seek a greater understanding of himself. As long as man is given a choice at the various phases of his life, conflicts are inevitable. The way he handles these conflicts is determined by his mental and physical constitution, his upbringing, his environment or an interaction of these factors. Whether he breaks down or not will depend on how successful he is in dealing with these conflicts. If he fails to recover from his break-down, a psychiatrist is often called upon to help.

This same Consultant suggested that I read the great classical novels such as those written by Fyodor Doestoesky. He felt that the portrayal human frailties by these novelists could easily outshine the chapter on Personality Disorders in the best psychiatric textbooks. After all, novelists and psychiatrists share something in common: an interest in the lives and conflicts of the common people. What makes a person tick? Why does one breakdown whilst another thrive under the same stressful condition? How does one cope in the face of a rapidly changing and highly confusing world? Jealousy, anger, hatred, love, joy, sadness, grief – these are the emotions which novels are made up of and which our patients are frequently troubled by. I started to take a keen interest in the biography of the notorious and the famous; from Hitler to John Lennon.

Working for six months at Tan Tock Seng was a meaningful learning experience. I saw that the boundary between Medicine and Psychiatry is not as clear-cut as I used to think. In fact, if one chooses to see one's patient as a whole (body, mind and spirit), it is not difficult to see how a physical illness invariably has a psychological component. Many of us will understand, for instance, the low spirits, poor concentration, lethargy which often accompany as common a physical illness as the common cold. Some psychiatric illnesses may present initially with physical symptoms alone and unless a doctor is well-versed in mental state assessment, he may not be able to tease out the differences.

I remembered vividly one Saturday morning when I was leaving the staff tea-room at Tan Tock Seng Hospital to return to my ward, a Registrar bumped into me and she said: "Would you mind going to my ward to see a 14-year old girl who was admitted last night and tell us what do you think of her?".

When I went to the nurses' station of that ward, I saw a letter on the table, addressed to the consultant psychiatrist-on-call. It was about the same patient whom I was asked to see; the diagnosis on the letter was Schizophrenia. When I walked towards her bed, the girl sat up and started giggling. I moved nearer. She had stopped giggling but appeared rather perplexed. Then, when I introduced myself and wanted to know her name, she suddenly shouted: "You are my boyfriend." When I asked her which place she thought she was in, she replied: "Singapore Swimming Club." She could not tell me the date or year. I knew that, from her replies and the perplexity she showed, she was totally disorientated. I told the house officer that one cannot diagnose Schizophrenia in the presence of disorientation or clouded consciousness. I suspected patient was suffering from an acute organic brain syndrome and instructed the house officer to alert the Registrar to treat the patient as a medical emergency.

I spoke to patient's grandmother shortly afterwards and obtained the history that patient had been complaining of severe headache the night before. She did not respond to the Panadol given to her and started to vomit in the later part of the evening. Later that night at home, her behaviour became more bizarre. She woke up suddenly and commented on a film-show which she thought was showing on the wall facing her bed. On her way to the

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MEDICAL EDUCATION

Let the patient give his or her story. Do not obtain a history through leading questions all the time. It is the patient's life and his or her illness. We as doctors are trying to help them. They could refuse our help. But if our attitude and behaviour strike them that we are sincere, honest and have their interests rather than our interests at heart, more likely then that they will be only too willing to heed our advice. Communication skills through words, actions, attitudes can be nurtured to promote fruitful doctor-patient interaction.

As we strive toward medical excellence we should guard our reputation jealously. If our profession sets a bad example for all the local and international community to see, where do we hide our faces? If we stress punctuality, we must be on time. If we ask for abstracts by a certain date-line, we should abide by that ruling ourselves. If we are to give an important keynote lecture, we should make it our responsibility and privilege to give a good performance. The more senior we are the greater our influence for good and unfortunately for bad also. Instead of looking for mentors for the younger generation doctors, should we not strive to be mentors ourselves, to whom they can easily look to.

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toilet, family members had noted that her gait was unsteady.

That Saturday afternoon, the neurologist was contacted and an urgent CT scan was ordered. The finding of cerebral oedema was consistent with the clinical picture. The patient was given immediate medication to reduce the brain swelling. It worked. The next morning, when she saw me on the ward, she was able to wish me "Good Morning" and her grandmother had commented that her granddaughter was "back to her normal self". That was a valuable lesson for all of us. Perhaps, a little attention to the history from other informants and a properly-conducted mental state examination would help one to separate organic from functional psychiatric disorders. Psychiatry is not as nebulous as many people thought.

During the last week of my posting in Tan Tock Seng, the Head of the Unit invited me to give a half-an-hour talk to the staff on the latest views on Schizophrenia. Since I have always enjoyed teaching, I accepted it readily. My talk was aimed primarily at dispelling the mystique which many still held towards Psychiatry in general and Schizophrenia in particular. I could not be sure how much of this aim had been achieved although the talk itself was well-received.

After six months at Tan Tock Seng, I went back to Woodbridge again in March 1983 to gain further experience in Psychiatry. For several months, I was at the Child Psychiatric Clinic at the Institute of Health, Outram Road. The Consultants at the Clinic were keen to teach and from them, I learnt the major differences between child and adult psychiatry. Often in dealing with troubled children, one has to consider the various causative factors such as family conflicts especially parental discords, school environment, peer relationship before one can formulate any effective management plan. Besides, children are in the process of growing up and I learnt that it is important to distinguish between behaviour which is appropriate for a particular age-group and behaviour which is not. For example, a child who wets his bed at aged 2 is accepted as normal but a child who still wets his bed at aged 10 may need treatment.

Sometimes, the disturbed child is shouldering, unknowingly, the tension within his family generated by a strained parental relationship and in such instances, the family (or at least its key members) should be treated together. I came to realise the importance of family therapy as an effective therapeutic weapon.

I was impressed with the use of modern technology at the Clinic to facilitate the teaching of Psychiatry. An interview room was converted into a sound-proof recording studio separated by a one-way mirror from an adjoining observation room. Medical students, psychologists and other doctors would use the observation room to watch, through the one way mirror, family interview or therapy sessions which were simultaneously recorded on video for future demonstration. Of course, this was done with the full permission of the family. This method is an effective way of teaching proper interview and counselling skills and is widely used in most psychiatric departments in the West.

In the midst of a hectic and tight learning schedule, I hardly realised the rapid passing of time. Soon, it was time for me to leave for Edinburgh. Armed with boundless enthusiasm and mixed feelings (excitement, curiosity, sadness), I boarded the plane on 27 September 1983 and headed for London Heathrow. ■

CONGRATULATIONS

EXAMINATION SUCCESSES

MASTER OF MEDICINE (INTERNAL MEDICINE) EXAMINATION – JUNE 1986

Dr Chee Eng Nam, Alexius
Dr Chong Siong Eng, Roland
Dr Koh Siam Soon, Philip
Dr C Rajasoorya
Dr Sarah Melanie Vijayasingam
Dr Wong Meng Cheong

ENDO-UROLOGY WORKSHOP

NOVEMBER 17-19, 1986 SINGAPORE

Organised by: Singapore Urological Association and the Chapter of Surgeons, Academy of Medicine, Singapore.

Programme:

DAY 1
Lectures on Uretero-renoscopy, Ureteroscopic Ultrasor Lithotripsy, Percutaneous Nephrolithotripsy and ESWL. Also, How I do it Sessions with Video Presentations. Venue: Lecture Room, Blk 6 Level 9, Singapore General Hospital.

DAY 2
Demonstration of Endourological techniques and instruments with pig kidneys at the Experimental Laboratories, SGH. "Hands-on" experience limited to 30 Full Registrants. ESWL Demonstration at the Lithotripter Center, American Hospital, Singapore.

DAY 3
Live Operative Demonstrations on Uretero-renoscopy, Ureteroscopic Ultrasonic Lithotripsy and Percutaneous Nephrolithotripsy at the Endoscopy Theatres of the SGH and the National University Hospital.

Registration Fee: S$350/- for Full Registrants and S$300/- for Partial Registrants.

For Application Forms and more information:

Contact: The Organising Secretary
20th Annual Combined Surgical Meeting, Academy of Medicine, Singapore
Harrower Hall, College Road, Singapore 0316.

"DOCTORS NEED PATIENTS' PRAISE & TRUST..."

Dr Ernest Wong

This was the message that one of our members, Dr Ernest Wong, left with his audience at a Rotary Club meeting recently.

He was speaking on the facts and myths of overcharging in relation to doctors' fees in the private sector in Singapore.

"Most of us, at one time or another, would be confronted with a medical bill either for himself or for our family.

This topic has been raised time and again in our local paper. I hope to be able to present an insight into the fee structure and the reasons for their variation. I also hope to give a balanced view of the situation as I see it.

Initially, it is important to outline briefly the areas where cost is incurred when a person becomes unwell.

AREAS WHERE COST IS INCURRED

First, is the cost for the hospital bed. In private hospitals, the cost always includes meals and the general nursing care. The cost ranges from $50 to $200 depending on the hospital. A suite would cost $600/– per day.

Second, is the cost for utilization of the operation theatre – if operation is needed. The rates are hourly rates, much like a car park, and the faster you get out of there, the better. On top of that, you pay for the suture material used and all disposable items expended on your behalf.

Third, you pay for the X-rays and blood tests that have been done and for all the medications and dressings that you have received.

All these will be totalled up and are payable to the hospital. All hospitals ask for a deposit or guarantee of some sort.

The next item on the bill would be the surgeon's and the anaesthetist's fees. The anaesthetist's fee is about 25% of the surgeon's operation fee. So one can perhaps say that an expensive surgeon begets an expensive anaesthetist.

Now we come to the doctor's fee. The doctor's fee is earned through the initial consultation, then the operation fee (if surgery is involved) and subsequently the follow-up fee, whether as a visit in hospital or as an outpatient. This is the variable part that has often been the subject of much misunderstanding.

MISUNDERSTANDING

The reason for the misunderstanding is that there is often a wide variation in fee with different doctors and with the same doctor in different patients with the same illnesses. It is no wonder that the public is bewildered by this apparent disarray.

STANDARDISE FEES?

Why then, one may ask, is it not possible to standardise the fees and so obviate all arguments. Doctors, after all, are not businessmen and they are expected to use their skill to treat the sick rather than to enrich themselves. This notion is generally accepted by most doctors and few would argue that the medical profession must stand apart in that it cannot withhold its service for lack of a fee. And I don't think there are many doctors who could refuse to treat the genuine poor if the poor has no other options.

However, the difficulties in standardising medical fee are due to the following:–

Now, medicine is an inexact science. Even, the most advanced computerised X-ray machines do not come near to matching the eyes, ears, nose and hands of the clinicians. This is because different patients with the same sickness can present in a totally different manner. The same blood or X-ray result in different patients can mean totally different things.

Also, the same illness can have more than one line of management and the wrong choice can be fatal. And the skill required to recognise these subtle differences cannot be gleaned from the books. And it cannot even be achieved through sheer exposure and experience alone. It has to be exposure combined with a conscious and consistent effort to analyse and challenge one's own knowledge and biasness over the years. A doctor must develop a sixth sense peppered on his knowledge and he must have logic in abundance. Now, how do we quantify the ability of such a person? Even if we can, what about the variations within the group? Furthermore, besides technical skill, genuine concern, consistent care and meticulous bedside manners are just as important and in these aspects, the variations are even greater among practitioners. Furthermore, can a doctor not command a higher fee because of his exceptional image. This brings to mind a saying that for a doctor to be successful, he should be bald, have a paunch and have haemorrhoids. This is because his baldness suggests intelligence, his paunch suggests prosperity and success and the pain from his haemorrhoids gives him a look of concern all the time.

On top of this, matters are complicated by the fact that the public is generally very unforgiving towards a medical error. There are people who make a living solely out of medical litigation. This results in what is generally known as 'defensive medicine', ie order a whole list of tests, however remote, and then collect a hefty fee to pay for the insurance.

To add to the difficulty of standardisation, there are great variations in patients' attitude toward their own illnesses. Some are more anxious and so more suspicious and consequently more demanding. As such, the fee then may have to be adjusted according to the time taken up.

We can now have an idea why the variation on the part of the doctors, on the part of the patient and on the part of the illness makes it not at all easy to standardise fee. If a fixed fee should be implemented, one drawback that immediately comes to mind is that doctors could sieve out the difficult and time consuming cases and take on the straightforward and easier ones. After all, one difficult patient can mean many sleepless nights.

OVERCHARGING

Now, the question is often asked, is there evidence of overcharging in private practice. Well, on a case for case basis, there must be and will always be instances whereby the fee would be in excess of what would be considered reasonable. The situation becomes further aggravated if cure or satisfaction has not been achieved. But, yet again, the doctor concerned may well have a good reason to demand that amount. In any case, if the patient has prior knowledge of the fee involved, then it is difficult to find fault. My own impression is that, by and large, the great majority of doctors in private practice do not overcharge. Private medical practice is not as lucrative as is usually thought and doctors, like everyone else, do not like to price themselves out of business. It might surprise you to know that the recession affects everyone including doctors.

Presuming that there is overcharging, is there any existing safeguard? At present, most patients do ask for the cost of the investigation or treatment involved. And often, they 'look around' before deciding. Also, GPs who refer patient do not like to be associated with a pricey doctor as patient tends to put some blame on the referring doctor.

Is there anything more that is being done? At present, the SMA and the APMPS are trying to work out a guideline of schedule of fees on surgical operations. At most, they can only come out with a range of fee and with that it becomes possible that the average fee then slowly climbs up till it arrives at the top of the range. Also, once the guidline becomes entrenched then the poor could lose out as doctors become unwilling to deviate below the limit just as they are unable to deviate above it.

Now, what advice can I give in order to avoid being made to pay excessively?

Firstly, get to know your doctor and try to use the same one. Choose one that suits your temperament. Some people are comfortable with the friendly type, some with the commanding type and some with the quiet type. If you find that you are not getting better and you want a second or specialist opinion, ask him tactfully and if you have no particular person in mind let him choose the second doctor. Then make it a point to come back to him for follow-up care. This would build up a trust between you and him. His fee would usually remain fair and he will also ensure that the person he refers you to would do the same.

Also, if you want a second opinion, do so openly, there is nothing vulgar or wrong about it. Doctor hopping and secretive second opinion would only ensure a high fee, due to repetition of tests already performed and the second doctor may have to pre-empt a third opinion by doing even more tests.

TWO-WAY AFFAIR

Finally, be patient, most specialists do spend time on their patients and are unlikely to miss any major condition. Pick a doctor you can like and trust him. Doctor and patient relationship is a two-way affair. Money and power alone cannot buy the best service. There must be trust and even a degree of fondness between the parties involved. I have known of patients who have so little trust in their doctors that they go from one to another and finally ended up treated by witchcraft much to the detriment of their health and wealth.

Finally, please remember that doctors are human and have their share of errors. They need to thrive on your praise and trust. Also, doctors merely treat. It is nature that heals." ■

Thanks to you Sandoz is 100 years old. We'd like to show our gratitude.

WIN A TRIP TO SWITZERLAND OR ONE OF 100 GOLD BARS JUST BY MAKING A GOOD SUGGESTION TO HELP US THROUGH THE NEXT 100 YEARS

For 100 years, professionals like you have been giving us good suggestions to help improve our products and services. This year, our Centenary Year, we'd like to encourage that tradition even more.

We invite your suggestions on ways of improving our products, literature, packaging or deliveries; suggestions on how to make product information more accessible to you; ways we could become more involved in your community. We'll entertain constructive suggestions in any area.

The prizes

- 100 Gold Bars (each 2.5 gram) will be awarded for the best suggestions.
- The Grand Prize, a trip for two to Switzerland and a week's accommodation plus a tour to Sandoz Headquarters in Basel, will be awarded by lucky draw from among the 100 qualifying entries. So, if you have a good suggestion, you have just as much chance to win the Grand Prize as anyone else.

The rules

- Suggestions must be written in English or Chinese.
- Maximum length is 300 words.
- To enter you must be a registered doctor, pharmacist or nurse and you must reside in Hong Kong, Singapore, Taiwan or Malaysia.
- Suggestions must be received by September 30, 1986.
- All winners will be notified personally and a list of winners will be published in the Asian Medical News (November 18, 1986 edition).
- All suggestions become property of SANDOZ.
- Staff of SANDOZ or their distributors are not eligible to enter.
- No alternate prizes will be given.
- Judges decision is final.

Send your suggestion to: Sandoz Pharmaceuticals Ltd, 1602 AIA Building, 1 Stubbs Road, Hong Kong.
Please include your name, profession, address and telephone number.

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