By Dr Jeremy Lim, Editorial Board Member

Are We Over-specifying Standards?

A recent conversation with a very disillusioned and demoralised general surgeon over the never-ending work in the public sector left me wondering whether we, as a system, were in part to blame for his sad predicament. I am not making reference to the unintended inefficiencies that we all try to overcome but rather to the straitjacketing paradigms of practice we have come to accept as 'gospel truth' and inviolable.

In the best-selling *The Innovator's Solution* (Harvard Business School Press 2003), Harvard Business School Professor Clayton Christensen describes how emerging innovations do not become mainstream until they are modified to the level that consumers want or need at a price consumers are prepared to pay. Often times, the standards of the prototype are more than sufficient to meet market demands, but the costs of production to maintain these standards and hence price may be too high. In short, specifications and standards are only as high as needed in the real world, and not in the laboratory or some theoretical construct. Are there parallels in healthcare?

At the system level, patient safety is a relative concept: healthcare is by its nature a resource-poor environment (because of the paradigm of infinite demand and finite resources) and there is an opportunity cost of our time and attention for our patients, specifically the ones we do not see and the ones we spend less time on. Whether we like it or not, trade-offs are made with our time, our expertise and our infrastructure. The renal physician whose clinic is crowded with early kidney disease patients deprives the patient with advanced kidney disease of an earlier appointment and potentially an opportunity to prevent progression to frank kidney failure and the need for dialysis.

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Three examples are food for thought:

REPORTING OF ALL RADIOLOGICAL IMAGES BY RADIOLOGISTS

Radiologists today report on every single image produced, regardless of the clinical relevance and additional contribution of a specialist radiology consultation. Is this really necessary? The public sector is so desperately short of radiologists that outsourcing to the private sector and even overseas has occurred. Should we critically examine all the tasks that our radiology colleagues perform to see how their time can be better spent? The post-lithotripsy X-ray (KUB) is a case in point. A pre-procedure film would have been assessed by a radiologist and any non-urological pathology screened for. The post-procedure film looks for only adequacy of stone fragmentation and haematoma formation and it is the surgeon and not the radiologist who decides on the need for further intervention. Should the urologist who in any event will critically assess the image suffice? Can the radiologist opinion be sought only when there is doubt? The same principles may apply to the chest X-ray taken after removal of drains in the coronary artery bypass graft (CABG) patient or even the follow-up images to assess fracture healing. The opportunity cost of reading unnecessarily an image means less time spent on the complex MRI reconstruction or one more 'worthy' image not seen.

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PHARMACIST COUNSELLING OF ALL INPATIENTS AT DISCHARGE

We require pharmacist counselling of all inpatients at discharge regardless of how straightforward their diagnosis and drug regime may be. Can the doctor who has been prescribing the medicines and the nurse who has been dispensing them suffice for the simpler cases? They are after all supposed to inform of rationale for medications and any possible side-effects at the point of usage.

I am by no means down-playing the essential role pharmacists play in our healthcare system, but when pharmacists are a scarce resource, we have to acknowledge the trade-offs. Would our pharmacists be better off spending time 'counselling' the discharging patient who is prescribed paracetamol for post-operative pain or running an anti-coagulation clinic?

MEDICAL REGISTRATION FOR NON-NUS MEDICAL GRADUATES

[This last example will undoubtedly be controversial and raise strong reactions, but the aim of this column in general is to provoke discussion and open debate.]

The Singapore Medical Council's (SMC) stand on doctors with basic medical degrees from non-schedule medical schools is unequivocal and non-negotiable. This is premised on the basis of patient safety and the maintenance of standards, but is this needlessly restrictive? When we face almost desperate shortfalls in vital specialties such as geriatrics and neurosurgery, should we re-consider?

All of us know of outstanding NTS doctors, fully certified as specialists in their own countries, who have come to Singapore and distinguished themselves by their clinical acumen and exemplary behaviour. For those in what the Australians call 'Areas of Need', should we waive the requirements for a 'registrable' basic or post-graduate qualification?

Fitness to practise need not be based on arbitrary approval of certain medical schools (Interestingly, both Harold Shipman, the British GP who murdered over 400 of his patients, and Jayant Patel, the general surgeon dubbed Dr Death by the Queensland media, would likely have been 'registrable' in Singapore, qualifying from the University of Leeds and University of Rochester respectively), but can also be assessed through peer recognition and clinical audit.
After all, that is the basis of our hospitals' re-privileging of specialists and arguably the more important part of the SMC registration process. All foreign graduates are conditionally registered and full registration granted only after a period of observation and proctorship. Could we obviate the need for recognisable qualifications if we accept that close supervision will suffice to identify doctors of high calibre? The patient safety question in specialties where shortfalls are acute is not whether the specialist has a recognisable qualification but rather will patients even get to see a specialist.

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We need to recognise that some degree of trade-off is inherent in all standards – there is a cost to meeting standards which consequently impact on availability. Standards of practice should be set high enough to ensure high quality care and minimise risk to patients but not so high that they compromise the equally important public good consideration of access and availability of care for all Singaporeans.
The world is short of an estimated four and a half million healthcare workers – if we are to meet the increasing public demand for high-quality, affordable and accessible healthcare, we will have to re-examine accepted notions of practice and ask whether we can revise them without compromising population health. ■