

## Dare To Dream

Delivered by Lee Suan Yew on 26 May 1995 at 5th Scientific Conference, College of Family Physicians Singapore

I am indeed honoured to have been invited to deliver the 15th Sreenivasan Oration. Dr B R Sreenivasan was an eminent Physician, Scholar and Administrator. When he retired as Vice-Chancellor of the University of Singapore, he resumed his career as a family physician.

As the first President of the College of General Practitioners he under-pinned the importance of Family Medicine even though it was fashionable to specialize. The daunting task was to educate the patients as to when to consult a family doctor and when he should be referred to a specialist. Specialization was inevitable and indeed necessary with the deluge of advanced medical knowledge. However, patients still needed a good family physician who still is the best doctor of first contact and who provides a personalized, integrated and continuing medical service.

I chose "DARE TO DREAM" as the topic of the Oration because of an article in the Straits Times published on 18th January 1995. The heading, "Dream big and dare to fail - 89 year old climber ". Mr. Norman Vaughan took 65 years, \$2.5 million, one failed attempt and 9 days of climbing to reach the peak named after him in the Antarctic.

On 16 December 1994, he travelled miles through snow with dogsleds. He climbed the 3,140 metre mountain, 385 km from the South Pole and fulfilled his big dream. He failed once but succeeded after a lapse of 65 years!

To achieve greater heights in our medical field we too have our mountains to climb. We need to work hard towards achieving our goals however long the going may be. If we fail, we try again until we succeed. On the contrary, we should not indulge in day dreaming whereby there is total inertia.

Permit me to dare our doctors to dream in several pertinent medical issues facing our medical profession. Due to time constraint, let me confine myself to five "DARES".

### **To DARE our doctors to actively participate in voluntary Continuing Medical Education programme in spite of our busy schedule.**

One could practise medicine the same way as our pioneer doctors did after World War 11 and could be quite adequate and contented. Nevertheless, as our patients' level of education increases, a high standard of health care is expected of their family doctors. Continuing Medical Education (CME) Programme was first launched in 1989 on the recommendation of the Singapore Medical Council. In July 1993 the Academy of Medicine (AM) and the College of Family Physicians (CFPS) automatically registered their members in the programme.

The 1993 data showed the number of practitioners registered as follows:

Members of the Academy of Medicine	994
Members of the College of Family Physicians	700
Others	332
Total Registered	<u>2,026</u>
Total practising doctors in Singapore	4,146
<b>(Total Registered = 49% of all practitioners)</b>	

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It is incumbent on us to keep abreast with recent advances in medicine however busy we are. If we are unable to attend lectures, seminars or workshops, there are video-tapes, audio-tapes and journals to update our knowledge. With the advent of Internet even our patients can gain access to the latest advances in medicine from many countries. Internet and teleconferencing will be more commonly used by doctors and hence, the dissemination of new knowledge will be worldwide. The whole scenario on transfer of medical information using "electronic skyways" will make it easier for the younger doctors who are computer intelligent. Those of us who are older may have to learn computer technology or gain information through conventional methods.

The College and the Academy are well placed to challenge our doctors to participate in our CME programmes.

However, a review of a study on the effect on CME intervention on physician performances and health care outcomes may be useful. In the US an objective study was done by a group of doctors: Davis, Thomson, Oxmen and Haynes. They coordinated with many centres to gather "Evidence for the effectiveness of CME". They concluded that:

### **1) PREDISPOSING CME INTERVENTIONS**

i.e. communicating or disseminating information through lectures, week-end symposia, reading journals and communicating with colleagues did not change doctors' performance. It was not effective alone. The findings were somewhat negative.

### **BUT**

**2) ENABLING FACTORS** were more effective. Enabling factors help to facilitate a desired change in the practice site. Setting up "hotlines" would provide the physician the necessary help in the process of change. The physician defines his objective in simple and measurable terms. For example,

(a) to increase the screening of diabetic patients for retinopathy, or

(b) to convey to every diabetic patient the importance of weight and dietary control.

Physicians improved their outcomes if they attended lectures given by "Opinion Leaders" or "Eminent doctors" because they found that the new information given by such persons was reliable.

**3) REINFORCING FACTORS** were also helpful in permanently changing physician performances. Examples are reminders or feedback.

Both enabling and reinforcing factors consistently improved physician performance and improved patient or health care outcomes. Doctors who wanted to improve their performance through formal CME should select courses that begin with a needs assessment, provide performance rehearsal and facilitate practice change in the clinician's practice setting. Hence, effective CME courses must be more individualized to be effective.

### **To DARE more of our younger doctors to sit for the Master of Medicine (Family Medicine) Examination.**

The College has played a key role in conducting the Member of the College of General Practitioners (MCGP) Diplomate course and examination. With the introduction of the M Med (Family Medicine) in 1993, the standard of family medicine will improve even further. With the two--year structured rotation postings in hospital and one-year posting in the Polyclinics, medical officer trainees receive a well rounded exposure to a wide spectrum of medical conditions. Since the course is so popular, perhaps more vacancies could be made available to them in other restructured hospitals in Singapore. In time, there will be more post-graduates with the M Med (E~I) degree. There are 19 presently.

In ten to fifteen years when there will be more such post-graduates, the NUS would be tempted to open a full Department of Family Medicine. Meanwhile, the NUS would be in a position to increase the staff in the Division of Family Medicine commensurate with the expansion of Primary Health programme in the curriculum.

In the foreseeable future, more research will be conducted by the Division jointly with the College and the Ministry of Health. One example is the use of Hormone Replacement Therapy (HRT) in menopausal Asian women. What are their benefits and drawbacks? We should not rely on Western studies alone. There are many studies that can be made to benefit our citizens.

It is quite apparent that as more of the physicians specialize and sub-specialize, there is a void in the body of physicians. This is worrying because there is a need for good General Physicians.

This void can be filled by the post-graduate of the M Med (Family Medicine). This may well be a "Paradigm Shift" as it were. There is a need to change our mind-set. All our young graduates are better trained and are capable of taking on a wider responsibility as General Physicians. As education advances so does productivity and quality of health care. The time has come to widen the scope of the Family Physician.

### **To DARE our doctors to understand the impact of Traditional Medicine in Singapore.**

Traditional Medicine in Singapore probably existed long before the founding of the King Edward VII College of Medicine in 1925.

According to a book on Principles and Practice of Contemporary Acupuncture, Traditional Chinese Medicine (TCM) was brought to Korea in 541 AD. It was probably the beginning of the spread of acupuncture in the Far East. A Chinese physician brought acupuncture books and charts to Japan in 562 AD. In the early 7th Century, Japanese scholars studied medicine in China. In 1362 AD an acupuncture school was established in Japan. Acupuncture went to Southeast Asia along with the trade and the emigration of the Chinese.

Chinese herbal medicine dates back to the earliest periods of Chinese history, and over a span of time many pharmacopoeias were written and revised. The oldest is the "Pen Ts'ao Ching", in which the "Red Emperor", Shen-ung described various medicaments and included instructions for their use. The "Yellow Emperor", Huang Ti reigned from about 2697 to 2595 BC. He was said to have composed "The Yellow Emperor's Book of Eternal Medicine".

An American cardiologist, Dr E Grey Dimond visited China and was quoted to have said, "We in the West had to learn to use primitive herbs in digitalis, in ephedrine, and the ranwolfa tranquillizers; there must be lot of pharmacology the Chinese can teach us too."

In Singapore, Traditional Medicine is allowed to practise independently without regard to training and licensing of herbal medicines or practitioners. There are over a thousand herbal shops in Singapore. There is a large market for Chinese Medical products. Many Singaporeans use herbal medicine, acupuncture, bone-setters, reflexology, Indian Ayurveda (in Sanskrit it means knowledge of health and long life) and Bomohs. Different coexisting medical systems are practised in Singapore.

Many Singaporeans use such alternative medicine. Eastern trained doctors naturally take a critical view of such traditional practices with no scientific basis. It is unlikely that the two systems will integrate as in the case in China.

Several countries are beginning to re-look at traditional medicine as an adjunct treatment. Our Government will be setting up an acupuncture research programme in the Ang Mo Kio Community Hospital but its involvement in other aspects of Tradition Chinese Medicine will be limited for the timebeing. The Ministry for Health, Information and the Arts, BG George Yeo informed Parliament on 20 March 1995 that acupuncture experts from China and the World Health Organization will be asked to help define research areas and identify the conditions under which this treatment will be clearly useful. He was cautious about other aspects of TCM since there are no regulations in the practice of

herbal medicine. He encouraged TCM practitioners to self-regulate the profession before any legislation can be contemplated in the future.

In the British Medical Journal of 22 April 1995, Peter De Smet, Clinical Pharmacologist of the Royal Dutch Association for the Advancement of Pharmacy posed the same question, "Should herbal medicine-like products be licensed as medicine?"

European Union legislation requires herbal products to be authorized for marketing if they are industrially produced and if their production or function or both bring them inside its definition of a medicine product. The problem is that such medicinal products may be contaminated with undeclared toxic botanicals, heavy metals, or pharmaceuticals. Consumers are in no position to distinguish between safe and less safe herbal medicine-like products.

One answer could be herbal licensing, De Smet suggested. The authorities are then able to screen the declared constituents, demand proof of product quality, restrict the level of potentially dangerous constituents, and enforce warning about correct and safe usage. Such marking surveillance will protect our consumers.

In the US a similar situation is present. The safety of patients, the efficacy, and fraudulent claims to "miraculous cures" are being assessed by the National Institute of Health under the division of "Alternative Medicine". They are using stringent and proper scientific principles. They will allow such practices to be introduced only when such standards are met.

It is just possible that our authorities could regulate such practices so that public safety be protected. Unproven practices can be dangerous and ultimately, costly. By the same token, closing a blind eye to their existence will not help our citizens.

### **To DARE all our doctors to practise a high ethical standard of medicine.**

On 2nd May 1995, for the first time in the history of the medical profession in Singapore, the newly registered doctors made the Singapore Medical Council Physician's Pledge before the Medical Council.

In his address to the doctors, the President of the SMC, Prof N Balachandran described the practice of medicine as a calling. I quote: "Success cannot be measured in financial terms only. It must be measured by the sum total of good we do for the community."

I wish to quote the next passage because Prof. Balachandran encapsulated the essence with clarity and depth:

"We have the responsibility to build a trusted and caring medical profession. We are today beginning to drift without an ethical consensus. We have to address these problems as it concerns the very soul of medicine. The sense of value which we still hold, and believe in, will not be sufficient for long when the system comes under strain. It is the fundamentals of our moral commitment that are going to determine the future of our profession and the trust of our patients. The profession is under continuous pressure. It is our ethical code and finally our own conscience that should guide us when there are conflicts in our financial interests and our social goals. To maintain our patient's trust, we must have moral integrity in our profession. Physicians are privileged heirs to a distinguished tradition and established traditional values and more urgent today than ever before in the practice of our profession." These are words of wisdom worth remembering.

In his interview with the Straits Times on 13 May 1995, Prof. Lenny Tan, Dean of the Faculty of Medicine, NUS, was asked, "What can be done to instill this sense of ethics and social responsibility in doctors?" Prof. Tan replied, "Ethics is not something that can be taught. You can test people. People read it, remember it, say the right things to pass the examinations.

But ethics is a culture. The senior doctors have to be role models. You have not only got to be ethical, you have got to be seen to do the right thing, you have got to live a reasonable lifestyle. On the other

hand, unfortunately, it is those less desirable role models that attract the attention that are held up as being successful."

There will be more ethical issues facing the medical profession. Not long ago, the Abortion Bill and the Organ Transplant bill were debated and approved. Soon, we will be finalizing the Advance Directives Bill (or the Living Will Bill).

The Law recognises the rights of an individual to accept or to refuse medical treatment. However, a patient is only able to exercise these rights if he or she is conscious and mentally sound. A patient who is terminally ill may lose that capacity to make decisions. An Advance Directive provides the patient with an option to make known his desire regarding life-sustaining therapy before he arrives at such a state.

Terminally ill patients often prefer to die in dignity and not be subjected to unnecessarily prolonged, painful and expensive treatment with no real benefit at the end. Euthanasia is out of the question and will remain a serious offence, whereas Advance Directives will be acceptable to most citizens.

The medical profession is a noble one. The doctor's character, conscience and skills are being tested all the time. Our profession can only be sustained in high esteem if doctors play their role in such a way that a high level of conduct, empathy and tradition is maintained.

### **To DARE our doctors to practise with compassion.**

Patients often know when their doctors are doing their utmost to get them well. Hence, minor faults, if any, are being overlooked. When doctors practise medicine with compassion, rewards of any kind, monetary or otherwise, play a secondary role. When every effort is made to heal, to relieve pain, or to comfort a distressed patient, the restoration of health is primary on the doctor's agenda.

Problems arise when medical fees are exorbitant and out of proportion to the time, skills and effort expended by the doctor. When medicine is equated with an "industry" or "trade", the public views the medical profession with disdain. While it is good to acquire entrepreneurial skills, it must not be used at the expense of our patients. By all means apply such skills to hospital administration as cost containment is important, to the manufacture of pharmaceutical products or medical instruments.

Patients look up to doctors with a human touch, not a micas touch. If we are not born with such a compassionate character we can learn by practising it. Acquiring such a skill is not difficult.

Doctors must practise with compassion. It is the hallmark of our profession. By the same token, compassion is not the exclusive virtue of doctors. Many people have as much compassion as, if not more than, doctors.

At the entrance to the College there is the famous Sir William Osler quotation inscribed so as to remind us that

"The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head."

Our profession is not far from the order of priesthood. We have very strict entry, a rigorous training and a strict ethical code of practice, conduct and confidentiality. The only difference is that priests lay up treasures in heaven while doctors are reputed to lay treasures on earth first and in heaven as an option!

## **CONCLUSION**

I have tried to dare or to challenge our doctors, in particular, our Family Physicians. I have attempted to pose five challenges:

- (1) To actively participate in the CME programme.
- (2) To sit for the M Med (Family Medicine).
- (3) To understand the impact of Traditional Medicine in Singapore.
- (4) To practise a high ethical standard of medicine.
- 5) To practise medicine with compassion.

These challenges are not beyond our doctors. Like the climber, Norman Vaughan, he failed once but he finally fulfilled his dream because he dared to fail and dared to dream.

We may not succeed at the first attempt but, knowing our Singapore doctors, we have the same grit and tenacity. We are already achieving something but it is not enough. We need to excel so that the beneficiary will be our patients.

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## **REFERENCES**