“Dr. Rajakumar is one of the icons of international family medicine. This book presents his intellectual fruits and his passion for high quality medical care. The papers span the broad field of primary health care: from health policy to the spiritual values of care, encompassing quality issues and human rights.”

Foreword by Professor Chris van Weel

Family Medicine, Healthcare & Society
Essays by Dr MK Rajakumar

Edited by CL Teng
EM Khoo
CJ Ng

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Family Medicine, Healthcare and Society:

*Essays by Dr MK Rajakumar*

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CL Teng
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Preface

The articles in this collection were written by Dr MK Rajakumar between 1974 and 2003. Even though some of these were published almost three decades ago, the issues discussed are still highly relevant today. The articles are chosen from an extensive list of lectures and publications that Dr Rajakumar had delivered or written over the years. It took me and two other colleagues about two years to source for the full text of these papers and put them together in this volume. This book is divided into two sections, reflecting the themes covered therein:

- Section 1: Family Medicine. The first eleven articles cover various aspects of family medicine, from philosophical basis of the discipline to quality of care. They address issues of family medicine in the local context as well as the international arena.

- Section 2: Healthcare & Society. The next seven articles present Dr Rajakumar’s thoughts on broader issues that have created impact on the healthcare professions and the society, covering ethics, healthcare delivery, and the civil society.

All professional bodies and journals holding the copyright of these articles had graciously given permission to us to reproduce them (see Acknowledgement).

A list of Dr Rajakumar’s presentations and publications is given in the Appendix. This list is unfortunately incomplete at the time of print – Dr Rajakumar had been too engrossed in lecturing and writing, in the midst of his busy clinical practice, to keep a complete list of his scholarly works!

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March 2008
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We wish to thank especially the following individuals:

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2. **Dr Wei-Seng Chen**, for supplying the cover photograph.
3. **Ms Ivy Yeo** (Dr Rajakumar’s nurse), for helping to retrieve Dr Rajakumar’s articles.
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[Journal of the Royal College of General Practice is now known as British Journal of General Practice]

Singapore Medical Association [Professor Wilfred Peh, Ms Miranda Lau]


The Star [Ms Asha Devi]


World Organisation of Family Doctors [Dr Alfred WT Loh, Ms Yvonne Chung]

- Article 5. Future of Family Medicine in Developing Countries. 10th WONCA World Conference, Singapore. 1983.
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Foreword

It is with great delight that I see the publication of this book, in honor of Dr. M. K. Rajakumar. The Academy of Family Physicians of Malaysia should be complimented for their wisdom to bring together in this book Dr. Rajakumar’s most important publications. This way, the book achieves a number of objectives in one: it honors the laureate, and at the same it documents the fascinating history of family medicine and it makes again available the scholarly work of an important thinker of the fundamentals of health and medical care of people in the community.

Dr. Rajakumar is one of the icons of international family medicine. He was the president of the World Organization of Family Doctors, Wonca, from 1986–1989 and his leadership directed academic family medicine to the developing world. His hand can still be seen in today’s position of Wonca, as this made it possible to gain the truly global representation Wonca currently holds. With it came the observation of equity as a core value of family medicine: family doctors are there, for all health problems and all patients, irrespective of their background.

The papers that have been selected, span the many years, Dr. Rajakumar has given us his intellectual fruits and his passion for high quality medical care. The papers span also the broad field of primary health care: from health policy to the spiritual values of care, encompassing quality issues and human rights. This is, indeed, what it takes to be a medical generalist and reading between the lines is the wisdom, that has to supplement factual knowledge. In the papers is another lesson for us, generalists: the importance of global ideas and local context. Most papers in this book are directed at issues of substantial and lasting importance of the health of people around the world. But often if not always, there is reference to Dr. Rajakumar’s experience in Malaysia. It summarizes the approach of ‘thinking globally, acting locally’.

I would like to take this opportunity of singling-out one of Dr. Rajakumar’s lasting contributions to the discipline of family medicine: the development of generic classification of health problems and other health related data. In an era dominated by information technology, it is crucial to have access to data of the highest quality. At this moment, Wonca through the Wonca International Classification Committee (WICC), is currently building the structure of the 3rd version of the International Classification of Primary Care (ICPC) to deliver such information.
Dr. Rajakumar belonged to the members of WICC of the first hour, and under his Wonca presidency, the first version of the ICPC was published. I could give no better example of global leadership!

I trust the book will keep alive for the future generation of Malaysian family physicians the important thoughts and vision – the proverbial shoulders on which we have the privilege to stand and gain a better overview of the vast domain of primary care. I hope it also keeps us in contact with this founding father of our discipline: Dr. M. K. Rajakumar.

Professor Chris van Weel,
President of Wonca
Nijmegen, The Netherlands,
28th February 2008
Foreword

I am very happy to write this foreword for this publication of the works of Academician Dr. Manacadu Kumar Rajakumar, a beloved friend and mentor. He has been an icon for me since the days of my first joining the then College of General Practitioners of Malaysia (later the Academy of Family Physicians of Malaysia) and an inspiration to my life in the College.

Dr. Rajakumar has been a man with deep passion for the cause he believed in. He has been a born leader all his life, from his early years at home, his school, his University days, and later, during his professional life. He was always able to see ahead of his time and this ability sometimes got him into some difficulties. He was influential on many issues relating to family medicine and society at the international stage. Despite the international acclaim, he has always maintained a humble self.

He has led the Malaysian medical profession into new frontiers. He was able to see general practice develop into a specialty. His presidency of Malaysian Medical Association, his adjunct Professorship at University Kebangsaan Malaysia and his leadership calling in China and also the Presidency of WONCA were all leadership roles he took on in order to promote general practice – all this while continues to be the Chairman of the Council of the Academy of Family Physicians of Malaysia. His constant reminder that our College/Academy and examination, although recognised internationally, could not be recognised at home!

These talks and publications which have been compiled here is a good testament of the passion and the vision of the man who has devoted his entire life to the development and betterment of the general practitioner, by promoting the discipline of family medicine through education and examination. All the members who have had the good fortune to understudy him are now making it a reality by implementing what he stood for during his life-time of service. He still continues to inspire us, recently even from his hospital bed!
The words of Ralph Waldo Emerson are apt to describe him as follows:

“To leave the world a bit better, whether by a healthy child, a garden patch or a redeemed social condition: To know even one life has breathed easier because you have lived. That is to have succeeded.”

The publication is a reflection of the life of the man, what he has believed in and what he hopes for and it is hoped that every one will benefit from his faith, his hope and his charity for the world.

Datuk Dr. D. M. Thuraiappah
Chairman of Council
Academy of Family Physicians of Malaysia
March 2008
SECTION 1:

FAMILY MEDICINE
Family Medicine, Healthcare & Society:
*Essays by Dr MK Rajakumar*
Section 1: Family Medicine

Synopsis by Professor Dr EM Khoo

In the first eleven papers of this book, Dr Rajakumar described the history of general practice and the implication of the changing socio-economic scene in the Asia Pacific region on the discipline. He discussed the need a ‘new’ general practice in Malaysia and the region, outlined the postgraduate training programme of family medicine, proposed the establishment of departments of family medicine in the country, stressed the necessity of research and quality assurance in general practice and expressed his views on rural health as well as health care movement in the region and ultimately, “Health for ALL”.

His *Put Not New Wine Into Old Bottles* outlined his vision for general practice in Malaysia. In *The Importance Of Primary Care* and *The Evolution Of General Practice* he addressed the problem of fragmentation brought about by the specialization of medical disciplines, and the advances of medical technologies and therapeutics that had called for the development of family practice as a new specialty in place of the ‘old general practice’.

He identified several areas that needed concerted action: 1) Training of general practitioners (GPs), which should start with acquiring a sound scientific basis in the undergraduate years from medical schools followed by comprehensive clinical skills training in graduate years and professional training, coupled with independent thinking and socialization into the role of a physician. 2) Continuing medical education which is integral to GPs and the role of the Academy of Family Physicians to provide for this. 3) Research, which is not merely desirable but essential. 4) Community involvement, to further improve care for the needy and the special groups. 5) Recognition of the discipline. Primary care provides the most cost effective health care and it should be made the foundation of our health care system.

In the *Future Of Family Medicine In Developing Countries* and other publications, he addressed the problems of primary care in the region, the need for the formation of colleges of general practice and the credentialing of the training programme. He further suggested the establishment of departments of general practice in
medical schools and the grade of general practice in health services. He outlined the responsibilities of the ‘College of GP’ (now Academy of Family Physicians of Malaysia) to determine the appropriate training of GPs and the establishment of quality assurance programme for general practice.

In several papers, he highlighted the enduring values of family medicine, and exhorted family physicians to serve the patient, the family and the community. This “new and rejuvenated general practice” must provide continuing care, comprehensiveness care, emphasise patient advocacy and preventive care, capitalising on the availability of the rapid advancement in medical technology and knowledge.

In *Quality In Family Practice*, he emphasised the importance of quality assurance to improve care and suggested all general practices to have an age-sex register, disease register, risk behaviour registers and records of quality indicators such as consultation time, patient satisfaction, compliance to clinical practice guidelines and adopting an evidence-based approach.

He called for physician to serve in rural area to enable majority of the rural population to have access to health care. He addressed the leadership role of WONCA to disseminate family practice globally, and urged family physicians and professional bodies to support this effort, so that meaningful ‘Health for all’ can be achieved for all people.

His philosophy on family medicine has relevance that go beyond Malaysia and the Asia-Pacific region. These writings deserve to be given the highest of recognition.

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March 2008
1. Put Not New Wine into Old Bottles


There is an old general practice and a new general practice reflecting different levels of development of medical science and society.

A profession comes into existence to satisfy the needs of society at a particular level of development. Unless, however, the profession continues to change and adapt itself to new circumstances and new needs, it will in time become outmoded. Such a profession then clings itself to its traditional rights and privileges to maintain its position rather than confidently rely on its value to contemporary society.

When a profession adapts, grows and evolves, it then requires new institutions and new learning to enable it to fulfil its new function.

“And no one puts a piece of unshrunk cloth on an old garment, for the patch tears away from the garment and a worse tear is made. Neither is new wine put into old wineskins; if it is, the skins burst, and the new wine is spilled, and the skins are destroyed; but new wine is put into fresh wineskins and so both are preserved.”

Matthew 9.14 R.S.V.

The effervescence of new ideas cannot be contained in outmoded institutions. The profession of General Practice as we recognise it today is a new one. It is possible to trace a long heritage that goes back to the earliest physicians; but they were in fact practitioners in multiple specialities, rather than general practitioners. Great names of medical history from China, from India and from...
Greece were general practitioners in this different sense of the term. The more recent tradition that we can identify goes back to Edward Jenner who discovered vaccination against smallpox, William Budd who discovered the mode of infection of typhoid, and James Mackenzie who made major contributions to cardiology.

The modern discipline of the new General Practice that is our concern today is in the early decades of its establishment and is developing institutions for its new functions. The question now has arisen as to the proper training of the general practitioner. In forming a College of General Practitioners, practising general practitioners are accepting their responsibility to identify the appropriate training of the general practitioner in this country.

A major responsibility continues to rest with the medical schools to train undergraduates that are fit to undertake a career in the discipline of their choice. The foundation of good general practice is laid in medical schools and medical schools should produce doctors of broad learning, culture and humanity. This may be an impossible task in the age of hurried ambitions in search of quick rewards, yet it is an endeavour not to be abandoned.

After medical school, the hospitals become the training grounds. The period as an intern and the two years hereafter should be the period for completing the professional training of the young doctor and to produce not the all-rounder but the well-rounded practitioner of medicine. During this period, the choice of speciality should be made and we should hope our College will attract a good proportion of the good and the clever.

The training beyond this period is the prime concern of our College. Nevertheless, we cannot fulfil our responsibilities adequately unless General Practice is adequately provided for by the creation of departments of general practice in medical schools and by the establishment of the grade of general practitioners in the Health Services. This is necessary so that the discipline of general practice appears as a career choice at the formative period of a young doctor’s professional life and he can see and experience for himself general practice functioning as a critical and vital department of medical care.

The responsibility of the College lies in determining appropriate professional training for general practice in this country. We have several models of syllabuses
for examinations in general practice as well as vocational training programmes, but the task of our College lies in determining a programme appropriate to the conditions of practice in this country.

The universal characteristics of medicine produce many common features in general practitioner training all over the world and without doubt our own curriculum and educational programme will reflect these common features. It is worthwhile to pause a moment to consider the advances of medicine that have produced the need for the new general practitioner.

The past two decades have seen the accelerated fragmentation of medical science into very highly specialised divisions with elaborate and expensive instrumentation and technology. At the same time, these developments in medical science have brought within the reach of the general practitioner, potent drugs, sophisticated screening methods and precise diagnostic tests, all available as office procedures on a scale and efficiency exceeding what was available just twenty years ago even in a hospital. These new possibilities have given rise to the new general practitioner to meet the needs of comprehensive care of the whole patient, taking advantage particularly of the new possibilities in preventive medicine and early diagnosis.

The general practitioner provides comprehensive care for the whole patient to which organ-specialised medicine is a supplement. The general practitioner provides continuous care to which the episodic therapy of the acute illness is a supplement. Finally, the general practitioner sees his patient as a person functioning in a family and community and regards the maintenance of his health as the continuous underlay of his work and play.

You might say that this is in fact what traditionally good medicine is all about. That is so and the new general practitioner is the inheritor of this tradition. By this, I mean that the role of the doctor as a person of broad human concerns has devolved as the general practitioner and the new general practice continues that tradition. The organ specialities do already and will increasingly provide highly specialised and intensive therapy and diagnosis. The new general practitioner will have available to him this highly specialised expertise with elaborate instrumentation and his training must enable him to take full advantage of it in
fulfilling his responsibility to provide continuous and comprehensive care to the whole person.

There are other aspects of general practice that differ from nation to nation varying with climate and culture with different histories and standards of living. The situation of the general practitioner in this country as regards to the organisation of his practice and his relations with the patient is a peculiar one. In addition we have different patterns of diseases as well as different customs and temperaments of the multiplicity of communities that inhabit this land. Finally there are the problems of poverty that overwhelm the general practitioner, determining access to him and distorting the quality of care to those who most need it.
2. The Importance of Primary Care


[Journal of the Royal College of General Practitioner is now known as British Journal of General Practice]

This address was presented at the opening plenary session on September 8th, 1977 of the combined Conference of the Colleges of General Practitioners of Malaysia, Singapore and Hong Kong, the Royal Australian College of General Practitioners, the Royal New Zealand College of General Practitioners, and the Academy of Family Physicians of the Philippines. The theme of the convention was “Caring for the Community” and this meeting was also a Regional Conference of the World Organization of National Colleges and Academies of General Practitioners/Family Physicians (WONCA).

Introduction

The past three decades have witnessed a worldwide surge of interest in primary medical care. This has reflected a deeply felt need for a physician who is close to the family and the community. Medical advances have made it possible to meet this need although the old general practitioner and an amorphous medical tradition are gone. The new general practitioner or family physician brings specific skills to the highly specialised disciplines of contemporary medicine.

Development of specialisation

There was a time when all physicians were general practitioners and the most important distinction between them was the school to which they belonged. The great divide in medicine came with the development of hospitals. The hospital as
a place for the treatment of sick people is not much more than a century old and in this time it has been the catalyst for medical progress.

The hospital became the home for specialisation in medicine, first into medicine and surgery and then into organs and diseases. Each separation was preceded by resistance but the evolution of technically difficult procedures and the institutional advantages of specialisation have made the process inexorable.

The hospitals have made great advances into the institutional management of relatively small numbers of cases of advanced disease, using high technology and specialised skills. The well-loved figure of the general physician and general surgeon dissolved into the technologies of the super-specialties whilst medicine outside the hospitals became neglected and stagnant, the familiar family doctor facing extinction. A hiatus in medical care developed.

This hiatus in medical care is at the root of the contemporary crises in medicine. The community resents the impersonality of hospital medicine and denigrates the services provided by doctors. Social thinkers deride medical achievement because most of the decline in mortality and morbidity is attributable to improvement in housing and nutrition, and much of the rest to immunisation.

Great numbers of ordinary people doubt the advice of their own doctors and turn instead for hope and help to mysticism and fringe medicine.

The newly discovered importance of primary care arises from the fragmentation brought about by specialisation. Paradoxically the solution has been to complete the circle of specialisation by developing the new specialty of primary medical care. The new concerns have been for health education and preventive medicine, the identification of populations at risk and the detection of early disease. Nevertheless, what is left from the old general practice still remains at the heart of good practice that is the relief of pain and suffering and the compassionate and skilful treatment of disease.

I use ‘primary care’ as the generic term for our specialty, for the professional and academic discipline of which the principal practitioners are family physicians and general practitioners. The word ‘primary’ admits many fine meanings. The Oxford Dictionary gives three principal meanings: “of the first order in time”,
“claiming first consideration”, and “independent with the connotation of having something else dependent on it” (also “direct”, “immediate” and “first hand”). I think we have enough there to cover the ideals of family medicine, of comprehensive and continuing care of the whole patient - through illness and in health - in the context of the family and the community.

The new general practitioner

In the training of the new general practitioner, there is a trend which I deplore that would reduce the clinical content of general practice. The general practitioner must not become an overpaid paramedic who carries out treatment initiated by the hospital, or an overtrained psychiatric social worker who has little to offer the patient looking for a physician. The medical hustler will always be with us but we need not dignify him with a postgraduate education. The training of high status but low function general practitioners would be a denial of the exciting possibilities of modern medicine. I am afraid that the tendency already exists to erect pretentious verbal structures which detract from the serious work of medical care.

General practice has become possible as a modern specialty because of the advances in medicine in recent decades. It is no coincidence that the revival in general practice and family medicine has occurred over these same decades.

The therapeutic possibilities in general practice are now immensely greater. The new antibiotics, the anxiolytics and antidepressants, the topical steroids and the beta-blockers, to mention a few in a growing list, have transformed the prospects of treatment. The vast majority of illnesses can now be better treated in general practice than they could be in hospital only a few years ago.

The advances that opened the doors of mental hospitals and closed down tuberculosis sanitariums also made possible a more effective and considerate treatment of sick people with minimal disturbance to their lives and their families. At the same time, clinical chemistry has made great advances, the electrocardiogram has become commonplace, and even endoscopy has become a potential general practice procedure. Technological advance has created exciting diagnostic and therapeutic possibilities in primary care. A high degree of clinical competence becomes not less but more important.
The need for good primary care

The good general practitioner is needed more now because he can do more. The team can extend his capacity to care but the competent clinician will remain the central agent in primary medical care. It is possible to train other categories of medical staff to undertake specific specialised procedures: the most experienced colonic endoscopist in the world is a paramedic in Hawaii and tubal ligation is done with superior results by nursing aides in Bangladesh. In my own country, hospital assistants do circumcisions very competently. At the other end of the scale, the Director of the Institute of Medical Research in this country is an outstanding biochemist but has no medical degree. Clearly, for many specialised tasks a full medical training may be superfluous. Nevertheless a good physician is still needed to act as a friend and counsellor, diagnostician and therapist.

The need for a superior primary care service is greatest in the poorer countries of the world, yet primary care is more neglected there than in the developed countries. This is partly due to the influence of the wealthy elite seeking treatment in centres of excellence and partly the result of having hospital-orientated foreign advisers. As a consequence, the health care of the vast majority of people is neglected as finances are strained to meet the voracious appetites of ever-growing hospitals. Where the most experienced are needed in primary care, the most junior are sent. Primary care in poor countries is a frustrating vocation because inarticulate masses are served whose need is great but whose voice is small. More money to primary care can produce dramatic changes in these poor communities. Ninety per cent of patients are treated at primary care level at a cost of nine per cent of the total health expenditure. This is true of the National Health Service in the UK and is likely to be true for most western countries. Hospitals will continue to be expensive facilities and we will continue to need first-rate hospitals with highly specialised equipment and staff. An advanced system of primary care will call for even more specialised hospital units looking after relatively smaller numbers of patients.

An unfortunate fact of life is that we cannot have all the equipment and help we need in our work. The competition for health funding is a zero-sum game. Priorities have to be determined and choices made, and the most important of these is the more rational allocation of functions and resources to primary care and hospital medicine.
A great number of people now directed unnecessarily to hospitals can be most efficiently and most considerately cared for by their own general practitioner or family doctor from well-equipped primary care centres. With good preventive health and early detection of disease a great number of those with advanced disease who fill hospital beds need never be there.

Consider the problem of heart disease. Vast numbers of hospital beds and coronary units and a great amount of diagnostic and research time and money have been spent on drugs to control hypertension and treat its complications. At best it has been unrewarding. We now know that this is also a futile approach to the problem. Thanks to the Veteran Administration Study and the Framingham Study we know that detection of raised blood pressure in the healthy young, and its early treatment before symptoms appear, can prevent the complications of hypertension, including ischaemic heart disease. A similar situation exists with regard to cancer. Carcinoma of the cervix must be tackled primarily by cytology of healthy women, not by heroic surgery and superlative radiotherapy. Ultimately the most rewarding approach to disease involves the identification of those risks, preventing its development, and early detection and treatment. These are uniquely the skills of primary care.

The skills of primary care

The skills required of the new general practitioner are greater than ever before. To deliver care of the level that is needed by the community calls for the best of each class with the additional requirement of good character and temperament. It calls for a demanding training, exacting scientific standards, sound research, sophisticated thinking and planning, and scientific meetings of a more rigorous nature than have been customary. It is certainly not the soft option! Nor is primary care the cheap option in health care delivery, although it will be most cost effective. To achieve the best for the health of the community will call for excellent equipment of a new generation designed for primary care, well-trained staff, and efficient accommodation. This will not be cheap but at any level of expenditure in health services it will represent the most effective deployment of health resources. Investment in primary care brings its impact at the point where the largest numbers of people can be most economically benefited and where the community itself can play an important part.
The responsibility of the individual

The strength of primary care is that it provides for the involvement of the individual, the family, and the community. This is in an indispensable factor in efficient health care. The individual must retain responsibility for his health, otherwise the professions of medicine take on responsibilities that they are incompetent to deliver and become the lightning rod for the anger of unfulfilled expectations. Recognition for the autonomy of the individual is essential for his mental health and an important factor in his recovery from disease. Patient compliance and co-operation will not be obtained unless the patient takes the initiative in the maintenance of his own health. On the basis of the respect for the individual patient, the family and the community can recover their interest and concern for health and appreciate the contributions of the sciences of medicine and the art of its practitioners.

The future

The time has come for primary care to be considered as the central axis for the system of health care. It has become important because of the hiatus in medical care caused by unbalanced medical development resulting in the dominance of fragmented hospital medicine. It has become possible as a specialty because of the great advances in medical science and technology. Modern concepts of primary care promise to transform the prospects for health by shifting the emphasis to health education and preventive medicine, early diagnosis and early treatment, and by bringing the physician and the medical team into the life of the community. The task of training staff and practitioners with the special skills required in modern primary care is a challenging one. The hopes raised by these new developments in primary care can be fulfilled only by creating practitioners capable of coping with these new challenges. Recourse to mysticism and quackery by human beings in distress is partly a reaction to the failure of medical practitioners to deliver the promises of medical science. Primary care at the front line of medicine will be searchingly tested. The serious business of the day is to develop the profession to withstand the closest scrutiny of an intelligent and articulate population and retain the confidence of those who turn to its practitioners for help.
3. Primary Health Care for All the People


Opening address delivered at the 4th Combined Colleges Conference and Southeast Asia Regional Meeting of WONCA in Manila, Philippines from September 17-20th 1979.

We live in an age when expectations of people are high yet their confidence is low on the experts who will be needed to fulfil these expectations. This is most acutely true of medicine and in recent years, physicians have come under scrutiny and challenge in the face of a demand for better health care. These increased expectations on health have occurred contemporaneously in the developed as well as the developing countries.

At the Thirty First Meeting of the World Assembly, in May 1978, an appeal was addressed to the political leaders of the world to make the target of health for all by year 2000, the social target for the last quarter of the twentieth century. This was proclaimed at the Conference on Primary Health Care held at Alma Ata in September 1978 under the sponsorship of the World Health Organisation (WHO) and the United Children’s Fund. This was an inter-governmental conference attended by 134 governments and by representatives of 67 United Nations organisations, specialised agencies and non-governmental organisations in relation with WHO and UNICEF. The Declaration of Alma Ata reads in its fifth part:

“Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of Governments, international organisations and the whole world community in the coming decade should be the attainment by all peoples of the
world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary Health Care is the key to attaining this target as part of development in the spirit of social justice.”

This, you might well say, is the business of all of us gathered here today yet not a single organisation of physicians in Primary Care, general practitioners or family physicians, were present at Alma Ata or contributed to the Declaration. It is a sad and astonishing fact that organisations represented here today were neither invited nor put in anything to a historic Conference that placed Primary Care on the top of the agenda of social objectives.

Part of the reason, no doubt, is that planning and organisation of health care is very largely in the hands of public health physicians and of health administrators who advise the politicians. Notwithstanding that, it would be letting us off too lightly to accept that as the whole reason.

The sad truth is that General Practitioners and Family Physicians have allowed themselves to be overtaken by events, even as they relaxed in the warm glow of the achievements of the past two decades in giving our discipline its rightful place in medicine. Particularly in the developing nations, where the challenge to the physicians is greatest, the general practitioners have prospered in a professional ghetto and lost sight of the necessity of making their skills relevant to the needs of their people.

The impact of the Declaration of Alma Ata promises to be great on the nations of this region for two reasons. For one thing, as still underdeveloped nations, they are in the line of the main thrust of the WHO campaign. For another, being a relatively better off and better organised group of nations, they are better able to receive and implement the ideas of the WHO. It is therefore important to study these ideas closely and critically.

There are three aspects of the Declaration that I should like to examine. Firstly the term Primary Health Care is used loosely and often appears as a synonym for a form of minimal health care activity designed for poor countries as a substitute for good health care; a basic system planned by public health officials and delivered by lay health worker and using traditional healers where necessary. This seems to me to be a retrograde development. It must be admitted that there
are a few nations in the world so poor and so disorganised that very little health care is better than none at all. Nevertheless if not today, then tomorrow, all developing countries can and must aim at delivering modern medical care through trained teams.

This bring me to my second reservation regarding the WHO’s Primary Health Care. It appears to give up too easily on the prospects of getting physicians to work in rural areas where they are needed most. It seems to me that rural populations need the best trained and experienced physicians because their health problems are more severe and more complex. At the present time throughout the developed world there are no rewards for the physician in the rural areas, neither financial inducements for private practice nor career advancement in government service. Is it any wonder that bright young doctors quickly recognise that politicians do not wish to be taken seriously when they say that rural health is a top priority but do not provide the funds to make that possible?

Finally, there is the use of traditional medicine. It has become politically popular to push the use of traditional medicines or even urge their incorporation into modern medical practice. I am not saying that there are not therapeutically active agents in traditional medicine. On the contrary, it is likely that research will continue to discover therapeutic activity in various herbal preparations. Traditional medicine is part of the historic heritage of modern medicine. A great deal of the modern pharmacopoeia is still of herbal origins, reflecting the traditional medicines of western and other societies. We owe to herbal medicine a good number of our most important drugs, including morphine, digitalis, ephedrine and atropine. No doubt, more active agents are waiting to be discovered. However, this is quite a different matter from advocating the introduction of unknown, unidentified and untested medications and methods into medical practice. Such a development would open wide the doors to charlatantry and the community would be the worse.

Notwithstanding these reservations, the primary health care objectives of the Declaration of Alma Ata are important developments which have the potential for much good in this region. It is up to each country to make what it will of it. As primary care physicians from this region we can help to determine the shape of the primary health care delivery system and to train a new generation of physicians to deliver this care. We can make primary health care in this region a genuine
contribution to raising the standards of life and not merely a cover for neglect. The organisation of general practitioners in this region can play a vital and decisive role in determining the shape and standards of the new general practice in this region as a vital part of the movement to achieve health for all.

Regrettably, we have done very little. Over the past few years, there have been a series of regional workshops on different aspects of primary health care and there has been no participation by general practitioners. General Practice in our region has become equated with private ‘shop-house’ practice confined to episodic care of those who pay, irrelevant to the health needs of the community.

I believe then the fault lies with us. General Practitioners in the region have failed to keep up with the advances in primary care and the new concepts that have appeared over the past two decades. There has been neglect of education and a lack of ideas to contribute to solving the health problems of the community. As a result even within the area of our expertise, other specialists have had to do the thinking and propose solutions. The awful standard of primary care in developing nations of this part of the world is a reflection of neglect by the practitioners of primary care. We have failed by default.

We need a strategy to reverse this drift and to rescue primary health care from its deformed existence. There must be many approaches to this task and I give you my own thoughts and a little bit of the directions of my own College. To begin you need an organisation. The College of General Practitioners of Malaysia was founded in 1973. There is a great deal worth discussing on how to set about forming a College but I need not preach to the converted assembled here today.

Then there is the matter of establishing credentials as an educational body. The national medical association is the appropriate body for medical politics, not the College or Academy. The Universities have to be persuaded that we are collaborators and not rivals. The decisive argument is an active and superlative educational programme. My College has an active but not-yet-superlative continuing educational programme. This has been in no small measure a factor in the acceptance of the earnestness of our purpose by the medical profession as a whole in my country. All the organisations participating here today have excellent continuing educational programmes and we all envy the Family Medicine
Programme and the Check Programme of the Royal Australian College of General Practitioners.

The development of vocational training is a milestone. We have put our concepts on training into a report which we have called ‘Specialisation in Primary Health Care - Training for the New General Practice in Malaysia’. This report outlines the objectives, content of training and the mode of examination. At the same time, our College has joined a Committee of the Malaysian Medical Council to define the qualifications and experience of those who are entitled to be called ‘Specialist’. Significantly one of the categories of specialist under discussion is that of ‘Family Physician’.

Finally there is the role of providing expert advice on the future of primary health care in our countries. If general practitioners are the experts in primary health care, then they must provide expertise in that area. We must have expert committees and ensure that our views and advice are sought and used in planning and decision making. We have to be expert and we have to be persuasive.

The developing countries of this region urgently need good systems of primary health care delivery. They have committed themselves to a hospital-oriented system which has shown an infinite capacity to absorb all health funding. Fortunately the developing countries of this region are relatively prosperous and can afford a reasonable investment in health.

The common dilemma of these countries is that they are unable to get doctors to go to the rural areas. As a result some form of compulsory service has been introduced. Young doctors are sent to the rural areas from which they rush back to the cities as soon as their compulsory service is completed.

The problem is a very real one. In developing countries, four-fifths of the population live in the rural areas, but four-fifths of the physicians are in the urban areas. Four-fifths of the morbidity and mortality is in the rural areas, but four-fifths of health funds go into the urban areas. Four-fifths of health problems need primary health care but four-fifths of the health budget goes into hospitals. These proportions are generally true for the developing nations although the percentages may vary from nation to nation and according to the definition of urban and rural.
In Malaysia, my College has addressed itself to these problems. We have argued that primary health care in the rural areas is no less demanding professionally than hospital medicine. It needs well-trained physicians and not inexperienced ones. Primary rural health care must not be considered an exile or punishment but as exciting and challenging work. It must not be a job in which the physician loses out but one in which he gets rewards and recognition.

The creation of teaching Health Centres is an important part of the solution of attracting primary care physicians to the rural areas. These teaching Health Centres must receive the sort of priorities for funds that are now reserved for teaching hospitals.

The teaching Health Centres can fulfil the following functions.
1. Develop new approaches to the delivery of primary health care.
2. Train and motivate a new generation of physicians and other health care workers.

In primary health care delivery, we are in new and unexplored terrain and we need to try out different approaches. The aim is to develop primary health care teams led by physicians who are expert in their field, can function as a unit and deliver health care of a very high standard.

The expectations of people are high and they will if necessary bypass inferior health providers and trek to the cities for their medical care. These teaching Primary Health Centres must be well equipped centres with skilled staff if they are to win the confidence of the community. From these centres, we can provide the new generation of health care teams who work well because they know they have been well-trained and that their work is recognised and rewarded.

To plan the programme, you need a National Institute of Primary Care. The National Institute can provide the resource backing, help to develop medical record systems and treatment protocols and summarise the experience of the Centres.

Ultimately success or failure depends on the availability of funds. Good Primary Health Care is not cheap but it is the most cost-effective. When politicians promise top priority for rural health, will they pledge the necessary funds to go with their promises? One encouraging development has been the inclusion of health within
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the area of interest of the World Bank. If good schemes for Primary Health Care delivery can be proposed, international finances surely can be found. Health is the most precious possession next to life itself and there can be no development without health.

The Primary Health Care movement is an endeavour worthy of international support and one that can bring decisive improvements at the level that touches the lives of great numbers of people.
4.
The First William Pickles Lecture: The Evolution Of General Practice


It is indeed a great honour for me to be invited by the Council of the College of General Practitioners of Malaysia to deliver this address which has been named after a great general practitioner.

Dr. William Pickles was a country doctor who served the small community of Aysgarth for forty years. He studied the epidemiology of infectious diseases in the community. Using to advantage his familiarity with every single member of the community, he traced each contact and drew a complete picture of the spread of communicable diseases in the district. Pickles confirmed the incubation period of infectious hepatitis and of several other communicable diseases. He described and suggested the name of ‘farmer’s lung’ and was one of the first in the United Kingdom to describe accurately ‘epidemic myalgia’ or Bornholm disease. His own book, ‘Epidemiology in Country Practice’ has become a classic and is a monument to the art of observation and record keeping.

William Pickles was the kind of doctor that some of the best students in medical schools dream of becoming. Our patients continue to expect doctors of this kind and our inability to provide this sort of personal care any longer has been the source of disappointment and disaffection towards the medical profession. What place is there in the future for the tradition of personal and continuing care that the life of William Pickles exemplifies?
Until the middle of this century, it seemed that general practice was dying. In the United States of America the number of General Practitioners was diminishing rapidly and in the United Kingdom General Practitioners were losing status and prestige. Only in the Colonies were general practitioners important in the community but that was because the major hospital posts were reserved for colonial officers. Tiruchelvam with the FRCS could find no place in hospital practice and entered general practice. Sreenivasan with the MRCP was eased out of the General Hospital, Singapore and found refuge in general practice to which he brought resounding distinction. Tan Kim Seng who provided surgical care throughout the Japanese Occupation found he had no prospects in hospitals after the return of the colonial administration and went into general practice. General Practitioners were then the medical elite but in the twenty years after independence, specialisation has attracted many of the brightest from our medical schools.

This trend away from general practice was worldwide but we know that it was reserved and a renaissance in general practice occurred. In the United States, the American Academy of General Practice was established in 1947 and in the United Kingdom the College of General Practitioners was founded in 1952. Our own College in Malaysia was founded in 1973, at the same time as a College of Surgeons and a College of Physicians.

The task I have set myself today is to trace the historical process by which specialisation developed in Medicine. How did the undifferentiated generalist healer of ancient times give way to the doctor specialising in a single organ or a single disease? What were the factors responsible for the fragmentation of medicine into specialities? How finally was the ring of specialisation closed by the emergence of the latest and last specialty from the transmutation of general practice into family medicine?

I shall endeavour to show that the art and science of medicine developed in the most profound sense in response to the needs of the community and the specialities grew as a consequence of the level of scientific and technological development. It has been a long journey to our present situation and we carry constantly with us the historical imprint of our origins. To understand the present, you must know the past.
We belong to a very old profession, situated in ancient times between King and Priest, both of whom claimed divine healing powers and were suspicious of any others who made similar claims. Nevertheless both King and Priest resorted to a Physician in times of their own need. Throughout human history there has existed a great variety of healers, using charms, incantations, magic, as well as secret remedies. Every community had its herbalists and every family its own remedies.

The earliest step in the evolution of the medical profession was the separation of physicians from the purveyors of magic and charms. In our society the dukun and the bomoh are separate persons. Hippocrates had, 2000 years ago, already expressed his doubts regarding the ‘sacred disease’ epilepsy, but untangling the interwoven threads of magic and medicine continued until recent centuries. The other important step in becoming a distinct profession was the legal restriction of medical practice to those with the necessary skills. However, restriction was rarely possible as the community continued to turn to whoever it had confidence in. Nor was skill the necessary criterion as high social class was in practice the basis of determining entry. Nevertheless, a distinction was made and the Physician was separated from the quacks. The immediate reason given for this restriction was death and crippling resulting from the work of uncontrolled practitioners. Over 4000 years ago, Hammurabi of Babylonia specified fees and punishment for the physician in a code of 282 paragraphs that was engraved on a pillar of black stone. Eleven of these paragraphs dealt with the practice of medicine. In AD 931, a patient in Babylonia died from mismanagement and the Caliph ordered that thereafter none should practice medicine unless he satisfied the Physician-in-Chief of the hospital at Baghdad. In 1512, Henry VIII passed the first Medical Act on the grounds of protecting the community.

The third step in the emergence of medicine into the profession we now know it was the discovery of the scientific basis of medical practice. The practice of accurate observation, the pre-requisite of scientific progress, had been practised by physicians since ancient times. We know that five thousand years ago in ancient Egypt precise descriptions of clinical conditions were kept and we can read them in the Ebers and the Smith papyri. Contrecoup injury was described and the physician was warned against trying to treat head injuries with neck rigidity and bleeding from the nostrils and ears. The Hippocratic collection, which was written about 2000 years ago, contains many excellent descriptions of clinical conditions and shrewd observations on management. The spirit of describing only what he
saw inspired Andreas Vesalius to dissect in detail the anatomy of the human body in defiance of the clergy as well as the medical profession, thus correcting a thousand years of neglect and error. Sydenham published his precise and systematic observations of clinical conditions to give a scientific basis to bedside clinical medicine.

These then are the historical foundations of our profession. Medicine had a share in the general pace of scientific development. Physicians filled the ranks of the scientific societies and contributed in various areas of science whilst chemists and others contributed to medical progress. To the Renaissance in Europe we owe the intellectual attitudes that have given us modern medicine. The most impressive advances were in surgery because surgical conditions could be identified with relative precision and the response to treatment could be quickly seen. Surgery required special manual skills and knowledge of specific procedures. For these reasons, surgery can be identified as the earliest specialty in medicine. For several thousand years until very recent times, the rest of medicine could offer at best only the placebo effects of useless preparations if the patient survived toxic preparations and murderous procedures. Surgery could provide definite and generally predictable benefits. We have seen that ancient Egypt and Babylon already had its surgical craftsmen. The Hippocratic Oath enjoins the physician to leave cutting of stone to those who practised this art although this may be a reference to the ill-reputation of lithotomists. The Arabs gave a higher status to surgery and described surgical syndromes and procedures over 2000 years ago. Susruta in ancient India described 125 surgical instruments and gave instructions for plastic reconstruction of the nose and ears.

For several hundred years in Britain there existed only surgeons and physicians. I will use the developments in Britain to describe the further emergence of specialties. I do so because the British experience is well documented and accessible and it has determined the pattern of our own development.

In 16th Century England, the medical profession consisted of three separate branches, each with a different origin. From the grocers came the apothecaries with their familiarity with herbs. From the barbers came the surgeons with a knack for the knife. Lastly were the individuals in the Royal Court with an interest in medicine. The King, Henry VIII instigated the first Medical Act. By this Act the control of physic and surgery was restricted to graduates of a University or
those licensed by the bishops after examination by a panel of experts. This in effect excluded the lower classes from the practice of medicine.

In 1518, the physician to the King, Thomas Linacre then petitioned the King to set up a Company of Physicians which became the Royal College of Physicians in 1551. The Charter empowered the Royal College to license physicians throughout the kingdom and control practice within seven miles of London. The Surgeons followed through the influence of a barber- surgeon, Thomas Vicary who had the confidence of the King. In 1540 he obtained the King’s Assent to a union of all the guilds in England into the United Company of Barber Surgeons. This Charter was a victory for the surgeons in their long battle to separate from the barbers; although full separation was to take another 200 years, as a result of the 1540 charter, surgeons were no longer required to act as barbers and barbers were restricted to dental extraction. Dentistry thus was to develop independently.

The Apothecaries too were struggling to improve their status by separating from the grocers who were politically powerful and had the City on their side. However the Apothecaries had the support of the population they served. They succeeded in forming a separate section in the large Grocer’s Company in 1606 and in 1617 established a separate society. All the time they had to fight the efforts of the Grocers to reabsorb them.

The Physicians used their new powers to harass the Surgeons and the Apothecaries. They claimed that the Surgeon was a subordinate who must operate under the Physician’s order. They warned the Surgeons against prescribing medicine as part of their treatment. The Apothecaries were forbidden to prescribe but only to dispense and were to collect fees only for medicine and not for advice. To get around this, the Apothecaries charged highly for their medicines and gave their advice free. To counter the Apothecaries’ popularity with the poor, the physicians enjoined all fellows and licentiates to treat the poor free of charge. This had little effect.

During the great plague in 1665, the King and Court fled London and the Royal College of Physicians followed. The Apothecaries were left to tend to the population. When the court returned after the great fire, the physicians found the apothecaries serving as doctors and tried to reverse this. In 1703 they prosecuted
an Apothecary named Rose for practising medicine, but the House of Lords upheld Rose thus establishing the right of the Apothecary to act as a doctor.

In Edinburgh, in contrast, the Surgeons held the upper hand. Edinburgh was a great centre of medical learning and was in contact with the medical universities of the Continent. In 1505 the Barbers and Surgeons of Edinburgh formed a Corporation and obtained permission to dissect the bodies of executed criminals. This was before Vesalius, and before the Physicians and the Surgeons of London had been incorporated. The Surgeons in Edinburgh separated from the barbers in 1722. The barber surgeons exercised their prerogative of supervising physicians in Edinburgh. Two attempts by the Physicians to get a Royal Charter failed because of the opposition of the barber surgeons of Edinburgh and of the College of Physicians and Surgeons of Glasgow. Finally in 1681, the Royal College of Physicians of Edinburgh was founded.

In London, till the 19th Century, the Surgeon was still considered a tradesman. When he was called to the great houses, he entered by the tradesman’s entrance whilst the physician went through the front door. But surgery was growing in importance. During the Napoleonic Wars, the surgeons increased in numbers and the methods of care of the wounded improved from the experience of the war.

Meanwhile the Apothecaries Hall had organised training programmes for their pupils. The Apothecaries Act of 1815 gave them the power to control the practice of medicine throughout the Kingdom. They used these powers wisely to insist on five years’ apprenticeship during which attendance at courses in anatomy, physiology and the theory and practice of medicine was compulsory. In addition a candidate must have attended the wards of a hospital for at least six months. In this we can see the forerunner of the modern undergraduate course.

In contrast, the Royal College of Physicians stagnated as a small club of graduates of Oxford and Cambridge, where they could pass with very little teaching of medicine and without seeing a single patient. The strength was in their high social origins and in their connections at Court.

When the Royal College of Surgeons was established in England in 1800, they sought to attain equality of rights with the Apothecaries Hall. When they failed
to obtain an Act of Parliament, they came to an agreement with the Apothecaries to raise the status of the surgical diploma by confirming to the Apothecaries’ requirements and by additional lectures on surgery and an additional six months in hospital wards. Thus up and coming young men now sought the double qualifications of the College and Hall, that is, the membership of the Royal College of Surgeons and the licence of the Apothecaries Hall.

Those were the first general practitioners qualifying in medicine and surgery and the forerunners of the MBBS of our time. For many years, the Royal College of Surgeons and the Apothecaries Hall provided a home for the rising number of general practitioners.

The Surgeons continued to rise in status. Surgery received a tremendous boost from the activity of John Hunter. He is one of the great names in the history of medicine, and placed surgery on scientific foundations. A colleague said of him “He alone made us gentlemen”.

The 19th Century saw the rise of the Surgeons in achievement and esteem. The limitations upon surgery were pain and infection. As surgeons grew more daring, mortality rates became fearful. Then came two major advances in great succession. Anaesthesia became possible with ether and nitrous oxide and infection was controlled by antisepsis and asepsis.

The rapid advance of surgery now became possible and separated the surgeons from the general practitioners. The great body of General Practitioner - surgeons was eased out of surgery which was now concentrated in hospitals.

The rise of the hospital introduced a new cleavage into medicine between those with access to hospitals and those without. The hospitals were controlled by a small medical establishment. The Fellows of the Royal College of Physicians sought with diminishing success to control the Surgeons in hospitals. The younger physicians and the surgeons found that they could not rise or practise their new ideas because the medical establishment viewed with suspicion the emergence of new subspecialties.

In 1860, a Surgeon on the staff of St. Mary’s Hospital London was dismissed for accepting an appointment at St. Peter’s Hospital for the Stone. The development
of new instruments such as the ophthalmoscope and laryngoscope generated new skills and with these, new specialities. Dermatology emerged as a branch of surgery and became a flourishing field for private practice for the same reasons as now. With rapid growth of the cities, epidemics developed and public health emerged as a speciality. Obstetrics was discouraged in hospitals for fear of infection and gynaecology for fear of immorality. Practice in this area was looked down by the Royal Colleges and a President of the Royal College of Physicians was quoted as saying that “Obstetrics is no calling for a gentleman”. Repeated efforts early in the century to improve training within the Royal Colleges were rebuffed. Finally an attempt was made to set up a separate College. This was refused. However maternal mortality had become an election issue and political pressure was brought to bear on the Royal Colleges to agree to the British College of Obstetricians in 1929. To counter this in the same year, the Royal College set up a rival diploma which they proclaimed was a “guarantee of a high standard of attainment” in Obstetrics. This diploma never caught on and the new College never looked back.

During the period of great growth of hospitals, general practice languished. Whereas at the end of the 18th Century there was no difference between the type and quality of work in and outside the hospital, by the end of the 19th Century, there was a vast difference. The Royal College of Physicians emerged as a great force in medical training based on the hospital.

The hospital had become a centre of high technology. Powerful new agents were becoming available for the treatment of diseases and new equipment had been developed for diagnosis and therapy. General Practitioners were excluded from the advantages of many of those new diagnostic and therapeutic advances. Individually, general practitioners were amongst the founders of specialities such as cardiology and neurology but collectively they were excluded from a share in the advance of medicine. When the stethoscope was introduced by Laennec it was considered as too difficult to be used outside of hospitals. Similar arguments have been used to discourage the use of electrocardiography, radiology, clinical chemistry and new drugs outside the hospital.

What happened in the mid-century to change all this? I will identify two important forces. Firstly the rapid development of specialisation had undermined not only the position of general practitioners but also that of general surgeons and general
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physicians. The greater the fragmentation of medicine into subspecialties, the more severely was missed the lack of an integrating personal physician. The same changes that were destroying the traditional general practitioner were creating the need for a new type of physician who would be the principal or primary source of care, who would integrate the contribution of specialists and undertake continuing care of the patient. Secondly the advances in medicine that strengthened the hospitals also opened new possibilities in general practice.

The antibiotics, steroids and psychotropic drugs made treatment more effective in general practice than they were in hospital just a few years previously. It is possible now to do a great many more things in general practice better than it had ever been possible to do in the hospital only a few decades ago. New technological developments opened the door to new possibilities both in hospital medicine and in general practice. New knowledge on diseases has led to a realisation that many of the major diseases have to be dealt with by prevention. Hypertension is better dealt with by prevention of its complications than by treatment, in coronary care units. Cancer of the lung must be prevented by behavioural changes and can never be treated effectively by surgery. As our understanding grows, new possibilities emerge that give the general practitioner a central role in the maintenance of health.

The establishment of Colleges and Academies of general practitioners Family Physicians is a sign of awareness of these new possibilities. William Pickles was a founder member of the Royal College of General Practitioners of the United Kingdom and to his efforts can be traced in a distant way the establishment of our own College.

We too will have to find a proper place for general practice so that it can contribute effectively to human health and welfare. We will have to work out new relationships with other specialities. General Practice is at the same time the youngest and the oldest of the specialities, the first and the last speciality.

The medical challenges that we face and the health problems of our people are such that it will tax us to the utmost and test to the fullest extent our skills and knowledge. It is foolish to be inhibited by fading boundaries of traditional medicine and by outdated beliefs. It is the mentality of guilds to resist new disciplines and, unworthy though it is, this mentality is common in medical history.
We can be certain that almost all current techniques and all the newest drugs that we use will be replaced within a few decades. Even as we are filled with wonder and pride at the pace of medical advance, we should contemplate with humility the first aphorism of Hippocrates:

“Life is short, the art long, opportunity fleeting, experience deceptive and judgement difficult”.
5. Future of Family Medicine in Developing Countries

Rajakumar MK. Future of Family Medicine in Developing Countries. 10th WONCA World Conference, Singapore. 1983.

Plenary Session 4. 10th WONCA World Conference, 20-24th May, 1983

Ten is an anniversary number and the Tenth World Conference marks the growth of Family Practice to a greater degree than the numerals would suggest. From Montreal in 1964 to Singapore in 1983 marks the universal spread of the concepts of Family Practice. We might well say that Family Practice has come of age. But if that is so, why do we tell it to ourselves so often? Why are our scientific contributions so meagre? Why are we not in the forefront of the plans to bring health for all by the Year 2000?

Two-thirds of the population of the world live in developing countries. By bringing the technology of modern medicine to them, we enable these people to determine their family size, to reduce maternal and infant mortality and to produce a generation which is stronger, fitter and better able to learn, work and function as citizens.

Do we as Family Physicians have anything to offer? If you look at the traditional hospital specialties you will find that the senior physicians, surgeons, obstetricians and other specialists in developing countries were trained in the eminent postgraduate centres of the developed countries but were able to adapt their skills to the problems of their own countries. There is, in other words, a common
body of knowledge and skills in these specialities that have a universal application. Does Family Practice have universal relevance?

I have had this argument before. A few years ago, one of our distinguished colleagues from the US wrote in the Journal of Family Practice to ask provocatively whether Family Physicians in the developed world had anything in common with those in the poorer countries. In my answer, which regrettably was not published, I pointed to the spectrum of health care, from urban sophistication to city slums and rural isolation that exists in all countries, to neglected minorities, the poor, the aged and the unemployed. Which nation is free of them? I will repeat it today, that there is much we have to learn from each other and to teach each other wherever we come from.

The emergence of Family Practice is not just a successful organisational effort. It is the success of an idea whose time has come. The ideal family doctor that the community has longed for became scientifically a reality by virtue of the technological advances of the past few decades that have placed effective drugs and new diagnostic equipment within his reach. This is the explanation for the resurgence of primary care that has brought the traditional specialities tumbling out of their institutions into the market place to offer their hospital skills on the basis of age groups, sex, single organs, single diseases or even single operations. Family Practice has evolved, alone and unique, to offer continuing and comprehensive care to the individual as a whole person and to the family as the functioning social unit.

These great advances were anticipated by the use of the term ‘primary physician’ in the Millis Report in the US to mean the principal physician who would have overall charge of a person’s medical care, reuniting the scattered fragments of modern medical care. Primary Care is not only what we Family Physicians do but Primary Care is what can best be done by Family Physicians.

The governments of all our countries put their names in September 1978 to the Declaration of Alma Ata which sets the target of ‘Health for All by the Year 2000’ and identifies Primary Health Care as the strategy whereby to achieve it.

The Declaration describes Primary Health Care as “the first level of contact of individuals, the family and the community with the national health system bringing
health care process - providing promotive, preventive, curative and rehabilitative services ..... sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need.”

No doubt we phrase these things differently but these are objectives that are best addressed by family physicians. Behind these phrases is the great debate on the future direction of health investment in the developing countries of the world. Does Family Practice have some relevance in this debate?

Health expenditure in the developing countries has tended to remain in the groove of the colonial pattern. It consists of heavy investment in building hospitals and training of specialists for these hospitals; responding annually to population growth by mechanical increments in hospital investment. As a result the health budget haemorrhages into hospital building. The population crowds to the largest of these institutions, seeking care for the whole range of symptoms and disabilities; they are responding in the only way they know how. A great many capital cities in the developing world may not have a safe water supply and have appalling standards in primary care but nevertheless will have more than one CT scanner, cobalt bombs, coronary care units and so on, and there are urban elites who will purchase a CT scan for their common headaches. The urban areas of the developing world have elites whose standards of living are in excess even of Western standards. The hospitals are the rest and recuperation centres for the trivially ill amongst the rich whilst the hospital specialists are their primary care doctors. In urban private practice, every internist wants to be a cardiologist, obstetricians taken normal deliveries only, surgeons take out cysts and general practitioners thrive on episodic care of coughs and colds. Perhaps the rich countries can afford this but the rest of us cannot.

To this expensive irrationality, we need to apply the logic of family practice. Acceptance will not come easily. The spread of national colleges and academies into so many developing countries represents the triumph of the concepts of Family Practice in parts of private medicine. This has yet to happen in the centralised decision-making apparatus of governments and they are the principle employers of physicians. Entrenched lobbies of vested interests competing for limited funds command access to political decision makers and to the bureaucracy. It will need more than patient explanation and quiet reasoning to break through, even though the interests of the community as a whole will be served.
Family Practice will serve the interest of the community by its emphasis on continuing care, on prevention, on early diagnosis, on team work and on caring for the whole person and the family unit. This is a prescription of perfection for poor countries but acceptance of these objectives will serve to point us in the right direction.

We must see in the official commitment to Primary Health Care an opportunity for demonstrating the universal relevance of the concepts of Family Practice. We must demonstrate that the Primary Physician trained in Family Practice is the crux to success in Primary Health Care.

The entry of Family Physicians into Primary Health Care will benefit Public Health by creating an influential lobby for a secure water supply, safe disposal of sewerage, control of vectors and a safe environment as well as for anti-poverty programmes. Investment in Family Practice will enable the Primary Health Care programme to counter the awful effects of poverty.

These are realities of health in developing countries and the magnitude of the problem overwhelms the mind. The World Bank reports that the annual increase in income of developed countries exceeds the total incomes of the poor countries. But I believe this will be reversed in many developing countries; the countries in this region for a start.

What can we do? The World Health Organisation is the political centre for international health activities and WONCA is currently awaiting acceptance as a non-governmental affiliate. At the present the WHO gets its advice on primary care from everyone except family physicians. The American Public Health Association played a key role in preparing the Alma Ata Conference. The WHO also collaborates with the International College of Surgeons on a primary health project. We must change this and to change the WHO we must start in our own countries.

Family Physicians in every country must provide the expertise in planning the delivery of primary care. We must provide the research reports and publications that are the resource documents for planners and decision makers. The Colleges and Academies and the University Departments of Family Practice of developed countries, if they share this vision, can help developing countries but we must
push on regardless. Is it possible for Family Physicians the world over to share a vision of service to the world as a community?

If Health for All is not achieved by 2000, it will be because of a failure of the political will to achieve a more fair and just distribution of limited resources within each country. Nevertheless a start would have been made, and the expectation of ordinary people is no small thing. Let it not fail because Family Practice concerned itself not with those who needed us most, but with those who could afford to pay us best.

The target of ‘Health for All’ creates the occasion for an international pooling of faith and idealism, knowledge and resources, for a truly worthwhile purpose that will transform health care at the point where it touches the life of the great majority of the population of this plan that we share. Do you see a challenge here for Family Physicians?

The establishment of a universal target “Health for All by the Year 2000” provides an unparalleled opportunity for us to demonstrate the centrality of the concepts of Family Practice to the health and welfare of human beings everywhere. The closing years of the 20th century provide a testing of Family Practice, the chance of a century to provide ourselves.

“There is a tide in the affairs of men,
Which, taken at the flood,
leads on to fortune:
Omitted, all the voyages of their life
Is found in shallows and in miseries.
On such a full sea are we now afloat,
And we must take the current
when it serves.
Or lose our venture.”

[Shakespeare, Julius Caesar: IV, iii, 217]

Let us take heed of the words of a great man who lived and died close to the venue of the next World Conference.
Family Medicine, Healthcare & Society:
*Essays by Dr MK Rajakumar*
6. A Proposal For The Training Of Physicians In Primary Care For The Rural Areas Of Malaysia

Rajakumar MK. A proposal for the training of physicians in primary care for the rural areas of Malaysia. Family Practitioner. 1984;7(1):58-61

Introduction

The majority of the population in developing countries live in rural areas, and they are not only economically but also culturally deprived. This is true also in Malaysia although our higher national income makes it less excusable.

There is an internal brain drain that deprives the rural areas of all trained people, their most promising children, and even their young men and women with the most initiative. Urban industry and schools are a powerful magnet to the young people of the rural areas. As a result, cultural life in the rural areas is impoverished and retrogressive attitudes, superstition and obscurantisms add to the burdens of rural life. Young people find the climate in the villages and estates to be oppressive and flee to the freer and better quality of life they see in the urban areas.

In health, a parallel process is reflected in the very small numbers of physicians in the rural areas. Not even the children of rural people go back to work in the rural areas. The government sends the most inexperienced physicians to the rural health centres and the brightest of these young men and women are in a desperate hurry to resume their careers on a specialty ladder back in the urban hospitals.
Whatever the official pronouncements regarding the high priorities of rural health care, rural health service is, in reality, an unrewarding and unsatisfying career for the physician.

I present my proposals to encourage physicians to serve in the rural areas as part of a vision to see more trained people live and work there. If good health care is available, then this is one factor to encourage others to follow. This proposal concentrates on the training of primary physicians as a prelude to the training of the entire health care team.

If government is willing to divert a relatively small amount of money, it is possible to make a satisfying and rewarding career for all members of a health care team in the rural areas and to improve the quality of health care at the point where it touches the lives of the greatest number of people.

These ideas are offered in all humility to all those in the community who share a concern for the welfare of our rural people and to those decision-makers who have great personal knowledge and experience regarding these problems.

**Malaysia**

Malaysia has subscribed to the Declaration of Alma Ata which makes ‘Health for All by the Year 2000’ a universal target and identifies Primary Health Care as the strategy to achieve it. To achieve the ambitious target of health for all by the year 2000, Malaysia will need to give a high priority to primary care and this has to be translated into objectives in a succession of Five-Year Plans.

**The concepts of primary care**

The term ‘primary care’ is used with different meanings. In the United Kingdom, it is synonymous with general practice, and in the US, it refers to primary medical care given by any type of physician. Over recent years there has been much original and innovative thinking directed towards a sophisticated form of primary care that is described as ‘family practice’.

Family practice aims at comprehensive and continuing care that is directed at the family as a unit, with emphasis on the preventive approach. This complements
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the emphasis placed by the WHO on primary health care that meets total health needs in contrast to episodic medical care, and aims at the whole community and not just the individual sick person. A similar parallel exists with the Ministry of Health’s own programme of Family Health Care which addresses the family as a unit for health care, identifying within it the pregnant mother and the infant as the target group for special attention.

The Malaysian programme is distinguished by the use of the concept of ‘Family Health’ and by the development of rural health centres intended for use by health teams led by physicians. This is in contrast to the situation in many developing countries where the majority of the population living in the rural areas is denied modern health care in comparison to the urban areas; a double standard in health is accepted as a political fact in life. Such a double standard should be unacceptable in Malaysia as it would be in conflict with the objectives of the New Economic Policy.

The gap in Malaysia in primary health care has been the absence of a grade of physician dedicated to its success and trained specifically in the skills necessary for primary health care.

**The place of the primary care physician**

A new type of general practitioner has to be created to meet national needs. Such a physician would differ from the traditional general practitioner in that he or she is specifically trained for his task by receiving general clinical training as well as specialised vocational training, by passing a qualifying examination, by undertaking continuing education and by making service in primary care his or her life-long vocation. The new general practitioner emphasises the preventive approach and is trained to work as the leader of a health care team. The appropriate designation for such a physician would be Family Physician or Primary Physician. These trained family physicians would also serve in casualty and out-patient departments but their principal area of practice would be the Rural Health Centres. They will be attracted to a service that provides them with excellent training, the status of a postgraduate diploma, the reward of a career in specialist grades, and the satisfaction of service in modern health centres. Many will continue to leave the service of the Ministry of Health, but private practice too would benefit from a new standard of skills and a new calibre of physicians.
Training family physicians for the ministry of health

The postgraduate training of any physician consists of housemanship, general clinical experience and specialised vocational training. Under the Medical Act, a three-year service term with the Ministry of Health after provisional registration is required by law. This provides an opportunity for postgraduate training of all young doctors which would make this period in their lives both valuable and professionally satisfying.

Some assumptions can be made regarding this period of service. Firstly, we may assume that two of these three years will be spent in the rural areas. Secondly, young doctors in the traditional hospital specialities will want to proceed to specialist units of their choice as quickly as possible in order to fulfil the requirements for their diploma whereas doctors intending to specialise in primary care will wish to obtain experience in a variety of specialty departments. Finally, we may safely assume that doctors pursuing traditional specialities will spend most of their practising life in urban hospitals whilst primary physicians must be persuaded to settle in the rural areas.

Housemanship and general clinical experience

It is essential that young doctors preparing for primary care should receive training during housemanship and general clinical experience that is as comprehensive as possible. The following recommendations are made with a view to ensuring this.

The Outpatient and Casualty Department should be part of the primary care service and during the period of general clinical experience in hospital, the young doctor should have that department as the base: the four months in this department should be broken into four one-month periods, interposed between postings to specialist departments so that the trainee will be able to apply his experience in an outpatient setting and retain his orientation in primary care.

There should be a training committee in each hospital to ensure that every young doctor receives the experience that is appropriate to his speciality of choice and each specialist department must accept responsibility to ensure that trainees on rotation are adequately prepared during their posting in that speciality.
Further clinical experience in Public Health, Internal Medicine, Paediatrics, Obstetrics and Surgery will be obtained by rotation from the rural health centre posting to an affiliated district hospital.

**Specialised vocational training**

Training in primary health care as a speciality should take place at selected health centres. The rural health centres of Malaysia provide an ideal environment for the training of family physicians and selected centres should be upgraded to teaching health centres. The teaching health centres will function in conjunction with the local district hospitals. These teaching centres will provide vocational training in primary care as well as provide housemanship and general clinical experience for those doctors pursuing other specialities. These health centres will provide a model of primary care integrating, prevention and treatment, cooperating with the hospital services and with the public health services.

The period of specialised vocational training including periods of rotation to the affiliated district hospital should be three years after a general clinical experience of two years. This should be a requirement for postgraduate certification examinations which will be taken usually four years after housemanship.

**The teaching health centres**

Teaching health centres should be selected for their relative isolation and proximity to a small district hospital which can be integrated with the teaching programme of the teaching health centre. The centre and sub-centres should cover a population of about 15,000 - 30,000.

Each training health centre should have two senior physicians; one with experience in administration and one with teaching skills. Two trainees will be posted to the teaching health centre each year up to a total of six trainees.

The teaching health centre will serve as a model for the continuing and comprehensive care of the whole community under its care, directed to the family unit and orientated to the community, emphasising the preventive approach. The teaching health centre will have the following functions, in addition to health and medical care of the community: Training of the health care team including
primary physicians, housemanship and general clinical experience for young doctors who intend to enter one of the hospital specialities, continuing medical education and research.

The upgrading of rural health centres to become teaching health centres is emphasised as the high standards necessary of a teaching centre must be met. Together with a full complement of staff, there should be a clinical diagnostic laboratory, radiology, operating theatre and library.

The key to the success of rural health care is the rural health centre. If these are given the fullest support in terms of funds and staff, then a posting to a rural health centre will be an exciting and professionally satisfying event for a young doctor.

**The Institute of Primary Health Care**

There should be a primary health care institute in Kuala Lumpur, incorporating the outpatient department and casualty at the General Hospital, Kuala Lumpur. This institute will be the support organisation to the teaching health centres and will have the following functions: Teach ambulatory care based on the outpatient department; teach emergency care based on the casualty department; teach the concepts and approaches of family practice in a health care team; train teachers for the teaching health centres; teach diagnostic and therapeutic procedures appropriate to primary care; organise continuing medical education; develop diagnostic and treatment protocols, computer programmes, etc., needed in primary health care; assist and coordinate operational and clinical research at teaching health centres; develop a medical records system for use at health centres and organise a health information system for primary health care; evaluate and report on the progress and experience of the rural health centre programme.

If the rural centre is the key to good rural health care, then the Institute of Primary Health Care is the key to the success of the rural health centres.

**A plan**

In this part of the proposal, an outline plan is given for the implementation of a training scheme for primary physicians as part of a national rural primary health
care programme. It is proposed that the plan be implemented over the next two Five-Year Plans. It is proposed that:

- The national primary health care programme becomes a special project under its own director, with representatives from the Prime Minister’s department and treasury.

- The Institute of Primary Health Care be created early and given responsibility to make plans for implementation.

- Rural health centres should be selected, on the basis of defined criteria, to be upgraded into teaching health centres. It is suggested that five new teaching centres be established each year for the first three years, then 10 new teaching centres in the fourth year. The numbers needed should then be reviewed.

- Initially, young doctors with two years experience in rural postings should be sent abroad for training. They will become teachers at teaching centres and their programme abroad must enable them to acquire teaching skills as well as family practice skills.

- The first batch must be selected and sent quickly because the commencement of the programme must await their return. It is proposed that 30 young doctors be sent for periods of 12-24 months to carefully designated programmes that will match their individual talents and interests. At the same time, experienced officers in the Ministry who wish to turn to primary care can be sent abroad for 6-12 months orientation courses to University Departments of Family Practice.

- A detailed plan should be drawn to increase the number of teaching centres until approximately half the entry of doctors into the Ministry of Health can receive training. The first trained primary physicians should come out three years later after the acceptance of the programme and they should be put in charge of other rural health centres to upgrade them, as well as to sub-centres of the rural health centre.

**Conclusion**

These proposals will enable the majority of the rural population of West Malaysia to have access to modern health care by 1990. Well-equipped rural health centres, staffed by trained health care teams led by qualified specialists in family practice
will transform the quality of health care in rural Malaysia. The introduction of family practice into the rural areas will provide a qualitatively new level of service, improving health care at the point where it touches the lives of the largest number of our people.

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[Editors’ Note: Table I and Table II have been omitted]
7.

Family Practice:
Uniting Across Frontiers


Dr Rajakumar MK, President of WONCA
Keynote Address Regional Conference of WONCA, September 5-9, 1987, Hong Kong

Guest of Honour, Hon. J. W. Chamber, Secretary for Health and Welfare, Dr Eddie Chan, Chairman of the Host Organising Committee, Dr Peter Lee, President of the Hong Kong College of General Practitioners, Presidents of Colleges of Malaysia, Singapore and Australia, Honoured Guests, Ladies and Gentlemen.

It is a great pleasure to come to Hong Kong to enjoy the legendary hospitality of our friends and colleagues here and it is a great honour to deliver the Opening Address to this distinguished assembly.

We are meeting in a most exciting part of the world. The Asia-Pacific Region is the home of ancient cultures which interacted for many hundreds of years and then lost contact. We are now rediscovering each other, paradoxically under the auspices of Western civilisation. This is my own region and you must pardon me if I take pride in showing it off to our guests.

In this region, we are living through a period of great optimism and tremendous self confidence. They say that the Asia Pacific Region will show the highest growth rates for the rest of the century and the 21st century will see the full bloom of a Pacific Basin community. We are the heirs of ancient civilisations that lapsed
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into a stupor for a little over a century. We have woken up under the impact of Western technology. This meeting itself is one manifestation of the energy and vitality of this region.

This is the first international meeting of family physicians to be held in Hong Kong and is the largest and most representative meeting of family physicians of this region. It has also attracted family physicians from all over the world. I hope you will find it worthwhile to experience the diversity of our cultures and cuisines. The theme of this Conference, of crossing frontiers, reflects the universalistic outlook that comes naturally to the cosmopolitan city-state of Hong Kong.

As family physicians, we are highly conscious of cultural influences in the lives of the people we are caring for. The cultural values still cherished by our people may appear old fashioned. For example, personal relationships are very important and friendship is highly valued: ‘Friendship before business’ is almost an aphorism in our societies.

Age still attracts deference and our young people are taught to be respectful even when differing with an older person. Grandparents are honoured persons in a family and it is considered a privilege and a duty to look after them. Lucky children can turn to 3 sets of parents for love and guidance. Families bear the burden of the care of the chronically ill and the disabled as our social services are poorly funded. It is a moving experience to see how lovingly they are cared for at home on very meagre resources. Work is part of our culture and not working is considered shameful. So much so that often our problem as physicians is how to persuade sick people to stay off work to get some rest.

These are values that family physicians everywhere, across all frontiers, will recognise as values they themselves cherish. If they are being eroded in the West, amongst us too they are being undermined by the impact of urbanisation and industrialisation. You will be dismayed to hear that Westernisation is as yet more strongly represented, not by Shakespeare, Beethoven and the Sermon of the Mount, but the Beatles, Madonna and the Consumer Society. We need more than that. We need not only the benefits of modern technology but we must jointly work across frontiers to sustain and preserve the humane values upon which civilisation rests. The great problems we face today, of poverty, social inequity,
crime and the breakdown of families, transcend cultures and frontiers. We must find common purpose as human beings.

In a world of rapid change and social instability, the family physician represents enduring values and a commitment to compassion and caring. We are all here today because of this commitment.

Modern medicine has travelled beyond its Western frontiers to become part of our heritage. As with technology, we are assimilating modern medicine into our own way of life. The discovery of the new Family Practice has led us to share in the renaissance in General Practice, a renaissance that knows no frontiers. We owe to the British and Europe our pattern of healthcare delivery with the general practitioner providing continuing care and guiding the patient through the thicket of subspecialities. In recent decades, we have benefited from the powerful thrust in North American towards Family Practice. The new impulse has transformed our vision of general practice. Family Practice has emerged as a discipline calling for extensive postgraduate training and excellence in practice. We need highly trained and skilful family physicians to make full use of the potentials of modern medical knowledge and technology. We have a long way to go in this region to take full advantage of the potentialities of modern primary care. The colonial pattern of hospital building has persisted. There is a greater readiness to build hospitals than provide safe water and efficient sewage disposal, to start coronary care units than to prevent ischaemic heart disease from a family practice. Our policy makers still prefer to invest in high-cost episodic care in hospitals than in cost-efficient continuing care in general practices.

The new concepts we espouse place great stress on the preventive approach, on identifying for special attention persons at risk, on comprehensive care and not merely episodic care, on caring for the whole person and not merely providing medication, on the ambulatory care of the individual in preference to institutional care; at all times remaining the advocate of patient’s best interests. We need all we can get to educate policy makers to inform the community of the need for Family Practice as the foundation of our health care system.

Our academic organisations also have the task of projecting these concerns to the community. Joined together in a world organisation, WONCA, we project to the community and to international organisations these caring values that are at
the heart of Family Practice. The vigour of the new general practice is manifested in the strength and growth of WONCA.

In the past year, WONCA has established formal relations with two international organisations, the WHO and the UNICEF. WHO is the organisation linking Ministry Health of our governments; with them, we are collaborating on development of medical classification systems, on organising quality assurance and audit programmes, and plan to assist medical schools in developing countries to start departments of Primary Care and Family Practice. The noble objective of the Alma Ata Declaration that transcends national frontiers to bring ‘Health For All by the Year 2000’ is difficult to achieve but as physicians we must see in this global endeavour an opportunity to demonstrate the necessity of primary care of excellence as the basis to Health For All. The representatives of WHO are with us today and we offer the joining of hands with the Family Physicians of the world to achieve ‘Health for All’.

The other organisation with which we established a link is UNICEF, a much loved movement bringing together volunteer societies to care for children. We plan to associate with them in their work throughout the globe. We all perforce to share this little globe and everywhere there are hungry and neglected children who need care and food. Both individually and collectively we have a responsibility here - we must not avert our eyes and look away. All members of WONCA will have an opportunity in the coming years to give expression to the idealism and charity. There is no frontier of compassion for the hunger and suffering children. The question that Andre Gide posed—what price to put to a child’s suffering—is still with us today. So WONCA is uniquely fitted for such a worldwide-wide endeavour. Over 100000 physicians are represented in WONCA and they live and practice in virtually every community of the 35 members of WONCA, and we are growing every year. We are meeting at the doorstep of the largest nation in the world, People’s Republic of China. I am confident that they too will join our family in the not too distant future. Last year, I visited China and enjoyed their hospitality and I found that they too were beginning to discover the importance of Primary Care and the values of Family Practice. Who, you will ask, has been introducing them to Family Practice? It was a delegation for the Hong Kong College led by its President that formally presented Family Practice to them. That seed has taken root and I believe it will flourish. I believe that the
Family Practice way of Primary Care can make a tremendous contribution to the health of the people of that vast country.

We are meeting on this little rock off the coast of China. Can you imagine a place which faces greater adversity, or where the odds of success are smaller? Yet a flourishing metropolis exists here, managed by anonymous civil servants and amateur politicians, with a talented population. Hong Kong has absorbed a tremendous growth of population by immigration and has continued to flourish. Hong Kong is the gateway to China, not just geographically but for technology, trade and new ideas as well. It becomes part of the People’s Republic in a decade. I see a powerful symbolism in that families of doctors in Hong Kong whose ancestors came to Hong Kong from China when the British first arrived, will continue to be here when Hong Kong reverts to China. I am certain Hong Kong will continue to flourish and play Athens to their great Sparta. You may be surprised that I can see Athens in the harsh entrepreneurial environment of this island state.

Remember, this island has one of the great universities of the world and its Faculty of Medicine celebrates its centenary next week. They have as their Vice Chancellor one of the most distinguished academics my country has produced. Consider, in how many nations of the world is the Vice Chancellor of the University near the top of the order of precedence after the head of state. Now that is what I call showing Confucianist respect to learning!

These miracle makers are our hosts today. The tiny member Colleges in WONCA seem to concentrate talents and nowhere have I seen a more dedicated College Council than in the Hong Kong College. This has been a year of accomplishments. In addition to organising this splendid meeting, they have graduated their first batch of Fellows by examination. I had a small part in helping to develop this examination and the outstanding performance of candidates this year is a cause of pleasure to me. I must congratulate Dr Stephen Foo and his Board of Examiners for their very hard work for over three years to bring this examination into existence. The College has also published a pioneering survey of morbidity in Hong Kong, the third in a series, and I must congratulate Dr Paul Lam and his team for their very difficult achievement that only a few Colleges can match. Speaking for all of you, I must congratulate Dr Eddie Chan, Chairman of the Organising Committee of the Hong Kong College for the excellent planning of
what promises to be a most successful meeting. I am particularly looking forward to the excellent scientific programmes that Dr John Chung and his Committee have devised for us. I have kept in touch with the organisers and I can tell you that they have spared nothing to make this meeting a success. May I on your behalf tell the President of the Hong Kong College, Dr Peter Lee and the Chairman of the Organising Committee, Dr Eddie Chan and his committee, how much we look forward to enjoying this week with them and how grateful we are to them for having accepted the responsibility of being hosts to this Regional Meeting.

We belong to the oldest discipline of medicine, general practice, now renewed as Family Practice. Our meetings are occasions not only for learning; the fellowship of these occasions is a precious asset. So I bid you to learn and to teach, make merry and make friends. To our Guest of Honour and our honoured guests, I say thank you for gracing this Opening. To all I say welcome, my friends, to the Regional Conference of WONCA.
8.

The Family Physician In Asia:
Looking To The 21st Century


Those of us who live in the Pacific part of Asia are in the economically fastest growing part of the globe. Our societies are in the midst of rapid and continual change. The family doctor is subject on the one hand with the task of meeting new expectations and new needs amongst our people. On the other hand, the family doctor struggles to keep up with the rapid advances in medical technology and its increasing cost. I will speak briefly of the changes that societies are undergoing, and then of the changes occurring in our patients before I discuss the type of family physician that is needed.

Changes in Society and Its Consequences to Health Care

On my way here, I was glancing at the draft of my paper and read in the newspaper a statement by the Singapore Minister of Culture. What he said echoes my own thoughts. He said “…Culture follows economic dominance.” He believed East Asia will be the dominant culture, and he projected that within 30 years, East Asia will have GNP exceeding Europe and twice the size of USA.

The people in our care are being shaken up in their daily lives. While we are in need, we don’t notice we are moving very fast. But we have to stand pat and see great social, economic, and cultural changes overtaking our society and will inevitably change both our attitudes and the practice of our skills.
Look at the rapidly changing world around us. The population of the Asia Pacific region continues to grow. We remain a young population with a large proportion of young people. We are undergoing rapid urbanisation and industrialisation. Our cities are growing at a rate faster than the population. Cities are surrounded by the shanties of the urban poor. The elite of this region – in business, in politics and the professions – have a standard of living better than their equivalent social class in the West. But we also have extreme poverty, homelessness, gross undernutrition of children and high drop out rates from school occurring in some of the most populous nations of this region. Warfare and strife have been companions in the lives of the people in parts of this region, including the lives of the generous people who are our hosts today.

Although we are still nations of young people, the numbers of the aged have increased with population growth and increased life expectation. Educational levels of our young people have risen. Through TV, radio and the press, as well as books and magazines, they have windows into many societies and cultures and become contemporaneously involved with issues occurring in other parts of the globe. Their expectations of modern medicine are high; indeed they may be unrealistically high.

The health care system is also changing rapidly. Within this region we have both the diseases of poverty such as infant gastro-enteritis and tuberculosis as well as the diseases of affluence such as diabetes and ischemic heart disease. The state sector remains the most important source of health care for the majority of the people, particularly those in the rural areas. However, a vigorous private sector has developed, concentrating on private hospitals which attract most of the senior, most experienced and best qualified specialists.

Private medicine in the Asia Pacific region involves high capital expenditure, a strong procedure orientation and an expectation of high investment returns. The state sector in health concentrates quite rightly on public health but also provides hospital care mainly for acute illness and emergencies. Primary care is generally neglected. General practitioners usually do not have a stable panel of patients. Private hospital specialists are in primary care, seeking to combine procedural specialisation with pretensions to a universal curative gift. Thus, the so-called cardiologist may also do antenatal care, the dermatologist will treat infant illness and the specialist surgeon will also treat skin disease. The wealthier sections of
the population are creamed off by private hospitals that provide episodic primary care.

As a result, standards in subspecialties are low as specialists compete with each other, whilst trying to hold to everything that comes their way. General practice too suffers as practitioners work long hours, taking two or more jobs in some countries to earn an adequate income. Doctors are undertrained and have little time for continuing education, their staff is poorly educated and their premises are small and lacking in equipment and facilities.

The bright side is that things are also changing in general practice. The growth of academic organisations of general practice is one indicator of the great changes that are underway in general practice. We are the guests of one of the oldest academic organisations of general practice, the Philippines Academy. We have benefited from the advances made by sister organisations in developed countries, in the United States, the United Kingdom and Australia, and we are appreciative of their generosity in sharing with us the fruits of their endeavours in developing our discipline. Closest to us is the Australian College, and Prof. Wesley Fabb who is with us at this meeting is identified in our minds with the image of Australian willingness to share and learn together.

As for the United Kingdom College, they provided the impetus for the Australian College and have remained a distant friendly influence but I do wish we could interact more with them. I am delighted that Dr. Douglas Garvie, a friendly force of the British College, is here. The American Academy, pre-occupied though with its own problems, has had a profound influence on our region, most especially in the development of the concepts of family practice. Our host Academy is obviously created in the image of the American Academy.

Yet there is much that we too have to offer. The wealth of experiences that fill days in the life of a good practitioner in Asia is unrivalled. We see multiple problems with multiple diseases. We see a remarkable range of organic pathology presenting both as early and advanced disease. We see social and economic problems, psychological and spiritual crises, interwoven with organic pathology in the lives of our patients. We interface not only with scientific medicine but with magic and traditional healing arts on the one hand and with deep religious belief and piety on the other. Our patients fortify themselves with amulets and
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...charms, pray for divine intercession and take herbal medication. Often it is only when all these fail, that they turn to the physician and even then both magic, religion and science may have to go hand in hand. This adds profound complexity to the consultation, and the element of magic remains in the patients’ expectations of their physician. The individuals and families in our care are subject to severe sociological stress as our societies undergo rapid cultural change compressing into decades the effects of urbanisation and industrialisation that were spread over a century in the West.

We may become the last of the true family doctors in the World because the family is strong and healthy in Asia. Indeed, it is the secret of our growth and prosperity. We do not need to invent a hypothetical group to be called family because the true family is disappearing in our society; the family of three generations flourishes side by side with the nuclear family which nevertheless retains close ties with parents and grandparents. The family in Asia transmits stable ethical and cultural values, is a reliable source of succour in adversity, and provides loving care to their disabled and handicapped on the tiniest of resources.

I never cease to marvel at the young family surrounding the old man or woman brought to my practice and their determination to see good care provided, even at great financial distress to themselves. My task then is to help keep them out of the hands of rapacious for-profit private hospitals and to look for alternatives that would not ruin the family.

Yes, I do believe we have much to offer. I go further and say that the professional and personal development of a family physician trainee in a developed country is not complete without some experience of a Third World environment, perhaps within their own country, better still in the developing world. Such an experience, adding breadth to their clinical competence and depth to their personality, will make them better family doctors and better human beings.

I have spoken of the rapid changing socio-economic and cultural change in this region and of the changing character of the people we care for and of new developments in the health services of our countries.

**The Type of Family Physician Needed**

What sort of family doctor do we then need for the 21st century which lies only a
few years ahead? Physicians now in training as well as young people now in schools and universities will live most of their lives in the 21st century. It will be technologically a very different world but what is unchanging is the human need to be loved, to be cared for and to care. In health, in emotional distress and in economic adversity, families and individuals seek someone whom they can trust, to confide in, seek advice and direction. It is commonplace for general practitioners in Asia to provide free care to poor families, and often this means not only free consultations but free medicine too. We need this special kind of person to become family doctors. What can we do to produce such family doctors and to create an environment in which they can function effectively and efficiently? There are five areas of action.

[Editors’ Note: Figure 1 has been omitted]

1. **Training**

The broad range of competencies that are essential to good family practice requires a sound scientific basis in undergraduate education and the acquisition of a comprehensive range of clinical skills during graduate training. In our region at least, it is clinical competence that is paramount and the family doctor, whatever other skills he or she may have, will be judged as a physician.

We need an intellectually and spiritually challenging programme for the young doctor in training and to be able to provide attractive role models for them. Undergraduate education is the foundation on which we build, and we must remember that training is only part of the educational process involved in undergraduate education. Education involves the opening of the mind to new ideas, the capacity for independent thought and finally socialisation into the role of physician. Such qualities are more important in family practice than in a proceduralist hospital practice.

2. **Continuing Medical Education (CME)**

The vocation of a family doctor is one that calls for a lifetime of learning, the continuous acquisition of new skills and the constant renewal of one’s intellectual capacities. CME is integral to family practice. It must be a habit not a task, fun not a chore. It must be a voluntary activity. Provision of CME is the most important
role of our academic organisations. We have to seek ways to motivate our members and we have to provide a wide range of learning options to suit their individual needs and circumstances. There is a special problem in CME that we must take into account and that is catering to the needs of women who enter family practice in increasing numbers. Family practice is strengthened by the entry of many outstanding women who find family practice more congenial to their desire to combine family and work. Our CME program must be flexible and responsive to meet their needs.

3. Research

Research is the life blood of every medical discipline. Without research, we cannot provide effective health care and our discipline will wither away. Too much of our time and energy over the past few decades has been taken up in seeking definitions, justifying our existence and defending our role in patient care. Why are we not doing the important epidemiological studies that are best done by physicians working in the community? I can point to one exception: The longitudinal study of oral contraceptive users by the British College whose results are quoted to settle arguments on oral contraceptive usage. Where is the equivalent of the Framingham study on our side? In this region, we need morbidity data which is essential for planning health services. The outstanding example is the work of the Hong Kong College’s collection of morbidity data from general practice. I hope that this regional meeting will provide the impetus for more research in each of our countries as well as open the door to collaborative studies in the region.

Community Involvement

The doctor in the community in Asia is an influential member of society. We need to provide leadership in improving the community. The physician’s involvement is essential in improving the care of the handicapped and disabled. We should be active in organisations looking after handicapped children, battered women and old folk. Physician involvement gives more power to movements on the environment and action to improve the status of women and for plans against poverty. We must not only be in the community, we must also be part of it.
Recognition

This is the political aspect of the work of our academic organisations. It is pointless to train good family doctors if they are unable to deliver good care. It is universally acknowledged that primary care is the key to achieving Health for All. Equity demands that the majority of our people, the rural population and the poor in the urban areas should have better care. Yet it is the primary care physician who gets the poorest rewards in our countries. Our politicians may talk of the importance of providing better health care to the rural population, but then offer the lowest salaries and the poorest promotion prospects to the physician who goes to work in rural areas.

We have popular support and sound arguments behind our case but need to make them heard and make ourselves felt. We are close to the community and the majority of the people turn to us for care. We have to convert this into influence in decision making in each of our countries. The approach will be different, but the common thread is the necessity to use our numbers to bring national medical associations to our side and to use our presence everywhere to educate community leaders of the health needs of the people.

In the context of the five areas considered in the production of family physicians in the region, let us summarize the role of family physicians.

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Fig 2. The Roles of the Family Physician

He is a scientist who is trained for a comprehensive range of competencies essential in good family practice; motivated to maintain his continuing medical education and does research. He is a saint who cares for his patients and families
not only in terms of medical needs, but also assists families with their other problems. He is a shopkeeper who coordinates the care given to the patient and his family.

In conclusion, I go back to my opening remarks. The Asia Pacific region is the most rapidly developing region in the world. We have within the region all the skills and the leadership to bring about change. I can see people already in academic family practice, Drs. Goh Lee Gan, Cindy Lam and so many others who provide skills we have lacked in the past. We are today in a country that was once the most prosperous in the region and I have no doubt will lead it again. I am grateful for this opportunity to share a few ideas with you and I am honoured to speak to an audience that has so many of the leaders in family practice from this region. And for this particular meeting, I extend my gratitude to Drs. Clarke Munro, Lindsey Knight and to Dr Zorayda Leopando. This meeting provides a good starting point to energize ourselves and I offer my thoughts as a small contribution to the process.
9.
The Emergence Of Family Practice


The past 50 years have seen tremendous advances in medicine. Modern scientific medicine is a recent development: It is a new area of technology that has also inherited the ancient traditions of medicine. The fragmentation of medicine into subspecialties has produced brilliant advances in our understanding of pathology and in the treatment of diseases. Continuing technological and scientific advances have brought exciting prospects for the tasks of the family doctor in preserving health, preventing disease and managing ill health.

Why the Family Physician?

The fragmentation of medicine into subspecialties slowly diminished the place in the community of the generalists: The general physician/general practitioner and general surgeon. General medicine languished, while spectacular advances were made by subspecialists concentrated in hospitals, with expertise in single organs, systems or diseases, in the performance of specific procedures or in the use of expensive and advanced equipment. It is precisely the development of these subspecialists and their concentration in hospitals that gave rise to a demand in the community for a physician in the tradition of the old family doctor, who was caring and accessible and who was also more expert and better trained than the general practitioner of those days, but who could act as the patient’s guide, protector, philosopher and friend.

More was needed from this reborn family doctor. Advanced medical technology, new approaches and new techniques had became available in the consulting room
or were easily accessible from it. New advances made a real difference to the outcome of medical care. It was imperative, therefore, that the physician in primary care should have the training and expertise required to use these new advances effectively and efficiently. This led to the emergence of family practice as the natural inheritor of the ancient traditions of general medicine.

“...As both medical knowledge and specialism increase, I believe that the need for a special kind of generalist who will need a special kind of training will more and more emerge. He must be an astute diagnostician, particularly if he is to recognize and intelligently control the significant beginnings of disease. The management of chronic illness and its rehabilitation will be among his most important activities. His function will be to maintain and promote health as well as to prevent disease ... One of the fundamental responsibilities of this physician will be to guide his patients through the growing complexities of medical care. He will be keenly aware of the importance of utilising those community resources having something to offer in the management of his patients. In essence, then, I am proposing a new specialty.”

Distinct differences have emerged in the practice of medicine in hospitals and in the community. There are differences in the core content of information and skills, and more particularly in the attitudes and clinical methods appropriate to the physician in the different environments. Indeed these are two different subcultures of medicine.

A Question of Terminology

New disciplines need new terminologies, especially when the older terminology implied lower levels of specialised training and competence as well as lower status.

The different historical backgrounds to medical practice in each country have produced different terminologies. In the UK, where the term ‘general practice’ was firmly entrenched by custom and statute, terms such as ‘the new general practice’ and ‘family doctor’ are in use. The leaders of general practice in the UK founded their college almost surreptitiously, in the face of hostility from the older royal colleges, but it has subsequently gained acceptance.
“By the time of qualification, the graduate should have sufficient knowledge of the structure and functions of the human body in health and disease, of normal and abnormal human behaviour and of the techniques of diagnosis and treatment, to enable him to assume the responsibility of a pre-registration house officer and to prepare him for vocational training.”

In Australia, the term ‘general practitioner’ is still in use, but the state-funded training programme is called the ‘family medicine programme’. In Europe the term ‘medicine generale’ is in use. In the USA, three alternatives to the term ‘general practitioner’ have been proposed: Personal physician, primary physician and family physician.

A succession of commissions proclaimed the community’s urgent need for a family doctor, urged the creation of the new specialty and delineated an ambitious role for these new specialists.

The term ‘Primary Physician’ was used in the report of the Citizen’s Commission on Graduate Medical Education (1966) chaired by Dr. John Millis. This report saw the need for a primary physician who would assume primary responsibility for the patient’s welfare in sickness and in health, providing continuing and comprehensive care. This primary physician was conceived of as “the primary physician assuming primary responsibility for the patient’s welfare in sickness and in health; providing continuing care and comprehensive health care.”

The term ‘family physician’ comes from the USA. It was necessary to distinguish between family medicine and traditional general practice which was regarded, by the community and even by some of its practitioners themselves, as a career that did not call for graduate training and certification. In 1962, the National Health Commission and the American Public Health Association set up the Folsom Committee, which reported four years later:

“The certificate for family practice should be the primary and major certification provided by the board and not secondary to that of some other specialty. The board itself should not be subsidiary to any other board. The board should be recognised by the American Medical Association Council on Medical Education and by the Advisory Board for Medical Specialty in the same manner as all other specialty boards. The certification should fall within the established
framework for specialty certification, be judged by the same general standards, and have the same status as other kinds of specialty certification."  

The adoption of the term ‘family physician’, by the American Academy and the Canadian College, provided a powerful impetus to the universal use of this term to describe the new specialist.

‘The Ad Hoc Committee is convinced that the opportunity for specialty board certification is essential for those properly prepared for a family practice. Board certification is the only appropriate recognition for physicians who have invested the time and effort necessary to complete prescribed training programs and who have demonstrated their competence in this important field of medicine. Certification is necessary to provide status to the field and to reward those who have prepared themselves in a suitable manner. Both status for the field and regard for the individual are essential to attract young physicians to careers in family practice. The provision of board certification is not the only requirement to be satisfied if an adequate number of family physicians is to be prepared in the future, but it is an important point."  

This use of the word ‘primary’ was soon overshadowed by the WHO’s primary health care movement for basic and minimal health care services which would include traditional medicine and lay healers. Nevertheless, primary care medicine remains a useful generic term. ‘Primary physician’ or ‘primary care physician’ may be appropriate terms in most developing countries where family practice takes on a strong community orientation in the context of a national primary healthcare programme. The term ‘general medicine’ has a respectable lineage, but in many countries has been appropriated by general internists in unspecialised practice.

“Every individual should have a personal physician who is a central point for integration and continuity of all medical and medically related service to his patient ... Every hospital should have a service for the personal physician and each physician should have a staff appointment in one or more accredited hospitals”.  

Notwithstanding these differences, there is a common core of knowledge, skills, attitudes and common interests shared by family physicians worldwide, which
means that they are able to partake in scientific exchange in a common international organisation, the World Organization of National Colleges, Academics and Academic Associations of General Practitioners/Family Physicians (WONCA). WONCA is now better known as the World Organization of Family Doctors.

**What is Family Practice?**

A number of questions had to be answered, both within the profession and in the community, before family practice gained its present status and acceptance. Was it a separate discipline of medicine? Could it be taught? Did it need postgraduate training? Was it examinable? Over the past three decades, all these questions have been answered and the issues laid to rest. It is now a rare medical school, except in the poorer developing countries, that does not have a department of general practice, family medicine or primary care medicine. According to the Royal Commission on Medical Education, the purpose of the undergraduate course in medicine “should be primarily education. Its object is not to produce a fully qualified doctor but an educated man who becomes qualified in the course of postgraduate training”.

The family physician is a specially trained doctor who accepts personal responsibility for providing continuing and comprehensive care to individuals of both sexes and all ages. In providing this care, the family physician takes a preventive approach that is oriented to the family and based in the community.

When necessary, the family physician has the duty to refer to or consult with appropriate subspecialists or institutions, in order to achieve the best possible outcome in health care.

The family physician accepts personal responsibility for continuing and comprehensive care. Continuing care encompasses:

- first-contact care
- initial care
- emergency care
- episodes of illness
- long-term care for chronic disease
Family Medicine, Healthcare & Society:
*Essays by Dr MK Rajakumar*

- advice and counselling
- rehabilitation

Comprehensive care includes:
- whole-person care
- total care
- referral and consultation
- co-ordination and integration

The knowledge and skills needed to perform these functions mean that the family physician must constantly be evaluating his own competence, and be prepared to make a lifelong commitment to education.

The family physician practises in the community, and the life of the practice is closely woven into the intimate life of the community. The differences that exist between practice in the community and institutional practice have a profound influence on the personality of the physician and the character of the practice. The areas of difference include the following:
- the practice environment
- doctor-patient relations
- presentation of health problems
- process of care.

**Practice Environment**

The practice environment in the community is informal, while that institution is formally regulated. Family practice requires relatively small funding, whereas hospitals are heavily capitalised, with expensive equipment and very heavy running costs. A family practice is part of the community, whereas a hospital tends to be distant.

**Doctor-Patient Relations**

The individual seen in a family practice is autonomous, ambulant and wearing everyday clothes. The individual in hospital is psychologically institutionalised, dependent and is most often seen by the physician as a ‘patient’, often wearing
pyjamas and recumbent in bed. The institutional arrangements of a hospital create a vast social distance between the physician and the patient.

The physician in a hospital is an official of the hospital with a white coat and title; he has a rank in a hierarchy and must follow officially laid down procedures. He practises in one of the multiple disciplines for specific disorders or procedures. In contrast, the family physician seeks to behave more like a friend, dealing with a broad range of health problems and working with his peers, improvising solutions to problems. The family physician is also very sensitive to relations with the community, whereas the physician in an institution tends to be insulated, if not isolated, from the community.

In family practice, the physician takes personal responsibility for health care in a continuing relationship. The family physician’s relationship with his patients is based on trust, and he seeks to be persuasive to gain patient compliance with advice and treatment.

At each encounter, the family physician must win access to the thoughts and feelings of the person seeking care. Hospital care tends to be episodic, and responsibility for care is taken by an institutional unit or department. The individual in a hospital is treated as a member of the public rather than as part of a family. The physician in hospital exercises a certain official authority and dominance over his patient.

Finally, family practice is culture-specific and the ambience of a practice closely reflects the customs and preferences of each community, whereas the hospital is culture-neutral and the environments of hospitals anywhere in the world tend to be very similar.

Families interact with their physicians over long periods of time so that a comfortable and trusting relationship develops between the individual and his family, and their physician. The family physician enjoys a uniquely intimate relationship with the family and sees each member growing into the different phases and roles of life (Table 13.1).

Caring for successive generations, the family physician is aware of the inter-relationships and interactions within the family as they evolve over several
decades. This background of knowledge adds depth to the encounter when an individual presents with a health problem.

Table 13.1 Doctor-Patient Relations.

<table>
<thead>
<tr>
<th>General practice</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person</td>
<td>Patient</td>
</tr>
<tr>
<td>Autonomous</td>
<td>Dependent</td>
</tr>
<tr>
<td>Wears own clothes</td>
<td>Wears hospital pyjamas</td>
</tr>
<tr>
<td>Ambulant</td>
<td>Recumbent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend</td>
<td>Official</td>
</tr>
<tr>
<td>Improvises</td>
<td>Follows procedure</td>
</tr>
<tr>
<td>Peer</td>
<td>Hierarchical</td>
</tr>
<tr>
<td>Sensitive to community</td>
<td>Insulated from community</td>
</tr>
<tr>
<td>Has one generalist discipline</td>
<td>Has multiple narrow disciplines</td>
</tr>
<tr>
<td>Cares for a broad range of problems</td>
<td>Cares for specific medical health disorders</td>
</tr>
<tr>
<td>Deals with person-oriented problems</td>
<td>Deals with pathology-oriented problems</td>
</tr>
</tbody>
</table>

*Doctor-patient interaction*

<table>
<thead>
<tr>
<th>Continuing</th>
<th>Episodic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on trust</td>
<td>Dominant</td>
</tr>
<tr>
<td>Persuasive</td>
<td>Authoritarian</td>
</tr>
<tr>
<td>Sees individual as a member of a family</td>
<td>Sees individual as a member of the public</td>
</tr>
<tr>
<td>Culture-specific</td>
<td>Culture-neutral</td>
</tr>
</tbody>
</table>

Presentation of Health Problems

The full spectrum of the natural history of disease is seen only in general practice. Health problems are presented by a wide range of people: Those who are normally healthy, those who are at a higher risk of certain diseases and those with early signs and symptoms of disease, to the acutely sick, the disabled and the dying. Diseases present in an undifferentiated manner, in contrast to the highly selected cases seen by each hospital unit. Symptoms are described in spontaneous dialect,
unlike the tutored vocabulary needed for the chronic hospital case. Health problems in family practice frequently include psychological illness, potentially as disabling and life-threatening as any organic condition. There are also problems that are principally social or economic in their origins. As a general rule, it can be said that an individual who sees a family physician has multiple problems which have physical, social and psychological dimensions.

The characteristic presentation of health problems in family practice determines the function of the family physician. The presentation of problems can be considered in the categories below.

**People in Good Health**

Families cherish easy access to a doctor, which encourages them to visit him when they are troubled about their health for any reason, even with minor complaints or merely to discuss their health. Preservation of good health is the first priority, and the family doctor must scrutinize family and occupational history for risk factors; he must look into the social and economic background, and evaluate the physical and mental status for the earliest signs of diseases or for factors predisposing to disease. Advice and counselling on nutrition, exercise, recreation and lifestyle are important tasks of the family doctor. Such opportunities are uniquely available to the family doctor.

**Common, and Usually Self-limiting, Diseases in Family Practice**

Hidden among so-called minor or trivial illness seen in general practice are serious conditions such as acute rheumatic fever and carditis, acute glomerulonephritis, acute glaucoma and iritis, acute abdomens, meningitis and malignancies, to mention a few.

Even if the conditions are ‘trivial’ and self-limiting, the family physician regards whatever troubles the individual as worthy of his attention. If the physician has a different hierarchy of importance for the patient’s problem, this has to be explained and interpreted to the patient.
Major Illness in Family Practice

Serious diseases seen in family practice include asthma, hypertension, ischemic heart disease and diabetes. These are serious conditions that are potentially life-threatening or can significantly diminish life expectancy or impair the capacity to work. Most people suffering from these diseases are seen in family practice, and few need to be seen in hospital until complications occur. These diseases are the most important causes of morbidity and early death, and good prognosis depends on continuing care of a very high standard.

Emergencies

Many emergencies are first seen by the family physician and most are dealt with entirely in family practice. The ability to identify an emergency and to provide an appropriate response quickly, are important skills of a family physician. The child with fits, the victim of an accident or of rape, the woman with the pain of a ruptured ectopic, all turn first for help to their family doctor. Many grave emergencies will present in the first few minutes or hours with vague symptoms. The acute appendicitis seen in its early stages presents a very different picture just a few hours later. The family doctor must be able to pick out these serious problems from a multitude presenting with similar transient complaints.

Health Problems Requiring Mainly Preventive Care

Prevention is the most important activity in family practice. The family physician identifies different groups at risk and endeavours to lower the risk by advice and counselling to modify habits and lifestyle that are inimical to health, such as unbalanced diet, tobacco consumption, excessive alcohol intake, lack of physical activity or dangerous driving.

We now know that myocardial infarction, cerebrovascular accidents and renal failure can be prevented by early treatment of asymptomatic hypertension and other risk factors in healthy persons. New knowledge of the aetiology of the conditions shifts emphasis away from more intensive care units, more bypass surgery and more renal dialysis to prevention by cost-effective interventions. It has been discovered that diabetes, hypertension and obesity are best managed as a single entity and that the family doctor is in the best position to do this.
Problems with Important Social and Psychological Consequences

Many problems presenting in family practice have effects on the lives of others in the family or the community. A man with a urethral discharge or a child with a bruise must not be treated simply for the presenting complaint and sent away. There is a wife in danger of infection, a child’s life in danger or a mentally sick person needing help, whose interests also need to be taken into account, often urgently. Again, a mother attending frequently for minor illness or bringing a healthy child for examination may be appealing for help in dealing with her own alcoholism or with an alcoholic husband at home, or with a delinquent child. Often a somatic complaint is tentatively proffered to justify a visit and to test the physician’s receptivity before social and emotional problems are exhibited. The family physician sometimes has a pastoral role to fulfil in response to the needs of certain patients.

Particularly in developing countries, the family physician also has a welfare role and is called upon to provide free or reduced fee services to indigent families or to those going through temporary difficulties. This means not only waiving consulting fees: in a dispensing practice it means prescribing free medicines as well. The family physician must also struggle to obtain a share of welfare funds for the most needy, and arrange for the care of the deaf, the blind, and other physically or mentally disabled people seen in the practice.

Process of Care

The options in diagnostic and therapeutic procedure differ in primary care from those obtainable in hospital care. The range of investigations possible within the walls of a clinic have widened considerably. Only a few decades ago, diagnosis was limited to a clinical examination, height, weight and blood pressure measurement, and to boiling urine for albumin and glucose. Even a pregnancy test needed reference to a laboratory for a biological urine test. Today a wide range of dipsticks and office chemistry tests are available for urine and blood clinical chemistry, for the measurement of substances from phenylketones to chorionic gonadotrophins in urine to glucose, creatinine, cholesterol and CPK levels in blood. The range of tests available continues to increase in number and reliability every year with new developments in biotechnology and immunology. Ultrasound and endoscopy are technologies whose value in primary care is being
proved in many practices. The family doctor provides the unique combination of high technology with personal care, in a cost-effective manner: High tech with low cost.

The options in therapy are also multiplying. New psychotropic drugs have opened the doors of so-called ‘lunatic asylums’, so that most cases of psychosis are managed at home. The vast majority of cases of anxiety and depression are seen and managed entirely in family practice, with the aid of very effective anxiolytic and antidepressant drugs when necessary.

The treatment of acute upper and lower respiratory tract infections, soft tissue infections and urinary tract infections can be carried out on the ambulant patient, it being the rare infection that requires hospitalisation. The treatment of asthma, hypertension and diabetes is now carried out far better in family practice than was conceivable in hospitals only a few decades ago. Medical advances have greatly expanded the capabilities of the family physician in the management of a broad range of health problems.

The Delivery of Health Care in Family Practice

We have seen the range of health problems that present in family practice. The responsibility of the family physician in managing these problems is to provide continuing and comprehensive care.

Continuing care begins with the initial contact of the individual or the family with the healthcare system. Initial care is for all health problems. The initial decision on treatment is a crucial one, whether it involves referral, consultation or the initiation of treatment. Continuing care implies the ability to provide care in an emergency, to deliver care in episodes of illness, and to carry out the long-term care of chronic disease, rehabilitation, and the care of the dying. Continuing care therefore ranges from care in pregnancy and child health care to monitoring complications in the life-time management of hypertension and diabetes mellitus.

Comprehensive care means seeing the individual not just as a patient but as a whole person, and accepting responsibility for organising care for his total health needs. This may involve advice and counselling, referral or consultation. Comprehensive health care is principally about the maintenance of health and
the prevention of disease. This may involve changing habits and lifestyles, which is possible only when the relationship of physician and patient is close and trusting.

The choice of referral or consultation can have far-reaching effects on the outcome of an illness, determining the course, cost and effectiveness of treatment.

The family physician has a wider choice for referral and consultation than a physician working in a hospital, as the family physician is usually not restricted to experts belonging to a particular institution. He must be familiar with the availability of expertise in the community, the relative competencies and predilections of each consultant, and the likely cost to the patient. The patient’s medical destiny is often determined by the family physician’s initial choice of consultant or institution.

Comprehensive care considers the social, economic and psychological factors affecting the individual, as well as the organic pathology. It implies an understanding of the internal dynamics of the family, and of its social and economic situation.

The words ‘continuing’ and ‘comprehensive’ care summarize the great diversity and complexity of care provided by a family physician. The immense cultural changes in our societies as we approach the 21st century, and the rapid advances in science and technology, will make great demands on the family physician but they will also provide opportunities for better care.

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Quality in Family Practice


Opening Keynote Address. 12th WONCA Asia Pacific Regional Conference, Monday, 1 April 2002, Kuala Lumpur

Abstract
Quality programs are difficult to implement where social support for healthcare costs are inadequate and there is no institutional support for quality programs to guide and assist the doctor in practice. ‘Quality’ is not the good intention to do better, but the process of measurement of behavioral change against set targets. For the majority of the doctors of this region who practice under great constraints, this article outlines some quality activities that are entirely within their personal initiative and responsibility, but should make a real difference to the quality of care provided.

Key words: family practice, guidelines, professionalism, quality.

Our region encompasses over one-half of the world’s population. We have representatives from countries where impoverished doctors in rural practice in poor communities have no access to continuing medical education or to medical journals, who are even short of writing paper and paracetamol. Doctors from developed countries and cities of developing countries in the region however can use the latest drugs and equipment in their practices. The gap in quality assurance in healthcare is even wider.

There are many obstacles to organizing quality assurance although we have been very fortunate with Malaysia as it is moving rapidly towards computerization in all fields. Our health services, which are rigidly divided into public and private
sectors, have ongoing programs in the Ministry of Health for paperless health centers and hospitals. This means that electronic monitoring of performance data becomes possible. Unfortunately, the situation in general practice is bleak, with general practitioners struggling to survive in a highly commercialized environment that is dominated by for-profit hospitals.

The Idea of Quality

Our profession has an ancient commitment to quality, meaning we pledged to do our best for our patients. We require of ourselves to make our patient’s interests paramount. In this sense, the pursuit of quality is a virtue and part of our ethical commitment to professionalism.

Our traditional commitment to quality is shown in our struggle to preserve standards of entry into our profession, in our scrutiny of the appropriateness of training for a specialty, and in our obsession with continuing education. These have been our collective preoccupations, expressed through the leadership of our specialty societies. In this traditional expression of concern with standards, the medical profession has been a model for other professions and an example to society.

Our newer concerns with quality are related to measuring performance, and driven by the example of industry. In recent decades, industry has come to see ‘quality’ as good for business. Industry provides examples that range from strict conformity to specifications of manufactured goods, to the concept of ‘zero error’ in the cockpit of an airplane. In medical practice, it still comes down to fulfilling our ancient ethical commitment to provide the best possible care to our patients, but we also have to satisfy the community that we can demonstrate by measurements that we are doing well. Donabedian, who pioneered thinking about quality, saw three areas of quality:

1 Structure, in the context of health, refers to the characteristics of the healthcare setting. For most of us, there are serious economic and political constraints to making changes in the structure of practice. In developed economics with established third party payers for the provision of healthcare services, compensation for professional services incorporate an element for the maintenance
of a certain quality of structures. However, most of this region is at, what I call the pre-National Health Service (NHS UK) state of practice.

2 Process is what we actually do for patients. It is mainly the personal responsibility of the providers of healthcare. At the center of the processes of caring is the doctor–nurse dyad, and their close collaboration with the whole team is the key to improving quality in the processes of care.

3 Outcomes are the ultimate justification for the efforts and resources expended on quality. We promise better outcomes in the form of delayed death and less disability, as well as greater patient satisfaction and improved quality of life. Objective evaluation of improvements in the incidence of death and disability are research projects that are underpinned by exacting statistical tests. Research is therefore not merely desirable, but essential for making choices in healthcare. In normal practice, we have to be content with surrogate measures or intermediate outcomes that are related to ultimate health outcomes, such as exercise, the use of seat belts, ideal weights, alcohol and tobacco consumption, lipids, HbA₁c, and so on.

The Four Aspects of Quality
The four aspects of quality of performance in healthcare that lend to measurement and objective evaluation that all stakeholders subscribe to albeit with conflicting priorities are:

- **Effectiveness** is whether an intervention works in practice, improving outcomes, or providing relief, in a measurable way.
- **Efficiency** refers to the use of resources, or the most economical way to achieve better outcomes, or the best practical option to achieve the best outcomes for a fixed investment.
- **Patient satisfaction** is essentially subjective, but we do know what elements of care are the most important causes of unhappiness, and can attend to these areas in measurable ways, for example, communication, and waiting time. Individually and collectively, people want kindness and competence, fairness and equity.
- **Community interests** cover not only public satisfaction with the health services, but also the choices in health policy and health investment that favor the wishes of the community for equity and responsiveness to needs. These are political decisions, and the doctor as a citizen has a role and
obligation to influence public opinion, and to help shape health policy. There is tension between efficiency, effectiveness, and patient satisfaction, and the doctor must not stand apart from the debate to make difficult choices.

**Quality in Practice**

The stakeholders in healthcare – the individual patient, the doctor, the agency of the State to fund healthcare and the community – have different perspectives and different agendas about what constitute improvements in quality. The patient and family want the best possible care delivered swiftly to their satisfaction, by competent and compassionate carers. The doctor has a legitimate interest in personal income, but the doctor also feels passionately regarding professional autonomy to provide the most effective treatment to a particular patient in need of care, irrespective of costs to the health system as a whole. The third party payer, as with the NHS of the UK, wants to ensure that limited funds are used efficiently to achieve best outcomes and community satisfaction. The voice of the community in a democracy is articulated by their elected representatives, but also through the media where the loudest sectional interests may prevail.

For the commercial stakeholders, the paramount obligation is to the shareholder. Managers are under intense pressure to maximize profits out of the business of healthcare, through reductions in the ‘loss ratio’ – the amount spent on care, that is, drugs and services – within the limits of contractual obligations and legal liability. I do not believe that there is enough money in healthcare funding to pay dividends and business managers, without affecting the quality of care.

These are difficult and dangerous waters for the doctor to negotiate, more so if leadership and initiative in quality passes to the hands of bureaucrats or businessmen. This is already happening in most countries, and that is our own fault failure of leadership in our profession. We have to demonstrate to the community that we are totally committed to providing the best quality of care; that our position on the hard choices we have to make in healthcare will invariably be in their best interests, not just ours, and that we are their partners in winning resources for better and more equitable healthcare.
The practicing doctor must take moral ownership of the movement for better quality. We must regard quality in practice as inherent in our professionalism. Quality must be internalized into normal practice, not externally imposed by yet another group of watchdogs. Our specialty societies should be the ones to establish agencies to institute quality assurance, and to evaluate and monitor the quality of care that is delivered to our patients. We have to be tough on ourselves. Our Colleges and Academies have to win the confidence of the community and of government. I am aware that in many developed countries this role has been foreclosed by new agencies, because of the slowness of the medical leadership to respond positively to changing circumstances. The backwardness in development of some parts of this region could be an advantage as policies are not yet set in stone, and the profession still has a chance to show that the task of ensuring quality in care is best delegated to the professions of medicine. There is a vast difference between a personal quest for quality, and the mechanical filling in of forms to meet the requirements of some nuisance agency.

I must reiterate that when we speak of quality, we are measuring our performance, individually and collectively, to see how far we have met targets that are already set. It is never ending. The aim of our endeavors is to provide better care for our patients, and only secondarily to meet the requirement of some bureaucrat or businessmen. We seek to find ways to improve our work, not primarily to find fault, or to identify underperformers, or ‘bad apples’.

A personal Commitment to Quality

They say in industry that quality comes free, meaning that investment in quality is more than returned by the profits and savings from having a superior product. There is truth in that, but I know that many general practitioners struggling on low incomes will grudge any diversion of their time or income. How do we make a beginning?

There are several ways of implementing performance assessment for quality:

- **Review** your own practice, by yourself
- **Practice** review by colleagues and staff of a practice
- **Peer review** by trusted and respected colleagues
- **Institutional review** organized by your College/Academy
- **Agency review** required by contract
I should like to reserve the word ‘audit’ for the mechanisms of investigation when something goes seriously wrong, thus it is not used here.

Think in terms of the ‘triple components of medical quality’ in a never ending cycle:

- **Objectives** in quality
- **Targets** for improvements
- **Evaluating** results

I propose a very limited personal program to improve the quality of the care we provide. This approach, I hope, would be relevant to most doctors in our region, who have little resources to spare, and no access to institutional help to guide and assist them, and to monitor their progress.

**Making a Beginning**

I propose you make a beginning in just four areas. This is an exercise in raising awareness. In each area, I propose an objective, and just two targets for performance towards achieving that objective. The targets, to which you will have to set numerical values, must be seen as an integral part of the definition of the objective:

- Medical records
- Reception and communication
- Prevention
- Management of health problems

**Medical Records**

**Objective**: To have a common database for all patients and a problem list for every patient.

**Targets**: To be able to analyze your practice population by age, sex, and age groups. To know the total numbers for a specific diagnosis in your practice, for example, upper respiratory tract infection (URTI), asthma, hypertension, diabetes, ischemic heart disease.

**Comment**: If your practice is mostly URTI, then is it because your patients do not believe you are the appropriate doctor for more serious problems, or because
of costs. Another possibility is that you send most patients with chronic diseases to the hospital because you do not feel competent to manage them?

Bear in mind that sooner or later, whoever is paying your fees or salary will want to consider if URTI and some aspects of chronic care could be managed by less expensively trained staff. Therefore, do you need to learn to be more expert in managing more serious diseases?

**Objective**: To have a disease-specific database for major chronic illness, for example, asthma, hypertension, diabetes, ischemic heart disease.

**Targets**: To know the relevant history and risk factors that will determine your management plans. To be able to review treatment of co-morbidities in the light of estimated risks of complications.

**Comment**: These diseases are the principal causes of disability and death. Good medical care can make a vital difference, so consider, how much difference does your practice makes to outcomes in these health problems? Co-morbidities multiply risk of complications; do your records allow you to be aware of multiple risk factors in each patient?

**Reception and Communication**

**Objectives**: To ensure that the patient and accompanying persons leave your practice pleased and contented that they have received courteous and attentive service, and all questions in their mind have been answered.

**Comment**: To shorten waiting time before the consultation and to increase speaking time for the patient.

**Thought**: Do you know how long the wait to see you, and is it a source of irritation or distress? How much of consultation time is taken up by your talking? When you conclude the consultation, does the patient still have unanswered questions? Have you asked?

**Prevention**

**Objective**: To emphasize the preventive approach in your practice, and turn every consultation into an opportunity to practice prevention.

**Targets**: To identify in their problem lists, those patients with high-risk behavior, such as excess alcohol and tobacco consumption, drug abuse, overeating and inactivity.
Comment: Have you an approach to diagnosing alcoholism? How would you counsel a patient about tobacco cessation? Do you know the national guidelines on immunization? What proportion of women above 45 years age in your practice have you counseled about Papanicolaou smears and breast cancer?

Management of Health Problems

Objective: To plan treatment based on the best scientific evidence, and be able to assess if treatment is producing results.

Targets: To follow guidelines for the management of asthma, hypertension, diabetes, and coronary heart disease. To share with your patient knowledge of the benefits you expect from treatment, and together assess progress at each consultation.

Comment: Are you able to evaluate the evidence for the ‘best’ treatment for a disease, or do you know how to choose between guidelines? How would you diagnose diabetes or hypertension, and what measurements would you make at each consultation? What do you tell your patients about how they can improve their health prospects?

As I said, this is an exercise in creating awareness. When you become aware, then you can set numerical targets against which you can measure performance. At the end of each year, you are able to measure your progress. Find like-minded colleagues to share your experience and exchange ideas, and form a study group. Your group can lead your College or Academy in the pursuit of quality in care. I admit that having to say all this shows how far most of us have to travel to make a beginning in measuring quality.

A Word about Guidelines

Evaluating scientific evidence requires statistical skills, but there are countless guidelines that have gone through that process tat you can choose from (see recommended websites for guidelines). Beware of guidelines where the ‘experts’ do not reveal conflicts of interest, or are actually funded by the manufacturers of a particular drug. If you trust the source of the guidelines, or they have been endorsed by one of our Colleges or Academies then you should be safe. You still have to adapt general recommendations to the specific needs of your patient.
There are no ‘gold standards’ in medical treatment, no fixed set of specifications to apply to a particular diagnosis. Each patient is unique, for age and sex, personal habits and cultural practices, by environment and by genetic inheritance. Take the example of simple diagnosis of obesity, and consider the effect of co-morbidities on management options, by no means uncommon presentations in practice:

- Obesity
- Obesity with mild hypertension
- Obesity with moderate or severe hypertension
- Obesity with hypertension and diabetes
- Obesity with hypertension, diabetes and osteoarthritis
- Obesity with hypertension, diabetes, osteoarthritis and asthma

You can see that we are dealing with complexity that borders on chaos.

**A Word to Colleges and Academies Yet to Make a Beginning**

Quality is inseparable from training, and is the most important justification for the existence of Colleges and Academies. No third party payer will give money without knowing what they are getting for their money, so we might as well be prepared. I offer an approach we have used in the Malaysian Academy, where we too are struggling to make a beginning. We offered a negotiated ‘Learning Contract’ to members, comprising two linked parts:

1. **A continuing education program**, to help you update and improve your knowledge and skills
2. **A quality assurance program**, to help you apply your knowledge and skills to achieve better outcomes and greater patient satisfaction.

I believe that this friendly, helpful and unthreatening approach is a good way to make a start.

**Conclusion**

I would like to conclude with a note on how to have contented patients. Patient satisfaction is the outcome of good quality in practice. There are countless events
and images that impinge on the patient’s consciousness in an encounter, but it ultimately comes down to trust and confidence. The patient and family must feel that they can trust you to do your very best, and they need to have *confidence in your ability to do so*, in your professional competence to provide the best care.

Commitment to quality, obviously demonstrated by your practice, goes a long way towards winning trust and confidence.

**References**

11. Preventing Diabetes: The Task of the Family Doctor


A Growing Problem

The World Health Organization (WHO) estimates that the number of persons who have diabetes may double to 300 million by the year 2025, of which 90-95% will be type 2.¹ It is estimated that 76% of those diagnosed will be in developing countries and the Asia Pacific region will be at the forefront of that epidemic.² While those afflicted in developed countries will be mostly women and those over 65 years, those in developing countries will be in the 45-64 years age group, equally of both sexes. The WHO concludes that the world faces a global health problem of an epidemic nature, but we do have the knowledge to prevent many cases of diabetes mellitus and to reverse this epidemic that threatens young lives.

The great majority of the population that is at high risk of developing diabetes in five to 10 years’ time will present with the Metabolic Syndrome, otherwise known as Insulin Resistance Syndrome, or Syndrome X.³ At this stage they are already at risk for macrovascular and microvascular complications. For this phenotype, the new diagnostic category of impaired fasting glucose, as a marker of increased risk (plasma glucose of >6.1 to <7.0 mmol/L) has been proposed by WHO and the American Diabetic Association.⁴,⁵ The US National Institute of Health has proposed criteria for the Metabolic Syndrome.⁶

A Changing Pattern of Disease

Type 2 diabetes is no longer regarded as a maturity onset disease, but is emerging
as a disease of young people. There are intriguing findings that, at the pre-diabetic stage, markers of inflammation may be present. These include leucocytosis and elevated erythrocyte sedimentation rate and C-reactive protein. At puberty, patients present with signs of insulin resistance.

More females are affected and the following characteristics should be noted: overweight, hirsute girls with oligomenorrhoea or amenorrhoea, and the early presentation of polycystic ovarian syndrome. Acanthosis nigricans (intertriginous hyperpigmentation) is a marker of insulin resistance.

### Mobilising Lifestyle Factors

Many prospective studies have found that dietary change and physical activity can substantially reduce the risk of diabetes. A recent report from the Finnish Diabetes Prevention Study reported a reduction of diabetes by one-half of individuals with impaired glucose tolerance, through lifestyle interventions.

While good blood sugar control should reduce microvascular complications, the reduction of macrovascular complications to prevent cardiovascular disease requires intensive efforts to stop smoking, reduce blood pressure and weight, increase physical activity and improve lipid profiles. Moderate weight loss and moderate exercise, incorporated into everyday life can improve cardiovascular health. The Dietary Approaches to Stop Hypertension (DASH Trial) diet, which has been shown to lower blood pressure, also lowers total cholesterol and low-density lipoprotein cholesterol and should reduce coronary heart disease. The diet increases intake of fruits, vegetables and low-fat dairy products and decreases intake of saturated fat, total fat and cholesterol.

### What of Medication?

There is a place for drugs in the prevention of diabetes. Metformin (dimethylbiguanide), an old drug, acts by reducing insulin resistance, dampening hepatic gluconeogenesis and inducing weight loss, preferentially involving adipose tissue. There is a consequent lowering of levels of insulin required for glucose homeostasis. In a trial on American adolescents who were obese and
hyperinsulinemic, metformin reduced fasting glucose levels and bodyweight, without dietary restriction.\textsuperscript{16} The UK Prospective Diabetes Study Group reported, in their landmark study, that metformin had favorable effects on diabetes related endpoints, stroke and all mortality, in excess of what could be attributed to control of blood sugar.\textsuperscript{17} Several ongoing trials are examining the place of metformin in preventing diabetes. A new class of drugs, the thiazolidinediones represented by troglitazone and pioglitazones, also reduce insulin resistance, but their long term effects are not yet known. Their effect is principally on peripheral resistance in muscle and fat tissue and should complement the effect of metformin on hepatic insulin resistance.

**Conclusion**

We face a global epidemic of type 2 diabetes. There is a historic opportunity to demonstrate the effectiveness of family practice in preventing this major cause of disease and death.

**References**


SECTION 2:

HEALTHCARE & SOCIETY
Section 2: Healthcare & Society

Synopsis by Associate Professor Dr CJ Ng

When I was asked to write a synopsis for the essays by Dr Rajakumar, little did I realise that I was embarking on a momentous task that change my views about the practice of medicine. It took me more than six months before I began writing; one reason of my procrastination is my anxiety that this synopsis will not do justice to the excellent works of Dr Rajakumar.

I read these essays with the advantage of hindsight and knowledge of recent development in medical practice and social changes – but it strikes me that his writings, some dated back as early as 1983, are in every aspect as relevant and inspiring now as they were more than 20 years ago.

In the second section of this book, you will read a compilation of essays on the theme “Healthcare and Society” which covers wide-ranging topics beyond Family Medicine. These essays enlighten us on topical issues from ethics, professionalism, equity in healthcare to culture and politics. Dr Rajakumar examined these complex issues with depth and clarity; he studied them from the perspectives of the patients and their families; of the doctors and as the leader of the medical fraternity; and as the citizen of Malaysia and the World. The content in this section can be divided into four main categories: Medical Dilemmas, Ethics and Professionalism, Equity in Healthcare and “The World in One”.

The Medical Dilemma – Faith and Reasons

In the Dr Sun Yat Sen Oration in Hong Kong, Dr Rajakumar addressed a core issue in medicine – “the dilemma of reconciling faith (patients’ beliefs) and reason (the science of medicine)” in clinical practice. He recognized the failure of the medical profession “to satisfy the emotional dimensions of our patients’ dysfunctions” and called for the physicians to acquire “a very much deeper understanding of the complex roots of human behaviour”. He then walked the audience through the fascinating journey of evolution, arguing convincingly how human behaviour was shaped by biologic, cultural and ideologic input.
He proposed the idea of the physician as a “care-giver”, urging the medical profession to “always put first the interests of men, women and children in its care, thereby earning their trust and confidence… if they are to have faith in our reason, we must give them reason for their faith.” Dr Rajakumar, while discussing about importance of “faith and reasons”, also outlined what a good doctor should be: “The profession of healing needs a special temperament and character. It requires men and women of goodness, of culture and learning, who also possess experience with the lives of real people in the real world.”

Ethics and Professionalism
Medical ethics is the key subject in two essays in this collection: Ethical Consequence of Technological Change and Ethics, Professionalism and the “Trade”. Dr Rajakumar traversed the entire scope of ethical issues in medicine at the Singapore Medical Association Lecture, “from the ethical consequences of termination of foetal life to the maintenance of terminal life.” In these essays, Dr Rajakumar covered both the breadth and depth of the ethical issues. Abortions, contraception, cloning, assisted reproductive technologies, genetic screening, “right-to-die” and “living wills” were just some of the topics explored in the SMA Lecture. His insights to these issues go beyond the surface; for instance, in the discussion of the “right-to-die”, he argued that “the patient with the legal right to die may change his mind each day, indeed by the hour depending on the degree of pain and discomfort, on mood and relations with those he or she loves.”

Dr Rajakumar also empathized with doctors who struggle with ethical dilemmas: “Have you ever heaved a sign of relief when a patient in renal failure died before the family could sell everything they owned, and got in debt to purchase a few weeks of dialysis time?”

He not only highlighted the problems, he offered directions for the medical profession: “The profession must provide leadership in discussing ethical issues. We should discuss these issues with dignity and defend our ethical positions with passion and when the community sees that we stand up for values, and not only for personal advancement then they will be with us.”

On the issue of managed care, Dr Rajakumar warned us of the threat of turning the medical profession into a trade. “Remember that if we behave like ‘trades
people’, the community will treat us as ‘trades people’”. He reiterated the important role of the Ministry of Health hospitals, and that they should set “the standards of excellence for the private sector.” However, he was saddened by the lack of commitment of this country to “pay government doctors enough to retain them so as to provide a decent level of services to the majority of the people of this country.”

Equity in Healthcare
“Their voices are not heard, so we have to speak up on their behalf.” – this was exactly what Dr Rajakumar did on behalf of the poor and the marginalised at two international conferences: WONCA World Conference on Rural Health (Melbourne, 2002) and WONCA Asia Pacific Regional Conference (Beijing, 2003).

At Melbourne, he argued strongly that “rural doctors and health centres in wealthier countries (should) put out their hands to work with rural doctors in poor countries to help impoverished communities.” He spoke of the “diverse worlds of rural health” – one which aimed for better quality of life and longevity while the other, subsistence and survival – and the indifference of the rich countries in helping the poor. With the United Nations and World Health Organisation as allies, the political climate is beginning to change in favour of the task of eliminating poverty.

He challenged the medical profession “to demonstrate to the world that our tradition extends beyond our consulting room” and “in giving a bit of ourselves to help a stranger in a faraway land, we bear testimony to our humanity, we save ourselves.”

In the midst of the SARS epidemic in 2003, Dr Rajakumar visited Beijing and delivered a passionate plenary lecture on Achieving Equity Through a Primary Care-led Health System. He was critical of the global trend of healthcare delivery, which has “drifted into an inefficient and inequitable, commercialized and profit-driven, urban hospital-based system”. He, therefore, argued for a primary-care led health care that “is driven by the needs and preferences of the local community” and emphasized “cost-effectiveness, not merely cheapness.” He went one step further to suggest that “tertiary care has to develop in response to the ‘push’ of primary care for services that it needs, not to invent and drive demand.” Primary
care physicians, nurses, public health doctors, therefore, should become allies and push for this agenda. He lobbied for “friends in other countries…to help in seminal experiments to achieve equity in health in the poorer countries of the world.”

“**The World in One**”

Dr Rajakumar’s hope for Malaysia and the World was expressed in the essay *Looking Back, Looking Forward* written on the millennium year. “*We are a nation of nations, and we are discovering our shared destiny as one people*” set the stage for his vision of Malaysia: “*to become a nation of culture, education and skills.*” He felt that there was a need for “*plurality of options in public life, the emergence of civic activity across ethnic lines, and freeing of the energy and intellect of our people.*” His concluding thought was a sombre one: “... we really need a better quality of people in public life, but sadly, that is a dilemma that we share with the rest of the world.”

Dr Rajakumar’s essays are more than just academic endeavours; the quotations in this synopsis only reflect but a fraction of his wisdom. I urge you to read and re-read these essays; your faith in medicine will be strengthened, as is our hope for the country and the world.

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March 2008
12.

SMA Lecture: Ethical Consequences Of Technological Change


Dr Rajakumar delivered this lecture at the 14th SMA National Medical Convention on 16th April 1983

It gives me a great deal of pleasure to be honoured by the President and Council of the Singapore Medical Association by the invitation to deliver the Annual SMA Lecture. It is for me a homecoming as I am back in the city where I studied and graduated, among my friends and teachers. Presidents of both our national medical associations, which would be one but for an accident of history, have even until now shared this common background. In both the twin cities of Singapore and Kuala Lumpur, several generations of professional men and women share common memories and have strong ties of friendship between them. It must indeed be this special regard we have for each other that persuaded the Singapore Medical Association to go outside this island of such numerous talents to invite a man of my humble capacities to speak on a subject as important as Ethics.

A great many kind things are said on such occasions and your distinguished President and my old friend has been lavish in his remarks. I must go beyond the customary disclaimers to say that there is so much I wish I had done, so much I wish I had done better, and more I wish I had the capacity to do. I am clearly a case of aspirations overvaulting capacities and no one is more conscious of this than I am.
More still when I look at the distinguished line of speakers that have preceded me, many of whom were my teachers, all of whom I would consider it a privilege to listen to any day.

We are unique as a profession in that we alone are ethically commanded to protect, maintain and sustain human life and enjoined never to harm a human being. Because of our responsibility for life, at birth and at death, it is necessary to remind physicians that they must not play God with the lives of the men, women and children in their care.

We live in times of great and rapid change. These changes have already had profound effects on the way we live and the way we think. We have shown a remarkable capacity to assimilate into our lives the uses of new technologies. What has been dismaying has been mankind’s inability to develop the spiritual values and moral judgement to put technology to its proper uses. The spectacle of the first nuclear explosion brought to Robert Oppenheimer’s mind the words of the Bhagavad-Gita: “I am come as the Destroyer of Worlds”. We still live under the shadow of that mushroom cloud and I am amongst those physicians who take seriously the prospect of nuclear conflict that would disrupt civilized existence as we know it. Although less spectacular, the advances in medical technology have transformed dramatically the scale and scope of medical interventions and have placed stresses on our concepts of ethics that stretch them to breaking point. I welcome opportunities such as these to share my fear that we rush like the Gadarenes swine down the technological slope to our own destruction.

We sometimes lose sight of the truth that the practice of medicine has been technologically determined to a very great extent. Where would the practice of surgery be without the discovery of asepsis and anaesthesia, or internal medicine without the discovery of the circulation of blood? Until this century our pharmacopoeia differed little from that of traditional medicine as we know it today. Only the drugs, opium, digitalis and aspirin remain of that vast compendium.

Even as technology has changed the way we practise, our ethical concepts have come under pressure to change in response to what is seen as the needs of the times. Medical schools with overloaded technical curricula can find little time for ethics. All sorts of medical schools produce all types of graduates and sometimes they are ethically blind, aware only of the status of the physician and
not of the weight of moral responsibility that comes with it. Each year when I lecture to students on ethics, I commence with the complaint that ethics should not be taught in this way but in relation to their patient by every single teacher in the faculty. I find these young people extremely concerned about ethical issues and more than a little confused with the reality that they are already beginning to comprehend. There is a conflict in their value system.

In this part of the word, we are inheritors of ancient cultures, Chinese, Indian and Malay and our traditional values still dominate our private lives and dictate the pattern of our behaviour and our responses to events. Yet our professional lives are insulated from these traditional values; in our professional behaviour we are the distant inheritors of the Protestant-Puritan ethic and of the Hippocratic tradition. There is this schizophrenic quality to our educated elite that I will not explore further on this occasion.

We know little of the historical Hippocrates but the ideal of the good physician in the Oath is over 2,000 years old and was adopted by Christian Europe and Muslim Arabs.

You are all familiar with the Oath although few physicians take it and, no doubt fewer still measure their professional lives against it. The heart of the Hippocratic Oath is the injunction not to do harm, never to take human life, to keep confidences and to give equal consideration to people whatever their status.

These are ancient injunctions and are contained in ethical rules of physicians in all our cultures. How have these honoured injunctions withstood the test of time in the face of technological change?

To take one example, among the more important of these technological advances is the computer which can provide links between medical records and other data banks such as school records, police records, employment records. The individual’s medical records are no longer maintained by a specific physician but owned by and in the custody of institutions, and access to them is beyond the control of the physician. The patient himself is often not directly in relation to the physician but to the organisation that employs the physician. These are all very important issues but my remarks today will be directed to the problems of
ethics at the extremities of life, from the ethical consequences of termination of foetal life to the maintenance of terminal life.

Abortion has been legalised in many countries. It is sometimes forgotten that the impulse for the legalisation of abortion has come not from the medical profession but from the changing status of women and the grim hazards of illegal abortions. I would go further and say that if abortions were made illegal or if the laws against abortion were enforced where it is still illegal, I do not believe that the number of women seeking abortion would decrease but a vast illegal abortion industry would spring up and only the poorest would be condemned to maiming and death in the hands of unskilled operators. I shall not go into the profoundly important subject of the morality of abortion. My concern today is the consequences that arise from the changes in our norms of ethically acceptable behaviour with regards to the embryo.

Contraceptive technology has advanced very rapidly in the past few years. It is likely that in many societies, more births are prevented than permitted and there are countries that report more recorded abortions than births. The community as a whole and physicians in general have come to accept this with equanimity because it is argued as socially necessary in the face of pressures of population growth.

It is possible now to poison spermatozoa with a variety of drugs, or with hormones suppress the release of the ovum and make the endometrium inhospitable. By adding a little copper you can induce the endometrium to shed an implanted zygote. A few millimetres pressure of suction can extract endometrium and zygote even before a pregnancy can be diagnosed. You can operate or you can stimulate the uterus to contract and expel the foetus prematurely. It is likely that drugs will become available in the near future from the dispensing machine that will safely inactivate the sperm in the male or induce a monthly abortion in the female. That’s technology for you.

As a result of social pressures, abortion is legal and ethical codes have been changed to accept abortion and to exclude the pre-viable embryo from the protection of the injunction not to kill.
The question now arises of the status of the aborted embryo. Can the pre-viable embryo be used for experimental purposes? Can it be cannibalised for parts or used as an experimental subject? The embryo is not a legal person under the law; the ethical code has permitted its destruction. Is there now any restriction to what uses it can be put?

As you all know, foetal material can be obtained at an even earlier stage. For many years it has been shown in animals that oocytes could be extracted from the ovary and fertilised in vitro and reimplanted into the womb. Between 1970 and 1974, when Edwards raised the possibility of this in human beings, there were few who regarded it a serious possibility. Within a few years, it was an accomplished fact. You can now learn the technique in a fortnight and the numbers of centres and research workers able to do this multiplies each year. Multiple oocytes are withdrawn from the ovary and individually fertilised. A few are introduced into the womb and the rest are available for study of embryonic growth and for experimentation. What ethical restrictions are there on the use of these human zygotes?

Genetic material has become a valuable natural resource with the emergence of recombinant technology. It has become possible to introduce genes carrying specific enzymes or associated with certain traits into other living creatures. The first attempt with human beings has already been made. How do you monitor and control these experiments without retarding the acquirement of valuable, indeed essential, knowledge? How far do you go? How should we react to the possibility of para-human primates being grown in experimental farms as a result of recombinant technology in vitro fertilisation and reimplantation? If cloning becomes possible then there is the danger of cloned humanoids grown in surrogate uteri kept as ‘the imbecile in the backroom’, available for the cannibalising of parts for the wealthy and powerful who do not want to die. If controls in the developed countries prevent this sort of activity, will some developing country be used for such profitable but morally abhorrent genetic farming?

In the case of in-vitro fertilisation and transplant, if the ovum and sperm come from husband and wife, no moral or ethical issues arise. If in addition to blocked tubes the uterus is also unhealthy, then a surrogate mother can legally be used in the United States. The surrogate mother must be emotionally prepared and bound legally to relinquish the infant she has nurtured to strangers whose genetic material
she has carried. The problem has already arisen of an infant born deformed by AID to the surrogate mother which neither party wants.

A further step down the road is the establishment of commercial sperm banks. AID is used where the male alone is infertile and the impregnation of the women personally by a strange man is culturally and emotionally unacceptable. The physician acts as intermediary and undertakes the task of instrumentally placing the semen in juxtaposition to the cervical opening. Sperm banks have been established in the United States and it is already becoming possible for a woman to specify the characteristics of the donor male whose sperms she will accommodate.

The antenatal diagnosis of foetal abnormality has become an important new indication for abortion. It will soon be possible to make the diagnosis much earlier by use of recombinant technology on chorionic villi. Trisomy of chromosome 21 and thalassaemia are two important diagnosable conditions in our part of the world. Ultrasound allows early diagnosis of spina bifida and termination is advised in many countries although it has been found that the image of the embryo on the real-time scanner is sufficient to bond the mother to the foetus and for her to refuse termination. The other major cause for termination is rubella infection. This involves the destruction of a significant number of normal foetuses, depending on the time of infection. Pre-natal sex determination is now possible and there are foetuses being aborted for belonging to the wrong sex.

The rule then is that once the defective foetus is born it is protected by the laws of the country and will be entitled to loving care; if diagnosed a few weeks before delivery it may be killed. Once born it can even sue for damages against persons who may be liable for having caused the deformity or for not having prevented it. Imaginative lawyers in the US have even suggested legal action by the deformed infant for ‘wrongful life’, i.e. for not having been killed and spared the misery of life.

The extent of this misery is variable. The Down’s infant is generally a happy and contented person although it will have more than its share of complications. The spina bifida, say a meningomyelocele, is assured of a long miserable life which will tax the parents to the utmost. Where the infant is born with an additional defect that is incompatible with life, e.g. Down’s syndrome with duodenal atresia,
then can the infant be allowed to die by withholding surgery? You may think so, but in the recent Arthur case in the UK, a Down’s syndrome infant developing signs of pneumonia on the second day was denied treatment and died. Dr Arthur was saved from conviction only by the appearance of a pathologist who could find multiple congenital abnormalities that were incompatible with life.

The technology to sustain life has raised important issues at the other extremity of life. How far should we go to use our new machines to maintain life? The issue of sanctity of life is brought up with greater passion since the individual has developed a personality and a presence and has emotional and economic links in the community. No society accepts that human life is totally inviolate. Tribes and states since time immemorial have gone to war to kill members of other tribes or states that have annoyed them. Many states still break the necks of individuals who cause sufficiently big problems. Ironically those persons who favour abortion are usually opposed to capital punishment and vice versa although I believe there are countries that favour both.

Some states make suicide illegal and if you fail in your attempt at suicide, you will be punished for your pains, but this is changing. It is illegal as well as unethical for a physician to assist in a suicide. Every physician knows the terminal case who begs for his life to be ended, more often I sense out of helplessness and hopelessness than out of pain. Where the patient is in pain, we have powerful drugs and techniques to relieve the pain, even if in the process life is shortened and consciousness impaired. Beyond that, physicians may not ethically or legally go. If society wants to give individuals the right to kill themselves, then physicians will have the ethical obligation, not directly to help, but to continue caring. Direct involvement would introduce an ambivalence into the relations between the physician and patient and create new tensions that would destroy the heart of that relationship. Instead lay organisations have sprung up that provide advice on how to kill oneself and in Scotland you can buy a ‘do-it-yourself’ booklet.

In the United States, ‘right-to-die’ laws are being advocated and the physician, in determining the vigour of resuscitative efforts, is expected to be guided by the wishes of the individual expressed in ‘living wills’. Hospitals have their own policy on resuscitation. An elderly physician wrote some years back, noting with bitterness, that he was at the age where some London Hospitals would not resuscitate him if he had ventricular fibrillation.
Yet another distinguished cardiologist died from a myocardial infarction because his physicians reluctantly respected his firm instructions not to be resuscitated, although he might had many years of useful life if he had. One wonders if he would have felt the same if he had been defibrillated and lived to reconsider. Difficult though it is to talk about it, some patients should not be resuscitated but be permitted to die with dignity. We all must die one day, and as physicians we would choose a massive myocardial infarction before we become utterly senile; and we must live in terror that some enthusiastic intern with a defibrillator would shock our tired heart and revive our weary brain, not to give us a new lease of life but only to prolong our dying. Lay persons who are enthusiastic for the physician to undertake euthanasia are full of the good intentions with which is paved the road to hell. These good souls must be unaware of the complex emotions of guilt and recriminations that engulf physician and patient, family and friends around a death bed. The patient with the legal right to die may change his mind each day, indeed by the hour depending on the degree of pain and discomfort, on mood and relations with those he or she loves. Granted the right to die, he will look guiltily at his physician each time he changed his mind and feel pressured by the long, long suffering faces of those who are to mourn his death.

The brain damaged patient is an entirely different issue. If the cerebral cortex is permanently damaged, and physicians are agreed that coma is irreversible, then extraordinary measures need not be taken to sustain life. This means in practice that mechanically assisted ventilation is not offered but once initiated, disconnection is a more difficult matter. In the case of Karen Ann Quinlan in the United States, the Court returned the decision to the physicians in consultation with the family, the ventilator was disconnected and the young women continued to breathe, still in coma.

The new concept of brainstem death as defined in the UK means that death has occurred when there is permanent functional death of the brainstem. When the ventilator is disconnected, there will be no respiratory efforts and the heart will stop shortly. Even on the ventilator, dissolution of tissues will proceed and the heart will stop within a few hours to a few days. Once a diagnosis of brain stem death is made, if an organ is needed for transplant, the ventilator can be left on to sustain the heart until the required organ or organs are removed from a ‘beating heart cadaver’.
This concept has been cogently defended and the Conference of the Royal Colleges in the UK has clearly described how brainstem death can be established. The importance of this new definition of death lies in the need for organs for transplant that have suffered as little anoxia as possible. The logic is perfect but we must make allowance for the primitive reluctance to accept as dead a body with a beating heart.

Our techniques for life support are improving and most vital functions can be temporarily replaced. This is an expensive technology and in a society with limited resources – which is true of every society – that means life-support systems are either not available for everyone or else some other facility must be deprived of resources to provide more life support systems.

In the poorer countries, the choice may be simple and scarcity will determine that only those clearly going to recover to near normal life with reasonable life expectancy will be given the use of expensive resources. There are countries where unfortunately the choice may be simpler still and the politically most influential and the wealthy will get priority every time.

Much of the decision-making on the allocation of health resources is out of professional hands. Politicians make these decisions, physicians live with them. We have the technology to immunise children against diphtheria, tetanus, Poliomyelitis, whooping cough, rubella, measles, tuberculosis, even hepatitis B, and perhaps, liver carcinoma. The technology has been available for a long time to ensure clean water and safe disposal of sewage, control of vectors and prevention of pollution. Physicians do not have the power to determine how available technology will be applied but we do have an ethical obligation to speak out about it.

However, the physician has wide discretion in the use of extraordinary medical life-saving therapy such as bypass operations, organ transplant, dialysis and the exhibition of expensive drugs, and normally exercises it without challenge. We are ethically bound to make our choice of patients to benefit from these technological developments on purely clinical grounds yet social criteria must inevitably creep in. In the UK, for example, it was found that medical indications for dialysis were unconsciously adjusted by physicians to fit the number of places available. A majority of centres would regard with disfavour candidates above
60 years of age. When physicians in 25 renal units were recently asked to evaluate 40 patients in renal failure with a view to selecting 10 for dialysis, it was found that only a third of the patients would have been accepted by all units and no patients were rejected by all units. This would suggest a considerable degree of subjective variation on what is purportedly an objective clinical decision. At Seattle, where they pioneered dialysis, a civilian board makes the choice with the help of specific criteria and the report on the deliberations of this board makes depressing reading inducing one to revert to the view that these decisions are perhaps best left to physicians. In Los Angeles, optimum candidates are identified, that is, with no other significant organ damage, and one is selected by lot to fill the vacancy in the dialysis pool.

The physicians making these decisions or advising on them will in practice have a great say. It has been argued that physicians have no training in moral philosophy or ethical analysis, yet make what are essentially moral decisions in the guise of clinical judgement. Philosophers may go on principle, but physicians have to decide case by case. My fears go further. Do physicians in fact function as gatekeepers to scarce resources, watchdogs for the Treasury, so to speak? Does clinical judgement serve economic necessity and are physicians the instrument of politically determined rationing of scarce resources. In private practice, those who cannot pay can either go to a state hospital or go home and die; you ration by ability to pay. Extraordinary life-saving technologies such as bypass or dialysis are purchasable. Where it is available, the family is under great emotional pressure to purchase it with whatever resources they have for the satisfaction of having done everything possible. Have you ever heaved a sign of relief when a patient in renal failure died before the family could sell everything they owned, and got in debt to purchase a few weeks of dialysis time? These human tragedies will increasingly press down on physicians as medical technology advances and more can be done. For example, when the problems of transplant rejection are solved, there will be an explosive increase in demand for kidney, liver, heart and other organ transplants; or for the machines that are invented to do the task. Has the physician the moral qualities and the ethical strength to make these choices, or even to advise on them and to quietly reject decisions that are contrary to his or her conscience and his or her ethical standards. Or will events make us the custodians of interests other than those of our patients.
We are not permitted as physicians, ethically and in good conscience, to distinguish between millionaire and indigent, prime minister and peon, political prisoner and parliamentarian. Is this a sustainable position in any society? When it is breached, where do we stop? If a tyrant needs a young heart to transplant, will there be physicians ready to oblige by diagnosing brainstem death in the prospective donor?

When the technology is primitive and unsafe, the pressures are small, but when the technology is perfected, great indeed will be the pressures to get to the head of the queue.

The dilemma of the profession is a universal one. More and more physicians depend for their living on the State or on great private institutions or boards. More and more physicians see their personal advancement in the role of technologists dependent on expensive equipment and highly trained staff. Physicians are not invariably men or women of special moral qualities or of a compelling sense of vocation. They are selected as young men and women essentially for their examination results, and may be motivated by the high status and large incomes that they believe is assured by a medical career. If at medical school they see that their contemporaries lack ideals, that their teachers talk like tradesmen and, when they graduate, discover that the leaders of the profession are merely successful tradesmen in white coats, then all is lost. Under these circumstances, the chances of an ethical profession surviving are smaller than that of a snowball in the streets of Singapore.

Ours is a noble profession but it will not stay noble unless its members are individually seen to be noble in their aspirations and endeavours. We must at all costs cling to certain constant values as a profession, most of all an invariable respect for human life. If our professional ethics suffer brain stem death, then the annual ventilation of SMA Lectures will not keep off the stench of dissolution.

But I believe the high ideals of medicine will prevail. I believe that, the practice of our art of itself tends to enlarge the conscience and humane impulses of its practitioners. I believe that society as a whole needs in the most profound way the existence of physicians that people can respect and trust, next only to their separate gods and this will force the profession back to its ancient role. Our protection as a profession against the threats to our ethical standards lie in
increasing awareness of these issues both within the profession and without. The profession must provide leadership in discussing ethical issues. We should discuss these issues with dignity and defend our ethical positions with passion and when the community sees that we stand up for values, and not only for our personal advancement, then they will be with us. Whatever the technology, we must keep the doctor-patient relationship at the heart of the practice of medicine. We live on the threshold of the 21st century and we must prepare for the future by refining our ethical concepts and developing the application of our ethical code so that the medical profession is seen to be firmly on the side of those in our care, willing to defend their human rights and in whose care their rights will be safe.

In conclusion, may I remind you of the first Aphorism of the Hippocratic Collection, whose humility and wisdom should be our guide.

“Life is short and the Art long, opportunity fleeting, experiment dangerous and judgement difficult.”
13. Dr. Sun Yat Sen Oration: Between Faith and Reason


DR. SUN YAT SEN ORATION 1993. The Hong Kong College of General Practitioners Conferment Ceremony, 12th December 1993

Dr. Sun Yat Sen (1866-1925) was born in Kwangchow and went to school in Hawaii. He became a Christian. He dedicated himself to overthrowing the Manchu dynasty. After an unsuccessful uprising in 1885, he fled into exile with a price on his head. The rebellion succeeded in 1911 and Sun Yat Sen was proclaimed provisional President of the first Chinese Republic on 12 February 1912. He was forced to flee to Japan because of his opposition to the return of monarchy. He had three children from his first arranged marriage and none from his second marriage to Soong Ching Ling who involved herself closely in his work and was a much loved figure. Sun died in Beijing on a visit for discussions with Chinese leaders. He is regarded by all sections of Chinese opinion as the Father of the Chinese Republic.

Preamble

The past few days in Hong Kong have been historic. I have witnessed the inauguration of an Academy of Medicine that includes General Practice amongst the specialties admitted to its ranks. Meeting with many old friends has brought back memories of my long association with your College. It was a very small College then, with a remarkably dedicated Council who made great personal sacrifices in terms of their personal lives and incomes to build this College. We
spent many hours discussing the nature of General Practice and its future, the role of the Colleges, and the importance of involving Ministries of Health. I worked very closely with your Founding President, Dr. Peter Lee.

At Peter’s request, I lobbied both medical schools to establish departments of General Practice. I recall that one of those I spoke to is a previous Orator and now President of the Academy of Medicine, the very eminent Dr. David Todd, who was most supportive and encouraging. I also met the previous Director of Health to propose formal training in General Practice for doctors in government service. I helped to plan the first examination of the Hong Kong College and was external examiner. I was therefore in a position to certify to the Academy of Medicine that the examination conformed to the highest international standards. I urged you to move in the direction my own College had taken in having a conjoint examination with the Royal Australian College. That examination is now firmly established.

Subsequently I worked with Peter Lee to prepare a submission to a Hong Kong Government committee proposing a plan to introduce General Practice in the government medical services. On behalf of WONCA, Peter Lee and I with Dr. Syed Mahmood, then President of the Malaysian College, went to Beijing on a mission to introduce General Practice to China.

With no College have I had a closer association, and I have been friends with a succession of your Presidents. With your Past President Nat Yuen, I am contributing a chapter to a book on Family Practice that he is editing, the first international text from this region. I have always known Nat to sparkle with ideas and initiatives. With your current President Stephen Foo, I have had a very long friendship. He is a very special sort of person, and nowhere have I met a man with his combination of honesty, dedication and modesty. Your College is truly fortunate to have a man like him to lead you.

Coming back to Hong Kong, I find a strong and mature College. With your admission as a speciality into the Academy of Medicine, you are ahead of the rest of us. If I may offer a word of advice, it is that you face rapid change and great challenges and it is not sufficient to merely be more energetic with old approaches. There is a whole new world ahead of you that calls for new ways of thinking and working.
In accepting the invitation to be the Sun Yat Sen Orator, I noted that I was not restricted to a medical topic. A previous Orator, Dr. Wang Gang Wu, a Malaysian and a very old friend, is a renowned historian. I have taken the opportunity to organise my thoughts on certain philosophical issues that have preoccupied me in recent years, to speak to you on the place of faith and reason in the practice of medicine.

**Between Faith and Reason: The Quest of The Physician**

Each age has its challenges and great nations produce great men and women to take up these challenges. Such a man was Sun Yat Sen. He led a movement to free China from Manchu rule that was forerunner to the freedom movements that were to sweep over the globe to create the new States that now constitute the majority in the United Nations.

We have all benefited from the liberation of minds and the release of energies that resulted from the success of these movements for freedom. The world is a better place for that. The resurgence of Asia in the affairs of the world, both economically and culturally, after a lapse of a little over a century of Western dominance, is the outcome of a battle for national emancipation that was begun by the generation of Sun Yat Sen.

My own country, Malaysia, has a link to Sun Yat Sen. He is reputed to have travelled around the Peninsula, disguised as a peddler, meeting and talking to immigrant Chinese of all classes. He had many admirers amongst overseas Chinese, and to this day his name is a legend among the older generation of overseas Chinese. Sun Yat Sen was a hero figure of my youth.

Dr. Sun Yat Sen was a general practitioner who graduated in 1892 from a new school of medicine in Hong Kong. This was known as the College of Medicine for Chinese and had been established in 1882 by Dr. Ho Kai, a general practitioner and barrister who was a member of the Legislative Council. In 1907, the new medical school was renamed the Hong Kong College of Medicine and admitted all nationalities. In 1907 a Chinese benefactor donated $50,000 for a College building on a site provided by Government, whilst a Parsee gentleman provided $180,000 for building a university in Hong Kong. The College of Medicine was merged in 1912 with the newly founded Hong Kong University. Many young
men and women from this region came to Hong Kong University to study Medicine, including the Past President of my College, Dr. Syed Mahmood who is with us today. Some years ago, I urged your then President, Dr. Peter Lee, to direct his considerable influence and energies to establishing a Sun Yat Sen Chair in General Practice at the Alma Mater that they share. I still hope that the venerable Hong Kong University will come round some day to commemorating its most distinguished alumnus in this way.

Sun Yat Sen was a man driven by the vision of making China strong once again by modernising its institutions. No doubt he had a great many reasons for his actions but the driving force behind such men is faith, faith in the overwhelming importance of their cause and a profound faith in their ability to achieve their goal. On different scales, this is true of all human endeavours. We are all moved by a mixture of faith and reason. Life would be psychologically intolerable if we were not able to devise a basis for our actions in both faith and reason.

The physician in the practice of his profession faces daily the dilemma of reconciling faith and reason. Physicians are denied the expedience of formally combining faith and reason in medical treatment. By training and professional socialisation in modern medical practice, the physician is expected to ensure that every therapeutic intervention is rational and has a secure scientific basis. It is acknowledged that there are gaps in our knowledge; nevertheless the most rational choice should be made and defended in scientific terms. This obligation placed upon the physician is underpinned by law as well as the ethics of the medical profession.

The sick person in contrast reacts on the basis of faith in the complicated interactions that exist with their physician. After all information has been provided, after all questions have been answered and informed consent obtained, their relations with their doctor, their response to treatment and their acceptance of the outcomes of treatment still rest on a bedrock of faith. A sick person suffers simultaneously from organic and mental dysfunction. Often the psychological component of an illness is more severe and more demanding of skills in management. The state of mind that exists in illness favours despair and dependency. The truth of this can be seen in the physician too when fallen sick and it is a familiar observation that doctors make bad patients. In sickness we
behave in a primitive manner. Expectations of treatment are not rational but magical.

The practice of medicine has its source in a primitive human need for an altruistic hand put out to help, possessing expertise that is not just technical but actually magical. I shall not speculate on the evolutionary origins of this need for magical interventions but it must have emerged together with human intelligence. Only in recent decades have we had scientific explanations of disease and powerful technologies for cure. For ages before that, even the simplest of human societies had a special place for the Healer - as Medicine Man, Witch Doctor, Shaman or Faith Healer. Faith - the power of belief - then had uncontested space to demonstrate its power. Even now we can see the successes of magical systems of healing in achieving dramatic relief in those who believe.

As practitioners of scientific medicine, we are quite aware of the power of trust and confidence, of the power of faith over reasonable expectations. Hippocrates observed that sometimes the sick person got better, not because of medicines but because of faith in the goodness of the physician. Modern medicine in theory recognises the importance of this phenomenon but treats it as alien territory in which it is wary of involvement.

There is good reason for this attitude. Medical science lacks the instruments to measure the power of unstandardised faith. It can only disprove crude claims to measurable outcomes. It has no way to teach faith as a tool in medical care. Finally, there is no way to delimit the area of its appropriate use. The practice of medicine can be protected from quackery only by restricting it to its scientific basis. Yet the fact remains that we cannot meet the expectations of our patients and their families unless we learn to cope with the element of faith that is such a powerful factor in our relations with them and in their response to treatment. We know that healing and repair of the human body is linked to the psychological wellbeing of the individual but we make only perfunctory efforts to deal with the problem of morale.

Our failure as a profession to satisfy the emotional dimensions of our patients’ dysfunctions has provided space for pretenders to the role of healer, ranging from outright quacks to purveyors of pseudoscientific systems of treatment. Sick
people seek the assurance of magic and modern medicine cannot offer this, so others meet this need.

The continuous interaction of faith and reason, I am arguing, is integral to the practice of Medicine. Let me explore a little further with you how I consider faith and reason to be the sources of human behaviour.

Mind introspecting on mind finds itself to be a marvellous end-product of evolution! The brain is truly a remarkable organ but it was not designed ad novo for its function. Rather it is the by-product of countless millions of modifications, adaptations, improvisations and extensions to an ancient design; it is a sort of brilliant outcome for a Rube Goldberg contraption. That means that a vast number of behavioural responses – to colours and patterns, to scents, shapes, sounds and tastes; and also to facial expressions, bodily movements and posture – are overlaid by layer upon layer of new patterns of behaviour that were selected by the environment over hundreds of millions of years of evolution. New behavioural responses emerging in evolution were not fresh replacements to the old but modifications of the old; the new carries within it traces of a succession of earlier adaptations. Much of it is a common inheritance with other life on Earth; less than two percent of genes separate us from the primates closest to us. There is a thread of continuity through the Universe. The laws governing the Universe and their contingent patterns are embedded in all phenomena, from the sub-atomic world to consciousness to the galaxies.

A trace of that continuity in evolution can be seen in the embryological development of organisms; you may remember the dictum that ontogeny recapitulates phylogeny. We recognise that evolution has favoured the greater advantage as a trade-off for a small loss. The long, vulnerable recurrent laryngeal nerve is a small hazard when compared to the considerable advantage of having a neck to move the head. In contrast, evolution has not caught up with that vestigial organ, the appendix, which carries a small risk to survival without a countervailing function in mankind’s more recent environment.

There are equivalent adaptations - whether suited or not to life in contemporary society - that are incorporated in the genetic make-up of the human mind. They affect human behaviour and are not as readily apparent. With the emergence of consciousness, natural selection would operate to promote changes in human
behaviour that favoured the development of culture. Our understanding of the genes that determine human behaviour is growing very rapidly. It is only half in jest to say that we fall in love on phenylethylamine, stay married for oxytocin, work for endorphins, and enjoy life on dopamine. In order to selectively implant those values that sustain culture, a prolonged childhood and intense socialisation within the family and in school is required. In the long and hazardous journey of the human species from beast to barbarian to civilised human, the man faced the jungle and the woman faced the city. We are the inheritors of countless ancient patterns of behaviour that reside in inaccessible niches of our mind. Culture selectively consolidates them into masculine and feminine, and the dominance of the feminine element has made culture possible.

Human behaviour is the product of three sources of inputs - biological, cultural and ideological. Each of these sources dominates in certain behaviours and in certain situations. Biological evolution adapted the human phenotype to a particular niche of life in the wild. Culture emerged in response to the needs of life in an agricultural community. The human species has not evolved for life in large, crowded groups in urbanised, industrial society. Ideologies are our way of resolving the tensions and conflicts of these new ways of living that have emerged, beyond the capacities of biologic evolution to cope and swifter than our traditional cultures can accommodate.

Evolution has given us a set of behavioural responses that may loosely be referred to as instinctive. Culture emerged as an intuitive response to solving the problems of domesticated living in small communities. Ideology is the attempt to intellectually derive solutions to the vastly more complex tensions and conflicts of life in large groups with greatly different social dynamics. By ideology, I include economic doctrines such as capitalism, communism and socialism, political systems such as democracy or fascism, as well as movements for social justice such as feminism or for the environment or other forms of civic action. These movements are intellectually derived solutions to specifically analysed problems and they seek to win acceptance not by appealing to faith but to reason; at the least, they seek to rationalise their arguments.

Culture is essentially based on faith whilst ideologies rely on reasoning. Culture is value laden and gender specific whilst ideologies are value free and gender neutral. By faith, I mean the intuitive adoption of beliefs and behaviour on the
basis of custom, tradition or authority, not requiring reason as justification. By reason, I mean debate and discussion, relying on logical argument and objective observations as the basis of beliefs and behaviour. Not having been reasoned into a belief, we are not to be reasoned out of it; it is ours as a matter of faith. “The heart has its reasons”, said Pascal, “that reason knows not”. Faith in this sense covers a broad range of beliefs and behaviours, from love to the Faith (with a capital F) of religion. The most important things in our lives are matters of faith, although we may not think of them as matters of faith so much as belonging to the natural order of things. I refer to falling in love, marrying, caring for children, friendships, altruistic behaviour and belief in a divinity. Their roots in culture are deep, so deep as to find soil in our biological origins, so that we may be aware of it only as our conscience, or as an unarticulated consensus in acknowledging which we can only say, to borrow a phrase “That is so, is it not?”

The most powerful element in human culture that is based on faith is religion. The need to worship and the urge to seek divine intercession is so deep-rooted and universal that it must have a source in biological evolution. We readily admit that seeking food and the urge to mate are genetically driven. After Chomsky, we recognise that ability to master a common linguistic grammar is an intrinsic faculty of the human brain. Male-female bonding and nurturing the young is universal in the animal kingdom. Out of such ingredients, culture has generated universal human institutions such as courtship and marriage, the family, the prolonged socialisation of children as well as art and music, language and cuisine.

There is a similar shared need for the dimension of divinity in our lives but this is obscured by the distracting cultural differences in its manifestations: There is the austere monotheism of Islam, the personal god of the Jews, the Christian Trinity, the deities of the Hindus, the pious abstinence from God of the Buddha, and the prescription of conduct and ritual of Confucianism and in Shinto. The cultural characteristics of each religion on their own only make for strangeness to the outsider; what is so obviously sensible to the believer is just a little ridiculous to the unbeliever. It is the ideological superstructure of organised religion, expressed in its drive for conversion and supremacy that makes it alien and threatening to the outsider. Generic Faith, however, is inadequate to meet our personal spiritual needs. We need to believe in some One Faith, but there is nevertheless a care for humility in Belief. What religion we belong to is less a deliberate personal choice than the outcome of events beyond our control. It
depends on which country and ethnic group you were born into, what period in history, the religion of the conquering power, or the religion of the person who in that hour of need, puts out a hand to give food and shelter, provides education or just consoles. Even those whose ancestors were forcibly converted to a religion do continue to believe devoutly. It is likely that those who believe fervently in one religion have very similar personalities to those who believe equally fervently in another. Religious faith has deep and universal roots in the human mind that are the shared inheritance of the human race. It is the ideological overlay that separates us.

Whilst culture is rooted in biology, ideology grows away from our biological inheritance so that there is constant tension between ideology and culture. Modern society is too complex for the traditional solutions of culture. Each generation has to devise ideological solutions to the continual challenges of a changing social environment. Culture and ideology are continuations of evolution in an intelligent, conscious organism that is the human being, with a vastly expanded capacity to shape its environment. Biologic evolution operates over thousands of years and hundreds of generations. Cultural change occurs over hundreds of years and tens of generations. Ideological innovation can happen in tens of years or in a single generation. Ideological change is a swift, improvised response to technologically-determined societal change and is as transient as that technological era.

Whilst culture reflects a consensus, ideologies reflect the unreconciled responses of social groups under stress of technologically-generated societal change. New societies yet to emerge will generate new ideologies, and new tensions between culture and ideology will be generated unceasingly. As technology becomes more and more the principal determinant of human behaviour, these tensions will grow and place great stresses on the individual and on the institutions of traditional culture. Already in our tune, you can see how ideologies, in the broad sense I am using the word, have undermined ancient human institutions which are central to our culture, such as marriage, the family, and the lifelong commitment to bring up children. The consequential uncertainties in personal relationships introduce tremendous emotional strains into modern life. Last year several nations moved to allow women in combat positions in their armed forces. This year saw a grandmother give birth to her own daughter’s child through in-vitro fertilisation. This week saw a man and a woman work together in space to repair an orbiting
telescope. Next year we will know enough of genes to predict which among our children are likely to develop breast cancer or colon cancer. On the horizon lies the possibility of altering the human genome and of cloning a human being. This is only the beginning and we will need all the ingenuity which our highly evolved brains are capable of, if we are to preserve our sanity.

What has the physician to offer in the highly stressed life that is the inexorable destiny of the human species? Anxiety and depression are endemic in modern society and accompany every illness. Their management requires both counselling and chemical intervention. That is to say, we have to deal with emotions as well as with disturbed neurochemistry. Invariably our failure is in coping with emotions. The root cause of that failure is that physicians are relying on a one-dimensional view of the human situation.

The preoccupation of modern medicine with chemical interventions and technical procedures has overshadowed the essentially humane character of our discipline. The profession of medicine is being infiltrated by technology and by business; by mechanics and tradesman in white coats. Their impact is irresistible and Medicine will partition into functionally separate disciplines. The tradition of the physician qua physician will rest upon the physician as care-giver. That means a relatively smaller but more expert profession that is committed by vocation to always put first the interests of the men, women and children in its care, thereby earning their trust and confidence. This is no easy task but if they are to have faith in our reason, we must give them reason for their faith. We have to find a way between faith and reason that will enable us as physicians to regard each fellow human being in our care as a whole person and not as an assemblage of deranged organs.

That is the way to recovery of faith in the physician. The physician will need to acquire – by training, by learning and by experience – a very much deeper understanding of the complex roots of human behaviour, and indeed of his or her own reactions to events, situations and personalities. The profession of healing needs a special temperament and character. It requires men and of goodness, of culture and learning, who possess experience with the lives of real people in the real world.
Rapid technological advance makes for overconfidence. Generations of man that have forgotten the perils of hubris are inheriting the earth. We need reminders that just as there is in the certainties of faith, there are gaps in the certainties of reason. Life on earth occupies for a moment of universal time, a niche on the crust of a minuscule fragment of an anonymous universe governed by the indifferent forces of nature. Our free will is a precarious ledge on a treacherous cliff face. Speaking to an audience of physicians, I need not remind you how privileged we are to have intimate access to the human mind and body at birth, in life and at the leaving of it. This calls for humility. It calls for a realisation that we should bring to the practice of our profession not only expertise but also wisdom, not only knowledge and skills but also caring and compassion, not only being observant of signs and symptoms but also responsive to feelings and emotions, and manifesting not only love of reason but also sensitivity to faith.
Family Medicine, Healthcare & Society:

*Essays by Dr MK Rajakumar*
Our profession is facing a crisis. We can see this in the panic reaction of doctors responding to the threat of managed care. Serious division within the profession and tremendous animosity generated between friends have emerged over this matter of managed care.

For some time, there has been a deterioration in the ethical traditions of our profession. Community expectations of our profession is high, perhaps unreasonably high. They expect doctors will treat first and think of payment later. They do not expect this of other professions.

Remember that if we behave like ‘trades people’, the community will treat us as ‘trades people’. Conversely if the community treated us like ‘trades people’, we would tend to behave like ‘trades people’.

This is part of the challenges we face today: How do we preserve the values that have made our profession unique and special?

The community sees doctors in different ways. They expect us to practice as scientists – scientific medicine with modern technology. Some expect us to be the ‘saint’, but sometimes, they look at a doctor and say he behaves like a ‘shopkeeper’.
A correspondent in the *New England Journal of Medicine* (April 1996) says, “...We forfeited the moral high ground long ago when we let our own desire for private enrichment displace our commitment to service... We sold out ... We cultivated the industry of money making. Under the old system, we over-used resources because it was to our financial advantage, we will underuse them now.”

There have always been conflicts of interest, in dispensing, pressure on cost, pressure on referrals, pressure on sick leave, ownership of hospital, ownership of diagnostic facilities and now private hospital marketing. Private hospitals in primary care threaten destruction to the economic basis of the GP in this country.

The saving grace of our profession in this country is the Ministry of Health (MOH) hospitals – the ‘Crown Jewels’. These hospitals have to set the standards of excellence for the private sector. They provide health care to the vast majority of the country. This group of doctors, who have been insulated from commercial pressures, represents the practice of medicine at its best, with the spirit of good practice, long hours of work, not taking annual leave and ridiculous salary. It’s troubling that this country that can stand up to great power and fund big projects cannot pay government doctors enough to retain them so as to provide a decent level of services to the majority of the people of this country.

There are different methods whereby a doctor is remunerated: Salary (40-45% of our doctors are salaried), capitation (the British National Health Service works on this method), fee-for-service (private hospitals work on this with discounts for certain clients) and profit-sharing (hospitals take part of the profit of the specialist). Let not someone in one mode of compensation claim to be ‘holier’ than others.

I believe there has been a serious misunderstanding by investors in Malaysia regarding prospects in managed care. Great fortunes have been made by managers or investors in the USA. They think great money could be made here in Malaysian health care. But primary health care in this country is poorly paid; whilst hospitals are well-organised and specialists are in short supply. These managers or investors are misled if they think that there are great fortunes to be made. The overheads of private health care are very high – 20-30% (profits, salaries and cost of running; non-profit plans use less than half the amount: US non-profit plan – 6%; Medicare – 2.1%; Canada – 0.9%).
In the US, managed care has been irresistible. Three out of four doctors have converted at least part of their private practice and are involved in some types of HMO activities. 40 million people are in HMOs but 40 million people in US have no insurance cover.

The ‘Medical-loss ratio’ is the proportion of premium money spent on health care services. They consider this as the loss. So, to make more profit, reduce the loss. ‘Risk management’ is management to reduce medical loss (Total medical costs = utilisation x service cost). So, one way to reduce ‘loss’ is to get physicians to share risk. Certain HMO-type organisations offer incentives to physicians to share risk and also have various forms of utilisation and to punish those who over-utilise.

The strategies of risk management of a for-profit company are to advertise to the rich, recruit from the young and fit, share risk with the providers and give incentives to the physician to reduce utilisation of services. As a result, states in the US have passed laws stating that not more than 25% of doctors’ income can come from incentive payments.

There are restraints in managed care: Allocation of time, referral for second opinion, use of investigation, choice of drugs, admission to hospital, discharge from hospital, release of information and confidentiality.

**Two extreme examples of Managed Care**

*For-profit Managed Care (in US)*

A month-old girl with ALL was referred for bone marrow transplantation to a ‘preferred provider’ in another state although the physician preferred a local university centre. The mother had to give up her job to accompany the child. Since they could not afford health insurance, they gave it up and applied for Medicaid. The father could not see the child because the treatment for ALL was 6 - 18 months. The elder sister had to be sent to relatives to be looked after. When the time came for second course of treatment, the provider had been changed again to another provider. The end result was the family exhausted all their savings and had to sell their house to make ends meet.
Not for-profit Managed Care (in UK)

A six-month-old girl with motor and sensory neuropathy was in intensive care on a ventilator for one year with no possible treatment for her condition (they discovered this after they had put her on a ventilator while investigating). The regional health funding authority decided she deserved the experience of home life before she died. They set up intensive care in the home and she remained on a ventilator for 18 months before she died. The cost of home care was £160,000. The health authority met it because they are not for-profit.

Here, we can see the huge difference in the attitudes that are brought to bear on decision making in health-care depending on what your starting position is. The not for-profit managed care in UK was a civilised decision but no society can afford such an expensive choice. My point is that it is better to err in this way.

The general practitioner under managed care has increased responsibility and diminished autonomy. In UK, they are under ‘fund holders’—they have increased autonomy and they can negotiate with hospitals and get better service for the patient. In US, there is the ‘gate keeper’ system (because there is no family doctor system) and in New Zealand, the ‘coordinated care’ system (a variation of fund holding).

The role of Managed Care Managers

Quality: Desirable, acceptable demands

If the community is going to pay, they have the right to demand certain standards of excellence: equity, accessibility, patient satisfaction, cost-efficiency, rational management, justified outcomes. By rational management, I mean care that reflect guidelines or consensus that is evidence based.

Patient’s right
- choice of personal family doctor
- choice between competing health plans
- referral to most appropriate specialist or institution
- confidentiality
Doctor's right
- professional autonomy
- professional quality assurance and audit
- professional credentialing
- fair remuneration

Legislation on for-profit Managed Care

There is need for legislation to control all elements in health care. I would like the following:
- independent quality assurance and standards organisation (let QAP remain professional and not let businessman come in to set standards)
- separation of ownership of primary and tertiary care facilities
- confidentiality

What to do

1. Organise - every health district needs an organisation (an independent practitioner association, a charitable trust) to receive funding from the National Health Authority to look after the welfare of the people in the district. We will need new types of organisations and new skills to meet these new challenges.
2. Cooperate - cooperate with National Medical Association, Ministry of Health, community (unions, consumers or elected representatives of the people) and with other sections of the profession.
3. Negotiate - This requires expertise that we do not now have. Professional managers will be needed.

The delivery of health care will change in response to changes in health financing. Medical practice will be seriously affected as cost accountability or cost containment become determinants between alternative treatments. We have to respond positively and proactively in the interests of our patients, the community and the profession.
15.
Looking Back, Looking Forward

January 2000, Edited: March 2008

PART ONE
Preface
On Being Human
Sharing the Earth
The Politics of Globalisation

Preface

If I were to state a First Law of history, it is that history does not teach us how to anticipate the future. The lesson we must learn is that the future will be full of surprises; the best we can do is to prepare ourselves to cope with the unexpected. In this essay, I am taking advantage of the spirit of renewal occasioned by the beginning of a new millennium on the Christian calendar, to share my thoughts as a Malaysian, and as a citizen of the world. I refer to the unpredictable historical routes that have brought us to our present situation. I am trying to identify new ways of thinking that are essential for the survival of the human race, as well as for the survival of our country.

On Being Human

In the centuries of human history, nations have emerged and disappeared, and populations have shifted. Great empires have collapsed, while small countries
became powerful. All our ancestors, at some time, have been the oppressors or the oppressed, the exploiters or the exploited. The human species has travelled a long distance in a few thousand years. Beyond that, we should look back with gratitude to our ancestors, the small African tribes that left Africa some 100 000 years ago, and spread all over the globe. These ancestors brought with them the gift of language, the institution of the family and the tribe, the inventions of fire and farming, enabling us to survive the hazardous journey to civilisation.

In the course of human civilization, our ancestors have belonged at different times to different tribes and held different faiths. They moved freely over the face of the earth for many thousands of years, until the emerging modern state shut its borders just a few hundred years ago. Our culture and cuisine, the way we dress and the words we speak, carry the imprints of our pluralistic pasts. We cling to trivial tokens of our differences, but we are all children of a remote African mother.

We have reached an era of extraordinary and rapid change, driven by technological advances that are transforming the way we live, and how we relate to one another. Stability is an illusion. Changes that were spread over a few centuries in Europe have happened within a few decades in Asia. Like astronauts in space, we are not aware how fast we are travelling.

The human race shares a common destiny - on ‘spaceship earth’ - in our precarious existence in an infinitely vast, indifferent, universe, on the fragile crust of this tiny planet - ‘the third rock from the Sun’. Humanity has the capability to eliminate hunger and most diseases, and raise educational and cultural levels of all the peoples of the globe. We are incapable of performing these wonders because our technological achievements and skills have outstripped our moral capacities. Over a period of some ten thousand years, we have made huge technological strides, but our moral capacity remains at the level of the Palaeolithic family. The hi-tech modem world is not matched by an enhanced capacity to deal with the moral complexities that come with our new powers. We live in selfish, murderous societies. Masculine values have become dysfunctional in technologically driven societies. Humanity needs to intensify its feminine values to rescue it from calamity.

I am speaking not only of the morality of private life, but of ethical behaviour in human relations that we mould defiantly attach to our sense of what is right, just,
and fair. I have seen the collapse of communism, and I await the crisis of capitalism. Humanity has no future with social systems based on hate or greed.

Morally and ethically, we have responsibilities and obligations as members of the human race and citizens of the world, citizens of a State and members of a community, as well as belonging to a family. To each of these roles, we bring values, attitudes, and commitments, largely determined by ethnicity, religion, and education. These, you might say, are god-given. We share our parent’s ethnicity and station in life, and with it their religion. What religion that is, depends on where and in what age your ancestors were born to be converted by persuasion, for rewards or by force, or out of sheer gratitude for a hand that was stretched out to help in a moment of need. Even those whose ancestors were converted by bribes or by force, have remained faithful.

We have good reason to be modest about ethnicity and religion. It is natural that our own religion appears so reasonable and sensible, whilst the strange faiths that others hold appear faintly ridiculous, if not irrational. Those who are overzealous in their separate faiths are likely to be of the same emotional temperament. There is a case for humility and forbearance.

**Sharing the Earth**

If globalization has a meaning, it is that we are One World - One People. Fast travel, swift communication, the pervasive access of mass media, and higher levels of education, has opened our hearts and minds to our common destiny on earth. However, what is on offer now is sham globalization. Poor nations look suspiciously at secretive negotiations inside the World Trade Organization, because they fear it brings back, in a new guise, the old colonial relationships. What passes off as globalization is a marketing tool of the powerful, to take commercial advantage of the weak. There is not to be free movement of people, no sharing of the burden of poverty or a fairer distribution of wealth, no global democracy, not even democracy in the functioning of the United Nations.

The obstacle to globalization is the modern state, with its utterly amoral pursuit of its interests. Powerful states are predatory on weaker states. In a world with an ever-widening gap between rich and poor countries, the task of the state is to retain and expand its share by any means.
Only late in life, have I come to recognize that the practice of politics is the art of deception in public life, and diplomacy is its extension to relations between nations. The functioning of the state needs politicians to cater for the dark side of human nature, to tell the necessary lies, and to mask with righteous indignation the acts of wickedness committed on our behalf. It follows that the public debate on global problems is hypocritical and deceptive; it treats the global audience as gullible and ignorant.

The antagonistic rivalries amongst states prevent the efficient and equitable mobilization of the limited resources of the world. There is enough to satisfy our need, said Gandhi, but not enough to satisfy our greed.

In the context of population growth and vast unmet expectations of the peoples of the world, the sharing of global resources is seen as a zero-sum game. The gap between rich and poor is widening, between nations as well as within nations. Within countries, the rich will fight to pass on their privileges to their children. In both developed and developing countries, the rich numb their conscience, live in private enclaves, work out of guarded towers, send their children to private schools, buy imported goods, seek treatment in exclusive hospitals, breathe air-conditioned air, and drink only bottled water. This is their response to living in a society with serious inequities and inequalities, where social solidarity has been sacrificed to economic growth, where a large underprivileged mass are at the walls of their private cities. There is an internal secession of the elite from the societies to which they belong. This is devastating to the cultural life of that society, and it undermines the transmission of the values and attitudes that are the underpinning of good citizenship.

The pursuit of privileged consumption, inspired and driven by the awesome power of Western media, has become the dominant cultural style across the ‘wired’ globe. Developed countries are heavy consumers of energy and raw materials. Meeting the demand for goods from rich consumers of the developed countries has generated much of the prosperity of developing countries.

The Western nightmare is the prospect that developing countries will try to join them as high consumers. Rapid growth in developing countries means increased consumption of grain and meat, and an increased demand for power and raw materials. The competition for global resources will sharpen as the people of
poor countries aspire to developed country standards of living. There is an ever-intensifying scramble for control of natural resources. We prepare for war.

The environment – ‘mother earth’ – will be subject to vastly increased depredation. It is not a matter of insufficient food. Malthus had it exactly wrong when he predicted that, as with animal populations, human numbers would outgrow food supply. It is over two centuries since Malthus wrote. In that time, world population has increased many times over, but the technology to increase food production has more than kept up. The prospects for producing food have never looked brighter, in spite of marked inefficiency in its distribution. What humanity lacks is the wisdom to share food justly, starting with those who are simply starving. The environmental crisis of over-population is not from food shortages, but from the effects of excessive consumption of a variety of goods and services by an overweight, indolent minority.

Additionally, in a profound sense, the inhuman scale of human existence threatens our sanity. Human beings are unfitted by evolution for life on the scale of the city; we are too crowded for a humane existence. Our species also occupies too much ecological space. We put ourselves in competition with all life on earth, so that all other life stands to benefit from our extinction. We have a limited span of life on a dirty, overcrowded earth, but we have insatiable greed to own and consume more, even if others go hungry within our sight – ‘another day in paradise’.

To save the global environment of this tiny globe that we perforce have to share, we have to learn to moderate consumption to sustainable levels. That means rediscovering the virtues and values of the simple life. To preserve our environment requires a moral leap of the imagination by individual consumers everywhere in the world. Talk of sustainable development is mostly a diversion, because it shifts attention to developing countries that have the longest way to go in development. Sustainable consumption, in fact, requires lifestyle changes that will be resisted. Those of us who consume an excess of power, prefer to righteously protest against generating power for new consumers. If we occupy old land, we are indignant about new land being opened for new homes. It is much more demanding on us, individually, to learn to share, to practice charity, and live the simple life.
Developed countries that had the advantage of economic growth at low cost at the expense of the environment now want poorer countries to exercise restraint in growth, and share the cost of repairing damage to the environment caused in past centuries by their rapid economic growth. The wealthy of the world will defend to the death of others, their right to wasteful and excessive consumption of global resources; wealthy nations will go to war.

From the 16th to the 19th century, Western populations grew rapidly. A predatory West, fuelled by a combination of aggressive nationalism and religious fanaticism, used its superior armaments to occupy all the Americas and Australia, virtually wiping out the native peoples.

The relations of power are such that the powerful will have their way with the weak. Western powers until now dominated the world. I am dismayed to see the return of ‘gunboat diplomacy’, half a century after the end of colonial regimes. Just as Athenian democracy, the Western model, did not preclude ownership of slaves, democracy in the West has thrived on the enslavement and exploitation of colonial peoples. The rise of China and India, and the reemergence of Russia, is changing the balance.

Last time round, Asia had a superior civilization, but the Europeans had superior armaments. This time round the West has even better armaments, and they have economic might as well. Therefore, we learn a frightful lesson: that the power to retaliate and inflict unacceptable pain on the threatening power is an essential condition for the preservation of national sovereignty. The Russians struggle to retain this capacity, the Chinese act on this assumption; the Indians are coming round to this view of the world, and the fractured Islamic world wish that were possible for them. We have made a bad beginning to the 21st century.

The Politics of Globalisation

In such a world, the pursuit of a just global society and global democracy, and the defence of human liberties everywhere, cannot be left to governments. We need movements of citizens that organize themselves globally, a safe distance away from the proprietary or sponsored non-governmental organizations that occupy the field today. Only community-based movements of concerned peoples
can influence governments about the positions they take on behalf of their countries. The Internet has made possible the creation and functioning of such a community. We need to organize global movements of citizens, if we are to solve global problems in a civilized manner.

Western governments will clamour for democracy in an unfriendly authoritarian state if the beneficiaries are people in the opposition who are beholden to their interests and investments. They will be protective of tyrannies where the regime is amenable to their direction. We have the spectacle of countries that oppressed and exploited others, now lecturing them on human rights. Yesterday’s poachers want to be today’s gamekeepers. The defeated nations of World War 2 are more circumspect; we do not see Japan lecturing China on the human rights of people in Shanghai, or Germany lecturing Israel on its treatment of the Palestinians.

At the heart of the problem is the United States of America. Early in the 20th century, the United States was persuaded that its interests lay in an unshakable alliance with the old European imperial powers. Untrue to its own revolutionary tradition, it turned its back on the freedom movements that initially drew inspiration from the American Revolution. The US chose to take the side of the submissive tyrants of the developing countries. The US government rebuffed Mao Tse Tung and supported Chiang Kai Shek, fought Ho Chi Minh and set up Ngo Dinh Diem in power, and sought to undermine Nehru, Sukarno and Nasser. So it goes on till today with a new set of model tyrants for the Western-controlled media to exalt and glorify.

The future of the globe over the next half-century will be greatly influenced by the role the US plays in international affairs. It believes that to retain its excessive share of consumption – 5% of the world’s population consuming 25 per cent of its wealth – it needs to maintain permanent military domination of the globe. There is no military threat to its global dominance, yet it behaves like a guilty, insecure people under threat. It is driven by serious economic inequities but is indifferent to them. It has a broken down infrastructure but prefers to invest in the military-industrial complex. It has immense social problems, but sends its poorly educated youth to fight in other lands.

The US also generates a vibrant popular culture that has unrivalled dominance over the hearts of our children. It leads the world in technology, and its graduate
schools are the finest. The Americans are the most dynamic society in the world with a brilliant capacity for innovation. They have an amazing capacity to attract and nurture talented people from anywhere in the world. And they dominate the Internet. In the United States, we see a testing bed for all our possible futures.

The world is full of potential friends, yet what does it do? It projects arrogance and intolerance. The USA goes round the globe playing the bully, conscientiously working to make enemies, whilst the Europeans play the good guy, and the Japanese search for a part for themselves. America has lost its moral vision, and the message it broadcasts to the world is that greed is good for you, but their greed takes priority. A great nation with a desperate craving for a great enemy to confront is a danger to the world.

It may be just that their foreign policy is still driven by surviving old men and their technicians, who are addicted to the adrenaline-highs of the ‘cold war’. The 60’s generation has been a disappointment. The demonstrations at Seattle against the World Trade Organization, proclaim the arrival of a new generation in the USA with new values and attitudes. Perhaps they will learn to direct their energies, intelligently and constructively into global concerns. Meanwhile, it is best that the Russians, the Chinese, the Indians, and the world of Islam, keep their cool, and small nations should mind their step.

If the United States were to suffer a great economic depression and a persistent decline in its standards of living, American politics can turn very nasty. The ingredients already exist in their society for the rise of right wing, anti-democratic movements, whose ideas could spread like wildfire to the rest of a world that also has been dragged down into a depression. Democracy is a fragile growth, imperfect everywhere, and if it came under threat in the US, then it is in danger everywhere. There is also the likelihood of a contrary reaction. The US also has a strong populist tradition. With an economic recession, I envisage powerful movements emerging that would stand for a more just and egalitarian society. That too could spread globally. As before in history, the contradictions and conflicts within a dominant civilization, will be reflected in the world, in new ways of thinking and in new ideologies.

The influence of Western culture, technology, and lifestyle permeate our lives, and western political institutions are the models for developing countries.
Nationalist movements, in their struggle for freedom, fought to win for their own people, the historic advances in human rights, soon after they were won in the West. The most important acquisition was the idea of a government formed by representatives of citizens, elected through universal suffrage. Two other important concepts were of a permanent, profession civil service and an independent judiciary, and of self-regulating bodies of the professions.

Conscienceless elites have taken over from the occupying colonial powers in the developing countries. They struggle to sustain gross disparities in the distribution of wealth that are incompatible with democracy. These cosmopolitan elite aspire to mimic Western lifestyles.

In public life, many in an older generation still suffer from a postcolonial hangover. You notice cultural cringe. It takes at least half a century after the end of colonial rule for a new generation to take over, whose terms of reference are not all derived from the colonial experience, and who think in the language of their own people. Their evolution into an educated middle class with close links to their people is a prerequisite for progress. The way forward will be tortuous and painful, but it will produce a cultural revival, which will enrich global culture, that will open minds to rationality, and produce an intellectual climate that is supportive of the development of science and technology. Nowhere is this happening faster than in our own region.

PART TWO

The Malaysian Dilemma
Ethnic Politics to ‘divide and rule’
The Failure of Nation Building
The Politics of Race
Reinventing Malaysia

The Malaysian Dilemma

Malaysia is in a strategically important region. To the east is China, and to the west. India. To the north are the countries of Indochina, and to the south are the Indonesian archipelago and Australia. The peninsula lies athwart the Straits of Malacca that links the Pacific and Indian Oceans. We are at the heart of the ASEAN region where our future lies. The ten nations of ASEAN have grown
very rapidly through external trade, but they have developed neither a common political culture nor a shared vision of their future. Like the rest of Asia, we have still to make the transition from a postcolonial entity to a national identity.

ASEAN is one of the fastest growing economic zones in the world, but the benefits of economic growth are distributed unevenly, and large numbers remain in poverty. The main beneficiaries have been urban populations. It is likely that metropolitan Bangkok, Kuala Lumpur-Petaling Jaya, central Jakarta, and Manila, like the city-state of Singapore, enjoy per-capita incomes that approach those of developed countries, but ASEAN has remained backward, socially, culturally, and politically. We have failed to develop the cultural infrastructure to sustain democracy, so that what passes off as elected governments, are camouflage for squalid tyrannies. You could look back at the past three decades as the economic golden age of ASEAN, but spiritually and culturally, these are still the dark ages, nevertheless the outlook for Malaysia is exceptionally bright.

Malaysians have a sense of wonder and gratitude that this is their country: a green land of breathtaking vistas, not subject to typhoons or earthquakes, without volcanoes, or deserts. We are rich in natural resources, and richer still in talented people. No great mountains and no great rivers, but we do have the greatest cuisine in the world. Our region has centuries of history as the home of trading nations. Malacca is the original free market of the world, where traders came from many nations to buy and sell. We are a small country, a separate country by accident, invented to meet the strategic needs of Britain, and historically the outcome of casually contrived compromises between European powers.

Our country is at the confluence of old civilizations that are mature and tolerant – Indonesian, Chinese, and Indian – and they have profoundly determined our cultural heritage. In recent centuries, the impacts of Arab Islam and Christian Europe have shaped modern Malaysia. We are the better off for having travelled with light cultural baggage, freely taking what we needed from the civilizations with which we have interacted over the past one thousand years.

Malaysia’s strength is its cultural diversity, our common inheritances that give this country its distinctive character. We are a nation of nations, who are discovering a shared destiny as one people. Our people bring complementary talents to the task of growing up together as a nation. We have a rich spiritual
heritage. Although religion elsewhere in the world has been used as a vehicle for hate and intolerance, religion in Malaysia has been a benign influence. From universalistic Islam, we learn of the equality of human beings, and to regard personal wealth as being held in trust. From gentle Buddhism, we learn the importance of good conduct, and to restrain our attachment to material possessions. From the sage Confucius, we learn the virtue of decorum, and of the importance of the family. From contemporary Christianity, we learn that we must love our neighbour, and to care for the poor. From Hindu philosophy, we learn that diverse spiritual paths lead to the same ultimate reality, and that we have the right only to morally correct action, and not to its fruits. We are a truly fortunate people. We should celebrate our diversity.

We have made astonishing economic progress. This country can reasonably aspire to enjoy the quality of life of some developed countries within the next 20-30 years. That makes it a shining star among developing countries.

I offer two more observations of our society as tokens of an even more impressive success. First, conventional wisdom had it that if growth rates in Malaysia fell below 4 per cent, ethnic conflict was inevitable. In fact, we have had minus growth during the recent Asian economic crisis, but there was no ethnic tension and no political party sought to exploit ethnic issues. If your car breaks down anywhere in this country even in the most remote parts, irrespective of your ethnicity, you may confidently go to the nearest home and be certain of receiving help and hospitality. Malaysians are an incredibly hospitable people. My second observation is that, in the midst of an economic recession and unprecedented political conflict, it is still possible for a prime minister of Malaysia to hold open house, to personally greet thousands of visitors. This is universally our custom, that on festive days, anyone can walk in unannounced to any home, and will be made to feel welcome. Can you think of any other country in this region, or in the whole world, where this is possible? In spite of our politicians, we have done well. Now, that is something to be proud of. It is a tribute to the wisdom and tolerance of our people.

So why are we in trouble?
Ethnic Politics to ‘divide and rule’

Malaysian politics is the entrenched politics of race. All channels for Parliamentary politics are through race-based parties. Since independence, the components of the ruling coalition have projected themselves as fighting for the rights of their respective communities. Their mirror image is reflected in the opposition parties. Every country in the world has some form of ethnic differences, many more severe than Malaysia’s problems. In those countries too, politicians have made a small living out of exploiting ethnic conflict. However, in those countries, the dominant leadership at least, have projected themselves as leaders of all the people. In this country, ethnic issues have been blown up to gargantuan proportions, and nowhere have politicians prospered so well by nurturing ethnic politics.

The origin of race politics in Malaysia goes back to the years before independence. The British colonial power was faced with a multiracial nationalist movement that was anti-British and under the influence of the communists. The British responded very successfully by mobilizing the Malay feudal families and the Chinese trading community, into race-based political parties as champions of the rights of their respective communities. The Malays were promised an entrenched special position with the civil service in their hands. The Chinese and the Indians were promised free access to economic opportunities. Racial politics took root.

The Alliance of Malay, Chinese, and Indian racial parties, whom the British nurtured, thrived under the umbrella of colonial laws that strictly regulated the Press and allowed indefinite detention without trial of their opponents. The colonial power harassed the nationalist movement and nurtured their collaborators to receive power. This is the background to the racial formula of the ruling coalition, and explains why civil liberties are not on their agenda. With the colonial laws at their disposal to use, dissension within the ruling coalition as well as outside could be brutally suppressed. Opposition politics is regarded as near treason. In the decade after independence, faced with a serious electoral challenge from a multi-racial, left wing opposition, these police powers were used to destroy them. That was the starting point, and what we see today, is a continuation of the same pattern of repression.
Paradoxically, at the same time in urban English-medium schools, British teachers were playing a contrary role. British teachers were culturally and educationally the best of the British that came to Malaysia; after that, it was all the way down to the civil service, and uneducated British in the plantations. These teachers were urging a sense of nationhood on the young minds under their care. Many of them are remembered with affection. After independence, the mainstream in the professions and the civil service, who were mostly English-educated, were comfortable across ethnic cultures and had good friends of all races. That generation has passed from the political scene.

The need to create an educated Malay middle class and, to bring them into commerce and industry, was recognized by all sections of Malaysian society. Universally there is support for this because the Malays were neglected educationally by colonial policy, and did not benefit from the economic growth of the first half for of the 20th century. This remains a matter of concern to all Malaysians, although it had been optimistically anticipated that the handicap would be remedied within a decade of independence.

Only a small proportion of the national product can be set aside, in practice, to achieve social justice. The mistake is to divert it mainly to subsidize the emergence of a few Malay billionaires, instead of investing in education of the new generation, and into supporting emerging Malay entrepreneurs in small and medium industries. The theory was that if you fed the best quality grain to the horses, you got better quality manure for the grass. It did not work out that way. The creation of handpicked Malay ‘bureaucratic capitalists’ to take over and own productive assets of the state, resulted in risk-taking behaviour without personal risk. We have seen the outcome.

**The Failure of Nation Building**

From the perspective of national unity and nation building, the most important task that confronted the educational system at independence, was to remedy the inferior educational outcomes of rural schools, which was the cause of the educational backwardness of young Malays. There was nothing of greater consequence to our future as a nation. Yet over forty years of educational investment have yielded dismal educational outcomes, and produced several generations of school-dropouts with serious social problems. No one takes
responsibility for this failure. The truth is that rural education, like rural health, is a poor second to education and health in Kuala Lumpur and the main cities, where the wealthy elite have their homes.

Several generations of young people have grown up in an atmosphere of race politics that is poisonous to the idea of being a Malaysian. In schools and universities, young people separate into ethnic cliques. Few friendships are made across the ethnic divide. Young people are emerging from the universities, poor in skills, shallow in knowledge, narrow-minded, intolerant, and bigoted. This is the pool from which we draw our teachers, administrators, and professionals. Ethnic policies have prevented many brilliant young Malaysians from contributing to their fullest, and have driven others abroad to find a home for their talents. An iron curtain has descended among young people who are our hope for the future. We have polluted the springs of our nationhood.

Ethnic communities have withdrawn into their own cultural reserves, where they sustain a vigorous ethnic civil society. There is no forum for sharing our cultures, and the only common cultural activities are for Western culture amongst the English-educated minority. Within each ethnic ghetto, our young men and women single-mindedly pursue wealth and status. Our children are learning to survive in the world we created for them.

Whilst our political institutions remained stagnant, our country has changed as our versatile people respond to urbanization, industrialization, and to the onrush of information technology. Our people are familiar with the outside world; many have travelled abroad, or have been educated abroad. A growing number have been to university, and, happily, a large proportion of them are women. The media brings news of a swiftly changing world into every sitting room. We are a very different people from fifty years ago. The country has changed, but as elsewhere in the world, the politicians are the last to notice. On all sides, they scramble to adapt to the new circumstances that they have yet to comprehend.

The price of over-rapid prosperity has been the emergence of a new middle class, composed of all races, that is culturally impoverished and without a conscience. They disdain to accept the cultures of the other ethnic groups, adopting instead a mimic Western culture as their common ground. They have no values, but can put a price to everything. Friendships give way to ‘useful contacts’, altruism is
regarded as foolishness and compassion is seen as a weakness. They comfortably embrace corrupt practices, so that corruption permeates all parts of public life, and contaminates private life. There is total cynicism towards the possibility of virtuous conduct in public life. Intellectuals, mainly children of the same elite, have betrayed their mission, no longer articulating our conscience, or being sources of independent opinion and expertise. They are, instead, ‘guns for hire’, available to fluently defend the indefensible. Now the judiciary has been contaminated.

It is not surprising that corruption has flourished, that politicians felt safe to invest all their energies into making themselves rich beyond the dreams of avarice. Corruption has been institutionalized so that civil society is dominated by the successful corrupt. Corruption overflows, trickles down. Civil servants had the example of their political masters. The existence of wide discretionary powers and administrative law made the temptation of easy money irresistible. To many businessmen, corruption was a bizarre blessing, because decisions could be expedited at modest extra cost. ‘Nothing is easy, but nothing is impossible’.

To change this corrupt environment requires much more than laws. It requires a rediscovery of moral values. We desperately need examples, models in public life to emulate. Nothing would be more powerful as an example to all of us, than if you could safely assume that a good Muslim in public office, say a judge, was incorruptible, and could be trusted to be impartial. Most of us could think of one example of an honest politician whose religious faith keeps him honest, and there must be others, but it takes an effort to think of another one.

Clearly, we do some things right, we do some things well, and this is after all the season for millennial self-congratulation. I want, instead, to speak of our failures and of the grave dangers that lie ahead. I am proposing that we reconsider our approaches to building a Malaysian nation. I shall share my ideas on our country, the problems we have created for ourselves, and suggest some ways we can reconstruct Malaysia – re-invent Malaysia – for the very challenging times ahead of us.

I shall argue for the need for serious changes if we are to progress as a people, to take full advantage of technological advances, and to fulfil our part of the responsibility for the globe that we share with six billion other people. My limited purpose in this essay is to discuss the critically important issues that confront our
country. I wish to share my ideas on the way forward that we should follow. I believe that the stakes are great.

**The Politics of Race**

I must say that the race-based formula to govern Malaysia has, until now, worked out better than could have been anticipated from the experiences of other countries – at the cost of our freedoms. We had two opportunities to move away from race-based political parties. Once was when the avuncular Tengku, who was loved and popular, was our first Prime Minister. He was politically very strong at the beginning of his long term, and he could have got away with a lot, except that the Malays were very insecure at that time. The second opportunity came in the prosperous nineties, except that everyone was too busy making money to worry about the future.

Nor have we had much luck with visionary statesmen. Onn Jaafar, the founder of UMNO, a statesman ahead of his time and a Malay patriot, felt that the interests of the Malays would be best served by their leading a single multiracial governing party. The people who were to provide that leadership – the divisional heads of UMNO – rejected him. Mahathir has projected a vision of a developed country led by Malay managers and industrialists, but educated Malays who were to play that role, appear to be spurning this vision. The modernizing thrust in Malaysian politics has stalled.

The stability of the governing coalition has depended on the power of UMNO to regulate the behaviour of the other race-based parties in the coalition. UMNO could do this by virtue of its strength in the constituencies that returned its non-Malay camp followers. So long as UMNO could deliver the Malay vote, discipline could be maintained in the coalition. If the Malay vote can no longer be taken for granted, we face an entirely new scenario.

The deep split in UMNO, arising from the expulsion and trial of Anwar Ibrahim, could not be handled in the customary manner, by detention without trial and banning publications and organisations. Anwar Ibrahim’s defiant stance has profoundly divided the Malay establishment, marking a historic sociological transformation that has been in gestation over several decades. It has enabled the
emergence of a new coalition of opposition forces. Vigorous use of the repressive machinery of the state is constrained because Anwar Ibrahim has captured the imagination of a weary, disgusted people, and he has very powerful friends in the West, and the attention of supportive Western media. If only he could be presented as a ‘left wing, anti-American, Islamic extremist’, he would have been destroyed very swiftly, with little fuss.

We are witnessing a battle for the control of ‘UMNO Incorporated’, the heart of the conflict is the control of UMNO, and the opportunities for great wealth that it offers. There is now an establishment constituency for human rights. Some of those who were once strong supporters of the ruling coalition are discovering, in opposition, the vocabulary of human rights. The truth is that we are a trading nation, and the wealth of our ruling class is very dependent on exports, the stock market, and foreign investment. Therefore, our political masters, at this time, have perforce to restrain their normal reflex response to the sight and smell of opposition.

In the new political environment, it has become possible for an opposition alliance to effectively mobilize public opinion. Faced with massive disenchantment, it remains to be seen what strategy UMNO will use to rehabilitate itself. UMNO remains important but it has been deprived of its traditional weapons; it has been outbid on religion, appeals to racial sentiment could backfire, the threat of rioting would hurt their own economic interests, the Communists are no longer around to be a target, and Singapore is a poor substitute. The future course of Malaysian politics will hinge on how UMNO will adapt to the new environment.

Partai Islam, which is the core of the opposition, has been surprisingly astute in reassuring the non-Malays that their way of life would not be affected. They point, very effectively to the experience of non-Muslims in the state of Kelantan that they govern. Consequently, the DAP is willing to take a risk with its non-Muslim Chinese constituency by allying with the Partai Islam. The coalition may not last, but a thaw has set in, and no way will Malaysians agree to back into political deep-freeze. Partai Islam has made a dent on non-Malay suspicions regarding their true intentions. It is uncertain if they possess the faith and endurance to persevere in the historic task that they have taken upon themselves, to show to unbelievers the Islamic way to a new ideal in organizing society.
The danger always exists of conflicts of interests over wealth-generating opportunities being transformed into ethnic issues. I have in mind competition between big business interests or the career rivalries of employees in the public sector (including the universities) turning vicious and being elevated into a conflict of ethnic interests. The existence of a core of trusted persons in and outside politics is requisite to reassure our people on the rightness of major initiatives for change.

Reinventing Malaysia

We must have genuine multiracial coalitions in government and in opposition, as prelude to the emergence of dominant parties that include all races in their membership. For that to happen it must become clear to politicians that no more can any political party claim to be the sole spokesman for an ethnic community. That is a possible outcome of the present political crisis. It is the historic task of the majority community to set an example, to take the lead. We need the Malays, as the majority of voters to provide the leadership of both the governing coalition, as well as the opposition party coalition. Malay self-confidence in their ability to lead a multiracial state is the crux, and it is contingent on their educational and economic advancement. The Malay genius for political leadership may yet prove itself in the leadership of a plural society.

The role of government has to change. It has become the agency for private wealth creation. Its proper role is to look after the interests of the whole people, in particular those who need help to take advantage of available opportunities. The very difficult task that every developing country faces is to establish a state that is neutral between ethnic populations; this is prerequisite for the survival of the modern state. The state that cannot do that does not deserve to survive. The other task is to move beyond elite control of government to a participatory democracy. We need devolution of power to local authorities based on town-and-country units. That is where citizens can take responsibility for their own communities, as they have traditionally done, and can learn from their mistakes.

The State must encourage and actively support civic activity that brings together all ethnic groups. Existing professional organizations already provide such a model. The concept has to be extended to cultural and sporting organizations.
Government should preferentially fund activities that transcend ethnicity. In the same spirit, support for business should be directed towards encouraging multiracial enterprises.

Internationally, Malaysia has to lead ASEAN into strategic alliances with China and India, while constructing multiple links for technological development with the developed countries - USA and Japan, the United Kingdom and Europe. Our relations with Singapore and Australia have to be placed on a sensible, stable and constructive basis.

A preoccupation with education is the quintessential Asian value. Malaysian parents are obsessed with the educational performance of their children, and are willing to make great sacrifices to ensure this. There is a large national constituency in support of investment in education.

Malaysia needs massive investment in education. For any developing country, the most important occupation is that of the teacher. It is a measure of mistaken policies that teaching is a lowly regarded and poorly rewarded occupation. State-run schools have such poor reputations that a private school industry – from kindergarten to university – is flourishing to meet the demand for an alternative. Not even the universities can retain the best people in their service, and foreign universities have entered the business of providing tertiary education. The most rewarding profession is perceived to be that of the politician. When young people regard as their role models, not their teachers, but the politicians they read about, then you know we are deep in trouble.

We need quality in teaching, and good educational outcomes. The country must tighten its belt, and single-mindedly set about creating the finest schools in the world, particularly in the rural areas. The emphasis has to shift from awarding contracts for buildings and acquiring state land. Every country needs a few monumental structures, but for schools, as for hospitals and research institutes, you use comfortable, economical shells that can be replaced in response to the requirements of new technology. Our money should go towards getting the best teachers, and for the best teaching technology.

This new model school will be multiethnic, and incorporate all language streams in one place so that children interact in social, cultural, and sporting activities.
Our best skills should be used to create a cooperative spirit amongst young people, and encourage friendships between them. The teaching staff and the governing board would be judged on the performance of the students, and on their success in fostering a Malaysian identity. This would be an environment where Malay is the common language, and fluency in English is ensured. Those who wish to be educated in selected subjects in their mother tongues may do so in a superb environment. It is without doubt a very difficult beginning to make. I believe that the key to success is to make the schools so very good that they are irresistible to a majority of parents.

The funding and administration of the Universities should be entrusted to a Universities Commission, with a governing body appointed by parliamentary consensus, and receiving under the Constitution, a fixed proportion of the national budget. The universities should be able to recruit the best people from anywhere in the world to fulfil their responsibilities in teaching and research.

A parallel Research Corporation should fund and direct research through a chain of national research laboratories that recruit internationally. It is vital to form close links with graduate schools and research institutes abroad, particularly in the United States and the United Kingdom. Malaysia has to make very large investments internationally in the bright young minds that are generating advanced technology, so that we can keep track of new technology trends and development.

The impact of technology will transform our lives. Those who are unequipped to take advantage of the exciting new opportunities provided by technological advances, are condemned to poverty and backwardness. The most important resource we need to develop is our citizens. By importing large numbers of unskilled workers, we depress the incomes of Malaysians at the bottom of the economic pile to the benefit of influential but inefficient manufacturers. The availability of cheap migrant labour also retards the move up to technology-intensive industries.

To develop an indigenous capacity in science and technology, we need to attract highly skilled people to our shores. We should abandon policies that keep wages low by importing unskilled foreign labour. We need a variety of skills, including teachers and scientist. Good people are in short supply everywhere, and the best are in high demand in developed countries. Many foreign experts like the quality
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of life in this country, and they like our people; some might work here for less than they might get in a developed country. Without altering ethnic demography, we have to go all out to make Malaysia attractive to some of the best minds in the world.

A common culture emerges after a very long period of interaction and cultural intercourse between nations. Where there is compulsion, there is resistance. Our society needs a culture of tolerance. A distinction has to be made between private and public space. We need freedom in our private space to conform to our own moral standards, but in public space, we respect the moral sensitivities of others. We should always on the side of tolerance of behaviour that is not harmful to others. On this basis, we should actively involve ourselves in the social and cultural life of other ethnic groups.

Malaysians are unaccustomed to open debate of issues in the Press or in the public forum. We have the politics of threat, to which has been added the politics of abuse. Our people deserve to be treated with respect for their intelligence and judgment. We need rational, informed, and constructive debate and discussion of the issues facing our country.

That brings me to the importance of an independent press. With an educated people, we need the profession of journalism to be skilled and conscientious. Professional journalist should be the moderators of debate and discussion amongst the public, referee the conflict of expert opinion, and fairly and accurately report what is news. They have to avoid the temptation to jump in the ring, to make news themselves or to distort news to influence public opinion.

There has been a surge of energy in government and some good ideas, in response to the challenge of a serious opposition that has to be met in the next elections. Malaysia may be on the way to becoming a normal parliamentary democracy. This may mean more corrupt politicians, and more foreign intelligence manipulation. It could also mean a plurality of opinions in public life, the emergence of civic activity across ethnic lines, and freeing of the energy and intellect of our people.
Malaysians share a sense of wonder and gratitude that this is their country. Located at the confluence of old civilisations that are mature and tolerant – Indonesian, Chinese, and Indian – which have profoundly determined our cultural heritage, the region has centuries of history as the home of trading nations.

Malacca is arguably the original free market of the world, where traders came from many nations to buy and sell. In recent centuries, the impact of Islam and Christian Europe has shaped modern Malaysia.

With the successes in more recent times, we can take pride in our economic progress. This country can reasonably aspire to enjoy the quality of life of some developed countries within the next 20 to 30 years. That makes it a shining star among developing countries.

I offer two more observations of our society as tokens of an even more impressive success. First, conventional wisdom had it that if growth rates in Malaysia fell below 4%, ethnic conflict was inevitable. In fact, we have had minus growth, but there was no ethnic tension and no political party sought to exploit ethnic issues. My second observation is that, in the midst of an economic recession and unprecedented political conflict, it is still possible for a prime minister of Malaysia to hold open house to greet thousands of visitors to his home. This is universally our custom, that on festive days, anyone can walk in unannounced to any home, and will be made to feel welcome. Can you think of any other country in this region, or in the whole world, where that is possible? Now, that is something to be proud of. It is a tribute to the wisdom and tolerance of our people.
Race-based Formula

Malaysian politics is the politics of race. All channels for parliamentary politics are through race-based parties. Since independence, the components of the ruling coalition have projected themselves as fighting for the rights of their respective communities. Their mirror image is reflected in the opposition. Several generations of young people have grown up in this atmosphere of race politics that is poisonous to the idea of being a Malaysian. In schools and universities, young people separate into ethnic cliques. Few friendships are made across the ethnic divide. There are young people emerging from the universities, poor in skills, narrow in knowledge, intolerant, and bigoted. Ethnic policies have prevented many brilliant young Malaysians from contributing to their fullest, and have driven others abroad to find a home for their talents.

The origin of race politics in Malaysia goes back to the years before independence. The British were faced with an anti-British nationalist movement that was under the influence of the communists. The British responded very successfully by mobilising the Malay feudal families and the Chinese trading community as champions of the rights of their communities. The Malays were promised an entrenched special position with the civil service in their hands. The Chinese and the Indians were promised economic opportunities. That was the end of non-racial politics.

After independence, the mainstream in the professions and the civil service, who were mostly English-educated, were comfortable across ethnic cultures and had good friends of all races. That generation has passed from the political scene. The need to create an educated Malay middle class, and to bring them into commerce and industry, was acknowledged by all groups. This was a matter of concern to all Malaysians. Universally, there is support for this because the Malays did not benefit from the economic growth of the first half of the last century.

The race-based formula to govern Malaysia has worked out better than could have been anticipated from the experience of other countries. We had two opportunities to move away from race-based political parties.

Once was during the time of the avuncular Tunku Abdul Rahman, our first Prime Minister. He was so loved and popular at the beginning of his long term that he
could have got away with anything, except that the Malays were insecure at that time.

The second opportunity came in the prosperous 1980s, except that everyone was too busy making money to worry about the future. What to do? As Malaysia moves towards a “normal” parliamentary democracy, it could also mean a plurality of opinions in public life, the emergence of civic activity across ethnic lines, and freeing of the energy and intellect of the people.

We must have genuine multiracial coalitions in government and in opposition as a prelude to the emergence of parties that include all races in their membership. For that to happen, it must become clear to politicians that no more can any political party claim to be the sole spokesman for a community. The majority community has to set an example, has to take the lead. Malay self-confidence in their ability to lead a multiracial state is the crux and it is contingent on their educational and economic advancement.

Malaysia needs massive investment in education. For any developing country, the most important occupation is that of the teacher. It is a measure of mistaken policies that teaching is a lowly-regarded and poorly-rewarded occupation. State-run schools have such a poor reputation that a private school industry is flourishing to meet demand for an alternative. Not even the universities can retain the best people in their service and foreign universities have entered the business of providing tertiary education.

The most rewarding profession is perceived to be that of the politician. When young people regard as their role models, not their teachers, but the politicians they read about, then you know we are in deep trouble.

The country must tighten its belt and single-mindedly set about creating the finest schools in the world, particularly in the rural areas. The money should go towards getting the best teachers and for the best teaching technology. This school should incorporate all language streams in one place so that they interact in social, cultural, and sporting activities. This would be an environment where Malay is the common language but those who wish to be educated in their mother tongues may do so in a superb environment.
A very difficult beginning to make, but there are signs that there already is some thinking in the government along these lines. I believe that the key to success is to make the schools so very good that they are irresistible to a majority of parents.

At the other end of the spectrum, we have neglected the universities and research. The continuing loss of staff, and the pressure on remaining staff for unplanned expansion, has badly damaged teaching and research. It is not just a matter of pay. University appointments are often political appointments, more commissar than academic. The best people do not flourish in such an atmosphere. The administration of the universities should be shifted to a universities commission, with a governing body appointed by parliamentary consensus, and receiving a fixed proportion of the national Budget. A parallel research corporation should fund and direct research through a chain of national research laboratories.

We need strategic alliances in technology development with the United Kingdom, China and India. Our universities and research institutes must also link up with their counterparts in the United States, Japan and Europe. Massive funds have to be available for investment in promising technology companies within and outside the country.

The most important resource we need to develop is our citizens. We will need to attract foreign talent to our shores. We should abandon policies that keep wages low by importing unskilled foreign labour. We need a variety of skills, including teachers and scientists. Without altering ethnic demography, we have to go all out to make Malaysia attractive to some of the best minds in the world.

Local responsibility

The role of government has to change. We need devolution of power to local authorities based on a town-and-country unit. This is where citizens can take responsibility for their own communities, as they have traditionally done, and learn from their mistakes.

There has been a surge of energy in government and some good ideas, particularly in education, in response to the challenge of a serious opposition that has to be met head on in elections. As Nobel Prize-winning economist Amartya Sen has
observed, famines do not occur in democracies because governments are held responsible by the electorate. That might work for us, too.

That brings me to the importance of an independent press. With an educated people, we need the profession of journalism to be skilled and conscientious. Journalists should be the moderators of debate and discussion among the public, referee the conflict of expert opinion, and fairly and accurately report what is news. They have to avoid the temptation to jump into the ring, to make news themselves, or to shape public opinion.

Malaysia is at a crossroad. The world is at the threshold of technological leaps that will take us to the borders of the miraculous and the magical. Only a highly-educated people can participate in the new world that is unfolding before our eyes. We have to leave behind the senseless conflicts that belong to our past. We have to set our sights very high, to become a nation of culture, education and skills. We have to look for better quality people in public life.

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17.
Rural Health and Global Equity

Am I my brother’s keeper?

Keynote address. WONCA World Conference on Rural Health, April 30th - May 3rd 2002, Melbourne, Australia

Abstract
There are two worlds of rural health. In one, the targets are a better quality of life and longevity. In the other, it is subsistence and survival. This other world is not represented at meetings such as ours. Do we have an obligation to make our deliberations relevant also to the health needs of this poorer rural people who are a majority of the world’s population? Does the medical profession have a special burden of responsibility to be concerned about inequity and poverty? Do rural doctors in wealthier communities have a duty to show that they care for this other rural people? The time is opportune for an initiative on rural health where rural doctors and health centres in wealthier countries put out their hands to work with rural doctors in poor countries to help impoverished communities. This conference, following on our Durban resolution, could change good intentions into good deeds.

This meeting is for me also a renewal of many old friendships with people I respect and admire. I have travelled to Melbourne because rural physicians are the best audience that I have access to, with whom I can share my concerns about the world we live in. I am grateful for the opportunity to speak to you, and for the helpfulness of everyone I have related with in planning my visit.

I shall begin by speaking of the very diverse worlds of rural health, of the extreme poverty and bad health of our fellow human beings who live in the rural areas of poor countries. Then I discuss the indifference of rich countries. I shall argue
that physicians have a special responsibility, and that rural doctors are uniquely fitted to respond and be involved. Finally, I go back to the Durban Declaration where we pledge ourselves to a Global Initiative to Achieve Health for All Rural People.

Most of the people of the world live in the rural areas of poor countries. Less than a quarter of people in developed countries are in rural areas, whereas over three fourths of the poorer countries are rural people. For most of us present at this meeting, the issues in health concern quality of life and longevity.

For the absent majority in the rural areas of poor countries, the issue is subsistence and survival. The end of the ‘cold war’ also marked the end of competition to win the heart and minds of the people of the developing countries. The world entered a period of malignant neglect, increased poverty coinciding with great prosperity in developed countries. There was talk of ‘compassion fatigue’, even before compassion had been exercised. The very thought of helping poor people was tiring. The rural people of poor countries suffered most.

The rural poor of the world are farmers, and poor farmers can produce cheaply, but they are prevented from selling. Unexpectedly, it is a leader of French farmers who speaks up for them.

These poor rural people do not travel – except as refugees fleeing war, and then nobody wants them. When they flee to cities, they form an unwelcome underclass who are in the city, but not of it. When they seek to flee to other lands, they are received like criminals. We now look fearfully at the hungry outsider at our shores, and politicians know that they never fail, when they manipulate fear and hate for their private purposes. Barely two centuries ago, the modern state emerged and set about closing its frontiers. For the first time in human history, people can no longer move freely across the face of the earth. An iron curtain has descended between rich and poor countries.

Within countries too, the gap between rich and poor has widened, and in each country, the rich constitute a separate nation. Benjamin Disraeli saw two nations within industrialising Britain in the 19th century, and the world has entered the 21st century with the ugly division of rich and poor entrenched across the earth. Our conference addresses problems of rural health, but can we avert our eyes
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from the rural majority of the world that live in poor countries. Although the organisers of this meeting have made a special effort to get poorer physicians to attend, they are not represented here.

Their voices are not heard, so we have to speak up on their behalf.

The collective wisdom we have inherited in the scriptures of our separate gods, all teach us that we will be judged by how we treat fellow human beings. This is a cynical age we live in, and people need additional arguments as well as the power of example to be kind and charitable to fellow human beings.

Our biological inheritance has provided us the gift of altruism, a vital element in the survival of our species. The spiritual dimension with which we are endowed has enabled the emergence of civilisation, and recognises that caring for others, to make sacrifices for the stranger in need, are what makes us human. This is our feminine inheritance.

I despair of changing the masculine culture of testosterone-driven violence that is taking humanity, like so many Gaderene swine, down the slopes to our own destruction. If large numbers of women too were to abandon the virtue of caring that makes us human, then all is lost.

This is a difficult message in an age of possessive individualism. Humanity has slowly moved to destroy the qualities that make us human. The extended family, in which every child had access to two grandparents in addition to their parents, has dissolved into the nuclear, working family, and now the single parent family.

We live in a harsh, unforgiving world, and people have withdrawn into the solitary, mistrustful pursuit of personal interests. The initiative has passed to politicians who can successfully feed on our fears, and appeal to the worst elements in our nature. The rest are silent.

In rural life, there remains the chance to preserve some of the human qualities of fellowship and caring for each other, and to keep the family as a meaningful experience in our lives. This conference provides us with an opportunity to make caring part of our real life by helping the stranger in need.
Do physicians have a special responsibility to act on poverty and inequity? There is a collective consensus of every one of our associations that we do have a special responsibility, but individually we are trapped in a world whose only currency is money.

When I spoke on this vein at our first meeting in Shanghai, an Australian doctor in the audience later murmured in my hearing, that he just wanted to look after his own patients. I am sure there are days most of us could empathise with that sentiment. We are in many ways a demoralised profession. Struggling to practise good medicine in an unsupportive environment, we sometimes find the heavy burden of ethics and ideals to be just too much to bear.

Physicians are not people of special virtues, indeed some are tradesmen with medical degrees. We are selected mainly for our ability to pay for access to a medical school, and to pass examinations that tax the memory.

What makes us special is our work that moulds and tempers us, that requires us to care for others, and the expectations of our patients, who could not accept our care unless they trusted us to care for people like them.

I believe rural physicians have the temperament and character, the knowledge and skills, to help other rural people. When we met at Durban, South Africa, we proclaimed our commitment to a Global Initiative to Achieve Health for All Rural People. The time has come to make a start in delivering on our promise. In the past week, some of us have met to make proposals for you to examine, reshape, and take over. There have been consultations with the World Health Organisation, and the results are being presented to you.

There has been a sea change of political climate that favours the task of eliminating poverty. There are now more allies for us than ever before. There is a rising tide of passion and idealism all over the world, recoiling in horror at the direction the world is drifting. We naturally belong with these people who struggle in yet another endeavour to build a better world. There is a historic opportunity for the professions of medicine to demonstrate to the world that our tradition of caring does extend beyond our clinics and hospitals.
The United Nations made a Millennium Declaration in September 2000 pledging to spare no effort to free our fellow men, women and children from the abject dehumanising conditions of extreme poverty, to which more than a billion of them are currently subjected.

Nothing much happened, then a year later on 11 September 2001 that we witnessed that awful act of barbarism. The climate for aid would seem to have changed. At a UN meeting in Monterrey, Mexico, the rich nations of the world offered greatly increased funding to fight poverty.

Sad to say, it was not a reawakening of love and caring, or a renewal of Christian charity; fighting poverty, they explained, was the “best way to fight terrorism”. They would do the right thing, but for the wrong reasons. It was left to ecumenical groups to cry out that the heart of the matter was justice.

That meeting was coordinated by the World Council of Churches (WCC) in cooperation with the Lutheran World Federation (LWF).

The makings of a global alliance against poverty are now visible, and we are in a position to contribute.

The WHO is also an ally. Over two decades, we have succeeded in persuading them that family doctors are essential allies in bringing health to all the people of the world. Now they have decided to pay more attention to poverty, “Attempting to approach health as a means of combating absolute poverty.” Perhaps we can help them generate more enthusiasm for this task.

There are innumerable ways in which we could help, individually or collectively. Our associations can look at the example of the British Medical Journal. In a remarkable act of generosity, the BMJ offers free access on line. Richard Smith, its editor, now campaigns for the evidence-base of medical practice to be freely available on the Web. You cannot imagine the difference it can make to the quality of care provided by a lone physician in a remote practice.

Individually, we could all contribute a tithe for the rural poor in another country. But we could and should do more. Surely there will be some in this audience who have time and space in their lives to come forward to lead us all in a great
endeavour, to make a small difference to the vast problems of man-made suffering and the inequity of man to man, but a vast difference in the lives we touch.

I believe we can make a success of the Global Initiative to achieve health for all Rural People. We could bring a new approach that addresses global inequity as well as health.

I propose a new coalition of forces, starting with doctors and nurses, who are the face of medicine to the community, joining hands with teachers and technologists. Such an alliance brings together the core competencies needed to deal with the problems of poverty, bad health, and inequity. In each country, we should commence a dialogue with these allies, before extending ourselves to other global non-governmental organisations that share our vision.

To play our part effectively, we have to strengthen our organisations. We need a network of Academies/Colleges, university departments and rural health centres. Every Academy/College and Department of Family Practice should have a plan to help doctors working among poor people, both within their country and abroad. Let us form collaborative bilateral links for a pooling of experience and expertise that will have a beneficial multiplier effect on both partners. Experience in vastly different cultures and environments will make us better doctors and better human beings.

These are actions that are within our capacity. I believe there are many of you who want to help, if only there were a way you could relate to a greater enterprise to channel your contribution. Let us create these channels.

May I conclude with this thought: In giving a bit of ourselves to help a stranger in a faraway land, we bear testimony to our own humanity, and we enhance our humanity.
18. Achieving Equity through a Primary Care-led Health System

Plenary Lecture. WONCA Asia Pacific Regional Conference. 6 November 2003, Beijing, China

I am happy to have an opportunity to speak to the leaders of General Practice in this vast region. I am glad to be back in Beijing at this time, but I will have more to say about this.

May I begin on a personal note? When I came in the 80’s, as WONCA President, it was to advise on training of a new type of general practitioner for China, instead of the hospital-based specialist care for all complaints, and traditional medicine for the rural people. I found myself interacting with some very dedicated and intelligent people, who clearly knew what needed to be done, but nevertheless wanted my report to add weight to their views on the future.

Over a few more visits, the beginnings of a department of General Practice emerged at the Capital Medical University. A small hospital and a clinic tested out the new approaches, and I was most impressed by their enthusiasm. I helped to organise the first international conference of general practice to be held in China. I met with provincial health leaders who wished to have the same model for their provinces, but we had scant resources even for our Beijing program.

China at that time was reputed to have one of the most equitable health systems in the world. All this had changed when I came back in the early 90’s. This was the decade of a global infection that exalted greed into a virtue, and made money as the ultimate measure of personal and institutional success. Medical staff was under pressure to sell services to pay for their salaries, and for the maintenance of their clinics and hospitals. To survive, the small hospital I had previously
visited now used electronic gadgets and doubtful procedures to attract patients, whilst the clinic sold herbs and royal jelly; they still could not make ends meet. I can tell you I was heart broken, and felt I could be of little help to my Chinese friends, and declined further invitations to visit.

When I last came to Beijing, earlier this year, it was as a guest at a Harvard University alumni reunion. At that meeting, William Hsiao of Harvard Medical School spoke on the health services in China, describing it as one of the most inequitable in the world. I was greatly saddened, as his remarks confirmed my worst fears.

Now, once more, there is cause for hope. The winds of change are blowing through this great country. China has become the most rapidly growing economy in the world, and can, at last, afford to spend more on health. There is growing concern about equity, and the neglected health of rural people.

This conference is, therefore, most timely. I hope that our discussions will in some little way be helpful to their health planners, and strengthen the hands of our colleagues in primary care. I am especially pleased to speak under the auspices of WONCA which has grown so much since our humble beginnings.

**The Meaning of Equity**

All history is the struggle to build a fairer and more just society. Whatever our spiritual heritages, a common theme is to ‘treat others as you would wish to be treated’.

Equity is not a marginal philosophical issue, but central to human civilisation. Medicine is a moral enterprise, and the traditions of our profession are especially strong in our ethical commitment to treat all human beings equally, always placing first their interests in providing care to them. In health, the costs of an inequitable health system come in the shape of more illness, shorter lives, and failure to fully develop human potential. Neglect of any section of a people is reflected in poorer health for all. The SARS epidemic is a reminder that infectious diseases do not distinguish between rich and poor, nor does it respect borders.
A Global Crisis

All countries face some sort of crisis in funding health because of rapidly rising costs brought about by raised expectations of patients and their families, the high cost of new medical technologies, and inefficiencies in health delivery. Generally, I would say that United Kingdom, Canada, and Europe, have adopted the most civilised approaches in managing their health problems. Developing countries, tragically, have drifted into an inefficient and inequitable, commercialised and profit-driven, urban hospital-based system that seeks to market episodic primary, secondary and tertiary care. The focus is on profitable procedures, in a brutal competition for market share. This urban sector drains resources and personnel from the public sector so that the majority of citizens who cannot afford high costs receive very poor quality of health care from a run-down public sector. The rural people, who are still the majority of the population in developing countries, are very badly neglected.

Why Primary Care-led Health Care

Primary care-led means that the demand for care is driven by the needs and preferences of the local community. This enables health workers to share responsibility for outcomes with the leadership of that community. An organised, rational approach to problems can be designed to meet the specific needs of each community, beginning with public health measures. The experience and skills of a health team becomes available to a community. We must emphasise cost effectiveness, not merely cheapness.

Delivering Primary Health Care

Before you can deliver good care, you need enthusiastic, well trained and competent staff who have access to the necessary equipment and medicines. Health education, promotion of health, the prevention of disease, early diagnosis and treatment to prevent or delay complications, and continuity of care for chronic disease, becomes the responsibility of the health district. This health team of the health district has to be capable of providing care of quality for all health problems till the point when a few will require tertiary hospital intervention.
Primary care needs a defined population so that there can be accountability for the outcomes of the care that is provided. A health district of the appropriate size is the unit for planning, investment, and accountability. The health centres together with the community hospital constitute the functional unit of delivery of care. Each patient and family sees the doctor and nurse, working together, as the personal unit directly responsible for their care.

Making Friends, and Influencing People

The forces for inequity in any society are in the short term more influential than the voices for equity. As doctors, we need to patiently explain, educate, and win support for a transformation. Nurses in primary care are obvious allies. Public health doctors are that part of the medical profession that have always led in their commitment to Primary Health Care, and they can make the most expert case for a primary care led health system. Some have been co-opted into the present system, but many, especially teachers of Public Health, have remained loyal to the preventive values and approaches of their discipline. Public Health has lacked allies in clinical medicine, so we need each other. There are also eminent academic researchers, like Barbara Starfield of Johns Hopkins School of Medicine, who have been unflagging voices for primary care and equity.

Strategies

We need small beginnings before we can achieve policy changes that will initiate a transformation in values and investment policies in health. I propose that the budget allocations for health up to district level be separated for primary care from tertiary institutional care, and this be made publicly known. Only then can legislators and the community quantify the existing disparities, and measure progress that will be made in the future. The efficiencies of each sector are apparent and can be measured.

Tertiary care has to develop in response to the ‘push’ of primary care for services that it needs, not to invent and drive demand. The rewards for primary care, and for working in rural areas, must be greatly improved to raise the income as well as the morale of medical staff in primary care.
A Transformation

We are thinking in terms of a transformation of the health services of our countries. It is a struggle for the soul of Medicine. This is a task for the long haul, so we need patience and stamina to win people over. Our immediate responsibility is to enhance the competencies and revise the values and attitudes, of doctors, nurses, and others involved in providing health care. In training, we can help each other between countries, by sharing training resources. What I should like to see are programs in China, as well as in other developing countries, to test out primary-care led approaches to the delivery of health care. I am confident that our friends in other countries, with special expertise and resources, will rally around to help in seminal experiments to achieve equity in health in the poorer counties of the world.

I speak on a subject that is close to my heart. I pray that that my enthusiasm will be infectious to this distinguished audience.
Appendix:

Dr MK Rajakumar: A Brief Curriculum Vitae

Academician Dr. MK Rajakumar
MBBS (Malaya), AM, FASc, FAFP (Malaysia),
Hon FCFP (Singapore), Hon FHKCFP, Hon FRACGP,
Hon FRCGP (UK), FRCP (Edin)

Past Offices and Awards
1962-1975 Member, University Council, University of Malaya
1976-1995 Chairman of Council, College of General Practitioners of Malaysia
1976-1988 Member, Malaysian Medical Council,
1978 Fellow, Malaysian Scientific Association
1979 Chairman, Confederation of Scientific and Technological Associations of Malaysia
1979-1980 President, Malaysian Medical Association
1980 Foundation Chairman, Medical Association of South-East Asian Nations
1981-1983 President, Malaysian Scientific Association
1984-1986 External Examiner for the Fellowship Examination, Hong Kong College of General Practitioners
1986-1989 President, World Organization of Family Doctors (WONCA)
1988-1991 President, Malaysian Physicians for the Prevention of Nuclear War
1989 Visiting Professor, Tribhuvan University, Nepal
1989-1996 Member, Food and Drug Control Authority, Ministry of Health
1995-1998 Vice-President, Academy of Sciences of Malaysia
1996-1997 Adjunct Professor, National University of Malaysia
1996-1997 Honorary Consultant, University Hospital, University of Malaya
1997 Member, Committee on Quality Assurance in Managed Care, Ministry of Health
1989 Honorary Professor, Capital Institute of Medicine, Beijing, China
1999 Chairman, Organising Committee, 3rd World Conference on Rural Health
2003-2005 President, Academy of Family Physicians of Malaysia
2003 Award of Honour, Chinese Medical Association
2004 Senior Fellowship Award, Consortium of Thai Training Institutes for STD and AIDS (COTTISA)

Reports & Books (chronological order)
3. Specialization in Primary Health Care - Training for the new General Practice in Malaysia, Chairman of Committee, College of General Practitioners of Malaysia, 1979.
Family Medicine, Healthcare & Society:
*Essays by Dr MK Rajakumar*


8. Report of a visit to Beijing, People’s Republic of China to advice on Primary Health Care, May 1988, WONCA.


**Orations, Keynote Addresses, Lectures (chronological order)**


2. SMA Lecture: Ethical Consequences of Technological Change. Singapore Medical Association Annual Lecture. Singapore, 15th April 1983


4. New Perspectives in Family Practice. Hong Kong College of General Practitioners. Hong Kong, 13th October 1984

5. Contemporary Dilemmas in Medical Ethics. Evening lecture, Hong Kong College of General Practitioners, Hong Kong Medical Association. Hong Kong, 21st May 1985.


10. Dr Sun Yat Sen Oration: Between Fate and Reason: The Quest of a Physician. Hong Kong College of Practitioners. Hong Kong, 12th December 1993.
11. The Family Physician in Asia: A Man for All Seasons. 14th Wonca World Conference. Hong Kong, 10th June 1995.


Publications (chronological order)
3. Rajakumar MK. Problems of higher education. Suara Sosialis. 1971 May 24, pp 5-8
Family Medicine, Healthcare & Society: 
Essays by Dr MK Rajakumar
