Induction Address - 1993

Priorities in health care for the 21st century

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Our Chief Guest Mr. Robert England, Resident Representative UNDP, Prof. Priyani Soysa the immediate Past President, members of the Diplomatic Corps, members of the Ceylon College of Physicians, and Honoured Guests.

Let me begin by thanking the College for electing me to the high office of President of the Ceylon College of Physicians in its twenty sixth year. It is with humility and trepidation that I accept this great honour. I must pay tribute to the sixteen illustrious past presidents who have preceeded me in our twenty five years of existence, each of whom has played a magnificent role in taking our College forwards.

Our very first President was Dr. E.M. Wijerama who adorned this post for three consecutive years from 1967. In our twenty fifth year we elected a Lady President for the first time in the history, Prof. Priyani Soysa. It took our sister College, the Royal College of Physicians of England over three hundred years to bestow such an honour on Dame Margaret Turner-Warwick who was our chief guest at the Annual sessions last year.

Three of our Past Presidets have gone beyond the veil, Dr. E.M. Wijerama, Prof. K. Rajasuriya and Prof. N.D.W. Lionel. All the others are present here this evening.

I know I face onerous duties but I am greatly encouraged by the goodwill expressed by so many of my colleagues and particularly the members of the Council.

I guess every President standing on the threshold of induction looks at that which has been inherited and tries to discern those things which should be cherished and developed. There is one brief year in which to make this journey and implement any grand design which may have some influence on the mosaic of medical life. We have just celebrated our Silver Jubilee and are now in the first year moving towards our golden Anniversary in the year 2017. As we move into the twenty first century let us pause a while and consider two subjects that may be of importance in the practice of medicine in the next decade, one of which is esoteric and the other of a very practical nature, namely the mechanisation of medicine and the geriatric revolution.

Medicine by satellite: This was an article which I read while on an Indian Airline in the "*Hindu*" of the 25th October 1992. It depicts a patient in a hospital in Paris. His MRI scan was being read by a Japanese Radiologist in Tokyo, teleconferencing with a Surgeon in New York. The Surgeon then pressed a few buttons and instructed the robot to operate on the patient.

We see that emphasis on science and technology characterises the present era. I quote "as medical practice grows more rationally scientific enlarging its vast array of technical devices like the artificial heart, as medical science become more capable of treating organ disease, physicians seem less and less able to come to terms with symptoms which have no objective counterpart" — Howard Spiro.

DISEASE	PATIENT
PATIENT	CASE
CURE	CARE

Are we forgetting the difference between a patient and a case? A patient is a person who has a disease.

A case is a record of the course of the disease in a patient. The emphasis in a case is on a disease entity — it tells of the life of the disease but not the life of the patient.

In these days when alliteration seems very fashionable, to quote our President — Consultation, Concensus and Compromise becomes for us Compassion, Care and Cure. Hospital training lauds the virtues of cure but seldom care. Our goal in Medicine seems to be diagnosis and cure, care is sometimes ignored. Our own College motto exhorts us to cure, comfort and relieve. We must make an attempt, if possible, to cure, but always comfort and relieve. We need to rediscover the sense of a person in a patient. We must learn the importance of healing the whole person, not merely curing the disease which afflicts him (even in those depressing situations when no cure is possible).

There is much in the lure of technology for Physicians particularly when it gives them little print outs to be shown to one another. The Icons of disease like X'rays, Echoes which show the heart and its valves in motion, the ultrasound scan (this shows an enlarged Gall Bladder), the ECG which depicts the fluttering of our heart as a poet will describe it, but to the prosaic doctor its rhythm.

1 *President, Ceylon College of Physicians 1992.*

An EEG shows the electrical impulses of the brain but say nothing about the emotional output. They do give an image to the symptom of the patient but these images are sterile and flat. They do not carry all the emotions, fears and feelings a patient experiences. This kind of flattening is seen not only in Medicine which is a Science. Look at what this outlook has done to Art. This is a picture by George Keyt whom I would like to call one of the foremost artists Sri Lanka ever produced. Pause a while and look at this picture. Again Cubism but it seems so sterile. It hangs in the ICU of one of our best equipped hospitals in Colombo. Does it not convey the sterile atmosphere of an ICU as opposed to the warmth of the George Keyt.

Now Radiologists need not touch or talk to a patient. The patient can be wheeled into a silent CAT scan room and put into what almost looks like a coffin. The Radiographer talks to him from behind a sheet of glass. His whole body is examined in millimetre cuts and then put together again. But do we put the whole patient back together after his complaints have been fractured into MRI and CT scans?

For many years we in Sri Lanka practiced primary health care and being a Third World nation we had to depend on our faculties to make a diagnosis. I know my teachers and Physicians before them who could virtually smell a disease from the top of a ward.

When I was an Intern I remember very well a young boy being admitted on casualty night. The house-officers and registrars struggled to make a dignosis and even a Lumbar puncture was done. It was night and the lighting in our ward left much to be desired. In the morning the senior physician came in, stood at the entrance to the ward, heard the patient restless and screaming. "Is he in liver failure" he asked. Sure enough as we moved on to see him we could see the yellowness of this eyes in the morning light. I know a neurologist, still active, who with a swing of his knee hammer and a look deep into the eyes with an ophthalmoscope made the diagnosis which a CAT scan now can merely confirm.

But now we are moving into Tertiary care medicine and even to more sophisticated modalities like the intensive care units. We are happy that the Department of Health has given us facilities for CT scanning, Digital subtraction angiography, a Lithotripter to blast renal stones, Laser treatment to the eye and various Intensive Care Units. As we progress to use these technological advances, which I do not by any means deride, let us examine how the concept of disease changes when we depend on such imaging techniques to show us disease rather than infering the diagnosis by simply listening to our patients. We have switched from the ear to the eye. As Meyer put it, blaming it on the Americans for the technological explosion (I am sure with his tongue in his cheek) — "the English ear has been killed by the American eye." Modern diagnostic images give the objectivity which we physicians so prize but these images may denature and dehumanise disease. This tendancy is by no means modern.

Looking back into the history of Medicine, the real father of medicine Aesculapius relied on magic and oracles. Their learning was a learning on how to deal with men. They themselves were the therapeutic agent by which cures were effected. This may have been unscientific. Is it not paradoxical that the serpent of the cult of Aesculapius is still the symbol of modern scientific medicine. Hippocrates then came along with a more scientific approach to medicine, the basis of which was

1. Wide knowledge of natural science.
2. Experience in practical medicine.
3. Clear and logical reasoning about cause and effect.
4. Ethical concepts.

Diagnosis depended on what you saw and heard and prognosis on the knowledge of what happened in the past and would happen again. In the Middle Ages the liberal arts were divided into:

1. Trivirium which consisted of grammar rhetoric and logic (Verbal methods of analysis)
2. Quadrivirium with Arithmetic, Geometry, Astronomy and Music (Measurement and Calculations)

Both these disciplines enjoyed equal status. However, faith in mathematics and science rose in esteem and the Trivirium yielded in importance to the quardrivirium.

To William Osler, one of the greats of Modern Medicine, medicine was as much an art as a science. Poetic imagination is as important in medical practice as science. I quote Howard Spiro. "It is instinct and intuition first leads to beliefs which reason subsequently confirms or refutes."

"Already the shrill lark is out of sight
Flooding with waves of song this silent dell
Ah! There is something more in that birds flight
Than could be tested in a crucible."

Garden of Eros — Oscar Wilde.

Part of the fault may lie in our method of selection for medical studies. To enter the portals of medical college students need to obtain very high grades in scientific subjects and have to study hard in a narrow spectrum of scientific disciplines. The humanities are neglected. This process tends to produce convergent thinking skilled in assimilation and regurgitation as opposed to divergent thinking with its originality and critical thought" — Ballint.

Interest in the humanities, in art, literature and music will produce a more complete doctor. A well read physician will be more aware of the tones, shades and nuances in the history than one who knows only the cold world of science. After all look at what poetry, a good film, music does to us personally. They are media that move us and have great power over us. Medicine they say, has become a world of silence between the doctor and the patient broken only by the bleeps and whirrs of monitors. We have to cultivate our listening and communicative skills to bridge the gap between us and the patient. The therapeutic power of speech needs more attention and studies. Upto now I have emphasised the difference between high tech low touch. Do not get me wrong. We physicians have always been caring but our focus seems a little blurred by technological advances. So thorough has been our indocrination in the world of science that we have moved away from intuition wholly to reason and science. Medical life has become separated from intellectual life a phenomenon so decried by C.P. Snow in his Rede Lecture. The two cultures given in Cambridge as early as 1959. By always ensuring high touch and applying appropriate high tech we can provide the ideal.

There is another aspect to this problem. For many years, almost to the advent of Fleming and Penicillin the physician was virtually unable to influence the course of physical disease. But the physician not only survived but was held in high esteem using the front entrance to palaces, as opposed to our barber Surgeons who had to use tradesman's entrance.

Now in the 20th century when we have the ability to change the course of disease even with genetic engineering (apart from common — or garden antibiotics, pacemakers, brain cell transplant, renal support systems) society has become critical of its doctors. This in simplest terms reflects the disparity between what the physician sees as his job and what the patient seeks of him — the expectation of patient. The only way to stop this deterioration in relationship, which in many countries has led to the practice of defensive medicine, is to bring back the art and craft into medicine.

However, do not get me wrong. We have to move with technological advances to provide better chances of cure for our patients, and I am all for it. But let us not lose sight of the patient as a person. A few days ago, at the inauguration of the Annual Sessions of the College of Anaesthesiologists I was happy to note that Dr. Aung Myint the WHO representative in Sri Lanka, promised to introduce the state of the art technology to Sri Lanka, but I was also so glad when Dr. Sunitha Gunawardene pointed out that the Class I monitor in the ICU or the anaesthetic setting was the Consultant, that placed the human element before pulse oximetry and ECG monitoring.

Most of the craft of medicine will always be an intuitive process concerned as it is with the magic of our profession. Medicine, Marguli says, is primarily an art and dependently a science. Let us make it an institutionalised service concerned with care as well as cure of the ill.

Now we move on to a very practical topic that of the aging population and medicine. A population is said to be aging when the proportion of its elderly is rising. This may be due to decrease in mortality, decrease in fertility, or major historical events like wars and migration.

In Sri Lanka, a combination of all these factors operate so that the older age group will grow faster than the younger age group, changing the age structure of the population gradually to an older configuration. In 1981 the age structure is broad based and gradually tapering to a pyramid.

While in the year 2001 it assumes a dagoba shape and two decades later may even assume that of a cylinder with a hemispherical top.

The aging index, i.e. the number of population under 15 years/number of population over 65 years, projected from 1963 to the year 2000, shows a sharp rise.

Dependency ratio is the number of young children and elderly persons who depend on 100 people of the working age group in a population. This old age dependency ratio increases as we zoom towards the year 2000.

Dr. Suren Ramachandran studied 5809 consecutive admissions to his ward over nine months and found that 1/10th of the admissions to Medical Wards were in the geriatric age group.

Over 65 — 9.5%
75 years — 6.3%

A study in British Hospitals in 1975 showed that the bed occupancy of the over 65 age group was 23%. In 1980 this rose to 50%. At this rate it is estimated that hospital bed occupancy may reach the phenomenal proportion of 80% by the year 2000.

Let us leave the economics of the problems to able economists but how do we the medical profession prepare ourselves to face the geriatric revolution.

Increased life expectancy of a population indicates not only an increasing number of healthy elders but also a growing number of senior citizens who are not healthy and are frail. They will need specialised care, in Geriatric facilities.

Geriatrics is not a speciality that applies internal medicine, surgery or psychiatry to patients who happen to have grown older. Rather it is an inter-disciplinary data base on human aging, drawing on biological, clinical and behavioural science. It has been an established speciality from the 1959s.

This means that special knowledge and skill is needed for the optimum management of the elderly patient. Disease processes in the elderly occur against the background of age related changes in all body systems. These changes result in altered reactions to disease.

Altered reactions to disease:- manifest themselves in several ways.

1. Symptoms of an acute illness may be non-specific. Confusion, falls, incontinence may each be due to a wide variety of diseases in different body systems.
2. Modification of symptoms may alter the presentation of disease. What is painful in the young may produce very little or no pain in the elderly e.g. silent myocardial infarction.
3. Multiple pathological processes may be found in the same patient, e.g. C.O.A.D. due to smoking could co-exist with carcinoma of the lung and ischaemic heart disease, so that we are faced with a chronically disabled patient with multiple active problems. Our training has not prepared us for this. We have been brought up on the doctrine of the unifying hypothesis, i.e. one patient, one diagnosis. Perhaps the new problem orientated teaching methods will change our outlook and prepare us to deal with the Geriatric patient more efficiently.
4. Failure to report illness, which may be due to misappreciation of the significance of symptoms, e.g. pain in the joints due to Rheumatoid Arthritis may be attributed to just old age.
5. Optimum management of the elderly patient requires knowledge and skills related to rehabilitation. Rehabilitation is, however, regarded as an uninteresting aspect of medical care, left best to para-medics. But to be effective necessitates a detailed knowledge of the natural history of the medical condition, and who other than the Consultant is best fitted to do this?

Classification of impairment disability and handicap must be analysed in terms of four dimensions.

1. The underlying disease
2. The resulting physical and anatomical impairment
3. Resulting functional disability
4. Resulting social handicap.

This will ensure a search for potentially effective interventions for each problem.

Drug Therapy:- Multiple pathology is a standing temptation to poly-pharmacy, the adverse effects of drugs increase both with age for the individual drug and with age related increase in the number of drugs prescribed per patient.

In this country, we have no health-care professionals trained in Geriatrics. It is time to introduce this discipline at undergraduate level and also plan for consultants trained in Geriatrics so that they will be able to take a more positive approach to the great tidal wave when it hits us early in the next century. We have no wards or beds set up for Geriatric patients. Not all elderly patients need to be admitted to hospitals. The basic components of a Geriatric service should be,

1. A Geriatric Unit for illness requiring assessment and therapy including rehabilitation, which is an important aspect of Geriatric Medicine.
2. Out-patient services at hospitals with preference in the queue given to senior citizens.
3. Transport facilities to and from hospital for the disabled.
4. Day care centres and home visitors.
5. Institutionalised care for those who have no relatives to look after them or for terminal care.

I hope I have been able to show the imminence of the Geriatric revolution which is almost upon us.

The presentation of illness in the old age is often mis-leading and different. Treatment requires a knowledge of pharmacokinetics and pharmacodynamics of drugs in the elderly.

Rehabilitation is an important aspect of Geriatrics.

The emphasis of our health system in Sri Lanka has been on vulnerable groups. Originally it was children, youth and mothers. In the year 2000 we hope to have health for all. The elderly have not been spècifically considered a vulnerable group.

Because of the break-up of the institution of the extended family and emerging nuclear units, the decrease in family size, so that there is a decrease in the number of persons who could care for the elderly, women entering labour market, migration to urban centres and abroad reduces traditional support for the elderly. Age brings with it increased medical requirements and we have to meet this challenge. If Paediatrics was important in the 60s, health for all in the year 2000, Geriatrics now takes over in the 21st century.

I quote:-

"For age is opportunity no less
Than youth itself, though in another dress
And as the very twilight fades away
The sky is full with stars invisible by day."

— Longfellow