Convocation 2013

HIGHLIGHTS FROM THE SREENIVASAN ORATION 2013

by Dr Tan Tze Lee, Honorary Secretary, 24th Council, College of Family Physicians Singapore

Professor Richard Murray delivered the Sreenivasan Oration 2013 at the NUSS Kent Ridge Guild House on 23rd November 2013.

Our Sreenivasan orator this year was none other than Prof Richard Murray President of the Australian College of Rural and Remote Medicine. In his address he focused on Medical Generalism and his vision of the future of Family Medicine.

In Rural communities there is an urgent need for an expansive generalist role for Family physicians to provide comprehensive coordinated ambulatory care for individuals, families and communities. This extends to hospital inpatient care and emergencies, extended specialized skills and a systems and population health approach relevant to the community of practice.

Why is there a need for medical Generalism? The issues of affordability, safety and effectiveness comes to mind, unfortunately we can only choose 2 out of 3.

Professor Murray's address on the "Medical generalism & the future of Family Medicine".
Courtesy of Prof. Richard Murray's presentation slides

Affordability is always at the fore. However is there really a shortage of doctors? Doctor densities globally have been decreasing globally. The real issues confronting us are in fact the excessive subspecialisation, geographic maldistribution, and inefficient models of care. Most specialist doctors in Australia are found in the major urban coastal cities, whereas the GPs are fairly well spread out in the nation, both rural and urban.

Specialism, now a necessity, has fragmented the specialties themselves in a way that makes the outlook hazardous.
The workers lose all sense of proportion in a maze of minutiae. Everywhere, men are in small coteries, intensely absorbed in subjects of deep interest, but of very limited scope…
Applying themselves early to research, young men get into backwaters far from the main stream.

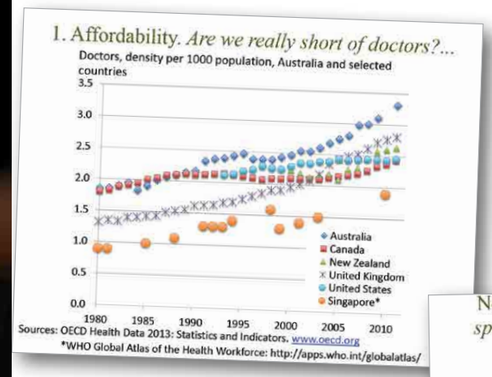
~ Sir William Osler

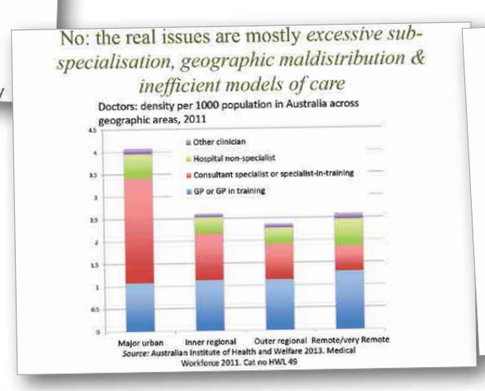
He also added that even though health expenditure had increased far above inflation over the past 10 years these increases were mostly accounted for by new improved and more services per individual rather than the result of population growth or the ageing population.

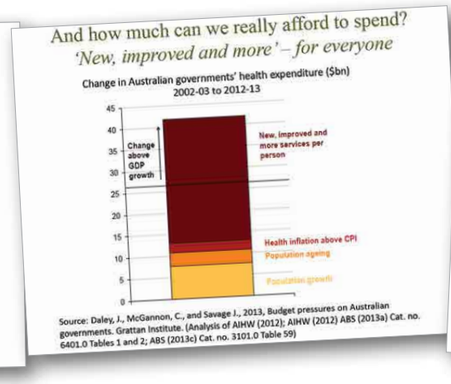
He touched on the need to radically change the systems to care to beyond the individuals' professional credentials and scope, and that the Family physician should be working at the top of his license. He gave the example of managing kidney failure in rural Australia. The numbers needing renal replacement is doubling in remote Australia every 5 years, and access to haemodialysis is a key issue. Metro service models based on Home HD" or major centre "satellite HD", with remote embedding "satellite' in a PHC context in remote centre, with training and support for "home HD". Home was often better in a local clinic, with a salaried health worker, community nurse or lay helper. This would be complemented with medical oversight by GP nephrology with extended skills, and a delegated practice relationship with distant specialist nephrologist. Better outcomes were the order of the day and results were not inferior to those from major urban centres.

The features of a successful system of care are two-fold, first the Network of referral pathways, training, supervision, 'phone a friend', education, QA, advocacy for and with communities. And secondly the Culture of the system, which is patient centre, inter-reliant, cultivation of personal relationships, trust and respect.

We have to rethink questions about quality and safety. Volumes have poor correlation with outcomes and it would appear that team competence is as important as individual competence. A whole system planning is required, not just narrow facility focus. Accessibility acceptability is integral to quality and safety with generalism being preferred as opposed to organ-based care.







He highlighted the use of disruptive technologies to help rebalance generalism, such education at a distance, information at the bedside and breaking down the walls of medical care.

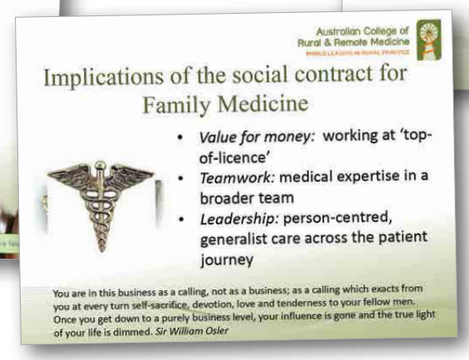
He gave several examples of telemedicine at work, such as Dr Jim Muir Teledermatologist extraordinaire who provides the ACRRM TeleDerm service and education resource. Consultation was just an email away, even for colleagues serving in the military in the Middle East. Such telemedical consults is just the beginnings of an educational resource. In the rural setting, telemedicine gives communities access to consultant care, and allows for education and skills transfer and is wholly efficient in supporting a 'system of care'.

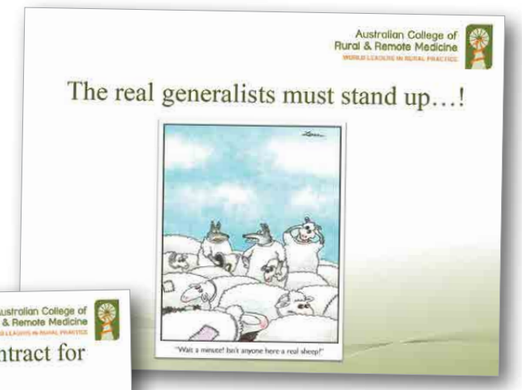
As medical practitioners, society grants us monopoly over the use of a body of knowledge and the privilege of self-regulation, whereas the profession in turn guarantees professional competence, integrity and the provision of altruistic service to society.

"For the ideal of professionalism to survive, physicians must understand it and its role in the social contract. They must meet the obligations necessary to support professionalism and ensure that healthcare systems support, rather than subvert, behaviour that is compatible with professionalism's values." Cruess S, Cruess R.

What that means is that family physicians should work at the "top of licence', and be advocates of team-work providing medical expertise in a broader team, and provide leadership in a person-centred generalist care across the patient care journey.

The generalists must standup!





You are in this business as a calling, not as a business; as a calling which exacts from you at every turn self-sacrifice, devotion, love and tenderness to your fellow men. Once you get down to a purely business level, your influence is gone and the true light of your life is dimmed.

~ Sir William Osler