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Editorial

The Training Of Future Doctors

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INTRODUCTION

In the training of our future doctors there is a need to address balance and integration. Specifically, there is a need to balance the provider's thinking which is "supply-side" with the public's thinking which is "demand-side". There is a need to integrate scientific excellence with humanistic concern, horizontal with vertical levels of care and the roles beyond care giving.

The professional development and socialisation of a doctor as a healer has three phases, namely, the undergraduate, the early postgraduate and the later postgraduate phases. The undergraduate phase is primarily educational. Under Professor CC Tan, the Dean of the Faculty of Medicine, NUS, the new curriculum for undergraduates has been finalised. The details have been described in a paper published in the June issue of the SMJ and in this issue[1,2]. This is also a phase where exposure to good role models can have a lasting impact[3].

The training of the postgraduate doctor refers to the acquisition of knowledge and skills to enable him to practice. It is the focus of the vocational training period and the life-long continuing professional development period which follows.

BALANCING TWO KINDS OF THINKING

A paper by Evans[4], based on a lecture he delivered in October 1991 at the University of Chicago Centennial Conference, "The Future of American Medical Education: The Legacy of Lowell T Coggeshall" provides food for thought in the way ahead for training our doctors in Singapore.

Evans alluded to the Health of the Public programme launched by the Rockefeller Foundation in 1988 to encourage American academic centres to shift from "supply-side thinking" to "demand-side thinking". Since academic medical centres shape the training and practice of doctors passing through them, there is a need to examine this idea more closely. He described "supply-side thinking" as thinking driven by the need to find patients to fit the interests and technical capabilities of specialists and the equipment and services of hospitals. It tends to overlook those who do not fit supply-side interests.

"Demand-side thinking", also known as "Health of the Public thinking", in contrast, addresses questions from the perspective of the patient and the population of a community. What is the burden of disease in the population? What factors influence the severity of illness or disability? What interventions are most effective in prevention, diagnosis and treatment? What individuals are being missed? How can available resources be applied more effectively or new resources mobilised to cope better with these needs? How can policies and investment in other sectors influence the health status of both individuals and the community?

Both supply and demand interests are important in the design of the doctor's training but generally there is an imbalance in favour of supply-side interests. To redress this imbalance, there is a need in the training agenda of the future to define the new roles and competencies needed by doctors to meet the health needs and expectations of the public.

His concluding paragraph points to a more meaningful way to international fame. He said, "If supply-side factors dominate the academic health centre, the measures of success will be peer recognition, institutional ranking, and fund-raising. These goals might be achieved without a significant impact on the health status of the community. But academic health centres can also achieve international eminence by having local relevance, through attention to the health needs of the populations served by the centres. For most academic health centres, this will involve a broadening of perspective with greater emphasis on demand-side factors, restatement of mission, and development of an appropriate implementation strategy. Through a better balance of the driving forces of supply and demand, the academic health centre will fulfill its fundamental and enduring mission – the fostering of the health of the public."

INTEGRATING SCIENTIFIC EXCELLENCE AND HUMANISTIC CONCERN

The study by Fones et al[5] in this issue defined the wants of the public. The public regard being knowledgeable in medical matters, keeping up-to-date and being responsible as the top three characteristics they would like to see in a doctor. The public also liked items relating to the emotional and communication domains and gave these domains higher mean ratings than doctors. This study emphasises the point that the doctor needs both technical competency as well as humanistic skills to meet the wants of his patients. The results of this study are validated by the views of non-medical professionals asked to describe the characteristics of a good doctor in this issue of the SMJ. See pages 532-534.

INTEGRATING HORIZONTALLY AND VERTICALLY

One of the reasons for rising costs in health care and disenchantment of modern Western medicine is the increasing fragmentation of care, the consequent duplication of services and lack of consensus among health care providers. There is a need for the doctor in future to be able to integrate horizontally relevant aspects of care. The rise of specialisation and subspecialisation must have opportunities for such integration. For the young specialist upon completion of training, there should be one or two years that are spent in general work of the discipline. Thus, a specialist who is training to be a cardiologist as a life career should spend a stint in general medicine. Similarly, a vascular surgeon should spend a stint in general surgery. They may not like it for the moment but will see the wisdom of that in years to come. In America, the specialist goes on general calls so that he is exposed to the problems outside his narrow specialty. Perhaps, this should be practised in Singapore, if not already done so.

For those who choose to be family physicians, another type of horizontal integration is needed in their mindsets. McWhinney, a doyen of family medicine from London Ontario, Canada observed, "The family physician acts not only across clinical boundaries, but across that very difficult one: the boundary between medical and social problems. The boundary is difficult because it is seldom clear-cut. Patients' problems have a way of bestriding it. To the family physician, therefore, falls the responsibility of managing the interface between clinical practice and the counselling professions."[6]

Then, there is a need for exposure and cross-fertilisation of ideas, concerns and expectations of colleagues in the different levels of care, primary, secondary and tertiary. The interactions between generalists and specialists should be encouraged both during vocational training and in subsequent years. The paper by Lim et al[7] in this issue highlights the way for a new approach to vocational training in later postgraduate years for family physicians.

INTEGRATING ROLES BEYOND CARE GIVING

It is no longer enough just to be a care giver. There is also a need to train doctors to take on other roles relevant to health care delivery in the broadest sense. He needs to be trained in the basics of decision maker, community leader, manager, educator, investigator and policy maker. These are generic roles applicable to both the specialist and the generalist of today and tomorrow.

THE TRAINING AGENDA FOR TOMORROW

What then will the training agenda for our doctors be like in the future? The future doctor needs to be

- well educated in the core knowledge, skills and values set out in the new undergraduate curriculum of the National University of Singapore,
- able to balance the needs of the medical profession on the one hand and the needs of the individuals and community he serves on the other hand,
- able to deliver care that integrates scientific excellence with humanistic concern.
- able to integrate health care delivery both horizontally and vertically, and
- able to take on the roles beyond the care provider to be decision maker, community leader, manager, educator, investigator and policy maker.

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