Address by the Master, Academy of Medicine, Singapore at the 1999 Annual Induction Dinner at the Regent Hotel

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Past Masters of the Academy, Your Excellency Ambassador of Mexico, Fellow Academicians, Ladies and Gentlemen.

We are in the last year of the nineteen hundreds. Next year will be year 2000. Time magazine, in choosing this century's greatest minds and best brains, named 3 in the field of medicine—Alexander Fleming and the discovery of penicillin, Jonas Salk and his vaccine against polio, and Watson and Crick for unravelling the secrets of life in DNA. Can we emulate them? Let me discuss with you 5Cs, or more specifically five com….s.

You know about the Bristol tragedy where surgeons operated on children but the mortality was too high and this was not detected for several years. My first C concerns ***Competency***. Our new Fellows, especially those who have recently completed advanced specialty training, are the "new kids on the block". You have learnt well and are equipped with good skills and expertise, but you lack experience compared to your seniors. This you have to recognise and make the necessary allowance for it. As you further mature and your clinical judgement sharpens, you will then become the consultant you once dreamt about. How would your peers and the public know of your competency? What records and audits must you do or be subjected to, to demonstrate your competency? Think about it yourself. Whatever the Ministry puts in place can only be the minimum standards to safeguard public safety. But as Fellows of the Academy, a much higher standard is expected of you. How would you as an individual therefore go about maintaining your medical professional competency?

Continuing medical education has been in existence ever since the founding of the Academy in 1957. But more structure was put into CME only recently—1989 under the Singapore Medical Association and 1992 under the Singapore Medical Council. Yet the response from specialists has been dismal. In 1998, only 10.1% of specialists in Singapore attained the 25 points necessary to qualify for the recognition award for CME. Will it improve? Must CME be mandatory for participation to improve? The ball is in our hands. I would urge you not to ignore the system as it stands, imperfect though it is.

Can we propose something better, knowing that our objective is doctor competency coupled with acceptable patient outcome? One suggestion to maintenance of professional standards amongst Fellows is through CPD—continuing professional development, of which CME through workshops, conferences and lectures is but one component. I am not talking about revalidation or recertification although in the US, this is their system. In Canada, it is the MOCOMP, maintenance of competency of medical practice and in Australia it is MOPS, maintenance of professional standards. What are the key elements of a CPD scheme? These are:

- Firstly, the cooperative development of the scheme with the specialist training committees, specialist societies and other interested parties. We are on new ground here and the more brains to think through the issue, the better;
- Secondly, emphasis on education, audit and quality assurance activities;
- Thirdly, the development of an appropriate specialist review process; and
- Lastly, the issue of a time-limited certificate.

I am not categorically stating that this is the direction the Academy is moving into, but as we observe what goes on internationally, it is necessary for us to make changes so as not to be left behind. Quote, "The trouble with a doctor not involving himself actively in CPD is that he doesn't know what he doesn't understand about things he has never heard. He is simply unaware of his limitations, and if left alone is a sleeping bomb." Failure to keep up with advances in medicine leaves a doctor with no defence. Repetition of bad practice or outdated practice does not turn it into a good one.

I turn to my second C—***Complaints***. As you practise your specialty, your patients will complain to you as part of the history-taking process. As medical Sherlock Holmes, you pick up the historical clues to diagnosis and proceed forthwith to manage your patient as best as you know how. Some will be satisfied, others will not. So what do they do—they complain about you to others, be they the SMA, the SMC, your hospital administrator, etc. Some complaints are frivolous, others are about efficiency and costs. But those that affect your professional practice can lead to big trouble and the experience of appearing before a complaints committee or discipline committee of the SMC is not worth having. Better avoid than have to face it. If it concerns your professional competency and a poor outcome, your medical defence lawyers may be your saviours. But more frequently complaints against doctors are because of miscommunication. Perceptions are important. Having done your best may not be enough. You must be seen to have done your best if a poor medical outcome is to be accepted by the patient and his relatives. Patient satisfaction surveys are tools used to gauge the medical service. So while we know we have delivered the best, our patients and the public must perceive it to be so. Complaints are feedback that can help us improve ourselves.

This brings me to my third C—***Communication***. The doctor-patient relationship is sacrosanct between you, the doctor and your patient. This relationship can flourish or it can turn sour and very soon at that. In this relationship it cannot be said today that " Doctor

knows best". Instead patients and his relatives want to be involved in their own care and in the decision making processes. We, as a profession, should not deny them that. Explanations are necessary and even more necessary the higher the technology, the risks and the costs. We owe to them to explain the good and the bad, the positive and the negative, the joys and the sorrows. Further, we need to empathise with them to show that we care. Do you consider these expectations unrealistic?

Many years ago, Dr Gwee Ah Leng, our previous Master, said, "There are four important things a patient should know when he leaves hospital: what is wrong with him, what expectations he can have, who is the doctor responsible for him, and what he has to do when he leaves hospital." This is as relevant today as it was then.

My fourth C is ***Complementarity***. "The secret of life is complementarity." So proved Francis Crick and James Watson when they announced on February 28, 1953 in the Eagle Pub in Cambridge, England that " we had found the secret of life." That morning they had figured out the double helix nature of DNA. The Watson and Crick story is one of sublime harmony, an example of the marvellous resonance between two minds—that high state in which 1 plus 1 does not equal 2, but more like 10. In the "complementarity" between A & T, C & G lay the key to replication. As medicine advances, there are more reasons for multi-disciplinary approaches to complex medical problems. A solitary doctor, especially a specialist, will need to more and more involve other specialists in the care of a single patient, especially the senior citizen who suffers a multitude of medical problems. We as specialists should learn to complement each other rather than do the opposite, which is to compartmentalise parts of patients to the care of different doctors. I am sure patients will appreciate one doctor in charge with other specialists contributing their expertise to their care, in a coherent, coordinated and efficient manner. You may be aware that a new specialist has been born in US hospitals—he is called the hospitalist.

And finally my fifth C —***Complacency***. Alexander Fleming discovered penicillin because he wasn't complacent. He had left a culture plate, smeared with staphylococci bacteria on his lab bench while he went on a 2-week holiday. On his return he noticed a clear halo surrounding the yellow green growth of a mould that had accidentally contaminated the plate. Unknown to him, a spore of a rare variant called *Penicillium rotatum* had drifted in from a mycology lab one floor below. As the staphylococcal bacteria grew, it covered the entire plate save for the area surrounding the mouldy contaminant. Seeing the halo was Fleming's "Eureka" moment. He correctly deduced that the mould must have released a substance that inhibited the growth of the bacteria. I do not know how many times Fleming must have examined culture plates. It would have been easy for him to discard this one too when it did not go according to plan and throw it away because of contamination, but Fleming was not complacent. Repetition did not breed familiarity. He was prepared to consider the unfamiliar unexpected result.

So must we as we embark on more quality assurance and audit work as part of Continuing Professional Development. When a case does not fit its natural history, nor a result come out as expected, it is a fertile ground for questions. Offence is not the intention of those who ask why. Opportunity is given to rediscover anew. Which brings me to Jonas Salk and his polio vaccine. His deactivated killed virus vaccine protected children from polio and the days of the iron lung were numbered. The virus I wish to touch upon this evening is the Nipah virus. For too long, say the experts, the culprit was said to be the Japanese Encephalitis Virus. But today the truth is out—this is a new virus, the Nipah virus. As farmers and their families up north began to take ill, with weeks of prolonged fever leading to coma, the diagnosis was Japanese Encephalitis. Who would ever think there was a new virus to be discovered? The Nipah virus is a para myxovirus, a family of bugs whose members include those causing mumps and measles. Nipah's closest cousin is the Hendra, a fruit bat virus which killed a trainer and 14 horses in Australia.

So in the recent past, man has deliberately killed by the thousands, cows and bulls (because of mad cow disease), chickens and birds (because of bird flu) and hogs and horses (because of Nipah virus). However, it is reported that the worst is not yet over. Hendra virus is believed to enter a dormant phase a year before erupting in its virulent form. The Nipah virus may behave the same way. Hence, we cannot become complacent. The war of man against microbes (and I could quote the MRSA also) is never over. We have to be vigilant. Likewise for new drugs and new technology. The side effects may yet reveal themselves though not always as dramatically as Viagra.

I will conclude by urging all of us Academicians to uphold at all times the honour and integrity of our profession, that we practise our specialty to our best ability with the highest moral and ethical standards and that we practise within our specialty. Towards this end, I hope you will find these 5Cs—Competency, Complaints, Communication, Complementarity and Complacency of some help. Practise your speciality and practise within your speciality.

Thank you. 4 May 1999