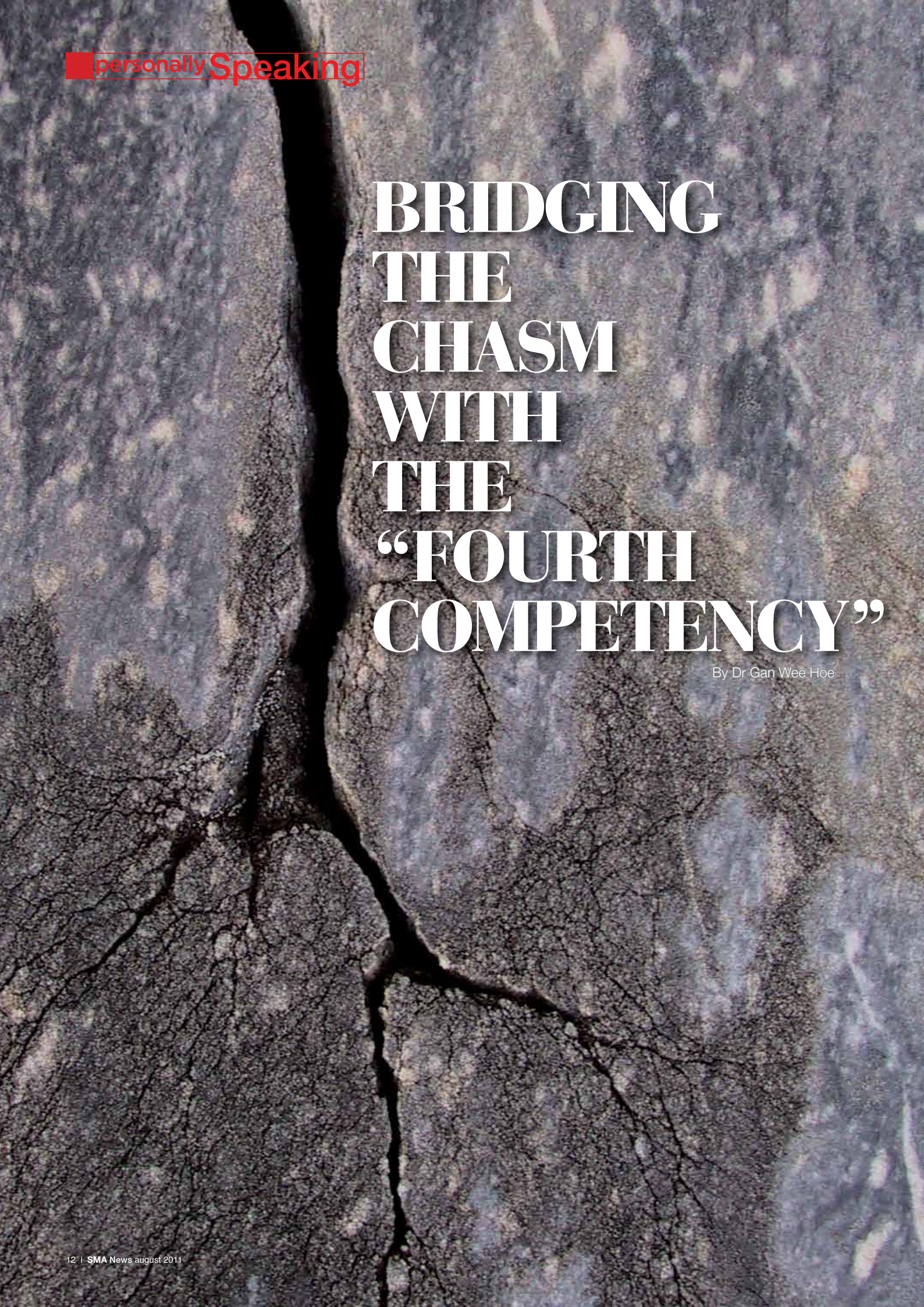
BRIDGING THE CHASM WITH THE "FOURTH COMPETENCY"

By Dr Gan Wee Hoe



Mr Tan entered the consultation room, tightly clutching his queue number after having waited for almost an hour to see the doctor. He was greeted brightly – "How are you, Mr Tan?" – by Dr Lee, who was at the same time busy flipping through the medical notes and latest test results. "Mr Tan, your diabetes control is getting worse. Have you been taking your medications? Have you been watching your diet? Are you exercising regularly? I think I better increase your medication dosage and see you earlier, say in three months' time?" Dr Lee looked up at Mr Tan briefly as he proceeded to gravely expound the perils of poor diabetic control, while at the same time furiously keying an updated prescription into the electronic medical system. After a period of quietly sitting in silence, Mr Tan spoke tentatively: "Doctor, hm, can I continue to work? I don't know if…" Without missing a beat, Dr Lee interjected: "No problem, Mr Tan. But if you don't feel well, better come back to see me, ok? So I shall see you in three months." With a determined finality, he bid Mr Tan a firm goodbye. After the patient left the room, it occurred to Dr Lee that he did not ask what Mr Tan's job was. But as quickly, he refocused his thoughts back to the mounting patient load for the morning, and called for the next patient in the queue.

The above narrative is purely fictional. It does not refer specifically to any medical specialty, practitioner or healthcare entity. However, a scenario as such is conceivably encountered by many patients on a daily basis. Doctors are competent and confident when it comes to clinical management of diseases. We gain a deep sense of professional satisfaction if we are able to pin a perplexing constellation of symptoms to a diagnosis, cure a patient suffering from an acute illness, and bring another's chronic disease under control. But when it comes to addressing a patient's concern on how his health status may impact his job, and vice versa, many of us would fall short on numerous counts.

No one will dispute that the primary competencies required of medical practitioners are clinical proficiency, ethics-based practice and good communication skills, not necessarily in that order. The first competency is what we spent our entire undergraduate years training for and postgraduation years honing. The second competency of ethics guides our professional ethos; some argue that it is not nurtured, but already present through self-selection in the majority of those who choose to pursue Medicine. Lastly, good communication is a skill that is increasingly emphasised as it forms the very interface of the entire spectrum of doctor-patient interactions. It would appear that these competencies, by themselves and in combination, constitute a holistic approach to good doctoring. Or is it? If not, what is the gap?

A clear and present chasm that we are already facing is the occupational fitness management of an expanding and ageing workforce. In Singapore, the government will enact a re-employment legislation by 2012, to enable more people to continue working beyond the current statutory retirement age of 62, up to 65 in the first instance, and subsequently up to 67. Today, more older patients who seek medical consultations for a myriad of clinical conditions continue to remain in the workforce. The working population – young, middle-aged and elderly – already constitutes a large proportion of a doctor's daily consultation list. This is set to grow with time. How can their occupational health and fitness issues be addressed?

It would be unrealistic to engage Occupational Medicine services in the management of every patient, and neither would it be necessary to do so. In our daily practice, we recognise that many medical conditions do not affect workers to the extent that it inhibits their ability to perform their current job safely and competently. In this regard, workers often do not seek, and clinicians do not offer, further medical advice in this area. Similarly, the issue of disease control within the context of patients' occupations (occupational hazards aggravating pre-existing diseases) is also seldom discussed.

However, it is acknowledged that with greater awareness and a good understanding of the "Work ↔ Health" paradigm, doctors other than Occupational Medicine physicians can effectively undertake this "fourth competency". For a long time, clinicians in various specialties are already managing occupational and work-related diseases. Prof Goh Chee Leok is a leading

figure in the field of Occupational Dermatology for many years. Among many other accolades, he is regarded as the father of the Asia-Pacific Environmental and Occupational Dermatology Symposiums (a group which aims to further the understanding of environmental and occupational contact dermatitis). In the domain of occupational respiratory disorders, Dr Tan Keng Leong has been involved in the diagnosis and management of occupational lung diseases. A/Prof Sum Chee Fang is an advocate in forging interdisciplinary collaborations, including with Occupational Medicine physicians, in the continued improvement of diabetes care in general and for workers with diabetes mellitus.

While this short list of clinicians is far from being exhaustive, it illustrates that occupational health and fitness of workers do not come under the exclusive purview of Occupational Medicine physicians. In fact, specialists and general practitioners have an equally central role as they are the first line of contact when workers seek medical attention. Besides clinical management, doctors also have an obligation to advise patients on the occupational impact of their illnesses. There is therefore a role to consider occupational health and fitness as a fourth competency that doctors, regardless of specialty, should be conversant in. Apart from the Occupational Medicine module in medical school, further mandatory training should be considered for all medical practitioners at the postgraduate level, akin to the Medical Ethics, Professionalism and Health Law course currently mandated for all trainees under the Advanced Specialty Training and Family Medicine programmes.

Occupational Medicine physicians will continue to play a pivotal role in research as well as the management of complicated cases that require the integration and application of niche domains such as occupational hygiene, ergonomics and practical workplace assessment. Practitioners with interests in specific clinical specialties can spearhead research and deepen the existing base of knowledge, leading to improved occupational health management of the worker with a medical condition. Prof David Koh, A/Prof Chia Sin Eng and A/Prof Lee See Muah and their work in Occupational Dermatology, Neurology and Diabetology respectively, are but a few examples. Occupational Medicine must also expand its traditional bounds to encompass occupational basic science research and molecular epidemiology now, as is undertaken by the likes of Prof Chia Kee Seng. The workplace is continually evolving with the introduction of new substances, materials, technologies and processes. All of these may have health impacts on workers that will require the specialty to understand, front and resolve.

The chasm, therefore, lies in doctors' contextual management of patients. It is no longer acceptable to view a disease solely by its organ system involvement, but to manage it in the context of the whole person. Additionally, it is no longer sufficient to adopt a systemic perspective of disease in a person, but to view it in the context of the nature of his job, work exposures and occupational environment. There is a need to relook the present paradigm and consider that the fourth competency may bridge the chasm. SMA

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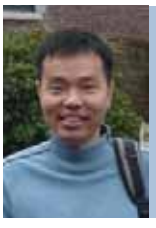

Wee Hoe recently completed the Master of Public Health programme at the National University of Singapore. He has commenced Advanced Specialty Training in Occupational Medicine.