



Speech by Dr Robert Loh Choo Kiat,

President, National Council Of Social Service,

**at The Physician's Pledge Affirmation Ceremony on 2 May 2002 at
The Auditorium, College Of Medicine Building**

Abiding by the Code of Conduct or Ethics

Dr Lee Suan Yew, President,
Singapore Medical Council;
Distinguished Guests;
Ladies and Gentlemen:

I have come here today at the invitation of the Singapore Medical Council.

It is a pleasure for me to be here with you at this most important event in a doctor's medical career – the affirmation of the Physician's Pledge by newly registered doctors.

Like every other profession, doctors live by a code of conduct or ethics and you have to adhere to this code. It forms the basis of self-regulation and the perpetuation of high ideals and noble traditions of our medical profession.

Doctors have always been held in high esteem, trust and respect by society.

In the early years of medical history – more than 2000 years ago, medicine was more an art form than a science. It was ancillary to nature. The physician was subservient to nature and his practice was guided by the need not to hurt or harm his client. The physician was trusted. He had a paternalistic role in the community. His authority was supreme, his advice seldom questioned.

When the 20th Century began, science shaped the development and practice of medicine. Doctors armed with

surgical knowledge and skills combined with vaccines, antitoxins, serum and chemotherapy could come to grips with disease and would take the initiative to manipulate rather than subserve nature. Science then drove medicine into a position where medical care was perceived to foster well-being, i.e. it offered something that was significant and reliable, and that it was desirable and good. As a result, medicine gained in prestige and the demand for medical service grew in volume. The growth of medicine was tremendous just before and more so after World War II.

Patients of today are much better informed and will be even more so with the growth of Information Technology and the expansion of the Internet. The patient and his relatives will want to actively participate in the decision about his care. Many of them will question the doctors' clinical decisions and the standard of service. More communication will be expected. The patient's expectation will be very much higher.

Among the many problems that will arise, there are three which will play a more important role:

1. Access to medical care
2. Unequal distribution of medical services (availability)
3. Increasing costs of medical care

Patients, being better informed and with higher expectations of doctors,

want medicine to be available, fairly distributed and costs to be contained.

Thus, medical skills and knowledge will not be enough. The development of communication skills as well as the need to have compassion and concern with professionalism are of utmost importance in a doctor's handling of a patient.

Medicine enjoys a rich history starting with Hippocrates more than 2,000 years ago. Even as recently as the turn of the 20th Century (100 years ago), medical care, especially of the poor was considered a moral obligation of the physician and mind you also of the hospital. Physicians as well as the hospital were not motivated strictly by profit but were governed by a moral dictate of a principle of beneficence, which carried an implied obligation to care for patients who were unable to pay. Physicians were expected to make a living from the patients who could afford to pay.

General hospitals in those days were run by the governments which accorded free treatment to those who could not pay, supported to some extent by paying class patients. Other hospitals run by various community groups, church bodies, were largely supported by philanthropists.

Then again, much of the treatment of patients was done in patients' homes. However, the emergence of technology in medicine, which increasingly

became housed in hospitals or in physicians' offices, resulted in the shift of patient's care from house to hospital or doctors' clinics. Growth of health services became the growth of hospitals. In Singapore, growth of health services is seen in: -

1. Restructuring of government hospitals
2. Increasing number of private hospitals
3. Establishment of clinics in hospitals' precincts.

Home visits, which formed more than 50% of my father's practice before World War II, have become less frequent. Patients with any ailment of some seriousness requiring a doctor's attendance daily would now be admitted to hospital. Doctors succumbed to patients' expectations and demands. This gradually developed into a personal health service as we know today – the private voluntary hospital and the private physician. This model further expanded with the emergence of a third party to pay for the expenses – i.e. Medical Insurance.

So as our country became wealthy, and as demographic changes associated with healthy living occurs – ageing population. With the explosion of high technology and availability of information resulting in increasing consumer expectations and demands – inevitably healthcare cost increases, and the introduction of medical insurance schemes with a more litigious society running in tandem.

These developments in medicine have resulted in a turn, such that the profession is no longer regarded with the respect and confidence it used to enjoy. The profession is no longer regarded as highly prestigious and has lost a good deal of its moral authority and public trust. In the final analysis in the delivery of health care and the distribution of health resources, the doctor must have control because it is the doctor who has to manage the patient and has the ultimate responsibility for his patient's welfare to the community.

It was Oliver Wendell Holmes who said, *"Lawyers are the cleverest of men, men of the cloth (ministers) are most learned, doctors are the most sensible."*

The present erosion of trust in a physician can be reversed only if the practice of medicine returns to its roots:

1. Application of clinical acumen and judgement
2. Use of good common sense
3. Humanitarian approach – compassion and accessibility
4. Beware of costs to the patient-efficient and cost-effective. It is difficult for medicine to remain moral if purely profit motivated.
5. Holistic
6. Less defensive

In general terms – return to the ethical code. Remember the old saying – If it is not necessary to do it, it is necessary not to do it.

Only with the restoration of public trust and confidence, can the physician resume the physician-patient relationship where the physician is in control.

In today's context, the doctor has to interface with health management

process of diagnosis. Yet in the US, it amounts to much more than 50% of the costs in health care.

With the appearance of medical insurance, health schemes have enlisted physicians as gatekeepers to control costs by setting up certain norms relating to admission, length of stay, specialist referrals and the utilisation of diagnostic and therapeutic resources. The traditional notion of clinical freedom becomes cramped.

With the diminution in the role of clinical decision and the rise of corporate medicine, physicians may well be on the way to becoming little more than employees of health care institutions and the practice of good medicine is severely put to the test.

Can the physician be gatekeeper and remember his moral duty and social



Newly registered doctors taking the pledge.

systems or medical insurance beside the patient. Then again, doctors are practising in an increasingly litigious society. In the phenomenon of defensive medicine where the management of a patient is not only with an eye on his welfare but also with an awareness of possible future malpractice litigation, it may lead to an extension of care far beyond the patient's needs.

The best interests of patients are supposed to guide clinical judgement and management of the patient. The most important component in diagnosis is listening to the patient's history, next in importance is the physical examination; medical tests and investigations should account for the smaller proportion (25%) of the

mission? This is the moral dilemma facing doctors today. Physicians will require considerable courage and endurance. But it must be forthcoming in order that public trust can be restored.

Let us regain a higher level of public trust and confidence and this can only be achieved in the era of increasing health care costs, increasing expectancy, increasing demands, increasing litigious society, by an increasing degree of altruistic behaviour and sense of social mission in our profession.

Abiding by the code of ethics will help us to do this in our practice of good medicine and being a good doctor.



Director of Medical Services Prof Tan Chorh Chuan's Speech

At Physician's Pledge Ceremony 2002

Held on 2 MAY 2002 at the College of Medicine
Building Auditorium

A Career of Continuous Learning

“Bear in mind that all knowledge has a shelf life and that we must continually update ourselves in order to provide our patients with the standards of care we have sworn to uphold.”

- Prof Tan Chorh Chuan

Dr Robert Loh, our Guest of Honour this afternoon;

Dr Lee Suan Yew, President of the Singapore Medical Council;

Members of the Singapore Medical Council;

Newly Registered Medical Officers; Colleagues,

Ladies and Gentlemen:

Firstly, I would like to extend my heartiest congratulations to the newly registered medical officers. We look forward to working with you as colleagues in the medical profession, delivering care to our patients to the best of our ability and upholding the noble traditions of medicine in Singapore. To those newly registered doctors who have joined us from overseas, I would like to extend a warm welcome and my best wishes.

You are starting medical practice, or building up careers in medicine, at an exciting time filled with both unprecedented opportunities as well

as great challenges. All of us are familiar with the promise that medical research and biotechnology hold for medicine – fundamental understanding of diseases, more accurate and rapid diagnostic tools, more effective treatments, more curative therapies. At the same time, the rapid advances in medical knowledge and practice are creating formidable challenges to doctors and to the medical profession as a whole.

As individual practitioners, a key problem is how to keep up with the explosive rate of knowledge accrual. This problem is compounded by the fact that the average patient today has such easy access to medical information through the Internet, some accurate and relevant, others totally wrong, but all of which influence the patient's perceptions of his medical problems and his management.

Within institutional care settings, a major challenge is how to get our

healthcare teams to work effectively together, to prevent fragmentation of care delivery and to minimise the uncoordinated management of each individual patient as a collection of body part problems. As a healthcare system, how do we ensure that rapidly evolving “best clinical practices” or “evidence-based guidelines” are incorporated into the care delivered by doctors across the whole spectrum of healthcare settings so as to minimise inappropriate variation in care standards across practitioners and institutions.

As a profession, we need to assume leadership roles in engaging these weighty issues proactively and diligently. However, for the purposes of my brief address today, I would just like to focus on one central plank of our response to these challenges - that is medical education.

BASIC MEDICAL EDUCATION

In recent years, medical education has

undergone a series of fairly profound changes as a result of the pace and nature of advances in medical knowledge and practice.

Today, basic medical education in medical school no longer attempts to provide graduates with knowledge and skills that would last them through their subsequent career. Instead, the basic medical curriculum seeks to establish a sound foundation in the basic medical sciences, skills in clinical medicine and communication and very importantly, the honing of the faculties of critical thinking and analysis, and the skills and habit of life-long learning. The NUS medical faculty carried out a wide-ranging revamp of its medical curriculum along these lines in 1997 and the Singapore Medical Council has started to strengthen the training component of housemanship in the year 2001.

Beyond medical school and housemanship, each medical practitioner needs to keep himself current with changes in medicine generally and in areas relevant to his own practice in particular. Our patients and society at large also want to be assured that the doctors they consult are practising up-to-date medicine and offering them care of a good quality.

For these reasons, the SMC will be making continuing medical education (CME) compulsory for all doctors in Singapore from January 2003. Doctors will be required to obtain a minimum of 50 CME points within a two-year qualifying period prior to the year in which their practising certificates are due for renewal. For example, doctors

whose practising certificates are to be renewed in 2005 would have to obtain a minimum of 50 CME points for the two-year period from 2003 to 2004 as a condition for renewal. Half* of these points should be in core areas, which for specialists would be from CME activities in their specific specialty, and for non-specialists, would be broad topics identified by the College of Family Physicians as being vital for all general practitioners.

The linking of certificate renewal to CME is a practice that is already



required of doctors in many countries all over the world, including most states in the USA, some states in Australia, New Zealand, Hong Kong and some countries in the EU. The UK will be incorporating CME into its framework for the revalidation of doctors.

The SMC has worked very hard to make the fulfillment of this CME requirement as convenient for busy practitioners as possible. The SMC had launched its Online CME System in 2000 to allow all registered doctors to review the calendar of accredited CME activities in Singapore. They can also log in their CME activities and track their cumulative points to date. All of you will be able to gain access to this system now that you have been awarded full or conditional registration. Over the

past two years from 2000-2002, the SMC has also enhanced the Online CME system in response to feedback from doctors and the professional agencies.

The SMC has also worked closely with the College of Family Physicians, the Academy of Medicine and the Singapore Medical Association to ensure that there are enough CME activities available for GPs and specialists, and that they are genuinely useful to the doctors concerned. The SMC has also made

it possible for doctors to gain CME points from a wide variety of activities apart from attending talks. These include reading journals, participating in distance-learning CME, attending workshops, seminars and lectures as well as conducting research. I am sure you will be glad to hear that participating in grand

ward rounds and Clinical-Pathological Conferences (CPCs) also count for CME points.

CONCLUSION

One of the hallmarks of professionals is the desire to continually upgrade themselves in order to stay at the cutting edge of their practice. As you embark upon your careers as full-fledged medical professionals, I urge you to bear in mind that all knowledge has a shelf life and that we must continually update ourselves in order to provide our patients with the standards of care we have sworn to uphold.

Once again, congratulations to all of you and best wishes for the future.

**Afternote: The SMC has since decided to reduce the percentage of core points to 20% for compulsory CME. This will be reviewed at the end of 2004.*

Core CME Activities

By A/Prof Gilbert Chiang, Assistant Master, Academy of Medicine, Singapore



Sample calendars of approved core CME activities for all the 35 specialties are posted on the Academy's website

Continuing Medical Education (CME) has been an integral component of our clinical practice; it is set not only to stay with us but also to grow in importance and significance for all of us, especially when it becomes compulsory in the year 2003. How will the Academy help our Fellows in planning their forthcoming CME schedules?

Firstly, the Academy has compiled sample calendars of approved core CME activities for all the 35 specialties and these are posted on the Academy's website <http://www.academyofmedicine.edu.sg/cpd/index.html>. Each sample calendar lists regular Category 1A and 1B events, recommended journals, regional/international specialty-specific meetings and distance-learning programmes, if any. The minimum, maximum and attainable points for each activity are listed as well.

Secondly, the Academy will continue to circulate Notices of our Chapters' CME Activities to our Fellows to keep them updated. These are posted at <http://www.academyofmedicine.edu.sg/activitiesprogrammes/index.html>.

Thirdly, where there is a perceived lack of core CME activities in a specialty, the Academy will take the lead

through its relevant Chapter, offering additional CME activities either on its own or jointly with societies/hospital departments/centres. The Academy hopes that this will provide ample CME activities to doctors, thus giving them greater flexibility and choice to meet their CME requirements. The Academy will continue to monitor these activities to ensure that only quality CME activities are provided to our specialists.

Fourthly, the Academy is developing online specialty CME programmes to bring CME to the desktops of our specialists. These online programmes will be helpful to doctors who have difficulty meeting their CME requirements due to time constraints as they can access the online programmes in their free time and at their own pace.

Last but not least, the Academy will monitor the progress of our Fellows, sending "personal" reminders and counselling those with low CME scores. The effectiveness and acceptability of the overall CME programmes will be regularly reviewed.

We hope that the above efforts will be helpful to our Fellows in meeting their CME requirements for years 2003 & 2004.

Meeting Compulsory CME Requirements – An Overview for Family Physicians

By A/Prof. Cheong Pak Yean, President, College of Family Physicians Singapore

This overview is written to help Family Physicians plan their personal CME programmes based on their individual learning needs and preferences from the different types of CME activities available.



Compulsory Continuing Medical Education (CME) which is to be implemented with effect from 1 January 2003 requires doctors to achieve a minimum of 50 CME points for a 2-year qualifying period. At least 10 of the 50 points must be earned from CME activities designated as core for the specialty of the doctor. This overview is written to help Family Physicians (FPs) plan their personal CME programmes based on their individual learning needs and preferences from the different types of CME activities available.

CME activities are divided into three broad groups:

Category 1	Activities which entail attendance in person.
Category 2	Activities relating to publication and authorship of scientific papers and would relate to some doctors.
Category 3	Most doctors will achieve their points from this category which is based on distance learning.

CORE FM CME POINTS AND CATEGORY 3A CME

The anxiety of some doctors regarding Core CME points is now allayed as 10 Core CME points can be obtained under Category 3A by reading medical journals designated as core journals for the discipline. For example, there are nine medical journals that have been designated as core for Family Medicine (FM), see table 1.

Table 1: Core FM Journals

Singapore Family Physician
Singapore Medical Journal
Australian Family Physician
American Family Physician
British Journal of Family Practice
Canadian Family Physician
Annals of Internal Medicine
British Medical Journal
Journal of the American Medical Association

Most of the articles in these journals are available free-of-charge on the Internet. In the printed form, two of them, the Singapore Family Physician (SFP) published by the College of Family Physician and Singapore Medical

Journal (SMJ) published by the Singapore Medical Association are circulated to doctors who are members of the two organisations respectively.

When the FPs have completed studying the articles in any of the nine journals, they can log onto the SMC website to document the articles and be awarded 1 core FM CME point per article, up to a maximum of 10 points for the two-year period. Doctors who are members of the College may request the College to register these points on their behalf after studying articles in the Singapore Family Physician.

CATEGORY 1B & 1C – CME EVENTS

Core CME points can also be obtained from other CME categories. Since many FPs would have already achieved their mandatory 10 FM Core points from journal reading, core FM CME designation is in practice a quality assurance system for CME activities especially beneficial for family practice. FPs would therefore wish to accumulate the majority of CME points from such core FM CME events.

Category 1B CME events are those held in Singapore requiring attendance in person. The College has set up a peer-review system in which any CME event organiser organising Category 1B events may seek the advice of designated senior FPs on what is directly relevant to FM. Those events recommended by the College Board of CME Assessors for Core FM status would hence be a guide for FPs as the topics have been prospectively reviewed by at least two colleagues.

FPs who attend CME overseas may claim CME points under Category 1C by logging onto the Internet themselves. CME events which are part of courses leading to SMC registrable FM degrees or diplomas and those events organised by WONCA are eligible for core FM points.

CATEGORY 1A – PRE-APPROVED ESTABLISHED CME

Pre-approved established CME activities organised by restructured hospitals, Division of Graduate Medical Studies, NUS and College of FPs, e.g. Grand Ward Rounds, tutorials etc are included in this category. For FPs, this category includes the training programmes and courses leading to the Graduate Diploma in Family Medicine (GDFM), Masters and Fellowship of the College. As the duration of such courses may span a calendar year, NUS and the College would update at the end of each year the CME points accumulated during the year.

CATEGORY 3B – DISTANCE-LEARNING WITH VERIFICATION

Category 3B encompasses distance-learning activities with verification. For FPs, the College will produce at least eight such activities in the next two years, one each quarter. The first distance-learning activity for 6 core FM points under Category 3B is on "Home Health Care" launched on 27 October 2002 at the FM Convocation 2002. FPs may, after studying the course materials published in the SFP, complete the

answers in a special form and send it back to the College. On verification that the doctor has completed the course to a required standard, the College will submit the CME points achieved to SMC. College members will receive the course materials and the special answer form as part of their membership privileges. Other doctors can subscribe to the courses by paying the course fees.

Besides the distance-learning activity, related training and clinical sessions are organised so that together these CME activities become FM skills courses. For example, in the Home Health Skills Course, FPs on completing the distance-learning component may elect to attend a three-hour seminar under Category 1B eligible for 2 points. A FP who completes the third component, a three-hour clinical attachment to a

homecare organisation can get another 2 points and also apply for a certificate of attendance from the College for the entire course. FPs can thus earn 10 CME Core FM points and a certificate of attendance as well, by completing all three components.

There are hence a variety of CME activities that a FP can participate in to earn the 50 points in the two-year period. Alternatively, he may at one extreme achieve all 50 points by attending Category 1 activities. Or he may wish to earn most of the points from Category 3 as a maximum of 10 points are allowed for reading medical journals and another 36 points are allowed under Category 3B for distance learning with verification. Table 2 gives details of the various CME categories and the maximum CME points allowable for each category in a 2-year period.

Table 2: CME Categories & Maximum CME points allowable

Category	Description	Max points allowable in 2 years
1A	Attendance of pre-approved established CME activities organised by Restructured Hospitals (Grand Ward Rounds, Teaching/Tutorial Sessions), NUS Division of Graduate Medical Studies & College of Family Physicians Singapore	50 points
1B	Attendance of other approved CME activities in Singapore - Scientific Meetings, Conferences, Seminars, Lectures, Workshops	
1C	Attendance of certain CME activities held outside Singapore - Scientific Meetings, Conferences, Seminars, Lectures, Workshops, Recognised Postgraduate Degree Courses	
2	Publication of original papers in Refereed Medical Journals/Editorial Work/Presentation of original paper or poster	40 points
3A	Self-study: Reading of papers from Designated Refereed Journals/Clinical Practice Guidelines, Self-study from visual tapes, Online education programmes without self-assessment (Maximum 10 points in 2 years)	46 points
3B	Distance-learning courses through interactive structured CME programme with verifiable self-assessment (Maximum 36 points in 2 years)	

CME – A Process of Self Renewal

by A/Prof Goh Lee Gan, Singapore Medical Association (SMA)

“Well why don’t you take a break for a few minutes and sharpen that saw?” you inquire. “I’m sure it would go a lot faster.”

“I don’t have time to sharpen the saw,” the man says emphatically. “I’m too busy sawing!”

*From: Stephen R Covey,
The 7 Habits of Highly Effective People*



An invitation from the SMA Representative on the SMC-CME Coordinating Committee to all doctors to participate in Continuing Medical Education (CME) activities for 2003:

“Well why don’t you take a break for a few minutes and sharpen that saw?” you inquire. “I’m sure it would go a lot faster.”

“I don’t have time to sharpen the saw,” the man says emphatically. “I’m too busy sawing!”

From: Stephen R Covey, The 7 Habits of Highly Effective People

The picture of a man feverishly sawing away with a blunt saw is portrayed by Stephen Covey in his book, *The 7 Habits of Highly Effective People*. The secret is of course, there is a need for space in our lives for sharpening that saw and there is time for that. This is called self-renewal. It is also called CME. If you are even more current in thinking and wish to go beyond

knowledge to skills development as the way to go, you will be embarking on continuing professional development or CPD.

THE IDEA OF COMPULSORY CME

Since the announcement in April 2002 by the Minister for Health that CME would be made compulsory from 2003, there have been exchanges in the newspapers, a petition by 600 doctors to downscale the points required and also a meet-the-doctors session to discuss the subject.

What is clear is that the majority of doctors have activities that enable them to keep up. But not all of them have registered their CME points with SMC since CME is currently still voluntary.

Why then make it compulsory? There are many possible answers. The best answer to my mind is let your CME attendance provide the facts that speak for themselves, that you have been sharpening your professional saw.

CME IMPLEMENTATION

In the article on CME implementation in the April 2002 issue of SMA News, the three professional bodies each wrote on how the 25 points in a year could be achieved in a workable way. That article is still useful to refer to. It is available on the SMA website http://www.sma.org.sg/sma_news/3404/education.pdf.

SMA'S CME PLAN

The SMA's CME plan for doctors in Singapore is to build professional capacity in areas that are not done as the major focus by other bodies. The SMA has therefore chosen to focus on Law, Ethics, Practice Management and Professionalism for the practising doctor.

WHAT CME ACTIVITIES TO LOOK FORWARD TO

The Centre of Medical Ethics and Professionalism (CMEP) in the SMA has planned a set of CME activities for doctors in Singapore. The following is a synopsis of the activities held this

year and some information of activities for the coming year. Check out the dates of future activities on the SMA Website or call the SMA Secretariat at 6223 1264.

ACTIVITIES HOSTED BY CMEP AND SMA

1) SMA Annual National Medical Convention

- The aim of this Annual event is to update the knowledge of the public and the medical profession on an important health topic. The topic this year was "Effective Health Screening". The Committee is working out the topic for 2003. Home Health Care is a possible topic.
- Over 200 doctors and allied healthcare professionals attended the medical symposium this year. We look forward to your participation in April 2003
- 2 CME points

2) SMA Annual Ethics Convention

- This event aims to update medical practitioners on their ethical responsibilities, and skills for good clinical practice
- The convention consists of 5 symposiums which focus on a Convention theme. This year, the theme was on "Improving Patient Safety and Outcome with Ethics and Professionalism".
- 9 CME points were awarded to those who had attended all 5 symposiums held over the weekend on 9 & 10 November 2002.

3) SMA Lecture

- The SMA Lecture was instituted in 1963 by a grant from the SMA

to the NUS Faculty of Medicine to establish an Annual Lecture on medical ethics and related topics. The SMA Lecturers are appointed on the invitation of the SMA Council and the Lectureship is awarded in the main to eminent and distinguished persons who have made significant contributions to Medicine and the community.

- This year, we were honoured by the presence of Professor Edison Liu, Director of Genome Institute of Singapore, who gave a Lecture on "Genomics and Medicine in Singapore". This was held in conjunction with the SMA 6th Annual Ethics Convention, on 9 November 2002.
- 2 CME points were awarded to those who attended this Lecture.

SMA AND EXTERNAL COLLABORATION:

4) SMA-TTSH monthly seminars in bioethics and health law

- This is a continuation of last year's programme. At each session, which lasted one-and-a-half hours, we focused on the Bioethics and Health Law aspect of selected specialties, such as geriatrics, paediatrics, obstetrics and gynaecology, infectious diseases, and psychiatry. There were also sessions on the legal interpretation of the Medical Registration Act and Private Hospitals & Medical Clinics Act, which all practitioners ought to be familiar with.
- An average of 80 doctors attended each session.
- 1 CME point per session was awarded to those who attended.

A new two-year course is being planned to start in January 2003.

5) SMA-SGH monthly seminars in medical negligence & risk management

- We started this two-year programme since January 2002. We aim to provide a forum for sharing and learning on the issues in law and ethics that doctors need to be aware of in their day-to-day practice, and to empower doctors to take steps to avoid medical errors and reduce the risks of litigation.
- An average of 50 attendees at every session.
- 1 CME point per session was awarded to those who attended.

6) SMA-MOM practice management seminar on Occupational Safety & Health

- The learning objective of this seminar was to keep doctors updated on the Factories Act and its subsidiary legislations.
- It was a collaboration between the SMA and the Occupational Health Department of the Ministry of Manpower. It was well attended by over 100 doctors.
- 2 CME points were awarded to those who attended.

AN INVITATION

Do include some of SMA's CME activities such as those listed above in your CME study plan for 2003. Come and join us. You will practise with greater professional assurance.

Acknowledgement:

Thanks are due to Ms Ng Wee Fong from the SMA Secretariat for compiling the information in this article.

The Patient, First...

The doctor-patient relationship

Professionalism and society

By Dr Lawrence Chan, Consultant Obstetrician & Gynaecologist

The most important person in the hospital or clinic is the patient. Without him or her, the doctor, nurse or other healthcare person will be without a job!

This has been well accepted. The most important person in the hospital or clinic is the patient. Without him or her, the doctor, nurse or other healthcare person will be without a job! So, the patient is our reason to be. But, how most important?

Firstly, he is a fellow human being in medical need. He may suffer from a complaint that incapacitates him, and makes him unable to function normally. He needs not only attention but also sympathy. For the medical doctor to empathise with the patient is to go the second mile with him. A psychiatrist once told his students while watching one of his patients walk away from the clinic, "There, but for the grace of God go I." We are not only capable of suffering any illness of our patients. We feel the same

weaknesses of flesh and spirit. We are the same as him, but for his particular illness.

Secondly, as trained medical practitioners we have the knowledge and skill to treat, alleviate and sometimes cure the person of that affliction. No wonder that in the past, healing was first practised by priests. They held that their ability to minister to the sick was part of sacred duty. Whether we are religious or not, we can agree that to touch and minister to the mind, emotion and body of a fellow human being, is close to that of a religious act. No wonder that the duty of the doctor is to put his patient's interest above that of his own. It is only by so doing that we earn the trust of our patient. Thus the real doctor-patient relationship is forged.

Thirdly, we need to uphold professionalism in medicine. There are competing needs in the delivery of healthcare today. While legitimate in their own rights, they may dilute the central aim of the practice of medicine; that of the ability of a doctor to deliver the best care he knows of, to his patient.

In 2001, a Physicians' Charter was drawn up by the American Board of Internal Medicine, the American College of Physicians – American Society of Internal Medicine and the European Federation of Internal Medicine. This was done as concerned physicians saw the erosion of professionalism and the doctor-patient-relationship in the healthcare system of today. Interestingly, they affirmed that despite differences of healthcare practices in the world, there



National Day Award

In August 2002, Dr Lee Suan Yew, President of the Singapore Medical Council was awarded the Public Service Star (Bar) (BBM) (L) in public recognition of his contributions to the medical profession in Singapore, and to the Council. He was awarded the Public Service Star in 1991.

Dr Lee has served on the Medical Council since Sep 1993. He was elected as the Council's President on 3 October 2000 after the late Professor N Balachandran had stepped down as President due to illness. Dr Lee was re-elected as President for a second term on 1 October 2002.

Dr Lee has actively participated in the work of the Council in spite of having to run a busy family practice. We extend our warmest congratulations to Dr Lee on his award. We look forward to his continued leadership of the Council.

are common ethical principles that bind doctors in the practice of medicine in different countries and disparate cultures. Some of these principles are:

PROFESSIONALISM AND SOCIETY

The medical profession has a duty to society. This is the acquisition of knowledge and its translation into medical practice that earns the trust of society as a whole. As a profession we claim the right of self-regulation. In the debate about compulsory continuing medical education, all doctors must be seen to be doing what is proper to win the trust of the public. We must also increasingly practise evidence-based medicine.

An important duty today is implementation of the ethic of justice; that is the wise use of limited health resources. I am convinced that here the doctor holds the key. We have to realise our need to preserve valuable

resources. This can be done if we practise good clinical medicine, utilise appropriate investigations and advocate the right treatment for the patient. The appropriate use of modern technology is also needed as its use increases the cost. Giving or withholding antibiotics and other types of therapy is often not only cost effective but also safer for the patient.

THE DOCTOR-PATIENT RELATIONSHIP

Apart from community medicine, patients are treated by the doctor one at a time. This doctor-patient-relationship is precious and needs to be preserved. In the need to save the healthcare dollar, well-meaning healthcare managers sometimes disrupt this relationship. They bind the hands of the doctor so that he is unable to give the most effective treatment to his patient. There is a need for the healthcare provider and the doctor to work together to better

understand different medical problems of the patient. With this partnership and trust, we can better use the resources that we have.

Confidentiality is necessary for the doctor-patient-relationship. This is particularly so today in the need to obtain informed consent for HIV testing and management of HIV-Aids. Also, looming round the corner is individual patient genetic profiling. Its proper use requires confidentiality and respect for the patient's rights.

The new Physicians' Charter considers other aspects of a physician's responsibility. These are best referred to in the Charter.

References:

Medical professionalism in the new millennium: a physicians' charter.
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Thank you

Dr Kwa Soon Bee & Dr Chan Heng Thye For Your Contributions...

Two senior members of the Singapore Medical Council (SMC), Dr Kwa Soon Bee and Dr Chan Heng Thye, stepped down when their terms of office ended in September 2002 and May 2002 respectively, after many years of dedicated service to the Council.

Dr Kwa had been an active member of the SMC since 1972. From 1984 until his retirement in 1996, as the Director of Medical Services, Ministry of Health, he served as Registrar of the Council. During his term, he had spearheaded several new initiatives to further improve the structure and operation of the Council.

Dr Chan had been a member of the SMC since 1990. In spite of having to run a busy orthopaedic practice, he had actively participated in the work of the SMC and chaired many Complaints Committees and Disciplinary Committees.

As men of integrity and wisdom, the SMC had benefited much from their contributions. We wish them all the best in their future endeavours.



Dr Kwa Soon Bee



Dr Chan Heng Thye

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