Medicine: quo vadis

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Medicine has made rapid progress, but has it lost its direction? Medicine is but one of the factors on which the health of a community depends; others include sanitation, housing, education, and life-style. Developments in medical education and practice must take into account the needs of society, changes in demography, patient expectations, costs, and the importance of preventive medicine. While the humanities, communication skills, and medical economics are important, these should not be taught at the expense of a sound core curriculum and clinical skills, which may be declining. Can human kindness and understanding be taught? Role models may help, but are their numbers sufficient? Postgraduate organisations have been successful in vocational training, but 'professionalism' must be further nurtured. This concerns doctors' responsibilities and relationships with patients, colleagues, the profession, and society. Specialists and subspecialists are needed but so are the 'generalists'. The education and training of doctors must be done in the context of the overall training of health care personnel. The Hong Kong Academy of Medicine and its Colleges must have a significant voice in making decisions and policies that affect health and medical matters. A patient should be a satisfied patient and not a statistic or a client. Where is medicine heading? Let us pause, think, and then act to lead it straight ahead.

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Lord Horder, in his address to the West London Medico-chirurgical Society in 1949, posed the question "Whither medicine?" and replied "Why, whither else but straight ahead, forging still more weapons with which to conquer disease, taking still more toll of science in the interest of humanity, adding more and more culture to more and more learning, improving both the art and the crafts. Medicine has only just begun its task...."[1]

Porter[2] contends that no thinking person knows where "straight ahead" is. Taken literally, that may be true but in a broader sense, medicine has not deviated from its objectives: to understand, prevent, and cure disease, and to palliate. There has been significant progress in all these areas but much remains to be done. Along the way, we have been sidetracked by forces both within and outside the profession, but medicine is moving ahead.

Good doctors with high standards of medicine are needed to take the profession forward. The Hong Kong Academy of Medicine is involved in the education and training of doctors and dental surgeons, and the maintenance of standards. Its task is not easy. What are some of the problems?

Are we satisfied with our medical schools? Many would answer "no". Nonetheless, most medical graduates do well, but could they be better? There is perhaps no 'best way' to teach medicine. The curriculum reviews, which take place from time to time, endeavour to find a better way. This is a healthy sign because medicine does not stand still. Developments in medical education must take into account the progress of science: notably, molecular biology, changes in demography, the needs of society, patient expectations, costs, and the importance of preventive medicine. This would go some way towards meeting the criticism of the World Health Organization—namely, that educational planning for health professionals

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is isolated in most cases from consumer needs and the needs of health science delivery.[3]

The medical curriculum remains overcrowded. With the advent of the computer, need one remember so much? While the humanities, communication skills, and medical economics are important, these subjects should not be taught at the expense of a sound scientific core curriculum and clinical skills. A continuing decline in the latter among medical students in the United Kingdom has recently been reported by McManus et al.[4] The reasons for this are not clear, but could be related to changes in the National Health Service's organisation or in the medical curricula.

According to Weatherall,[5] present-day medical graduates are seen as deficient in the basic skill of handling sick people as humans, are poor at communication, and lack kindness. He said, "A core of facts required to practise medicine together with communication skills and an understanding of social and ethical issues can be taught and continued into postgraduate training. But, except by example, no medical school can teach a young person how to be understanding and caring. This can only come from experience of life."[5] Role models among teachers and senior doctors should help, but do we have a sufficient number of such leaders?

Horton[6] believes that graduate medical schools along the lines of those in North America would provide a more mature and humane doctor with a sound scientific discipline. Certain Australian medical schools have introduced such a system. This would not only increase costs, but can we be sure the graduate will be more compassionate? British medical schools and those using this system have certainly nurtured sound clinicians and medical scientists. Many schools have an intercalated BSc course and some provide an MD/PhD programme for students with a strong scientific inclination. This should be encouraged.

Whatever the curriculum, the direction seems clear. There must be a core of scientific knowledge and adequate instruction on clinical skills. In addition, guidance on critical thinking and the teaching of ethics, communication skills, social issues, and professionalism are important. Students should be computer-literate and this will put them in good stead in the ensuing years of postgraduate and continuing medical education and in research. More role models would definitely help. The advice of Hachinski[7] to a newly qualified doctor is worth remembering: "Learn to distinguish information from knowledge and wisdom. Information is overwhelming but largely trivial and retrievable. Knowledge is understanding, and wisdom cannot be taught but can be acquired."

Much of what I have said about undergraduate education applies to postgraduate medical education and training. In Hong Kong, this was not structured nor funded until the advent of the specialty colleges and the Hong Kong Academy of Medicine. But their task has just begun. The professional medical colleges, General Medical Council of the United Kingdom, and various health authorities have published excellent guidelines on both postgraduate and continuing medical education. Governments should recognise the importance of investing in training and developing their professional work force and should act accordingly. Time and facilities for educational purposes must be provided, and there has to be close liaison between the professional educational bodies and health and hospital authorities.

In general, vocational training has been a success, but has there been enough emphasis on 'professionalism'? Cruess and Cruess[8] state that this must be taught, beginning from medical school. It extends beyond the art and science of healing and involves integrity and responsibility not only to patients, but also to colleagues, the profession itself, and society. Senior doctors should demonstrate by example professional values in daily practice.

What about examinations? They are used to determine the success of education and training. Personally, I feel there are too many formal examinations which do not reveal how the person performs as a doctor. Surely, more time and effort should be spent on direct and continuous assessment, with counselling when appropriate. Of interest is the report by Holsgrove and Elzubeir[9] that multiple choice questions used in the United Kingdom, both in the MB, BS final and the MRCP (UK) Part I examinations commonly contain undefined and imprecise terms. Apparently, the true/false format has been largely abandoned in the United States. This preoccupation with examinations has also discouraged research and reflection at a time when the young doctor should take an interest in such matters. The research could be clinical; indeed, in the United States, increasing investment in clinical research that involves humans, with the aim to translate basic science into practical clinical knowledge.

What types of doctors are needed? Their education and training must be in the context of the overall training of health care personnel. After all, much of

medical practice nowadays is teamwork, involving colleagues in the professions allied to health and social services. As for specialists and super-specialists, one cannot do without them. Sir William Osler stated that "the rapid increase in knowledge has made concentration of work a necessity. Specialism is here and here to stay."[2] On the other hand, proportionately there should be many more primary care doctors and 'generalists'—after all, they see the majority of the patients.

In view of the ever-increasing importance of preventive medicine, this subject should receive greater emphasis in medical schools and be the specialty of more trainees. Doctors should remember that food, sanitation, housing, education, and life-style are perhaps more important determinants of health than medicine, vaccinating being a special case. What is the most important cause of preventable death? It is poverty.

What about continuing medical education? It is vital that doctors keep abreast of advances and developments in patient care. George S. Kaufman said, "The kind of doctor I want is one who, when he's not examining me, is home studying medicine."[10] The General Medical Council of the United Kingdom has again underscored the importance that doctors keep their professional knowledge and skills up-to-date and recognise the limits of their competence. Patients expect and deserve a high standard of practice.[11] Self-regulation within the profession is in place but has to be further developed. The public has recently lost confidence in the profession following incidents of medical misadventure or professional negligence. It is time that medical institutions and practices establish systems that will demonstrate to the public that standards are being monitored and maintained. Such systems should be able to detect, at an early stage, individual, team, or organisational problems that may compromise patient care, and to determine the appropriate action to be taken. The setting up of such a system of clinical governance merits our immediate attention.

Medicine was traditionally small-scale, disaggregated, restricted, and piecemeal in its operation.[2] This can still be found in Hong Kong. However, the remarkable progress in basic and clinical research, and the surgical and pharmacological revolutions have transformed medicine into a corporate enterprise.[2] With the passage of medicine from individuals or even partnership administration to corporate management, has medicine lost its personal touch? While the answer is in the affirmative, given the resources and will, this situation can be remedied. For example, in the case of internal medicine in Hong Kong, a coordinated system with primary care doctors, general physicians and specialists in which patients are cared for by the same team would go some way towards achieving this goal. Depending on the Hong Kong Government's policy, this could be all or partly public. At present, if the public system were to be more personal, more staff directly involved in patient management will be needed. The community desires this, but it will have to be prepared to meet the increased cost.

Corporate management has been mentioned. There is considerable disquiet that lay managers are dominating the profession. In view of the high cost of health care, efficient organisation and rational use of resources are mandatory. But medicine cannot be run as a business in the commercial sense—patients ask: "What can you do for me?" not "What can you sell me?" Therefore, health care personnel with a suitable background must be involved in a significant way in decisions on medical issues. Dare I suggest having a subspecialty of Health and Medical Administration within an Academy College?

Lastly, in the late 1940's Sir Stewart Duke-Elder and Lord Horder, among others, felt the need for a mechanism by which the medical profession in the United Kingdom could express itself as a corporate whole to the government.[1] They urged the formation of an Academy of Medicine but failed to get support. We are fortunate that the committee so ably chaired by Dr Keith Halnan was successful in persuading the Hong Kong Government, through the then Secretary for Health and Welfare, Mrs Elizabeth Wong, to establish the Hong Kong Academy of Medicine. This is the 10th anniversary of the Halnan Report. The Academy plays a vital role in medical education and training and in ensuring a high standard of health care in Hong Kong, and its influence should extend beyond this special administrative region. It can help medicine move forward. While the medical profession has its detractors, we should learn from past errors and must not lose faith in ourselves. Karl Marx, as quoted by Lord Horder, said, "For thousands of years medicine has united the aims and aspirations of the best and noblest of mankind. To deprecate its treasures is to discount all human endeavour and achievement as naught."[1]

In closing, I wish the Academy, and indeed medicine in Hong Kong, every success and the brightest of

futures. Since the future is in the hands of the younger generation, may I quote the late President John F. Kennedy? He said, "It is time for a new generation of leadership, to cope with a new problem and new opportunities. For there is a new world to be won."[12]

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