# AMS News

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*A Newsletter of the Academy of Medicine, Singapore*


# Message from Master

## Reflection at the 50th Anniversary of the Academy

Dear Fellow Academicians,

The Academy of Medicine, Singapore celebrates its 50th Anniversary, or Golden Jubilee, this year in 2007. This is OUR very own Academy. Our Academy has a relatively short history of 50 years. However, considering that we just celebrated 100 years of medical education in Singapore in 2005, our Academy has come a long way since its inception.

When the Academy celebrated its 25th Anniversary, or Silver Jubilee, in 1982, one of our Past Masters vividly recalled and described the need for the formation of a local Academy of Medicine and the plight of the local specialists in those early days:

*"In 1957, there was an awakening among the population and a surge of sentiment towards running its own affairs. Many of the leaders who have grown up and matured during the war years have witnessed the breakdown of the orderly and detached way in which this part of the world was run.*

*The local professionals had no role to play in the policy making. The local graduates were only accepted into the ranks of medical and dental officers. The more able and dedicated had no opportunity for self-fulfilment.*

*In 1957, there were only a handful of local specialists among the founding members. The Academy functioned in a cursory manner with the running of postgraduate courses as part of its activities from time to time.*

*There were years of relative inactivity. The leaders of Singapore were working hard at finding and securing a meaningful role for Singapore in this archipelago. The leaders of the medical and dental professions had to bide their time."*

We would like to pay tribute to the leading role of the senior academicians whose passion and pioneering spirits have brought the Academy to what it is today. The challenge is for the current and future generations of academicians to work even harder towards realising the vision of the Academy and to protect its dignity. Our Academy is for us to cherish, to nurture, and to serve with a sense of mission for the profession.

Our founding Fellows have set very high and noble objectives for the Academy. It has to be so, as our profession has to distinguish ourselves eminently from the other professions and set even higher standards of professionalism and ethics in our practice and behaviour. Some of the main objectives of the Academy are:

a. to advance the art and science of medicine;
b. to promote study and research into medical and scientific problems;
c. to sustain and foster postgraduate education; to conduct higher professional examinations and to award diplomas;
d. to grant specialist certification to persons who have fulfilled the criteria laid down;
e. to maintain and promote the highest standards of professional practice;
f. to maintain a high code of ethical conduct amongst its members;
g. to represent, express and give effect to the views and opinions of its members; etc

With these main objectives in mind, we should critically examine our current stance in our quest for professional excellence in order to bring our Academy to new heights. Much has been achieved, but even more have yet to be fulfilled.

There are 3 major thrusts the Academy must play a critical role in moving forward: postgraduate medical education, continuing professional development and maintenance of competency, as well as in generation and dissemination of knowledge and to provide expert advice to society on matters of health.

The Academy of Medicine, with a membership of more than 2200 specialists and corporate Colleges, should have the full capacity to conduct training courses and examinations, together with the University. The Ministry of Health will provide the training facilities, set the standards of specialist practice and control the accreditation of medical specialists. The core values necessary to accomplish the above mission are competence and integrity. The medical specialists must redouble their commitment to professionalism. They must strive to ensure that Singaporeans will continue to have full confidence in entrusting their well-being and even their very lives to them. In the article entitled "*Self Regulation Within the Academy*" in this edition of the AMS Newsletter, our Past Master Chee Yam Cheng has written passionately on this important issue.

Today, we do need leadership that will help to steer our profession to keep its rightful role in society. We need leaders who will stand tall and be men and women of the highest professional and personal integrity and honesty, trusted and respected by the profession and public alike. I plead with and urge all Fellows to not only remain within the fold of the Academy, but also be engaged in its activities. Build up the stature and reputation of the Academy in the society in the same standing as our Sister Colleges and Academies, which have withstood the test of time.

May we have many more happy Anniversaries to celebrate.

**Ho Lai Yun, Master**
**2006-2007 Council**

## 41st Singapore-Malaysia Congress of Medicine, 19-22 July 2007

You are cordially invited to join us at the 41st SMCM at the Raffles City Convention Centre to celebrate the Golden Jubilee of the Academy of Medicine, Singapore. We are privileged that the Prime Minister, Mr Lee Hsien Loong, has accepted our invitation to be conferred as an Honorary Fellow. For more information and registration, please visit our website at: **http://www.ams.edu.sg/41smcm**

# News from Chapters and Colleges

### Chapter of Dental Surgeons

#### Visiting Academician Lectureship 2007, 23 January 2007

The Chapter of Dental Surgeons together with the Department of Restorative Dentistry, NUH co-hosted a CPE lecture by A/Prof Jens Ove Andreasen. A/Prof Andreasen is based at the Department of Oral and Maxillo-Facial Surgery, University Hospital (Rigshospitalet) in Copenhagen, Denmark. He is recognised as the Father of Dental Traumatology. He delivered his lecture titled "Implants and Transplant Use After Tooth Loss". It was very well attended with 100 participants.

*Dr Chan Siew Luen, Chairman, Chapter of Dental Surgeons, presenting a token of appreciation to A/Prof Andreasen.*

### Chapter of Psychiatrists

#### First Professional Lecture 2007, 29 January 2007

Dr Michael Robertson, Director of Pyschiatry, Royal Prince Alfred Hospital & Sydney South West Area Health Service delivered his lecture titled "Why Can't There be a Universal Code of Ethics in Psychiatry".

### College of Physicians

#### 1st Asian and Oceanian Parkinson's Disease and Movement Disorders Congress (AOPMC), 20-22 Oct 2007

The Congress will be held at the Suntec International Convention & Exhibition Centre, Singapore.The Asian and Oceanian Section of The Movement Disorders Society (MDS-AOS) was formed to bring together doctors, researchers and healthcare professionals involved in treating Parkinson's Disease and Movement Disorders throughout Asia and Oceania. For more information and registration, please visit the website http://www.aopmc.com.sg

### College of Obstetricians and Gynaecologists

#### HMDP Visting Expert Lecture, 19 Jan 2007

Professor Mark Crowther, a renowned Haematologist, delivered a lecture on "Anti-phospholipid Syndrome and Other Thrombophilias in Pregnancy: Therapeutic Considerations for Improving Outcomes" at the Lecture Theatre of KK Women's and Children's Hospital. This lecture was well-attended by College Fellows and Haematologists from the Chapter of Haematology, College of Physicians, Singapore.

#### 7th Regional MRCOG Part II Examination Course, 25-28 Jan 2007

As part of its annual series, the College, in collaboration with the Royal College of Obstetricians & Gynaecologists (RCOG), UK, Singapore Representative Committee, RCOG, KK Women's and Children's Hospital and the Division of Graduate Medical Studies, National University of Singapore, conducted the Examination Course at the KK Women's and Children's Hospital. The College had the privilege of inviting 2 RCOG examiners – Dr Antony Hollingworth and Dr Edmund J Neale – to conduct this course. Unlike previous years, this year's course was extended to 4 days to enhance trainees' learning. A total of 36 trainees from the Asian and Middle Eastern countries had greatly benefitted from the coaching/ teaching of the RCOG examiners and the local trainers.

# Schedule for Annual General Meetings (AGMs)

| Detail | Day/Date | Time | Venue |
|---|---|---|---|
| College of Physicians | Sat/14 April 2007 | 2 pm<br>Lunch will be served at 1 pm | Lecture Hall, National Cancer Centre |
| Chapter of Psychiatrists | Wed/18 April 2007 | Details to be confirmed | |
| Chapter of Dental Surgeons | Thur/26 April 2007 | 6 pm | Lee Kong Chian Room, Neil Road |
| College of Radiologists | Sat/28 April 2007 | 12.30 pm<br>Lunch will be served at 12.30 pm | Gallery Hotel, Amadeus Room, L3 |
| Chapter of Public Health & Occup Physicians | April | Details to be confirmed | |
| College of Obstetricians & Gynaecologists | Fri/11 May 2007 | 6.30 pm<br>Light refreshment will be served at 6 pm | Lecture Theatre, KKWCH |
| College of Anaesthesiologists | Sat/19 May 2007 | Details to be confirmed | |
| College of Surgeons | Fri/25 May 2007 | 6 pm<br>Refreshments will be served at 5.30 pm | Gleneagles Lecture Theatre, L3 |
| Academy of Medicine, Singapore | Sat/26 May 2007 | 2 pm<br>Lunch will be served at 1 pm | National Cancer Center |
| College of Paediatrics and Child Health | May | Details to be confirmed | |
| Chapter of Pathologists | Fri/13 July 2007 | 5.30 pm | Library, Dept of Pathology, SGH |

# Self Regulation Within The Academy

## Introduction

*"Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession".*[1] This I quote from the Physicians Charter for this new millennium reflecting the US and European views.

I would like to suggest that the Academy of Medicine steps forward in a similar direction to lead its Fellows so that the public trust in us, specialists, will not wane but instead grow stronger. This is in spite of the complicated political, legal and market forces that we are immersed in.

## Fundamental Principles

There are three and these are internationally accepted and practised. The first is the primacy of patient welfare, that patient's interests come first and the doctor is dedicated to serving the patient's interest. Altruism contributes to the trust that is central to the physician-patient relationship. There should be no compromise by market forces, societal processes, and administrative exigencies on this principle.

The second is patient autonomy. We must be honest with our patients and empower them to make informed decisions about their treatment. These decisions should be in keeping with ethical practice and not lead to demands for inappropriate care. The doctor is advisor, often one of many, to an autonomous patient. The centre of patient care is not in the physician's office or the hospital. It is where people live their lives, in the home and the workplace.

The third is social justice including the fair distribution of healthcare resources which are forever finite.

Can we live by these principles? What if we do not?

## Professional Responsibilities

The Physician's Charter lists 10 of them but I will be selective.

### *1. Commitment to professional competence*

We all know that there is an explosion of technology, changing market forces, problems in healthcare delivery, bioterrorism and globalisation. Yet we are committed to lifelong learning. We are responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. The profession is only as strong as its weakest link in the chain of healthcare. Further, there are other health professionals heavily involved in the delivery of quality care. But can we as a whole profession see to it that all our fellows are competent as well as ensure that appropriate mechanisms are available for fellows to achieve this goal?

Each College of the Academy should provide these mechanisms for its fellows and help them achieve continuing competence. In Miller's pyramid for clinical assessment there are 4 levels – at the bottom is knows, then knows how, then shows how and finally at the top, does.[2] And as part of our CME, we should achieve the doing level i.e. put into practice the knowledge we imbibe.

Another challenge is for each College to be aware of fellows who are unable to achieve this goal and help them do so. The key word in this commitment is "all members are competent", not some.

### *2. Commitment to honesty with patients*

Physicians must ensure that patients are completely and honestly informed at two points in time. The first is before the patient has consented to treatment and the second is after treatment has occurred. This patient expectation allows them to decide on the course of therapy. Further it allows them to decide when further care is no more necessary. Living on endless hope is unrealistic, may be costly and unaffordable. Medical Science has its limits: we must acknowledge this and the same realism communicated to the patient.

Physicians should also admit that in healthcare, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. There is no other basis for improvement and fair compensation unless medical mistakes are reported and analysed.

The challenge here for the Colleges towards its members is to provide free voluntary audit of each fellow's medical practice. Another pair of eyes seeing what we have done to and for our patients will uncover good and bad results. Both are extremely useful for the doctors – strengths to be built upon yet further and weaknesses to be corrected. So it begins with openness between colleagues and leads on to openness and honesty with patients.

### *3. Commitment to patient confidentiality*

Earning the trust and confidence of patients requires that appropriate confidentiality safeguards are applied to disclosure of patient information. The widespread use of electronic information systems for compiling patient data only serves to reemphasise the importance of this commitment. While we may feel comfortable with the security of the electronic banking system, even though some scams have been reported, we have yet to feel safe with patient records. This misperception needs correction.

In the public healthcare system, all employees sign a confidentiality agreement if they have access to patient information. Also, certain groups or levels of staff have access to certain types of information. So unlike learning from medical errors where reports are on a "need to share" within the organisation so that there is organisational learning, for electronic medical records (EMR), sharing access is on a "need to know" only. And there are serious consequences for staff should they gain unauthorised access to the EMR. The most severe penalty is termination of employment. I suppose the Official Secrets Act (OSA) of government is for the same purpose and a term in jail is one of the consequences.

So the challenge for the Colleges is how can it facilitate those physicians outside the public institutions access the latter's EMR (to improve patient care) while ensuring commitment to this responsibility? What action can/should the College /Academy take if one of her fellows breaches this responsibility?

### *4. Commitment to improving quality of care*

Doctors must be dedicated to continuous improvement in the quality of healthcare. It means not only the first commitment of maintaining and improving clinical competence but also working with other professionals to reduce medical error, increase patient safety, minimise overuse of healthcare resources, and optimise the outcomes of care. Physicians must actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the

performance of all individuals, institutions and systems responsible for health delivery. This Physician's Charter states explicitly that *"Physicians both individually and through their professional associations,* (and here I would specially mention College/Academy) *must take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care"*.

This is not a one step journey or a short 5-year plan. This would be work in progress for a long time to come. The Ministry of Health is committed to giving the public more information on the web pages – first about bills, then process indicators and outcomes of care/operations/procedures. The aim is to educate the public at large and the consumer of healthcare. More and more consumers will over the years come from overseas. To assist them to make the conscious decision to come to our shores such quality data is important, and even vital if we are serious about 1 million health tourists coming here per year by 2012.

The College/Academy can assist by providing updated information of its Fellows, information that would help a foreigner decide to come to Singapore to seek a particular expertise. A short write up on the specialist's training, special expertise and outcome data (voluntarily given and verified by the college) would go a long way. One caveat ought to be stated – that in the present complex state of the art of medicine, more often than not it is a team effort that achieves excellent results and every team member is critical to the successful outcome. Not only good or great people make a difference but good systems are also essential.

### *5. Commitment to maintaining trust by managing conflicts of interest*

We have many opportunities to compromise our professional responsibilities by pursuing private gain and personal advantage. In dealing with equipment manufacturers, pharmaceutical firms conflicts of interests may arise. Physicians have an obligation to recognise, disclose to the general public and deal with conflicts of interest that arise in the course of their professional duties and activities.

While doctors may become entrepreneurs or technopreneurs themselves, the patient should be informed if a test e.g. CT scan, or equipment e.g. a pair of spectacles, is to be ordered from the facility he has shares in. The patient has the right to go some place else if he so chooses. Linkages with insurance companies to be on the preferred provider list should not undermine the patient's choice to consult a non-listed provider.

What can the College do? As all company directors declare their interests regularly to the Board about their companies they help run, the college could maintain such records on behalf of her Fellows and make this public knowledge.

### *6. Commitment to professional responsibilities.*

"As members of a profession, physicians are expected to work collaboratively to maximise patient care, be respectful of one another, and participate in the process of self regulation, including remediation and discipline of members who have failed to meet professional standard.

The profession should also define and organise the educational and standard setting process for current and future members. Physicians have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance".[1]

This last commitment needs to be given more thought by Council and Presidents. While the Singapore Medical Council is at the pinnacle of self-regulation for doctors, should the Colleges self regulate its specialist fellows?. What about those not fellows of the College? What avenues of discipline are available for enforcement? Who decides who has not/does not meet professional standards?

## Singapore Medicine

"If we are so good then the people will come". "Word of mouth is not good enough. We need to give more relevant health medical information on the web". Today, tourists come to Singapore and for 2006, the number has exceeded all projections. Some tourists would, by the way, seek medical help either a proper consultation for a second opinion, or some form of health screening. But this was not the objective for setting foot here. Some tourists are evacuated here as medical emergencies for treatment. But Singapore Medicine is more than all this. It is our brand of medicine – inherited from the British but with best practices from all over the world. How do we make our medical services attractive to others in lands where if they had a choice, they would still fly here? So in the US if you have no medical insurance but have some cash why not come to Singapore for your problem to be fixed? Yes why not? – Is the service and outcome and cost here better and cheaper than where they are living? Since the majority of them come for specialist care and treatment, the Academy can do much to make this initiative a success.

## Conclusion

Revalidation is round the corner, at least in the UK.[3] Standards of practice of individual doctors throughout their professional lifetime will be tracked. Revalidation is being considered along 2 tracks – relicensure and recertification. In the US, specialist certification is already time-limited (at 10 years). Stronger standards of practice with outcome measures, practice audit, and professional self regulation will better protect the public and increase their trust in specialists.

Doctors will have to be recertified from time to time to remain on the specialist or general practice register. Periodic assessment of competence will be led by the royal colleges.[4] So the Academy should do the same by setting standards of specialist practice and by assessing against them. In its paper " *Good Medical Practice for Physicians,*" the Royal College of Physicians has already set a framework down to the level of each of its more than 20 specialisms. Multi-source feedback or $360^0$ review methods are also in place. The college faces risks: currently they are facilitators, helping their members to keep up to date. They are not regulators who may remove doctors' livelihood.

We in the Academy (like the Royal Colleges) "need to stand up and take responsibility for demonstrating that patients' trust in their specialists is justified".[4]


**References**

1. Project of the ABIM Foundation, ACP-ASIM Foundation and European Federation of Internal Medicine. Medical Professionalism in the New Millennium: A Physician Charter. Ann Intern Med 2002;136:243-6.
2. ten Cate O. Trust, competence, and the supervisor's role in postgraduate training. BMJ 2006;333:748-51.
3. Irvine D. Reactions to the Chief Medical Officer's report. BMJ 2006; 333:965-6.
4. Gilmore I. A new role of the royal colleges? BMJ 2006;333:969.



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