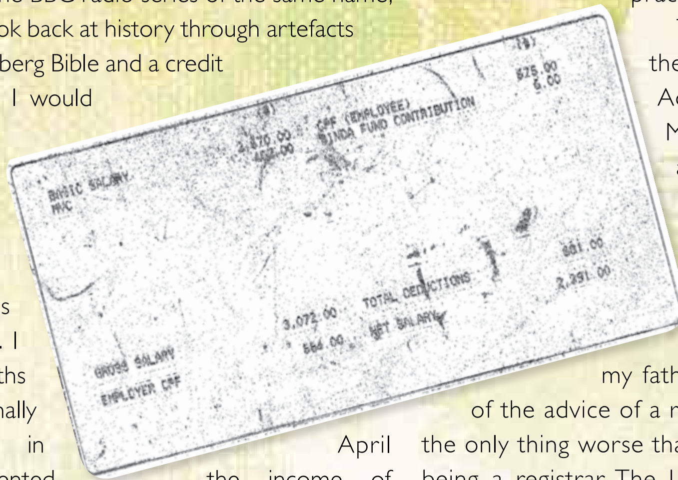
Postgraduate Medicine

– A Personal View in Three Objects

By A/Prof Paul Ananth Tambyah, Advisor, SMA Doctors in Training Committee

The usual disclaimer – the following is contributed entirely in my personal capacity and in no way reflects the views of any institution I am associated with.

I read a brief review of a book, *A History of the World in 100 Objects*, in a recent edition of the *Straits Times* (1 April 2012). The book describes the BBC radio series of the same name, which is a fascinating look back at history through artefacts as diverse as the Gutenberg Bible and a credit card. In a similar vein, I would like to share three objects which tell part of a personal history, of my life in public service.


BASIC SALARY
MVC
CPF (EMPLOYEE)
SINDA FUND CONTRIBUTION
575.00
6.00
GROSS SALARY
EMPLOYER CPF
3,072.00
564.00
TOTAL DEDUCTIONS
NET SALARY
581.00
2,291.00

The first object is a pay slip dated 1992. I received it four months after my Operationally Ready Date (ORD) in April 1992 and it represented the income of a first year medical officer (MO) with the national service adjustment. While it is quite a bit less than what first year post-ORD MOs get right now, it has to be remembered that, at that time, my wife and I could buy a 1,600 sq ft freehold walkup apartment in District 10 for $460,000.

As documented in the SMA GP survey conducted a few years ago, with the notable exceptions of those providing personalised attention to royalty, in general, salaries of doctors, especially junior doctors and GPs, are declining in terms of property purchasing power. That is assuming that most people who graduate from medical school want a roof over their heads and do not have wealthy parents willing to donate a property or two.

The best take on this development was something I heard during reservist training last year. During one of the breaks in sick parade, the jaded NSF (full-time national serviceman) MO commented, "Hopefully the word will get out, and those who go into Medicine thinking that they can make millions will realise that it is simply not true, and pursue careers in investment banking or law like they do in the USA. Perhaps we will finally get those who genuinely are interested indissection, Surgery, Psychiatry, family practice, etc."

The second object is a notice from the IT department from the Veterans Administration (VA) Hospital in Madison, Wisconsin (which is attached to the University of Wisconsin), dated 1996. As I have previously shared in these pages, I went to the US to do residency training in Chicago and Wisconsin partly because of my father's sage advice and also because of the advice of a respected senior who told me that the only thing worse than being an MO in the system was being a registrar. The University of Wisconsin is a state university (unlike Duke, Harvard or Yale which are private universities with high fees, regardless of whether you are residents of the state or not). The VA is the only form of state-provided healthcare in the US outside large urban county hospitals and it is restricted to those who fought in the various wars (WWI and II, Korea, Vietnam, Afghanistan, Iraq, etc). The VA hospitals used to be very run down and basic but during the Clinton administration, they took on some of the latest developments in IT for healthcare and patient safety by tapping on the large network of VA hospitals that covered the whole country. In 1996, the VA hospital where we provided Infectious Diseases cover had electronic order entry (see the notice).

When I returned to Singapore, I was impressed by the developments in the local ATMs. You could do a lot more with a Singapore ATM than you could with any similar device in the US – at least where I did my training. On the other hand, our hospital IT systems seemed to be really far behind. I am really pleased to see the widespread use of IT in local hospitals now. However, unfortunately, unlike in the US where the doctors

ORDER ENTRY/RESULTS REPORTING (OERR)
ELECTRONIC SIGNATURE
ACTIVATES
NOVEMBER 4TH, 1996

As a starting point toward clinician order entry, we are turning on the electronic signature feature of the OERR software on November 4th. No new requirements are being made, but we will be able to document the percent of orders for labs, Radiology and Consults that are at this time being electronically entered into our hospital computer system by clinicians. At this time our files show about 10-12% of orders in our hospital computer system are entered by clinicians. These entries meet the first goal set down for us by the VISNS' policy to implement physician order entry, with the exception that we must have those orders electronically signed. The VISN goal is 20% before the end of December. Our facility will be discussing that VISN goal in the near future.

WHAT IS AN ELECTRONIC SIGNATURE???? An electronic signature is a private code that an authorized clinician types after entering orders into the DHCP hospital computer system. This signature has the same validity as the written signature on the chart. We already use it at our facility for electronically signing Progress Notes and Discharge Summaries. It takes the place of your pen signature. It is legal and is backed by general counsel. An electronically signed order can be printed and will indicate that it was electronically signed by the provider.

WHAT CHANGES OCCUR WITH OERR (ORDER ENTRY /RESULTS REPORTING) ELECTRONIC SIGNATURE ACTIVATION? Upon completion of entry of orders for Consults or procedures, Labs or Radiology procedures into DHCP you will be prompted for an ELECTRONIC SIGNATURE CODE. Entry of this code is necessary for the orders to be released to the requested services. If you as a clinician DO enter orders, you will need not write them also. Physician order sheets print out to be placed in the chart either by yourself or clerical staff.

WHAT STAYS THE SAME WITH OERR ELECTRONIC SIGNATURE? All signature policies that apply to manual systems apply electronically, therefore all med student orders must be electronically signed by residents or staff before they are released to the requested service. All clinical staff have at minimum, the access to order consults electronically. Clerks do computer entry for all orders that are signed on chart.

write, key in or dictate the notes and ward clerks do the electronic order entry transcription, here in Singapore, the junior doctors have taken on that particular role of ward clerks. I was quite surprised to find in a major local teaching hospital, house staff yoked to heavy laptops which they need to access patient info, make orders and read up from online journals. While hospital IT is a great thing in theory, in practice, it should make life easier for all, but that is just my humble opinion.

Finally, I have included a more recent document, which is a bill from a relative who stayed in an A class ward in a restructured teaching hospital – not the one with the house staff yoked to laptops! What really struck me was the contrast between the costs of a consultant specialist review ($42.80), a speech therapy assessment ($49.22), a nurse insertion of an IV cannula ($64.20), and the charge for phlebotomy services ($35.31). I realised that the market subsidy for A class patients (at least in this particular hospital) is highly significant, given that under the late lamented SMA Guideline on Fees, daily consultation charges were usually in the region of $100 to $200. It was also humbling to realise that in this hospital, the services of senior consultants sitting down with patients, taking detailed histories or reviewing clinical progress, conducting physical examinations, and making diagnoses and treatment recommendations were valued at slightly over the cost of a phlebotomist obtaining a blood sample, but much lower than a speech therapy assessment or an IV cannula insertion.

SERVICES **DESCRIPTION** **AMT PAYABLE ($)**

Room Charge
Class A1
SUB-TOTAL (7 DAY(s))
Daily Treatment Fee
Class A1
SUB-TOTAL (7 DAY(s))
2,434.25
2,434.25

Consumables
08.08.2011 Adult Disposable Diapers (Large)
08.08.2011 Incoped - Six Large Pads
09.08.2011 Adult Disposable Diapers (Large)
09.08.2011 Incoped - Six Large Pads
11.08.2011 Adult Disposable Diapers (Large)
12.08.2011 Contrast Agent - 50Ml
13.08.2011 Incoped - Six Large Pads
SUB-TOTAL
674.10
674.10
12.84
4.17
12.84
4.17
12.84
69.86
4.17
120.89

Doctors' Fee
08.08.2011 Daily Ward Consultation
10.08.2011 Daily Ward Consultation
SUB-TOTAL
42.80
42.80
85.60

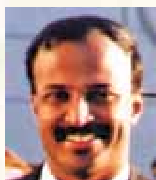
Speech Therapy
08.08.2011 Speech Therapy II
SUB-TOTAL
49.22
49.22

TREATMENT SERVICES:
Ward/ Clinic / Other Procedures
08.08.2011 I/V Therapy
08.08.2011 Insertion Of IV Cannula
08.08.2011 Use Of Infusion/Syringe Pump
08.08.2011 Use Of Vital Sign Monitor
09.08.2011 Administration Of Nebuliser
09.08.2011 I/V Therapy
09.08.2011 In-Out Urethral Catheterisation
09.08.2011 Intravenous Antibiotic/Medications
09.08.2011 Oxygen Therapy
09.08.2011 Use Of Infusion/Syringe Pump
58.85
64.20
63.13
64.20
40.45
58.85
33.22
44.94
43.87
63.13

I know that these objects present a one-sided picture of the life of a doctor in public service, and those who know me know that there are many more that I could have cited, like the N95 masks that we wore during SARS, the generic antiretrovirals manufactured in Thailand that sustain the lives of hundreds of Singaporeans, the wedding invitations from former students who are soon to be wealthy dermatologists or plastic surgeons, or the piles of rejection letters I have from the *New England Journal of Medicine*... Still, I thought it was interesting to see that doctors today are willing to make sacrifices in terms of salary support. We are also willing to take on additional order entry roles that are performed by the embattled ward clerks (who are at the frontline to the public anyway) in other countries, and be a minor part (at least economically) of the care of wealthy patients.

Many people of my vintage or a little younger will know that the most effective Junior Doctors' Committee was the one led by our former Dear Leader Wong Chiang Yin and Dr Goh Jin Hian. In the early 1990s, that Committee managed to secure a call allowance for house officers (HOs) and for the first four calls for MOs. I personally believe that junior doctors today have it rougher than we did – patient expectations are much higher than two decades ago, and while resources have increased, they have not kept up with the pace of patient expectations thanks to the almost unbridled advertising that has been allowed of late. The only way to change things (apart from getting involved politically I know ☺) is to work together just like Chairman Wong's team of the 1990s. This means that we back off from comparing sponsoring institution with sponsoring institution, or medical school with medical school, and focus on how we as a nation, or as a national "Voice of the Profession", can make things better. The Doctors in Training (DIT) Committee has been revived. Dr Tan Yia Swam has issued a clarion call in the previous issue (see http://news.sma.org.sg/4403/DIT.pdf).

And this issue is devoted to junior doctors. Remember, the enemy is NOT the patient, NOT your consultant, NOT even your fellow HO who only appears on the ball when the senior consultant or consultant is around. The enemy is death and disease. When we work together as a profession, better outcomes result for patients, for doctors and for society as a whole – just ask the VA. The DIT Committee wants to hear your views. Email them to feedback@sma.org.sg. SMA



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