Family Medicine, Healthcare and Society:

Essays by Dr M K Rajakumar

Second Edition, 2019

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Preface

The articles in this collection were written by Dr M K Rajakumar between 1974 and 2007. This second edition contains twenty-one articles, five additional articles than the earlier edition published in 2008 (two articles in the first edition were omitted). This book is more than just a historical record of Dr Rajakumar's scholarly works. Although some of the articles were published more than four decades ago, the messages contained therein have relevance to family medicine, health care and society beyond Malaysia and the Asia-Pacific region.

The articles are grouped in six sections: primary health care and family medicine, postgraduate training in family medicine, and issues in health care and the wider society. To improve readability, we have provided explanatory notes for some terms and added full text links for key documents referenced by Dr Rajakumar.

For family physicians, this book shed light on the critical role our discipline play in the health care system. This book challenges us to reflect on the progress of family medicine in this country and to evaluate how well we, individually and collectively, live up to the principles so eloquently presented by Dr Rajakumar. Family medicine has strengthened its place in the health care system since Dr Rajakumar first wrote about it in the 1970s, although many challenges remain. As society changes with the passage of time, many of the principles he expounded appear to be under threat. We hope this new edition of his essays will energise the family medicine and primary care fraternity to meet the challenges.

Dr Rajakumar is an exemplary family physician. As reflected in his writings, his philosophy dwell beyond the confine of a 'GP clinic' to global healthcare and societal issues.

"Wherever the art of medicine is loved, there is also a love of humanity."

Dr Rajakumar lived by the above Hippocrates aphorism. Reading his essays strengthen our faith in medicine, our hope for the country and the world.

C L Teng
E M Khoo
C J Ng
January 2019

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1. The Academy of Family Physicians of Malaysia
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    - Article 3. Primary health for all the people. *Singapore Family Physician*. 1980;6(1):12-4.
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    - Article 14. Quality in family practice. Asia Pacific Family Medicine. 2002;1(2&3):74-8.
    - Article 19. Rural Health and Global Equity: Am I My Brother's Keeper? WONCA World Conference on Rural Health. Melbourne, Australia, 30 April – 3 May 2002.
    - Article 20. Achieving equity through a primary care-led health system. WONCA Asia-Pacific Regional Conference. Beijing, China, 6 November 2003.

CONTENTS

Foreword

It is indeed a great honour to write a foreword for this book containing articles written by the doyen of Family Medicine, Academician Dr M K Rajakumar. It is timely that this second edition is produced just after the tenth year of his passing. When the first edition of this book was published in early 2008, the MAFP/FRACGP examination was "recognised internationally but was still not recognised at home" (a constant reminder by the late Dr Rajakumar). Today, it is recognised as a specialist qualification and has been listed in the National Specialist Register (NSR). On a personal note, I am proud that he conferred the postgraduate degree in Family Medicine on my Convocation.

Dr Rajakumar had a tremendous passion for whatever he undertook. Being a leader with passion it led him to lead various organisations, both locally and internationally. He was Presidents of the Malaysian Medical Association and World Organisation of Family Doctors (WONCA), and was accorded many accolades. It was during his tenure as President of WONCA that the first version of International Classification of Primary Care (ICPC) was published. That was the type of foresight this icon of Family Medicine had.

In the words, of Dr Naomi Harris "The late Dr Rajakumar was a highly regarded, well respected WONCA elder, a WONCA President and a respected leader of Family Medicine in Malaysia and the Asia Pacific Region." His contribution to Family Medicine locally and abroad are still being remembered. The Rajakumar Movement under WONCA is one of the many examples – a movement set up to foster mentoring between current and future leaders in Family Medicine to promote continuity in the Asia Pacific region.

This collection of articles from 1974 to 2007 clearly shows his passion for Family Medicine and its delivery to the community irrespective of their status. At a time when the society at large apt to dwell on triviality, and the march of commercialization of health care continues unbated, it is sobering to read the philosophical ideals so eloquently put forward in his articles. Indeed, his ideas were way ahead of his time, and I am confident that they will remain relevant for a long time to come.

I sincerely hope that this book will continue to shape the minds of current and future generations of Family Physicians, and to energise them to improve our discipline further and strive to deliver the best possible health care to the community.

Last but not least I would be failing in my duty if I did not thank, Datin Seri Sunita Rajakumar, Prof Teng Cheong Lieng, Prof Khoo Ee Ming and Prof Ng Chirk Jenn for their untiring efforts to prepare and get this published.

Dr Harbaksh Singh
President
Academy of Family Physicians of Malaysia
February 2019

Foreword (in the first edition)

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 fundaments 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 (in the first edition)

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 everyone 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: Primary Health Care and Family Medicine

This section contains seven articles on primary health care and family medicine. The articles are arranged in chronological order (year of publication in bracket):

1. Put not New Wine into Old Bottles [1974]
2. The Importance of Primary Care [1978]
3. Primary Health for all the People [1980]
4. The Evolution of General Practice [1981]
5. Future of Family Medicine in Developing Countries [1983]
6. Family Practice: Uniting Across Frontiers [1988]

In 1974, Dr Rajakumar saw the need to create *"… 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."*

He observed in 1978 that, while scientific advances created the opportunity for the development of medical and surgical subspecialties, these advances also made possible cost-effective and efficient clinical care by family physicians in the community through wider availability of diagnostic tests and medical treatments. *"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."*

In 1980, two years after the Alma-Ata Declaration, Dr Rajakumar noted that the World Health Organization failed to highlight the need for well-trained family physicians in rural areas. He further offered several strategies how the family medicine community can rise up to that challenge. *"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."*

Dr Rajakumar traced the ancient origins of medicine and the family medicine discipline in *The Evolution of General Practice*. He implored the family physicians to reclaim their rightful place in healthcare but needed to be adaptive to the new and emerging technologies. *"…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."

In the *Future of Family Medicine in Developing Countries*, Dr Rajakumar reiterated the many challenges facing family practice in the poorer part of the world but nonetheless was optimistic of its potential: *"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."*

In *Family Practice: Uniting Across Frontiers*, Dr Rajakumar explained the importance of international networking for primary care leaders and family physicians. At organizational level, the WONCA has been actively working with the World Health Organization and UNICEF to promote health. He also pointed out the role of regional family medicine conferences that encouraged fellowship and shared learning.

1.
Put not New Wine into Old Bottles

Rajakumar MK. Put not new wine into old bottles. Family Practitioner. 1974;1(4):15-7.

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

Rajakumar MK. The importance of primary care. Family Practitioner. 1977;2(8):11-3.

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 over trained 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 sanitaria 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

Rajakumar MK. Primary health for all the people. Singapore Family Physician. 1980;6(1):12-4.

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 charlatanry 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.

The College must get recognition. In Malaysia we have found that it was necessary to get an Act of Parliament to establish the College as a body corporate. Many years of persuasion and explanation have at last culminated in a public declaration by our Government that an Act of Parliament is being drafted. We expect that this will be passed in the next few months. We have therefore over five years, succeeding in constructing the foundations for our activities. In the ASEAN Region, two countries are still without organisations of general practitioners, namely Indonesia and Thailand. These are large and important nations and I hope that they will have their own organisations in the not too distant future.

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 Medical 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* (see Article 8 in Section 2). 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 pf 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 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 hare 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

Rajakumar MK. The First William Pickles Lecture: The Evolution of General Practice. Family Practitioner. 1981;4(1):5-10 *[The William Pickles Lecture is funded by ICI (Malaysia)]*

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 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. Syndenham 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 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 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 specialities 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 United States 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 United States 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."

Let us take heed of the words of a great man who lived and died close to the venue of the next world conference.

6.
Family Practice: Uniting Across Frontiers

Rajakumar MK. Family practice: Uniting across frontiers. Singapore Family Physician. 1988;13(4):157-9

Dr M K Rajakumar, 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 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.

Section 2: Training for Family Medicine

One of Dr Rajakumar's great contributions was his proposal to initiate postgraduate family medicine training, reported in: *Specialisation in Primary Healthcare training for the new General Practice in Malaysia*. Due to his persistent effort, forward thinking and leadership, we now see trained family physicians in Malaysia (known as Family Medicine Specialists), the products of this postgraduate training in family medicine in universities and the Academy of Family Physicians of Malaysia that provided key roles in the rejuvenated "rural health centres" (now called *Klinik Kesihatan* or health centres in English). It is through his vision that homes the birth of the family medicine department in the university training in the country.

Although we can see his original proposal in most of the current postgraduate family medicine training programmes, we note that two of his suggestions have yet to be materialised:

- The general clinical training during the internship years to be counted as part of family medicine training
- Teaching practices to include private general practices (not just *Klinik Kesihatan* or health centres)

Dr Rajakumar's passion in family practice also drove him to promote postgraduate training in international arena, notably China (when he was President of WONCA). These are described in the following four articles.

Articles included:

7. Specialisation in Primary Healthcare training for the new General Practice in Malaysia [1979, 1986]
8. A Proposal for the Training of Physicians in Primary Care for the Rural Areas of Malaysia [1984]
9. The Family Physician In Asia: Looking To The 21st Century [1993]
10. Training family doctors in a developing country [1996]

7.
Specialisation in Primary Healthcare Training for the New General Practice in Malaysia [summary]

Rajakumar MK, Ahmad MD, Balasundaram R, Low BT, Tan FEH, Wan KC, Catterall RA. Specialisation in Primary Health Care: Training for the New General Practice in Malaysia. Kuala Lumpur: College of General Practitioners Malaysia, First published in 1979, reprinted with correction in 1986

In 1978, the Council of the College of General Practitioners appointed the present committee to define general practice in this country, to determine the content of vocational training and to plan the diplomate examination. The 30-page report has the following sections:

1. State of primary care in Malaysia. This section described the population of peninsular Malaysia, socio-economic data (e.g. poverty, household income), health indices (e.g. maternal mortality rate, infant mortality rate), mortality and morbidity data from hospitals and primary care (health centres and private clinics) and doctor:patient ratio.
2. The speciality of primary care. This section described the key characteristics of family practice: first contact care, continuity care and comprehensiveness of care.
3. Educational objectives. This section described the educational objectives of the vocational training for family practice with detailed lists of the expected knowledge, skills and attitudes.
4. Specialised training. This section described four stages in the training of a doctor: basic medical education (undergraduate), general clinical training (internship), continuing medical education (life-long learning), and specialised training. The report remarked that the one-year internship of hospital rotations was inadequate for family practice training, argued for broader selection of clinical rotations (including pathology, ENT, public health, etc). The specialised training is suggested to be two years at rural health centres or selected private clinics (teaching practices).

5. Syllabus. This section describe the content that should examined and divided into three areas: clinical medicine (general medicine, paediatrics and obstetrics), community medicine (preventive care, maternal child health, health laws, etc), practice of family medicine (including family, consultation skills, medical records, research).
6. Examination. This section proposed various components of the College membership examination including theory papers, clinical examination, practical examination (e.g. ECG, X-rays) and oral examination.
7. The future. This section pointed out possible areas of future development, e.g. new technology, special courses for family physicians, and the importance of research for every family physician.
8. Notes and references. References to curriculum in USA, UK, Canada, and Australia, and World Health Organization's Alma-Ata Declaration are made.

8.
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. [**see Note 1**]

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 United States, 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 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. [**see Note 2**]

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 modem 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 (Table 1) 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 [**see Note 1**]. It is proposed that (Table II):

- 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 (Table II).
- Initially, young doctors with two-year 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.

Note: Tables I and II are omitted.

Editor's note

1. Five-year plan refers to the five-year development plans initiated by the government of Malaysia as a tool of medium-term economic policy-making since its independence.
2. The New Economic Policy was a social re-engineering and affirmative action program formulated by the National Operations Council in the aftermath of a major racial riot (13 May 1969) in Malaysia. This policy was adopted in 1971 for a period of 20 years and it was succeeded by the National Development Policy (NDP) in 1991. Source: Wikipedia

9.
The Family Physician in Asia:
Looking to the 21st Century

Rajakumar MK. The family physician in Asia: looking to the 21st century. Family Medicine Education in the Asia-Pacific Region. Core Curriculum for Residency/Vocational Training and Core Content for Specialty Qualifying Examination. The Philippine Academy of Family Medicine, 1993. [Published in the Filipino Family Physician in 1993]

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 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.

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.

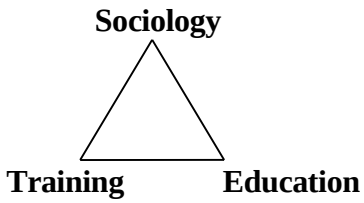


Fig 1. The Competencies Required of the Family Physician

1. 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.

2. 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.

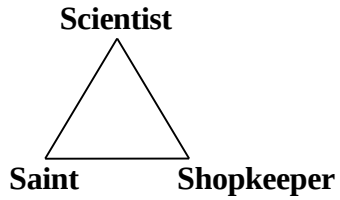


Fig 2. The Roles of the Family Physician

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.

10.
Training family doctors in a developing country

Rajakumar MK. Training Family Doctors in a Developing Country. Keynote Address. International Teachers Training Workshop on Family Medicine Education. Organized by the WONCA Middle-East and South Asia Regional Office & the College of General Practitioners of Bangladesh. 20 Dec 1996, Dhaka, Bangladesh

My talk today is directed to the problems of training of family physicians in a developing country. Globally, we share a large area of common concerns on the skills, attitudes and knowledge necessary to be a good family doctor. There are, however, special problems about the family physician in a developing country.

I am speaking to teachers - potential teachers - people who are going to organize programs for training family doctors, and teacher training programs as well. It is important that the training that you provide is not merely technical but a true educational experience. There is a philosophic element to being a family doctor which entails an understanding of the emergence of our discipline and the role we have to play. James McKenzie, a general practitioner who was the father of clinical cardiology, nearly 80 years ago, emphasized the importance of teachers who had experience of general practice.

"The teacher of practical matters must be one who experiences what he teaches. We all recognise that the best teacher for one who wants to be a shoemaker is the man who is in the habit of making shoes. Unfortunately this common sense is rarely applied to medical education. The vast majority of students who enter on the study of medicine ultimately become general practitioners and yet a student may pass through the curriculum and be instructed for years by a large number of teachers, not one of whom has had the experience of the life he is to lead as a general practitioner. As a result, a large portion of the students' time and energy has been spent in acquiring information that is of no use to him in the practice of his profession, which much of the knowledge which he often finds essential has never been given to him."

--- *James McKenzie, The Future of Medicine, 1919* [**see Note 1**]

We live in a period of great and rapid change all over Asia. There is economic and social change at an unprecedented rate. People's attitudes and values are changing, and the traditional way of life is under tremendous stress. The family doctor is in the front line dealing with the consequences of these changes.

Let me first of all deal briefly with the re-emergence of general practice to become the central discipline in the delivery of health care. In the fifties, entry into general practice had reached an all-time low. In the developed countries, nearly three quarters of physicians were entering a hospital speciality. The so-called renaissance in general practice is a response to community demand, societal change and technological

advance. First there was weariness in the community at the lack of a personal doctor to relate to. They recalled with nostalgia the old fashioned family doctor. Their experience with the hospital, without the advocacy of a personal doctor, was not a happy one. The detachment of the hospital doctor towards the patient, the division of responsibilities between a great number of sub-specialist doctors, and the absence of a one-to-one personal relationship in the intimate experience of medical care, all these caused great dissatisfaction in the unwell person and the family. At the same time, the community itself was undergoing sociological change. With higher educational standards, greater understanding of health and disease, better standards of living, and raised expectations about their entitlements. They wanted a well-trained doctor in a close personal relationship to them. The other factor was the development of sub-specialization and the disappearance in the community of the familiar figure of the general physician and general surgeon. Sub-specialization has produced brilliant results at the cost of losing the personal focus of medical care and becoming procedure-oriented. The best sub-specialist performs most brilliantly at just one procedure or a particular disease. Internal medicine and general surgery have divided into a great number of sub-specialities so that increasingly the family doctor needing advice looks for a sub-specialist. Precisely because of this intense specialization, there was increasing need for a better-trained family doctor. Finally, there is the emergence of new technology favouring care in the community. I am not one of those who identify Family Practice with low technology. I believe we are the beneficiaries of very high technological development and in new diagnostic and therapeutic approaches and equipment. New medical technology has transformed the prospects of the care that we can provide in the community to the still functioning ambulatory patient, as well as in home medical care. We can diagnose early and treat early. We have much better understanding of risk factors and of early presentation of disease. Just 50 years ago, there was hardly anything available in the best hospitals that made a serious difference to outcome. Then came penicillin and tremendous new development followed. We are now able to treat asthma, hypertension, diabetes and ischemic heart disease, immunise against all the killer diseases of childhood, and to do much more, better in general practice that was possible even in the best hospitals just a few decades ago. This great transformation that modern technology has brought to primary care is responsible for the strength and effectiveness of the family physician within the community delivering primary care. This was one of the great tides in human affairs that has pushed forward family practice.

"Now in order to bring medicine's enhanced diagnostic and therapeutic powers fully to the benefit of society, it is necessary to have many physicians who can put medicine together again."

--- *The Report of the Citizen's Commission on Graduate Medical Education [Millis Report], 1966* [**see Note 2**]

Many questions still had to be answered before the emergence of the modern speciality of family practice become possible. Did it require special experience, was it teachable and was it examinable? Most physicians in the Commonwealth are familiar with the British experience. In the United Kingdom, the Todd Report and the General Medical Council came out clearly on this matter. The undergraduate medical education did not train for general practice; it produced an undifferentiated doctor who was ready for training in any of the specialities of medicine, including general practice.

"Every individual should have a personal physician who is a central point for integration and continuity of all medical and medically related services 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 hospital."

--- National Commission on Community Health Services [Folsom Report] 1966 [**see Note 3**]

"It is no longer possible for anyone to obtain a comprehensive medical training during his school years. Graduation has become neither the end of medical education nor the beginning of the end, but rather the end of a beginning…"

--- General Medical Council, 1967 [**see Note 4**]

The general practitioner is "a specialist in his own right by virtue of his unique and essential contribution to medical care."

--- Report of the Royal Commission on Medical Education [Todd Report] 1968 [**see Note 5**]

Family medicine was pioneered in the United States following the recommendations of a series of Commissions. They spoke of the fragmentation of medicine and the need for a physician who could put medicine together again. Three designations were proposed for this new specialist, namely primary physician, personal physician, and family physician. In the event, the terms family physician and family medicine were adopted and spread worldwide.

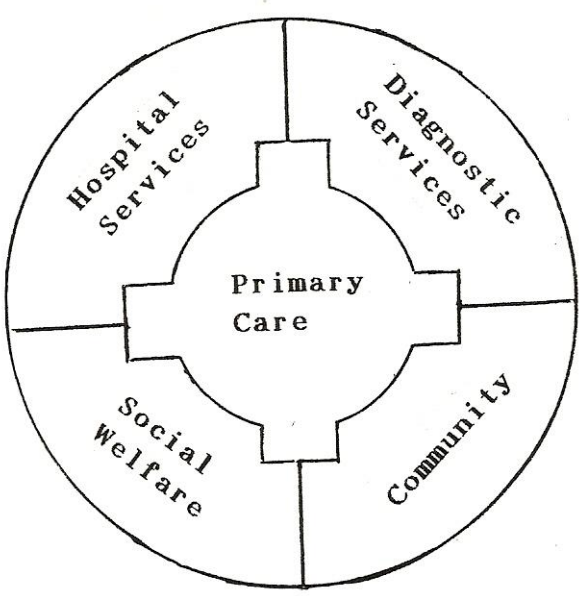
In developing countries, the family physician more often functions as general physician in private practice and as community physician when in government service in the rural areas. The expectations on them are very high and a superior level of clinical competence is assumed. The World Health Organization has summarized this as the Five-Star Doctor.

The Five-Star Doctor
**assess and improve the quality of care by responding to the patient's total health needs.*
**make optimal use of new technologies.*
**promote healthy lifestyles.*
**reconcile individual and community health requirements.*
**work efficiently in teams*

--- Charles Boelen, World Health Organization, 1995 [**see Note 6**]

The multiple roles of a family doctor in a developing country, particularly in the rural areas where the great majority live, calls for a person of extraordinary temperament as well as very special combination of skills. The role that they have to be prepared for in a developing country are:

- Clinician with strengths in emergency medicine, obstetrics, and paediatrics.
- Community physician with strengths in immunization, vector control, sanitation and infectious diseases control.
- Role model and counsellor.



The training of such a physician needs a strong commitment on the part of the State. We need two converging channels for training:
(a) Academy/College-based involving supervised practice, part-time study
(b) University-based involving full-time study based on government health centres and hospitals

These two channels of study should converge on a single examination leading to the speciality qualification. The remaining problem is how to make it rewarding for young doctors to train to specialize in primary care, and especially to serve in rural areas. A large discrepancy remains between the proclaimed importance of primary care by politicians and the actual treatment of doctors who serve the community in primary care.

Only when we have sufficient numbers of these highly-trained physicians can primary care fulfil its responsibilities as the central axis of the health care system. The family doctor/ primary care doctor in a developing country is a crucial link between the population-based programs of public health and the individual episodic care of the hospital. The family doctor in the rural areas of a developing country needs to work closely with public health specialists in assuring safe water, efficient disposal of sewage, vector control, and preserving the environment from chemical pollutants. The family doctor has to establish swift and efficient channels for consultation and referral with the hospital services. Less than 5% of the cases seen in primary care will need hospital care but when this is required, we shall expect a very high level of specialized expertise in the physician or surgeon who serves as our consultant. With open access to diagnostic and therapeutic services, most illnesses can be prevented while others can be managed with the patient still functioning as provider to the family.

We are making beginnings now and it is timely that primary physicians in developing countries take the initiative in helping to re-design the national health delivery system. The World Health Organization is in the midst of reconsidering how to achieve 'Health-for-AII' after the year 2000. Seminars such as this help us not only to train a new

generation of family physicians but also enable us to get our thoughts clear on our roles and responsibilities in a developing country such as this one.

Editor's Notes

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Section 3: Family Medicine journals

The College of General Practitioner (now known as The Academy of Family Physicians of Malaysia) published the journal *Family Practitioner* in 1973, the same year of its formation. Dr M K Rajakumar published 11 articles in the *Family Practitioners*, three of the articles were included in this book (Articles 1, 2, 8).

The official journal of the Academy of Family Physician of Malaysia has changed its name twice. In 1989, under the editorship of Dr Ho Tak Ming, it was named *The Family Physician*. Subsequently, in 2006, the prefix 'Malaysia' was added to the name of the journal, *Malaysian Family Physician* when CL Teng was the editor. Dr M K Rajakumar was the inspiration behind the production of a respectable family medicine journal. He was invited to write for these inaugural issues of the journal.

"Our Journal is not a magazine although there may be elements, nor only a professional publication. It should be most importantly a peer reviewed journal for the publication of research that provide the basis of the choices and decisions we have to make on health care, and the forum for the analysis and evaluation, and debate on the application of scientific evidence for better care."

--- Our Journal, *Malaysian Family Physician, 2006*

Articles included:

11. Family Physician [inaugural issue of *the Family Physician*, 1989]
12. Our journal [inaugural issue of *Malaysian Family Physician*, 2006]

11.
The Family Physician

Rajakumar MK. The Family Physician. *The Family Physician.* 1989;1(1):5-7

Throughout human history, there had always been a healer who played the role of family physician. That was medicine's ancient beginnings: the healer of all diseases. Our beginnings were in magic and it was a long journey from witch doctor to medicine man, from traditional healer to the practitioner of scientific medicine. There is still a bit of magic and a lot of tradition in medicine but the scientific foundations of medicine are secure. However, family practice requires more than science and technology. It needs a commitment to caring, the effort to understand and the willingness to win trust and confidence: this is the heritage of our ancient profession.

Specialisation of surgery became respectable a little over a century ago, and subspecialisation was in bad odour until very recently. The still surviving practitioners of generalist disciplines are the general practitioner, the general internist, the general paediatrician and the newly emerging geriatrician. Subspecialty development is rapidly dissolving these generalist boundaries into smaller, contested fiefdoms.

The term ‘general practitioner’ was first used in England and came to distinguish those physicians and surgeons who worked outside the hospitals from those who controlled the hospitals. In England, the general practitioner in the 19th century held qualifications from the Apothecaries Hall and the College of Surgeons. With the shift of medical education to the Universities, all doctors graduated with a university degree, and membership of the Royal College of Surgeons or the Royal College of Physicians became a requirement for hospital practice. Subspecialisation remained suspect and of low status until this century. General practice was isolated from the mainstream of medical advances that were concentrated in the hospitals. The practice of surgery separated from general practice but the term ‘surgery’ to describe the general practitioner's office has remained in use in the United Kingdom, a reminder of the old association with the surgeons.

With further advances in medical technology, the decline of general practice was reversed. New drugs and new technology have made it possible to manage major health problems, such as hypertension, diabetes, bronchial asthma, anxiety-depression, in general practice more effectively and efficiently than in hospital. The hospital is seen to be cost-effective when it is confined to problems that need intensive or continuing nursing care, for complex procedures that need repetitive performance to develop skills, for rare diseases in which one person or one unit could gain expertise, and for shared usage of expensive equipment

The decline as well as the revival of general practice was most dramatic in the United States. By 1972, the proportion of general practitioners had declined to below 18%. It was 75% in 1931 and 66% in 1940. There was disquiet in the community at the disappearance of the much-loved figure of the family doctor, at the same time as the

familiar general physicians and general surgeons of country hospitals were becoming replaced by procedure-oriented sub-specialists. A series of influential reports called for the creation of a new family physician.

In 1947, the American Academy of General Practice was formed It became quickly apparent that further progress required the establishment of Family Practice as a distinct specialty with a distinct name.[1] The movement toward reviving the family doctor gained momentum from three reports published in 1966. The National Commission on Community Health Services, known as the Folsom Commission,[2] stressed that every individual should have a personal physician. The Citizens Commission on Graduate Medical Education, known as the Millis Commission,[3] called for a primary physician who would take primary or the main responsibility for an individual's health care. The Ad Hoc Committee on Education for Family Practice of the Council on Medical Education, known as the Willard Report[4] called for a new specialist in comprehensive health care, to be called the *family physician*. In 1969, the American Academy of General Practice became the American Academy of Family Physicians. It is of interest that the proposal to designate *family physicians* as specialists was first made to the House of Delegates of the American Medical Association in 1917, two years after the first specialty, Ophthalmology, was designated. At that time, ironically, specialisation had low status and the profession was predominantly composed of general practitioners. The specialty Board of Family Practice, the 20th Board, was approved in 1969 when specialisation commanded esteem and the medical profession in the United States was predominantly composed of specialists. In Canada it was the College of Family Physicians of Canada.

In the United Kingdom, the College of General Practitioners was formed in 1952 against the wishes of the older Colleges, only to be warmly welcomed into the fold after its formation. In 1973, the examination for its membership was held. The term *general practitioner* is entrenched in the National Health Service although British newspapers refer to the 'family doctor'. In the United Kingdom it is now necessary to have approved postgraduate training to be a principal in general practice, closing the door to a soft option for failed or retired internists and surgeons.

In Malaysia, the College of General Practitioners was founded in 1973 with a promise from the Government that an Act of Parliament would be passed to establish the College, together with a College of Surgeons and a College of Physicians, as postgraduate medical institutions. Our first educational document was entitled *Specialisation in Primary Health Care: Training for the new General Practice in Malaysia*.[5] The College journal took a tentative step in a new direction with the name *The Family Practitioner*. It is now *The Family Physician*. The College itself has considered many times a change of name to 'College of Family Physicians' or even 'Academy of Family Physicians'. For various good reasons, Council has postponed making a recommendation to the membership on this but we expect to be known individually and collectively as *family physicians*. The new University Department at the University of Malaya, formed on the recommendation of the Board of Studies on General Practice,[6] is called the Department of Primary Care Medicine. We must hope that the term f*amily practice* will be incorporated into its name and that the staff will be family physicians.

Advances in medicine have made it possible to do more and to do better in family practice. Whatever the changes that will come to the practice of medicine, there will always be the need for a physician in the community to provide continuing and comprehensive care to the individual and the family. As modern technology creates more dramatic opportunities for family practice, there will be a need for even higher levels of training. Individuals and families will always look for a physician who is caring, makes the effort to understand them and to win their trust and confidence; that physician is their family doctor. The task of the College is to prepare that family physician to perform these functions to standards of excellence.

The College journal, now *The Family Physician* has an important part to play in this task. By its new name, the Editor has taken the initiative to point out to us the direction where lies our future as a discipline.

References (links added by Editor)

1. The perception that there was no future for 'general' practice led to the move for a separate specialty Board of Family Practice. Said one of the pioneers in this move: "Let us praise the old general practice - and bury it!"
2. The Folsom Committee was appointed by the National Health Council and the American Public Health Association in 1962. Their Report, *Health is a Community Affair* was published in 1966. This Report stated that "*Every individual should have a personal physician who is a central point for integration and continuity of all medical 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 hospltals*." http://www.hup.harvard.edu/catalog.php?isbn=9780674863385
3. The Citizen's Commission on Graduate Medical Education was chaired by John. S. Millis. PhD, then President of Case Western Reserve University. The Commission was appointed by the American Medical Association and its report was entitled *Graduate Education of Physicians*. This Report stated that "*It is time for decisive action to increase greatly the number of physicians who will devote their professional career to highly competent provision of comprehensive and continuing medical service. There should be a specialty board; certification examination and diplomate status for physicians highly qualified in comprehensive care*." https://www.aafpfoundation.org/content/dam/foundation/documents/who-we-are/cfhm/classicsfamilymedicine/GraduateEducationofPhysicians.pdf
4. The Willard Report made this recommendation which was adapted and implemented by the American Medical Association: "*The Ad Hoc Committee is convinced that the opportunity for specialty board certification is essential for those properly prepared for 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. The certification far 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 some other board. 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."
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12.
Our journal

Rajakumar MK. Our journal. Malaysian Family Physician. 2006;1(1):4

Why do we have a journal, the *Malaysian Family Physician*? We are a small academic organisation in a small, developing country. Our resources are thin, and there already exist, though not 40 years ago, a variety of journals in general practice/primary care. This is one of the debates we had in the early years of our existence. Other topics in dispute were whether you could *train* for general practice, whether general practice was *teachable* in a formal programme, and whether you could actually *examine* candidates in fitness for general practice. Other Colleges too debated these issues, and reasonable and sensible arguments were put forward why it was laughable to speak of a separate *academic discipline* that could be taught and examined. All this is taken for granted these days. If you are convinced that general practice was a separate discipline of medicine, as distinct as the others, then it must be underpinned by an academic organisation with its own field of scientific research and an academic journal. The reason for the existence of Colleges and Academies such as ours is to improve the care of patients and their families, and to improve care in the community in order to enhance the level of health. Our struggle to exist and function is a story to be kept for another day.

The second half of the 20th century saw the emergence of academic organisations of general practice. The first was the American Academy of Family Physicians had distinguished themselves from the existing general practice organisations that were not supportive of the idea of training for board certification - a trend taken by all the other medical specialties in the USA. We were probably the fifth in the world to be formed, and the numbers now approach 200 of vastly different sizes and strength. There is a strong an influential World Organisation of Family Doctors (WONCA) with 169 members, all with their own journals.

Our Academy was founded in 1973, the first examination was held soon after, and the *Journal* started publication also in 1973. The weakness of the Academy *Journal* is a mark of the weakness of our Academy. We have not had an easy passage, but I shall not go into the sad story of the obstacles to initiatives in this country.

Our *Journal* is not a magazine although there may be elements, nor only a professional publication. It should be most importantly a peer reviewed journal for the publication of research that provide the basis of the choices and decisions we have to make on health care, and the forum for the analysis and evaluation, and debate on the application of scientific evidence for better care. The *Journal* educates us, and guides us in our practice and in our professional lives. This is a vital task that requires some very good people.

We now have a very promising team taking on the task of managing and editing the *Journal*, and I feel grateful that they are taking on this important responsibility. They deserve the support of Council, of academic general practice, and of all general practitioners.

Healthcare improvement had been a dominant concern of Dr Rajakumar throughout his career. At national level, he chaired a committee to evaluate healthcare in Malaysia and produced a well cited book, *The Future of the Health Services in Malaysia*. We are grateful to the Council of the Malaysian Medical Association for allowing us to upload this 200-page report in the website.
http:// www.e-mfp.org/old/Rajakumar/index.html

A summary of this report has been written as item 14 in this book by Datuk Seri Dr Jeyaindran Sinnadurai.

Dr Rajakumar spearheaded various efforts to improve quality in family practice, including postgraduate training in family medicine (see Section 2 of this book). 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.

Writing in the Foreword of the book *Health Care in Malaysia*, he traced the development of health service in Malaysia. He observed that health indices in this country had improved in tandem with the remarkable economic progress. However, he noted the initiatives at corporatization and privatization of health services had resulted in widening of healthcare inequality among the rich and poor.
"With increased commercialization of health care, and diversion of health funds to private interests, a multi-tiered quality of care has become entrenched. The better-off in our society have sustained a parallel health system (as with education), from ambulatory care to tertiary centres, funded and managed by foreign investors under liberalized access claimed under free trade agreements and supportive government policies."

Articles included:

13. The Future of the Health Services in Malaysia. [1980] [Summary]
14. Quality in Family Practice [2002]
15. Foreword, in: Chee HL, Barraclough S. (ed) In: Health Care in Malaysia: the dynamics of provision, financing and access. [2007]

13.
The Future of the Health Services in Malaysia

Rajakumar MK, Suleiman AB, Lee CH, Cheah M, Yeoh PH. The Future of Health Services in Malaysia. A report of a committee of Council of the Malaysian Medical Association. Kuala Lumpur: Malaysian Medical Association, 1980

This summary is written by:
Prof Datuk Seri Dr Jeyaindran Sinnadurai,
Faculty of Medicine,
MASHA University.

Preamble

In 1979, the Malaysian Medical Association asked Dr Rajakumar (who was then the President-elect of the society) to produce a report on the health services. Dr Rajakumar assembled a committee of eminent persons within the medical community, which he chaired, and they produced a comprehensive and yet detailed report, that touched on all aspects of healthcare in our young nation.

This was the first such report and many of their recommendations were very far sighted! Almost forty years on, even today segments of this report are often quoted. As such it is timely to review this report and see where we are today, with respect with what has been implemented, what has not and why?

Introduction - The Health of the Nation

"Health is man's most precious possession for without good health, life itself is much less worth living. The cost in human misery as a consequence of bad health is incalculable. Healthcare is universally considered a right of citizens, placed beyond the need for economic justifications. The state of health of a nation has economic value, in terms of promoting human economic productivity. School and work-hours are lost when sickness necessitates treatment and rest, and premature death is a calculable economic loss to the community."

This opening statement in the report holds true till today, the Malaysian government has strived very hard to achieve the concept of universal health coverage as recommended by the World Health Organization as per Alma-Ata Declaration. Although when they wrote this report back in 1980, they did not envisage such a dramatic rise of non-communicable disease and the resurgence of infectious diseases such as dengue and tuberculosis, which today has a major impact on the health and wellbeing of our nation.[1-2]

Chapter 2 - Present state of health
Demographic characteristics
"Malaysia has a very young population, the median age is was 17.3 years (1970) with 64% of the population below the age of twenty-four. The population is predominantly rural, in 1975 only 32% of the population was found to be living in urban areas."

Today we know that Malaysia is rapidly moving towards an aging nation; in 2017, 6.3% are above 65 years and it will reach 14.5% by 2040 (an aged nation is when >14% are above 65 years of age).[3]

As for the urban shift it reached 50 % in 1991 and in 2010 it was at 71 %,[3] so now more Malaysian live in the urban areas that in the rural areas, a dramatic shift, almost a total reversal within the last 40 years!

Employment matters
"As an agricultural nation, the largest proportion of workers are employed in the agricultural sector, followed by the service sector. There are signs of shifting patterns with the movement of persons from the agricultural to the manufacturing, construction and public services. The change is not dramatic."

Once again, they were not able to predict the rapid change in Malaysia's economic focus from an agricultural to an industrial nation which was a result of the successive 5-year Malaysia Plans leading to the rise of the electronic and oil and gas sectors.

Now most of the agricultural, construction and a fair amount of the factory workforce is no more Malaysian but foreign migrant labor. The rapid industrialization, the rise of the economies in the ASEAN region and rapid globalization, has resulted in most of these changes in the employment patterns. These were changes which they would not have anticipated in the late 1970's.

2.2 General Health Indices
Life expectancy
"The life expectancy of the population in Malaysia has increased significantly between 1957 and 1976, indicating that the level of healthcare has correspondingly improved. In 1957 it was 57.0 years and rose to 68.8 years in 1976, an increase of 11.8 years (in a period of 19 years). This is about 5 years lower than the developed countries, in Malaysia it was 66.2 years for males and 71.4 for females against 72.07 years for males and 77.65 years for females in Sweden. In ASEAN, only Singapore had higher life expectancy than Malaysia."

Crude death rates and infant mortality rates
"Malaysia's crude death rate compares very favorably with both high and middle-income countries. It's crude death rate of 6.2 is one of the lowest. Sweden, Australia, Japan and the UK have higher crude death rates, but it must be noted that these countries have a larger portion of elderly people."

Today the life expectancy of Malaysian males is 72.7 years and females is 77.4 years, in 1966 it was 63.1 and 66.0 years respectively. Infant mortality was 79.6 in 1957 and now it is 6.7 and for below 5 years mortality was 70.2 in 1965 and has dropped tremendously to 8.1.[1-3]

3. Present State of Health Delivery

Malaysia Plan objectives

"Since the first Malaysia Plan was launched in 1966, the emphasis in medical care has shifted largely from the need to expand medical and health facilities for all to the correction of imbalances in the distribution of these facilities and services, and the launching of special programs or services to deal with specific health problems and the changing pattern of diseases. Attention has shifted from curative to preventive measures, from providing doctors, hospitals, nurses and medicines to ensuring there is safe water and sanitation. The thrust of health measures has expanded from the urban to the rural areas as evidence by the establishment of extensive rural health services."

As a result of the Malaysia Plans, today in Malaysia 96.8 % of homes have clean water (69.9 % in 1970), 96.14 % homes have sanitary facilities (68.9% in 1970), 66.01 % have sullage disposal and 70.94 % have solid waste disposal. The improving living standards due to economic growth of the nation coupled with social interventions have resulted in the decline in infant and under five mortalities. This together with the highly effective immunization programs by the public health services achieving coverage for BCG of 98.6%, DPT 96.77%, MMR 92%, Hep B 96.7% and HPV 84.4 %. Have all collective resulted in dropping infant mortality rates and the progressive increase in life expectancy rates.[1,2,4]

Chapter 4. Health problems of the community

"The highest priority should be given to the elimination of disease that add to the burden of poverty. New health hazards associated with urbanization and industrialization must be controlled from the onset. Citizens must be protected from illness producing industries primarily through the banning of advertisements of their products."

This has taken a long time to materialize but has been put into place in stages, clear examples have been the banning of hard liquor and cigarette advertisements in public places and also in stages the duties on these products have been raised as a disincentive for the consumer and finally with great difficulty the banning of smoking in all public eating places has finally been implemented with effect from 1st January 2019.

Chapter 5. Changing the health service

"The Ministry of Health should be concerned with planning the long-term objectives of the health services, the designing of strategy to achieve these objectives, determining resource allocation to meet these objectives and monitoring and evaluating the performance of all institutions receiving these funds towards achieving national objectives.

Apart from the nursing service, the pharmaceutical service and dental services, the structure of the Health service must provide for the following areas,

- *Hospital services*
- *Public health services*
- *Primary care services*
- *Health planning*
- *Health service administration*

A National Health Information System should be developed incorporating data from both the public and private sectors."

Over the years the Ministry of Health has expanded its services to look into the various segments and there exist specific divisions to look at the areas highlighted and also many more to cater for the growing needs of the nation such as the Medical Practice division that overseas Private health care facilities and the Food Control division that looks at all aspects of the safety of food.

In an effort to collect health data from both the public and private sector, in April 2017, the Ministry of Health launched Malaysian Health Data Warehouse (MyHDW) with the objective of using big data for health economics, however till today there is little information about what data has been collected and what is this data that has been collected being used for?[2,4]

Chapter 6. Primary health care

"A grade of primary physicians or general practitioners should be created in the Ministry of Health with the normal career prospects of other specialties. Standards of general practice should be raised through a rotation of experience in different specialties, post graduate training and certification."

Both the Ministry of Health and the Universities had taken note of this and specific fellowship courses have been implemented by both the College of GPs (now the Academy of Family Physicians) and also by the Universities in the form of the Masters in Family Medicine.

The trainees in these programs are given specific rotations in the respective disciplines of medicine to increase their core knowledge and competency to function as Primary care doctors. Also, as many doctors after completion of compulsory service become primary care doctors, to better equip them for this field of medicine, Primary care is a rotation now offered during their 24 months houseman training.[5]

Chapter 7. Hospital services

"Hospital administration should be designated a specialty, open to doctors as well as to suitably qualified graduates who are willing to make a career of hospital administration. Hospital directors should be doctors specially trained in hospital administration.
Casualty and Outpatient Departments need to be managed and staffed by persons who are trained in these fields.
There must be an effective hospital information system and medical audit must be introduced."

Most of these recommendations have been introduced, Hospital Administration is now a recognized area of specialization, but it should be given greater emphasis and more should be trained, so there should be enough to run all the MOH hospitals. Also, senior and mid-level clinicians must also be given management skills as they are now expected to play an active role in the administration of their clinical departments.

There are today more than enough trained Emergency Physicians to man all the Emergency Departments of all major and minor MOH hospitals with outreach

programs to the smaller hospitals. As for Primary Care specialist most, large outpatient and health centers are being staffed by not one but more than one trained Primary Care or Family Physician. All these trained specialists have upgraded the delivery of quality healthcare services to the public where it is needed most.[2,6]

Chapter 8. Maintaining health by preventing disease

"Public Health specialist should devote themselves to public health activities. The provision of safe water supply and efficient disposal of sewage must have the highest priority. Constant surveillance by the public health department on public kitchens and food handlers must be intensified. The Ministry of Health needs to greatly strengthen the Department of Occupational Medicine. There should be a total ban of all tobacco advertisements as well as on sponsoring of any sporting events."

The provision of safe water and disposal of sewage has been upgraded in that these activities are now being done by corporatized agencies which are expected to bring about greater efficiency. This seems to be working as 96.8 % of homes have clean water and 96.14 % homes have sanitary facilities.

Surveillance of public kitchens, food stall and other eating places has room for improvement. Thought generally standards have improved but we are still having a problem with rodents and outbreaks of leptospirosis. Problems with outbreaks of typhoid and cholera are a rare entity now both in urban and rural areas.

Occupational Medicine is often confused with Occupational Health, they are two distinct entities but work in a complementary manner. As such there is still the unfulfilled need to develop more Occupational Medicine Physicians to be able to provide better care and assessment of patients coming before SOSCO boards, this is needed as we move towards becoming a developed nation.

Finally, we are seeing the effects of a long-standing tussle between the tobacco industry and the Ministry of Health, with the progressive banning of advertisements to banning of smoking in public places (since The Control of Tobacco Product Regulations 2004) and now in all public food outlets. It has taken almost forty (40) years to finally reach this stage despite only about 24 % of the adult population are smokers, affecting 76 % of the population by their habits!

Chapter 9. Manpower

"The service structure should be more flexible allowing Malaysian consultants abroad to be employed on terms and status which are commensurate with the post they are holding.

The Ministry of Health must play an active role in the training and continuing medical education of specialist and medical officers. There should be a professional section within the Ministry to advise doctors throughout the country regarding career prospects.

There should be no discrepancy in the promotional prospects between the Civil Service and the Professional in the Ministry.

There should be compensation to doctors accepting unpopular posting such as rural health services."

Although TalentCorp was established to bring back talented Malaysian professionals to serve the nation as far as in the field of medicine, it has only brought some back to work in the private sector. The Public sector does not have any specific mechanism to employ such talented Malaysian and pay them a salary equivalent to what they were earning overseas. As such this has not been fully achieved, because this talent is most needed in the public sector to serve the 'Rakyat '.

Many people don't realize that the Ministry of Health is the largest training entity in the medical sector, training staff from paramedics, nurses to sub-specialist. It was only recently, in the 2015 budget that money was allocated for the establishment of a professional development unit within the Medical Practice Division of the Ministry of Health, to oversee and plan the future needs for specialist in the nation.

Today there is both the Master's program and the parallel pathways via the Royal Colleges to become a specialist and specialist in training are now given a personal development plan (PDP) which gives a career development pathway as a guide.

As for continuing medical education (CME) after trying the soft approach, finally with the new Medical (Amended) Act and regulations with effect from 2020, renewal of the Annual Practicing Certificate will be dependent on a mandatory 20 CPD points per year for all registered medical practitioners.[7]

To retain doctors within the public sector several incentives have been put into place such as time-based promotion, so on reaching a certain number of years of service they will be promoted to the next grade, gone are the days when promotions were based on vacancies! Also, many more senior grade post have been created for specialist but many are still not satisfied.

For junior doctors posted to unpopular or district postings, on completion of their posting, they are given priority in getting the requested posting of their choice and also have priority in getting into the various postgraduate training programs.[5]

As for specialist, they are given additional specialist allowance if they serve in rural hospitals and the more rural the greater is the incentive and all of these are tax free. So the Government has taken numerous proactive measures to make working conditions better for all levels of doctors in the Ministry of Health, but this has not been extended to other categories of healthcare personnel.

Chapter 10. Special problems

"The position of the Medical Council (MMC), as a statutory guardian of the profession's ethics and watch dog of its professional standards must be preserved at all cost. The disciplinary machinery of the MMC has to be strengthened and the MMC must extend its involvement in postgraduate training. The MMC must retain the power of certification for entry into the specialties."

Most of the recommendations in this chapter have been implemented. The position of the MMC has changed with the new Medical (Amended) Act 2012 and the Medical Regulations 2017. The MMC will function as a Corporate body and with the new regulations there will be changes in how disciplinary matters will be addressed, there will be a medical Education Committee which will oversee medical education from

medical schools to subspecialist training. The National Specialist Register (NSR) will be the sole body providing recognition to all specialist in the country.[7]

Chapter 12. The distant horizon.
"If we plan ahead carefully, it is possible for us to achieve extremely high standards of healthcare and avoid many of the bad consequences to health from industrialization and urbanization. We cannot succeed if we carry on stumbling from problem to problem, reacting in an ad hoc fashion to new problems and fixed in the current pattern of health care by mechanical incremental response to demands.
It is time to take a fresh look at the problem of health in our country, a Royal Commission on Health is needed to undertake a review and to point new direction. It will provide an avenue for the community to make know its views. We urge the appointment of a Royal Commission on health without further delay."

Conclusion

Looking at the recommendations of this position paper on "The Future of Health Services in Malaysia" it can be seen that they had a vision which was ahead of their time, it laid a strong foundation for a great health care service in a developing nation.

As we move towards a developed nation status, some of their recommendations have been implemented, some are in the process of being implemented but some have not.

Medical practice is dynamic, and it is imperative, that form time to time we must review our road map and make the necessary adjustment to ensure that what every healthcare reform or plan takes into consideration the changes in the demography and epidemiology on the national health scene of today.

A healthy nation with its citizens in the best of health, is an important factor in the economic progress of the nation and its social wellbeing, only then can we remain competitive in a globalized economy.

Since Independence, Malaysia has done well, we have brought down infant and maternal mortality and increased life expectancy to be at par with developed nations, OECD countries took an average of 120-150 years to achieve these results but we in the developing world thanks to medical advancements have reached these figures within 50-60 years. This has put many strains on the healthcare of our nations.

In Malaysian not only are we facing a challenge of an aging society which is not healthy, but the resurgence of infectious diseases which is taking a toll on our younger economically important population.

As a result of this, the Malaysian Health care system is faced with a new challenge. We have reached a situation of diminishing returns, where very large amounts of money will need to be invested to see similarly impressive improvements in outcomes, because we have an unhealthy aging population with high incidence of NCD, renal failure and malignant diseases. These conditions need lots more money to treat and even then the improvements in health outcomes is very small.

As such, I feel there is an urgent need for a high-level task force of multiple ministries to address the issues of the health of our nation. Whether this would be better addressed by a Royal Commission is an open question.

The Ministry of Health must take a lead role, each of the other relevant Ministries must play both an independent but more importantly an interdependent role for the better health of our citizen. Together let us move forward to towards a Healthy Malaysia of the future!

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14.
Quality in Family Practice

Rajakumar MK. Quality in family practice. Asia Pacific Family Medicine. 2002;1(2&3):74-8.

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]:

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, HbA_{1c}, 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 that you can choose from. 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.

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Health Care in Malaysia

Rajakumar MK. Foreword. In: Chee HL, Barraclough S (ed). *Health Care in Malaysia*: *the dynamics of provision, financing and access.* Routledge, 2007. ISBN: 9780415418799

Dr MK Rajakumar is Past-President of the Malaysian Medical Association and was Chair of the MMA Committee that produced the landmark 1980 report 'The Future of the Health Services in Malaysia'. His previous positions include President of the Malaysian Science Association, Vice-Chair of the Malaysian Academy of Sciences and President of the World Association of Primary Health Care Physicians. He was also the last acting chair of the Labour Party of Malaya, and he is frequently consulted on health care policy in Malaysia.

Health is a requirement for fitness to earn a living, to attract a mate and to raise children, indeed for life itself: it is a special good that you cannot do without. Shared health care, and education, are the principal sources of social solidarity and social cohesion between peoples sharing a land in the modern state. This is more strongly a factor in new states such as Malaysia.

Health investment also reflects the distribution of political power. Equity in access to health care is a measure of the effective functioning of democracy. Rapid economic growth in Asia has reduced poverty, but we need measures of equity that incorporate timely access to health care and education, to give direction to further economic growth.

In a complex plural society like Malaysia, continued ethnic harmony is contingent on the acceptance of a reasonable degree of economic and social inequities, and on an electoral consensus based on the assurance of progress in remedying these inequities.

It is useful to consider the development of health services in Malaysia in several phases, as determined by the governing power:

- Foreign administration
    - British colonial period, before and after the Second World War
    - Japanese military administration
    - Postwar British administration
- Independence, elected government
    - 'Malayanization'
    - Modernization
    - Privatization

British colonialism

Modern scientific medicine, so-called 'western medicine', was introduced during the colonial period. It was directed towards the health care of the British and, separately, for preserving a fit workforce in the plantations and tin mines. The principal cause of disability and death was malaria: rushed felling of the forests for plantations created a

favourable environment for the mosquito vector of the malarial parasite; and in reclaiming land for Port Swettenham, nearly half the indentured labour from India died every year so that constant replacement of imported labour was needed. On the plantations and mines, where British personnel were also exposed, anti-malarial work to keep the environment free of the mosquito vector was conducted vigorously.

As populations became concentrated into townships, prevention of epidemics of water-borne infections, typhoid and cholera necessitated investment in providing safe water. The health services moved into the hands of professionals who brought a degree of professionalism and conscientiousness to their work.

Only low status employment was given to Asian doctors, nurses and lab technologists, who were discouraged from acquiring postgraduate qualifications. In Singapore, the determination of the Chinese community was shown when it funded a medical school. Its graduates, as well as doctors qualified in India and elsewhere, were designated 'assistant medical officers' ranking below British matrons. This included a few who had acquired postgraduate qualifications on their own initiative from the United Kingdom (UK) royal colleges. (This formed the basis of a long, friendly, professional association with the royal colleges that lasted beyond British colonial rule.) Nevertheless, on returning home, they were denied specialist status, remaining 'assistants'.
Asian doctors held low rank in the hierarchy but were doing major surgery and managing all illnesses. Some resigned in disgust and entered private practice, which gave general practice a wide range of skills, high status and acceptance in the community that has lasted.

Japanese military administration

The Japanese faced a hostile population. Their brutality in China had earned the hostility of the Chinese in Southeast Asia. The British, when abandoning their territories, armed the communists, mainly Chinese, to provide a resistance. The Japanese sought to subdue the people by terror, brutality and killing, particularly targeting the Chinese.

Japanese doctors and medicines were needed for their soldiers, and the care of the population was relegated to Asian doctors. Overnight, Asian doctors found themselves running hospitals, and training their younger colleagues in managing severe illness and doing major surgery. A medical school was started in Malacca by the Japanese administration, and its students were to become the first entrants – mature, tough and experienced – to the medical school in Singapore when it reopened after the war.

A cadre of self-confident and experienced Asian doctors was in existence when the British returned to re-establish colonial administration. They would not accept reverting to being the juniors to inexperienced British doctors.

Postwar British administration

Events in Asia reflected a vastly different political climate. Malay nationalism was a powerful force and the civil servants and professionals moved to push out the British officers who remained. The reluctance to allow Asian doctors to acquire higher

specialist qualifications in the UK was now remedied by sending their younger colleagues, with much experience and
skills, but lacking formal qualifications, to the UK for the royal college diplomas.

'Malayanization'

With Independence in 1957, the drive to replace British staff with locals became effective. The new ministers went along with their influential professional staff. The driving force behind Malayanization were the medical alumni from Singapore. They moved systematically to replace the British doctors, although they personally liked some of them. In Kuala Lumpur, a medical school was started, which soon became a university. Demand for tertiary education – the principal channel for upward mobility, apart from politics – resulted in rapid proliferation of universities, both public and private, many of which set up medical schools.

The leaders of the health professions retained their orientation to British education, and doctors turned to the royal colleges for postgraduate training and certification. Soon local medical schools created their own postgraduate specialist programme in response to demands for Malays to be trained as medical specialists. The success of this policy can be seen in the preponderance of Malay doctors of all grades in public hospitals now. The same process took place in the civil service.

There was for the first time a preoccupation with the needs of our people. A rural health service was initiated, new specialties created, including the speciality of family medicine/general practice, and generous allocations of research funds became available. Even larger numbers of young doctors were sent abroad, still mainly to the UK, for training and certification.

Modernization

Following 'Malayanization', a high degree of professionalism emerged. Advanced training developed which was in time offered to other developing countries. The first new universities achieved high standards, and entered postgraduate training and qualifications. A self-confident generation of experts filled posts in the public services, gently replacing their local seniors who had risen by seniority out of the old colonial service.

In medicine, an emphasis on science and expertise, and keeping up to date with research became the paradigm. Research was regarded as important, and public health research, beyond malaria, received attention and funding. New specialty institutions began to appear at the Kuala Lumpur General Hospital.

The public health services, underpaid and over-extended, remain the mainstay of health care for the majority of people. They are further strained by VIP pressure for privileged access and expensive care. Health care is virtually free to anyone willing to wait, and to overlook the shabbiness of facilities and shortage of staff. Some 80 per cent of those hospitalized are in public hospitals, and half of all outpatients attend public clinics and the outpatient departments of public hospitals. The numbers increase sharply when the economy slows.

The public sector trains all categories of medical staff, and does all research. It is the exclusive source of care for perhaps half the population and provides a safety net for those whose incomes fluctuate with the economy. It is also provider of last resort for patients who are very ill and whose savings have been exhausted, or who have been admitted as emergencies.

Our health indices are very good. For example, in 2005, life expectancy was 76 years for women, and 71 years for men, and the infant mortality rate was 5.8 per 1000 live births. Since Independence, the public health services have performed brilliantly in dealing with the principal causes of mortality and morbidity associated with a poor colonial territory. The challenge to improve further will be more difficult.

The 'developed' country pattern of disease is the price of rising living standards. The new causes of morbidity and mortality, replacing malaria, tuberculosis, infant gastroenteritis and respiratory infection, are hypertension, diabetes, ischaemic heart disease/atherosclerosis and cancer. Increasingly important are the consequences of 'lifestyles' – tobacco smoking, alcohol excess, excess fat and calorie intake, physical inactivity and obesity, and sexually transmitted infections. Infections spread by international travel are a new phenomenon, including HIV and SARS. More research will be required to design new public health approaches, and a high degree of personalized intervention will be needed to reduce morbidity and mortality from the new causes of death.

Public hospitals and ambulatory care provide open access to all Malaysians. No financial barrier exists for ambulance services, receiving emergency or normal treatment, or for admission to open wards, that is 'Third Class', where conscientious care will be given by overworked and underpaid nurses and doctors. Government servants have assured medical care, and ward accommodation allocated according to rank. There is continuity with the colonial practice of East India Company employees in 'Company' hospitals! The public health care system is the 'safety net' for the great majority of Malaysians, and they are fiercely protective of this right to free access. It is now in a bad state, unable to deter all categories of staff from leaving for the private sector. Nevertheless, resources continue to be diverted to private contracts for building more hospitals that are beyond the available staffing capacity.

Privatization

Privatization was heralded by the 'corporatization' of profitable government departments and agencies. In reality, it was not a straightforward transfer of public assets to the successful corporate bidder in an open competition. Public assets were secretly allocated to powerful political interests.

For the first time citizen activist groups have appeared. Their hostile reaction to the possible 'corporatization' of public hospitals pressured the government to give a categorical assurance, before the general elections, that this would not happen. An unanticipated consequence was that the good idea of giving more management power to individual hospitals, instead of them being controlled by ministry officers, was scuttled. A sensible way out would be to establish statutory trusts, by Act of Parliament, mandated to manage the hospitals efficiently in the public interest.

Emerging issues

There are multiple tiers of care. The private sector looks after the better-off, and access is slowly being extended to senior public servants. Government servants are separated from the community, in the colonial tradition, by privileged access to public health care services, and to some private hospitals. Employees of statutory authorities may also have access to private hospitals.

The urban workforce has limited access to health care as part of their employment benefits. Relatively small numbers have private insurance. The majority are outside the sphere of organized care, and they move between the public and private sectors for episodic care, depending on their income at a particular time.

The take-over of health decision-making by politicians means that projects can be awarded without assessment by the expert professionals in the Ministry of Health. This cost is hidden, noticeable post hoc in the accounts and budgets, or from reliable leaks that have become the principal source of information. There is a cost to the community.

The persistence of low relative incomes amongst the majority of the population, with increased urbanization, has generated high levels of stress among people, with predictable consequences. The Malays remain the largest number amongst the underprivileged, in spite of a half century of privileges which never reached small Malay businesses and rural Malays. This is ominous for our future.

With increased commercialization of health care, and diversion of health funds to private interests, a multi-tiered quality of care has become entrenched. The better-off in our society have sustained a parallel health system (as with education), from ambulatory care to tertiary centres, funded and managed by foreign investors under liberalized access claimed under free trade agreements and supportive government policies. There are also World Trade Organization (WTO) concessions and an Association of Southeast Asian Nations (ASEAN) services network agreement. Foreign investors already own most private hospitals and they are now moving into primary care through so-called ‘ambulatory care’ centres. (In education, too, there is a fast growing parallel system with numerous foreign investors, from kindergarten to university, offering overseas qualifications, taught by visiting teachers from overseas.) The middle and upper classes have seceded from the national stream!

The commercialization of health care, and neglect of rural health, have serious consequences for the management of diabetes, hypertension and cardiovascular disease, which require continuing care, not merely episodic care. The rural population bypasses good government rural facilities and goes to the cities for private care, believing they will get better care. The urban poor, who cannot afford the loss of income that the long wait for care at government facilities entails, either neglect their health or make visits to private doctors when they can afford it.

There is under-investment in public health facilities and failure to retain skilled staff. It is more rewarding for politicians to build costly, unnecessary hospitals with expensive equipment that carry costly maintenance contracts. Training nurses, doctors and technologists has become a subsidy to the private sector, which is growing fast and pressing for more skilled doctors and nurses.

Malaysia has targeted 2020 to be a ‘developed country’. The collapse of the public sector in health (and education) gives rise to forebodings of a highly inequitable future, with health services transferred to foreign investors and their local partners.

Medical ethics is the main subject in two of the 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 (SMA) 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 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 challenge us to reconsider our ethical stand; 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 struggled with ethical dilemmas: *"Have you ever heaved a sigh 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, but 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."*

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."

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."

"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*."

Articles included:

16. Ethical Consequences of Technological Change [1983]
17. Dr Sun Yat Sen Oration. Between Faith and Reason [1994]
18. Ethics, Professionalism and the "Trade" [1996]
19. Rural Health and Global Equity: Am I My Brother's Keeper? [2012]
20. Achieving Equity Through a Primary Care-Led Health System. [2013]

16.
Ethical Consequences of Technological Change

Rajakumar MK. SMA Lecture: Ethical consequences of technological change. Singapore Med J. 1984; 25(1):1-5.

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 meningomyelocoele, 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 not 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 out 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 scare 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 sigh 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."

17.
Dr Sun Yat Sen Oration: Between Faith and Reason

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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 someday 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.

18.
Ethics, Professionalism and the "Trade"

Rajakumar MK. Ethics, professionalism and the "trade". National Conference on Managed Care. Primary Care Doctors' Organisation of Malaysia, 17-18 August 1996. Petaling Jaya, Malaysia.

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 United States. 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 the United States)

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 United Kingdom)

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.

19.
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 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.

20.
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.

In this article, Dr Rajakumar share his "*thoughts as a Malaysian, and as a citizen of the world*" 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*."

Below are a few quotes taken from this article.

He began his article with this humble statement:
"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."

He implored us to look beyond our trivial differences:
"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."

Here is his observation about politics:
"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."

A bold prediction:
"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."

Three suggestions for the world:

"Humanity needs to intensify its feminine values to rescue it from calamity."

"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."

"We need to organize global movements of citizens, if we are to solve global problems in a civilized manner."

Article included:

21. M K Rajakumar, The Millennium Lecture. Looking Back, Looking Forward. January 2000

21.
Looking Back, Looking Forward

M K Rajakumar, The Millennium Lecture.
January 2000, Edited: March 2008
An earlier version of this article was published in: Sundaram JK (ed). Reinventing Malaysia: Reflections on Its Past and Future. Bangi: Penerbit Universiti Kebangsaan Malaysia, 2001.

Editor's note: Only Part One of this lecture is included. Part Two of this lecture which discussed the political issues in Malaysia has been omitted.

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 re-emergence 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 c1amour 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 United States 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, professional 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.

Appendix 1: Dr M K Rajakumar: A Brief Curriculum Vitae

Academician Dr M K 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
1991-1991	Vice-Chairman, International Union Against V.D. and Treponematosis, Asia-Pacific
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)

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2. SMA Lecture: Ethical Consequences of Technological Change. Singapore Medical Association Annual Lecture. Singapore, 15th April 1983
3. Future of Family Medicine in Developing Countries. Plenary Lecture, 10th WONCA World Conference. Singapore, 24th May 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.
6. Towards Excellence in General Practice. Luncheon lecture, Hong Kong College of General Practitioners. Hong Kong, 24th May 1985.
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9. Second Taro Takemi Oration: Health, the Environment and the Physician. 18th Congress of the Confederation of Medical Associations in Asia and Oceania. Melaka, 19th August, 1993.
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.
12. Rural Health – A Global Issue. The First International Conference on Rural Medicine. Organised by the Chinese Society of General Practice, Chinese Medical Association in cooperation with WONCA. Shanghai, China, May 21-29, 1996.
13. Ethics, Professionalism and the "Trade". National Conference on Managed Care. Primary Care Doctors' Organisation of Malaysia. Petaling Jaya, Malaysia, August 17-18, 1996.
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16. Rural Health and the Global Village. 3rd Rural Health Week. Melbourne, Australia, 24-30 May 1999.
17. Appropriate Prescription of Medicines for Older Persons. National Conference on the Care of the Aged Population. 1999.
18. Millennium Lecture: Looking Back, Looking Forward. 1999.
19. Practical Guidance in Sexual Dysfunction. The 4th Teaching Course for General Practitioners, 14th Sept 2001, Penang. 2001.
20. Medicine, Law, and Human Rights. Third National Medico-Legal Conference, 2-3 June 2001, Kuala Lumpur. 2001.
21. Managing Sexual Dysfunction. Fakulti Perubatan, Universiti Sains Malaysia, Kelantan, Malaysia, 12th November 2001.
22. Re-Inventing Healthcare Delivery. Fakulti Perubatan, Universiti Sains Malaysia, 10 November 2001. 2001.
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24. Sexual Dysfunction - Causes and Evaluation. The 4th Teaching Course for General Practitioners. Penang, Malaysia, 14th Sept 2001.
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27. Quality in family practice. 12th WONCA Asia Pacific Regional Conference. Kuala Lumpur, Malaysia, 2002.
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29. Medical Records in General Practice. Seminar and Workshop on Medical Records, Organised by Malaysian Medical Council. Institute of Medical Research, Kuala Lumpur, Malaysia, 11th Aug 2003,
30. Planning A Primary Care-Led Health System. National Conference on Medical and Public Health. Balai Ikthisas Malaysia, Kuala Lumpur, Malaysia, 13 Sept 2003,
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Appendix 3: Reflections and Comments

"*This book,* Family Medicine, Healthcare & Society: Essays By Dr M K Rajakumar*, contains many articles that were written more than three decades ago. The messages contain therein are almost timeless and are still highly relevant today. There are many a useful lessons, not just for the family physicians, but for health professionals in general and for all right thinking individuals who wish to improve the world we live in.*"

--- Tan Sri Ismail Merican, Director General of Health, Malaysia
book launch of first edition,14th April 2008

"*Dr Rajakumar practiced the principle of thinking globally, acting locally. He practiced in the run-down district of Loke Yew, and remained faithful for many years to this population that did depend on him for medical care. And he fostered international relations for WONCA beyond the direct context of health care – in particular the collaboration with UNICEF, in line with his social conscience and political leadership.*"

--- Chris van Weel, President of WONCA
WONCA News 2009

"*Dr Rajakumar guided the establishment of academic departments of family medicine around Malaysia, Hong Kong, and China. His vision for developing and seeking recognition for the discipline, based on sound research, was rather radical when it was proposed some 15 years ago.*"

--- William C W Wong, University of Melbourne, Australia
Asia Pacific Journal of Public Health 2009

"*For Raja, medicine was not a means of gathering wealth but for helping people, especially the down trodden and the disadvantaged groups. He set up his private clinic (known as Klinik Rakyat – People's Clinic) first in a semi urban area near Klang and later in low-cost flat in Kuala Lumpur. He was dedicated to the poor. His fees were very low, and oftentimes he did not charge anything to those who could not afford to pay for his services and medicines.*"

--- Syed Husin Ali, retired politician
10-year Remembrance of M K Rajakumar
16th December 2018

"Dr Rajakumar's life and works had been inspirational for many. The Academy of Family Physicians of Malaysia has continued to honour his memory by holding the Rajakumar Oration during the annual convocation ceremony, as well as the Rajakumar Award for the best primary care research of the year."

--- Datuk Dr Daniel M. Thuraiappah
Past-Presdient, AFPM
10-year Remembrance of M K Rajakumar
16th December 2018

"Past failures to health reform are conspiring to further undermine 'value for money' spent on health services, both by the government as well as by consumers, while further weakening public health services and progress on health indicators in Malaysia besides eroding official commitments to 'health for all' and 'universal health coverage'. Before his passing over a decade ago, he was very concerned about and even anticipated some of these developments. He would be pleased to know that there are others, including those reading and inspired by his work posthumously, who continue to strive to realize his dreams in the new Malaysia."

--- Jomo Kwame Sundaram, Economist
10-year Remembrance of M K Rajakumar
16th December 2018