The First Sreenivasan Oration, 1978

The Future of Singapore General Practitioner

BY DR. WONG HECK SING MBBS, FRACGP. 19 November 1978.

I am greatly honoured to deliver the First Sreenivasan Oration.

When Baratham Ramaswamy Sreenivasan was invited to be the first President of the College he said the founding of the College was a great step forward in the medical development of our country. He spoke with the wisdom of one who had devoted over forty years of his life to medicine, fifteen years of which was in hospital practice and the rest in private general practice. He shared the concern that the concentration of medical development in hospital medicine and its specialties with little being done in the field of general practice would not lead to a higher standard of health care for the nation as a whole. He recognised the initiative taken by the founders of the College as the first step that would lead to the establishment and recognition of general practice as a separate discipline. Sreenivasan was a man of many parts—physician, scholar, teacher and administrator, but the role he found most fulfilling was that of a physician. Sreenivasan studied medicine at a time when specialisation in the local teaching hospitals had barely begun. His teachers were generalists. He worked many years in the hospitals at a time when modern therapy was relatively undeveloped.

Management of cases depended as much on patient care as on drug therapy. This gave him a deep insight of human suffering and to the human behaviour. Sreenivasan was a true scholar, for he was one of the few who faithfully pursued continuing education throughout his life. He had often said that the most difficult part in the study of medicine was the study of man himself and he made both the subjects of his life long study. Such were the qualifications of the man who found fulfilment in family practice.

It is seven years since the founding of the College but the greater step, which Sreenivasan mentioned, has yet to materialise into a great leap.

It is still thought today that all who have undergone the basic medical school and hospital training are adequately equipped for general or family practice. This situation might perhaps have been true in Sreenivasan's student days when medical knowledge and its application had not reached the present day level. The medical school was staffed by generalists and students were trained to be generalists. Whole person medicine was taught with emphasis on bedside or clinical skills. Such ancillary aids to diagnosis that were available were few and could be done by the doctor himself. Successful management of the patient depended to a large extent on gaining his confidence. The art and skill of building up patient confidence through good doctor patient relationship was part of the teaching process, which continued throughout the student days. It was undoubtedly a slow process—there were no miracle drugs or modern therapy to inspire quick returns. The teaching of medicine included imparting much of the attitudes and skills that were eminently suited for general or family practice.

Even during my student days the teachers were still relatively generalists. The Professor of Medicine was a general physician who taught internal medicine in toto, from neurology to nephrology, from dermatology to gastro-enterology. The Professor of Surgery was a general surgeon who operated from head to foot. The surgeon who removed the appendix also did ENT surgery. The surgeon who plated fractured bones one day repaired harelips the next. Teaching of medicine was less fragmented as compared to the present time.

The situation has changed with the development of the newer specialities in hospital medicine today. Specialists have replaced generalists in patient care and medical teaching. With improved diagnostic and therapeutic means, turnover of patients is accelerated and there is little opportunity to develop rapport with patients. Hospital care is disease orientated with little of the holistic approach. It is episodic in character and impersonal in nature. Contrast this with general or family practice where the care has to be personal and directed to the whole person and it has to be on a continuing basis.

While there has been tremendous development in hospital practice with an increasing number of specialists being trained for hospital secondary and tertiary care delivery, little has been done along the same lines for primary health care. General practice remains an unrecognised discipline and no further training is required for the practitioner apart from having a registrable medical degree. The result is a primary health care delivery that varies widely in its philosophy, in its standards and in its range. Many enter general practice by default rather than by choice. Medical students today are orientated early towards specialist hospital practice. In applying for the medical course a student fresh from school reads in the University's Faculty of Medicine Handbook which says "opportunities exist for the **better** graduates both in the government and the University for extended training in various specialities under a trainee-ship scheme. Such training is usually in preparation for obtaining specialist qualifications". General practice is not included in the scheme of extended training. The idea of specialising that is early implanted is reinforced as the student proceeds to his clinics where his exposure to specialists and to specialised medicine becomes total. It is no wonder that postings to a primary care area like the government outpatient dispensary or the accident and emergency unit are so greatly resisted by the graduate.

Can the neglect of general practice go on without serious repercussions? In the USA for instance the emphasis on specialisation with its growing number of specialists has led to the decline in the standard of general practice. The decline is due to fewer and fewer graduates venturing into a territory that is uncharted, untaught and unsung in the academic world. Those that do go into general practice have to learn by trial and error. The process is made much more difficult owing to the changing needs of the society and can be a painful experience for the patient as well as for the doctor. Since general practitioners provide the broadest spectrum of medical service to the greatest number of patients, the decline in their numbers and the lack of trained new doctors has had a disastrous effect on the health care delivery. It has led to a situation where some of the public has had to turn to specialists for their primary medical care needs. The results have often been unsatisfactory. Costs have been high, the care often discontinuous and fragmented according to the symptoms of the patient.

We see certain similarities in the Singapore situation. Specialisation is gathering momentum. At the recent medical convocation in October there were 111 new graduates and 51 post-graduates with specialist qualifications. Specialisation in hospital medicine only will not improve the quality of primary health care delivery. The entry of specialists into private practice will not materially alter the situation.

We should not have to wait till a crisis develops before taking steps to improve primary care delivery. There are sufficient indications that the time is now opportune, in fact overdue, for the setting up of a structured vocational training for the future general practitioner. Firstly costs in hospital development and its maintenance are so prohibitive that measures have to be taken to cut down the need for secondary care.

The answer to this is in preventive medicine and no one in the medical profession is as well placed as the general practitioner to do the job provided he is well trained. Secondly the changing society of Singapore has highlighted the importance of the environment and the behavioural patterns in relation to ill health. More and more of the cases seen in consultation in general practice do have a pathological basis but arise from causes in the environment and from interactions in human behaviour. Vocational training in the behavorial sciences and the study of the society in relation to medicine will provide what is deficient in the training of the present graduate. Thirdly there is a growing realisation that in the development of a comprehensive health service a hiatus exists at the primary care level. Quality secondary care delivery cannot be maintained if it is inundated as a result of poor primary care. The government primary health care service is now being reorganised in recognition of this omission. Fourthly with the narrowing of the doctor shortage in sight, as a result of mandatory government service for all graduates, it will soon be possible to give all new doctors a broader training for vocational development.

Reinforcing all this is the call by the College for vocational training. Who else are better qualified than the general practitioners to know what is necessary and needed in their field of practice?

Why is the present training of new general practitioners in Singapore inadequate? The basis of sound general practice lies in a good foundation of clinical medicine. The non-specification of what further

post-registration clinical training is required has resulted in many doctors entering general practice with gaps in this foundation. Moreover medical education today is essentially a study of the human **body** per se - its anatomy its physiology and its chemistry followed by its disease processes or pathology. This preoccupation with the physical body results in a hospital practice which concentrates mainly on its diseased parts. Therein lies the major difference from general or family practice. The general practitioner or family physician looks after the human **person**, whose illness is not only confined to the physical part of his body but extends to his being as a whole whether behaviourally or as a unit of society. Because of this difference of philosophy in approach general practice requires skills and attitudes which are not taught or emphasised in contemporary medical education. As a result philosophy of hospital practice persists when the new doctor enters private practice. His care is essentially remedial in function, disease orientated and is on an episodic crisis-to-crisis basis. This has given rise to the present misconception that general practice is a low level hospital type of practice for which training is amply provided.

To train the future general practitioner it is necessary to define his job. He is the doctor who is able to provide personal primary and continuing health care on a whole person basis to individuals in the context of their environment which includes the family and the community. The care is comprehensive regardless of age, sex or type of health problem, be it biological, behavioural or social, and includes mobilising the services of his professional colleagues and other resources of the community. To get better job satisfaction the general practitioner seeks to extend his care to the entire family where he is able to bring to bear his acquired attitudes, skills and knowledge to the best advantage of each individual member. The future general practitioner is therefore a family physician to many and his roles are preventive, curative, educational, rehabilitative and supportive.

It is impossible to provide a comprehensive training for so wide a discipline within a reasonable time frame. In no other field of practice is it more necessary for the practitioner to continue his learning process throughout his professional career. The vocational training provides the basic tools with which the general practitioner can practise his discipline and help him to avoid the early pitfalls which the untrained practitioner experiences.

The training of the future general practitioner or family physician should really begin at the time when he is in school. He needs a broad education and should not concentrate mainly on the physical and biological sciences to the exclusion of the humanities and the arts. His understanding of people may be drawn from the reading of novels, biographies, poetry and plays and from the visual arts and this understanding will heighten his sensitivity to the feelings of his fellow men in later life.

In the medical school he should be exposed early in his training to the health needs of the community. The present system of confining one to the laboratories in the preclinical years, followed by the further confinement within the walls of the hospitals defeats the main purpose of medical training- i.e. for a product which will cater to the basic medical needs of the community.

The student should be taught not only by specialists but by generalists as well in order for him to maintain a proper perspective to medicine as a whole. I will not dwell further on the early training.

The vocational training of the future general practitioner must be directed towards acquiring the knowledge, skills and attitudes required to meet his job definition. The training should include certain disciplines which are commonly taught in hospital practice and cover areas to which he is unlikely to have been exposed during student or post-graduate days. It must be relevance to the health needs of the community.

The vocational training has to begin with the study of the art of consultation, the point when the patient and the doctor meet. It is vitally important that the trainee masters this art which includes establishing rapport, effective communication, gathering necessary information rapidly and organising it logically, identifying the patient's problems and needs, and managing them appropriately. Unlike hospital practice where time and costs are less restricting the general practitioner has to work within these constraints to the patient's best advantage. Another skill necessary in the consultation is the doctor's ability to motivate patient compliance. Unlike hospital practice where the patient is captive, the private patient at large poses this continuing challenge.

The content of vocational training centres around three main areas:-

(1) The study of the core clinical knowledge comprising of (a) health and diseases. (b) the human development and (c) the human behaviour. These form the clinical foundation of general practice.

(2) The study of society in relation to health and illness.

(3) The study of the organisation and management of the practice.

In the study of the first area we have to begin by learning the norms- in health, in human development and in human behaviour. In hospital practice the student or the doctor is so preoccupied with the pathological that this study is often overlooked. It is only in general practice that one constantly poses the question- "is this normal?"

There are two ways of studying the disease content- by the medicial disciplines relevant to general practice or by the prevalent problems presented to general practitioners. Studies of the latter have been done in some of the western countries and they reflect more accurately the health needs of the community at the primary care level. Apart form morbidity returns by the government outpatient dispensaries we have no such information locally. In Singapore the study of disease may be done through hospital training in the relevant disciplines. Extended training is required in internal medicine, pediatrics, geriatrics, psychiatry and emergency medicine. In addition one should be competent in office procedures in obstetrics, gynaecology, general surgery, orthopaedics and laboratory medicine. Further there should be short attachments in ophthalmology, ENT disease, dermatology, venereology and occupational medicine.

The learning of human development covers the whole life span from conception till death, enables the general practitioner to help the individual under his care to attain optimum development as a person. The understanding of human development will help in better patient assessment and management.

Of the 3 components of clinical medicine human behaviour is perhaps the area where the general practitioner is least knowledgeable. It is commonly believed that its study is part of the training for the psychiatrist but this belief is soon dispelled as the general practitioner enters practice. So much of health or ill health is related to the behavioural patterns of the individual. The understanding of the behaviour in interpersonal relations and in family relationships leads to a greater understanding of the individual. The first step to patient care is to understand the patient. The teaching of the behavioural sciences will have to involve many people including psychologists, psychiatrists, anthropologists, sociologists, ethicists and philosophers.

So much for the core clinical knowledge- the first area of study.

The second area of study is directed to man as a biological unit of his society and how his environment influences his well being. In hospital practice the doctor sees his patient who is dislocated from his normal environment. In general practice the patient is much closer to his own world and the general practitioner has to face the realities of the society in managing his patient. The study of society includes the study of its cultures, its religions, its economics, its laws, its social values, its resources, its social stratification and its physical environment. Included in this area of study is the study of epidemiology, the basic science of preventive medicine.

The third area of study is the practice. It includes the organisation, the premises, equipment, the legal responsibilities and especially the medical recording. In Singapore all general practices are expected to provide dispensing facilities and the general practitioner has to learn how to run a dispensary.

The training of the future practitioner must be centered in a general practice situation with hospital attachments for the relevant clinical disciplines. The teachers should include not only members of

profession but will involve people outside the profession. Throughout the training the humanistic aspects of medicine are stressed. This coupled with the scientific aspects will help the future practitioner not only to identify the disease processes but also the personal needs and expectations of the individuals.

I have outlined the training of the future general practitioner. I have compared the different disciplines and philosophies of hospital practice and general practice. I should mention that all medical practice was at one time general practice. The evolution of the specialist disciplines is a reflection of the advancement in medical science but there should not have been any change in the physiology of practice. The study of general practice or family medicine is valuable to all medical students regardless of their intended discipline since humanism, compassion and concern for the patient should be basic to all care. The field of practice, which involves more than half of all the total doctor population cannot be ignored academically. It is the profession's bounder duty to see that the quality of health care is constantly upgraded and maintained at all levels of delivery. It is ironical, even unhealthy that the most broad and very demanding field of medical practice remains the least developed and untaught.

Sir Denis Hill writing in "Psychiatry in Medicine, Retrospect and Prospect" stated "The family physician's role is a difficult one. If it is to be sustained and developed, the general practitioner must become the most educated —the most comprehensively educated of all the doctors in the health service". Such a general practitioner was B.R. Sreenivasan, for few were so comprehensively educated, few had such an interest in the broad spectrum of clinical medicine, few had such an enthusiasm for continuing education, few had such a sincere interest in people, and few derived such personal satisfaction from intimate relationship with patients developed over long periods of continuous care. It is fitting we name the College Oration after this great family physician.

The Singapore Family Physician—1978, Vol. IV, Nos. 3 & 4