By Prof Chee Yam Cheng

Retrospectroscope 1977-2003

It is not often that one reflects on what might have been. But since this is Christmas and goodwill is in the air, those who may have felt aggrieved and affected by things past may be more willing to be understanding and forgiving. There are four somewhat negative (if you could call it that) and two positive experiences in my medical career that I would like to relate.

SOCIAL DEVELOPMENT UNIT

When Dr June Lou was the Head of the Social Development Unit (SDU) at Tan Tock Seng Hospital, I was asked to help out. This I gladly did. It was during the years of 1977 to 1985; the two-child policy of family planning had been overly successful to the detriment of Singapore (even up till today) and babies were becoming scarce. Dr Eileen Aw was the Head of the national SDU (Her daughter-in-law is a doctor) and this task was passed on to Ms Susan Chan (whose daughter is also a doctor). The job was to do matchmaking of our doctors but I can hardly claim any success stories. Many a time there were frantic phone calls to ensure that so and so would attend some prearranged social gathering. It was for me to broach the reason why they were being invited. This cut no ice with many of our doctors, and was more so for the gentle ladies than the gentlemen. It was not just about trying to get doctor to marry doctor – the net was spread further afield in the civil service, and doctor could also marry non-doctor.

The list of failures is long, and is longer for the ladies. There must be something I did not do quite right but try very hard we did, to the extent that several young lady doctors (now older of course) did not find it a happy encounter passing me in the corridors of the hospital. Perhaps today they can better understand why that little job was important. Even recently, the Minister for Finance mentioned in Parliament that a huge budget exists to try and produce a baby boom. So we have been trying for over 30 years without much success.

TRAINEESHIP INTERVIEWS

In the 1980s I was heavily involved in the selection interviews for traineeship in nearly all the specialties. Today I am "restricted" to Internal Medicine. Nonetheless the issue is the same across specialties, and the same today as it was then. Trainees were/are asked about their activities and contributions outside of Medicine. Of course the interviews are meant to elicit answers to three basic items. Firstly, on academic achievements – the ability to pass postgraduate examinations is a necessary hurdle to achieve specialist status. The second item is commitment to the chosen specialty, that it is the correct specialty choice for that individual doctor. The third is whether the doctor is committed fully to the training effort lasting some six years (comprising three years each of Basic and Advanced training). It was in seeking the latter that extracurricular activities; if any, became important. We are known for our efficiency and once the privilege of traineeship was bestowed, the expectation was for a fully trained specialist in six years (with no hiccups or delays).

To some of the lady doctors, the question about the loves of their life, getting married, getting pregnant versus training, travel arrangements of their spouses-to-be and so on elicited disdain. The mistaken belief was that there would be interference or even withdrawal of their traineeships once given, should any of the above events take place. However, the truth was far from it. The questions were raised so that proper planning and juggling of their lives would feature in their plans without compromising the national targets for specialists. There was no suggestion whatsoever that going forward to do these activities would compromise their traineeship chances. In fact, if a positive answer was forthcoming, and the plan was practical, there was no reason to deny traineeship. The country benefits from one new baby and one new specialist. Two months of maternity leave was automatically granted and breastfeeding was never denied.

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For the male doctors, it was about national service of course. Exact dates were elicited so that the national training pipeline would be filled, and places reserved for successful trainees when they rejoined the system from Mindef.

Despite the intention of careful planning down to details, some trainees dropped out. We estimated a 10% drop out rate and factored this into the numbers appointed. We agreed that "accidents could happen"; and we failed to prevent them. So Singapore gained one baby but no specialist. Anytime, up till today, the nation prefers to have both.

UNION MEMBERSHIP

I was the President of the doctors' union in the early 1980s. The union's name was long; Singapore Government Medical, Dental and Pharmaceutical Officers' Association. In short, the SGMDPOA. It was affiliated to the Amalgated Union of Public Employees (AUPE) led at that time by Mr G Kandasamy. We used to negotiate salaries, bonuses, allowances, leave, benefits and so on with the Public Service Division. Encik Haron Eussofe (Ex Member of Parliament and later Minister of State) was on our side at that time and seated across the table was Mr Herman Hochstadt, the Permanent Secretary.

Looking back, I think we were too soft. Us doctors worked too hard and hardly protested or complained. I think the nurses union did a better job. The reason I say so is because the nurses' components of salary have changed very little although the quanta for individual components has risen over time (and justifiably so). For the doctors, we had no allowances. Today you could list them as night duty, meal, weekend and so on all adding up to a tidy sum. Of course then there was no CFS (consultation fee scheme). Promotion exercises were few and far between. It could be scheduled, and then postponed indefinitely. I remember working as one of two medical officers in Medical Unit 2 (my colleague in suffering was Dr Teh Lip Bin); of course we had ten calls per month with no allowances. We took it as part of the job, part of the training. Fatigue was unheard of; it was not macho to mention. You learnt to sleep standing with eyes wide open. Our workload? Tremendous, with corridor beds everywhere.

The union no longer exists today. Its demise occurred when hospitals were restructured and the civil service extruded us from its ranks. But, are we still public employees? We still are servants, only not civil? Even though doctors are not unionised in Singapore (unlike say in the United Kingdom, where the British Medical Association is a trade union with its prestigious journal, the BMJ), it cannot be said that doctors today in the public healthcare sector are worse off compared to yesteryears. In my view things have improved so much that I feel aggrieved I was not in receipt of such benefits during my time. They tell me it serves me right for being born too early. Yet others have said that it serves me right for being born too late and hence becoming part of the first batch of National Service doctors by virtue of being born in 1949.

The SGMDPOA could not bargain for more as the millieu then was very different. To ask to go on strike was unheard of and to ask for more pay was seen as ingratitude.

GENERAL MEDICINE

"The brightest always do Medicine." So at O and A levels, the brightest studied hard and fought to enter the local medical school. There were very few overseas scholarships and in 1967 the Colombo Plan scholarship to study medicine was withdrawn for Singapore. After graduating with MBBS Singapore in those years, the brightest still did Medicine (rather than Surgery or Ob-Gyn). Today this does not hold true.

Adult medicine has fragmented and been torn apart. Knowledge explosion has led to this as more and more doctors are happier learning and doing more and more for less and less of the body. A simple example is doing just the skin with non-disease versus exploring the insides of the traumatised abdomen. The huge advances in technology, including drugs have made it nearly impossible for one doctor to deliver excellent quality care for common conditions, much less every condition. Just a cursory look at drugs used to treat hypertension will tell the story. It used to be two or three oral drugs as medication when I was in medical school. Compliance by patients with medication was poor as they needed multiple doses daily and the side effects were serious and unacceptable. Today there is a plethora of antihypertensive drugs. Likewise are the medications for diabetes mellitus. So it was just a matter of time before fragmentation of care occurred. Each physician wants to do the best for the patient in one system, one organ, and one orifice. This is the nature of things.

When TTSH was restructured in 1992, the four medical units were skilled enough and large enough to go do their own specialty. Hence was born the departments of Geriatrics, General Medicine, Respiratory Medicine and Rheumatology. But at that time those physicians still had the skills to continue the practice of general medicine and they desired it. However down the line, becoming more specialised meant giving up the general part and so they did.

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Could anything have been done to hold the whole together while yet letting specialisation flourish? On a theoretical basis, I could offer five hypotheses. One, the specialties had differing in- and out-patient workloads. It was natural for Rheumatology and Endocrinology to become more out-patient based. So some system should have been in place to reward those with large in-patient burdens, especially when these were beyond the control of the department, for example, when many acute admissions came through the Emergency Department into the Department of General Medicine. Two, trying to ascertain value to in-patient work was and still is difficult. Rather than overlook or ignore its value, some recognition could be given to the doctors managing such patients. Just because it is not countable, measurable or quantifiable should not equate to non-recognition. With there being more elderly admitted, the complexity of care has increased. It takes longer and is harder to manage these patients. Three, the inevitability of new medical departments breaking off on their own was a trend that one hospital on its own, could not easily prevent if some other bigger hospital elsewhere had started the ball rolling. Only the highest authority could mandate, if it chose to, which departments to be born or aborted. Put another way, how much fragmentation allowed should be a top down decision. The natural tendency is for smaller and smaller parts (especially if the practice is considered lucrative) to break away. Four, fragmentation seems to be compounded by the "faulty" accounting principles that promote more and more "profitable" fiefdoms breaking away from the core. What is then left in the core are the "unprofitable" bits and pieces after all the cherries have been gleefully plucked away. And to add to the injury, "profits" so generated are given as rewards to staff of these breakaways. Five, predominantly out-patient specialties are attractive to staff as clinics can close on weekends and public holidays with reduced overhead costs, whereas in-patient services do not take any days off. But staff running these clinics do not have any lower pay differential; often it is the reverse.

What would have been the right thing to do? While it is not correct to retard the growth of medical subspecialties, the core should be jealously protected. However if the mandate is bottom line driven and the "faulty" accounting under-recognises and undervalues the core, then the core staff would quickly disappear, and no new joiners would be forthcoming. Based on market principles in Singapore, there is hardly any place for general physicians in the private sector either in solo or group practice. Hence a private well-to-do patient who is in need of one will have to make do with several (maybe between five and ten) different specialists all emphasising how important it is that their specialty organ be well-managed. So the patient takes many drugs prescribed by different specialists in good faith and good money.

Two questions arise. Does the patient like it and can the patient afford it? Maybe Mr Tang's views would be helpful.

Two things I feel I did right and hold in positive light was to join the Ministry when I did, and to leave it when I did. I was posted to TTSH in 1977 (thus scuttling my ambitions to do further specialty training in addition to the MRCP) and never left since (except for a Colombo Plan Scholarship in 1980). Even though in 1985 I started work at the Ministry, it was on a part-time basis. My clinical base remained intact. It was a good decision to go and help contribute as Director of Medical Manpower. The mandate given by the PS/DMS Dr Kwa was clear – train the required manpower. The support to do the job was tremendous and the job got done. Of course, resources are never enough and sometimes difficult decisions are needed and priorities have to be followed. Of course, those denied have every right to feel aggrieved and angry. But it is not possible to please everybody everytime.

I left the Ministry in 1997. The way of thinking and direction changed dramatically after Dr Kwa retired. I could not be happy up there. Time passed. In 2003, SARS hit. Doctors in politics helped out in the Ministry, a first in quite some time. Hopefully the doctor's voice has been heeded. Then, a new Minister took charge.

Regarding men and women uniting, the SDU has not outlived its usefulness. Actually there are official private sector matchmaking agencies today out there. Doctors are considered high premium individuals. Family is central to the Singapore society and a family without children is not the desired outcome. Maybe I had pushed these concepts too early and too hard, and thus the success was not that great.

Then, worklife balance was a dream. Today, we are being forced to make it reality. In part, the great push factor has been globalisation and worldwide competition for professional talent.

Finally more knowledge is a good thing if properly managed not just at the individual but also at the systems level. If healthcare were a perfect market, we could and should let things be and take their own course. Unfortunately it will not be. So somebody somewhere has the responsibility to manage it well. Otherwise the body just goes to pieces. ■