

Hobbit's Seven Research Proposals



The latest big thing in medicine is research. And Singapore is really firing on all cylinders to get into research. Unfortunately, there are some areas that are worthy of research but may never see the light of day, while other research may be scientifically glamorous but quite useless in the real world. There are some research that are plainly too expensive, large-scale or too long for a small country like Singapore to undertake. Hobbit would like to take this opportunity to suggest a few research projects that are important, quick and cheap to do.

STUDY AREA I: EVIDENCE-BASED TRAINING AND FAMILY PHYSICIAN REGISTER – MBBS VS HIGHER QUALIFICATION

There has been much discussion about the Family Physician Register and the need for a GP to have higher qualifications so as to be able to give better care to patients. The fact is, a substantial number of GPs today in the private sector already have their GDFMs, MMed (FM), MRCP and MMed (Public Health), and others.

There is a lot of coffeeshop talk that higher qualifications do not translate into better practice or patient satisfaction in the local context.

To refute or establish such anecdotal claims, we should conduct a study on two groups of GPs: one group with only MBBS and another with further qualifications. The study must have adequate sample size: at least 100 if not 200 private sector GPs in each group. Then each GP

Page 14 ►

◀ Page 13 – Hobbit's Seven Research Proposals

will be assessed on criteria that can be roughly divided into three aspects:

- a) Better clinical outcomes for some diseases, such as DM and hypertension, and ability to effectively handle conditions without referring;
- b) Better patient satisfaction; and
- c) Charges as an indicator of affordability.

The study subjects should preferably be stratified and paired according to age. GPs with only MBBS should only be compared to those with higher qualifications of the same age group, for example, 35 to 45 years old, and so on.

Once we have these findings, we can then make an educated decision on the actual utility value of compelling our GPs go for higher qualifications.



STUDY AREA 2: EVIDENCE-BASED CME POLICY

There is a lot of talk about raising the CME point requirement above 25 so soon after CME was made compulsory. Again, we need an evidence-based CME policy. What is the evidence that by increasing CME point requirements to 30, 40, 50 or even 75 will achieve better clinical outcomes, better patient satisfaction or help keep healthcare affordable?

We can conduct a retrospective study on this. Again, divide the study population (that is, doctors) into several groups according to the average number of points attained over the last two years: 25, 30, 40, and 50 points. There are already quite a few doctors who have 'over-killed' and accumulated 40 to 50 CME points a year in the last cycle. Stratify them by age for GPs, and area of specialties for specialists. Then assess each group against criteria divided into the same three large groups of clinical outcome, patient satisfaction and charging. We need to know if more CME in the last two years had led to a better performance that is statistically significant in any of these three areas.

We should also conduct a literature review with other countries on their experience as to what is the 'sweet spot' in terms of CME point requirement leading to better or more affordable practice, beyond which the law of diminishing returns sets in.



STUDY AREA 3: CAUSE OF DEATH IS REALLY, TRULY, VERILY OLD AGE

Everyday, there are probably nice old ladies and gentlemen who die of old age in Singapore. Every GP has one or two of such wonderful patients: old folks who have led a full life by adopting healthy lifestyles advocated by the government. They wake up everyday to play with their grandchildren, practise *tai-chi* or play mahjong with their *kakis*. They see their GPs once every two or three months for a host of minor problems like URTI, rheumatism, a bit of occasional constipation and borderline hypertension. Their children and grandchildren obviously love them a lot. Then one fine day at the ripe old age of 90, this one patient of yours, as described above, is found dead in his or her sleep; a painless and peaceful death after a long and fruitful life. Their children call you up to certify death. You go to the house, take a deep breath and sign up the death certificate as either pneumonia or AMI contributed by hypertension – because it is illegal to die of 'old age' in Singapore.

We should conduct a retrospective study into such deaths and see if these folks indeed died of 'pneumonia' or 'AMI', or were they just diagnoses of expedience? Only when we are intellectually honest, can we even begin to look at our community mortality data.



STUDY AREA 4: EFFECTIVE CONSENT FOR EMRX

This is going to be a toughie. Some wise guys thought that EMRX could be rammed through the population; which is exactly what they did, based on the bewildering basis that by seeing one doctor in public hospital A, a patient has consented to this doctor in hospital A to access all his records in other public hospitals without the need for an expressed or written consent from the patient. The position is that the act of consulting this doctor in hospital A is implied consent for the doctor to access his records in other public hospitals.

Expressed, implied, written and informed consent are all bewildering terms to those with scant respect for patient privacy and confidentiality rights. Let us simplify the matter: there are only two kinds of consent as SMA

◀ Page 14 – *Hobbit's Seven Research Proposals*

Honorary Legal Advisor, Ms Kuah Boon Theng put it during a SMA seminar once: effective and ineffective consent.

Consent that is effective must be based on two parameters and two parameters alone:

- a) The patient knows the options; and
- b) The patient has the power to choose between the options.

Any other consent is logically ineffective.

Hence, it follows that one cannot consent to something he does not know exists. The current practice of implied consent is only effective if the patient knows that EMRX exists and that his records will be shared across hospitals. For the current practice of EMRX to continue ethically, all the patients who go through our public hospitals must first be aware of EMRX. The research is thus very simple but necessary: we should survey our patients on their awareness of EMRX and its capabilities, and that a choice exists for each patient to opt out of the system.

Only when we know that the vast majority of patients (Hobbit would say at least 90%) are aware of the existence of EMRX and a choice exists for them to opt out of EMRX can we conclude that the current practice of implied consent upon consultation without expressed or written consent is effective, ethical or even legal.

The act of continuing with the current practice of implied consent, while a substantial segment of patients might be unaware of EMRX or the choice of opting out, is like saying we can declare Singapore is a parliamentary democracy while a sizeable segment of Singaporeans are unaware that we have general elections and every adult Singaporean is eligible to vote. Both consent and democracy would be ineffective in either case.

Therefore, research into awareness of EMRX among patients should be the first precondition for implementing an effective policy of implied consent in EMRX.



STUDY AREA 5: MEDICS FAMILY INCOME AND FEE HIKES

Local medical school fees now stand at about \$17,000 a year. Twenty years ago in the mid-

80s, it was slightly over \$1,000. Defenders of the fee hikes in the last 20 years say that loans and financial grants are available to the needy so that the poor are not denied access to our local medical school. In theory, that appears sound. But in practice, the fee hikes may have been a deterrent to the poor – but clever – to even apply and get admitted into medical school.

To see if the local medical school is still a meritocracy instead of an 'elito-crazy', Hobbit suggests the following study:

- a) Obtain the average household income per capita in 1986.
- b) Obtain the average household income per capita in 1986 for the 1986 cohort of first-year medical students.
- c) Obtain the standard deviation (SD) of the average household income per capita for first-year medical students from the national average.

Repeat the same process for the cohorts of 1991, 1996, 2001 and 2006 (that is, every five years). Examine if the SD is positive or negative for the medical students against the national figure and see if the magnitude of the SD has increased or decreased over the last 20 years.

Hobbit suspects that the SD is positive (medical student's household income per capita more than national average) and that the SD has increased in magnitude. Hobbit however, would be more than pleased to be proven wrong in this instance.



STUDY AREA 6: PERCENTAGE OF GPs PRACTISING AESTHETIC MEDICINE

Regular readers of this column would know from a previous article that Hobbit is experiencing hard times as a GP and is tempted to go into aesthetic medicine. Since then, only more GPs have taken up aesthetic medicine. It is time we survey what percentage of GPs have made investments into this branch of practice and actually practise it on a regular basis.

The practical application of this research is simple. Half of our medical students become GPs. If only half of these new GPs (Hobbit's guess is more than half probably) practise aesthetic medicine eventually, that comes up to a quarter of each cohort. If there is indeed such a sizeable segment of each cohort that practises aesthetic

◀ Page 15 – *Hobbit's Seven Research Proposals*

medicine, is it not time we included the ethics, psychology and science of aesthetic medicine as part of the curriculum of MBBS or GDFM? If not, then we are NOT preparing or training our medical students for reality. But before we make changes to our undergraduate and postgraduate family medicine training programmes now, we must first quantify the extent that aesthetic medicine has taken root in our GP clinics. The study should preferably stratify the GPs into different age groups.



**STUDY AREA 7:
MANAGED HEALTHCARE
ORGANISATIONS (MHOS) LIQUIDITY
ADEQUACY**

Managed Healthcare Organisations (MHOs) hold large amounts of monies from clients – usually employers or patients. In return, they acquire a lot of liabilities through the monies owed to healthcare providers (including doctors) who service the MHOs' customers (that is, the patients). If the MHO is an insurance company,

then its financial viability is monitored by the Monetary Authority of Singapore (MAS), which is reassuring and good. But the fact is, many MHOs are not insurance companies. The reality is anyone today can set up a two-dollar company and call itself a MHO and keep funds for their clients. There is no regulation specific to MHOs. And history tells us that even in Singapore, MHOs have closed down in the past without paying what they owe to doctors and other healthcare providers. A study should be conducted to study the capital adequacy of each and every MHO in Singapore, to see if they have adequate funds to meet say, at least three months of liabilities owed to healthcare providers, that is, services rendered by doctors, laboratories, x-ray centres and hospitals.

Then patients, doctors and companies can be better informed of which MHOs to work with and which to not work with. Currently, the opaqueness of MHOs' operations leads to vast information asymmetry between MHOs on one side and all others on the other side of the equation: patients, companies and healthcare providers. ■