

## “Reflecting on our past, looking into the future”

Jayaratne S D<sup>1</sup>

*Journal of the Ceylon College of Physicians*, 2017, **48**, 2-7

Members of the Board of Trustees, Past Presidents, Members of the Council, Fellows and Members of the Ceylon College of Physicians, distinguished invitees, ladies and gentlemen,

I consider it a great honour and a privilege to welcome all of you gathered here today, on this momentous occasion. This year, the Ceylon College of Physicians commemorates 50 years since its inception. What started out as a small group of eleven distinguished physicians has now expanded to a college currently counting more than 700 members. Since 1967, the CCP has acted in the capacity of an academic body which advocates for improving standards in postgraduate education in medicine, promoting continuous professional development and learning, ethical conduct and research, in order to enhance professional standards in clinical practice.

It is with pleasure and humility that I accept the responsibility which has been bestowed upon me as the president of the CCP, at this important milestone in its history. I realize that I have quite large shoes to fill, as the distinguished past presidents and their councils have been the pillars on which our college has risen to be the establishment it is today. It is through their tireless efforts and noble contributions that we, as a college, have achieved so much over the past half a century. It is with deep gratitude that we must remember these exemplary pioneers of academic and clinical excellence on this occasion. Here, I would especially like to thank the immediate past president, Dr. Nihal Gunathilaka, and the council members for their excellent work over the past year. Thank you Nihal also for your grand introduction of me, for a moment I thought I was at my own funeral! As the CCP reaches its golden jubilee, it is only fitting that we should fondly reflect on our past, whilst looking ahead with optimism and readiness to the challenges that lie ahead of us. Thus the theme for this milestone year: “Celebrating our past, Igniting our future”.

Trail-blazing innovations and advances in medicine have kept medical professionals on their toes over the past century. It is crucial that we keep up with advances

in scientific research, changes in disease demographics, and public perceptions, whilst remaining true to the core values and principles of professional medical practice. The role of physicians is evolving with time. As a wise man once said “The only certainty with time is change”.

As president of the CCP, I wish to address some challenges we as physicians must be prepared to face in the coming years, highlighting steps that we may take to address these challenges effectively. But first, in keeping with the idea of celebrating the past, I thought it would be interesting to go back in time. Here, I refer to western medicine, as the traditional art of ayurvedic medicine was in place long before the introduction of western medicine in Sri Lanka by the Portuguese, in the 16th century. Exorcists apparently earned a considerable income, so much so that the king imposed a separate tax on them. Actually the colloquial term “ispirithal” is derived from the Portuguese language. There were only four hospitals at the time: Colombo, Mannar, Jaffna and Galle. These were in the cities where the Portuguese based their garrisons and treatment was only offered to the Portuguese. The Colombo hospital was situated near the present day harbour. The GMOA may be interested to know that at the time they received two rice rations and a “curry allowance” every day. However, they brought home additional “gifts”. Although they have to be given credit for introducing Western medicine and building the first hospitals, the Portuguese also introduced venereal diseases and tobacco, both of which have plagued this nation ever since.

In the 19th century there were only three hospitals for civilians: Henadala hospital for lepers, the Pettah hospital for paupers, and the Borella lunatic asylum. The first batch of medical students to receive a formal training in medicine in Sri Lanka, actually completed their training in Calcutta, as a medical school was not established at the time. The first batch of doctors sent to Calcutta also included Dr. W.R. Kynsey, who was the first president of the Ceylon Branch of the British Medical Association, which later became the Sri Lanka Medical Association.

The Colombo medical school, established in 1870, became part of the University of Ceylon in 1942. It initially had three teachers and 25 students. The Ceylon College of Physicians was established in 1967, and was the first College in Sri Lanka incorporated by statute by a bill

<sup>1</sup> President, Ceylon College of Physicians – 2017.



presented to parliament. Dr. E.M. Wijerama, the first president of the college, delivered the first lecture at the inaugural sessions of CCP in 1968, titled "Physicians, ancient and modern". Incidentally the Sri Lanka Medical Association is housed today in the residence of Dr. Wijerama. I wonder why he did not donate it to the College of Physicians.

Ladies and gentlemen, fifty years down the line, we are facing a new set of challenges. I found this quote by Dr. George Bernard Shaw, a famous playwright: "We are made wise not by the recollections of our past, but by the responsibility for our future." There is a need to re-define the roles of the internalist/general physician and keep up with increasing responsibilities: We must adapt to these changes caused by changing disease profiles, shifting market forces, altered public perceptions and new and greater demands on the services we provide as professionals. We must take this up as a challenge and drive through the changes that we need to adopt in a changing world. Rather than fear change and be paralyzed by the chaos around us we need to actively define and pursue a paradigm shift in our field.

As the great Charles Darwin once said, "It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change" I recall when I was a medical student if you look into a girls eyes and they were bright and glistening it meant that she was in love with you. Nowadays if the girls eyes are bright and glistening it probably means she got her lens changed or got a new contact lens. Who knows in the future we might have to do a PET scan of the brain to see if the love area is lit up to confirm that she is really in love with you. Ladies, and gentlemen, change is coming, and we need to change with it. Since our profession is based on patient centred care, one of the first and most important issues we must address as professionals preparing to face the future is the changing face of patient attitudes.

With improving socio-economic status of the population, there has been an increasing access to better health care facilities and more treatment options for the public. In the past, and at least in Sri Lanka, even at present to some extent, the role of the physician is seen as being a sort of "paternalistic" figure, a confidante a trustworthy advisor and a social role model. Most patients usually accept what their physician says without question. However, this is changing rapidly in Sri Lanka, whereas in the West, for the most part, such a doctor-patient relationship has almost ceased to exist. Consumerism has taken its place, with greater patient demands placed on our paid professional services which have been purchased by them. The intimate inter-personal relationships maintained with patients and their families, sometimes spanning several generations, now no

longer exist, with people often seeking second opinions, and doctor-shopping. One of the key reasons for this shift is the technological marvel of the past century – the internet and the ever-expanding reach of mass media. This has caused a massive dissemination of information to which there was previously only limited access. With so much knowledge and information being available with just a click, the public today are much more aware of disease conditions and the options available to them. This know-ledge equips patients to take more informed decisions about their own health, at the same time it places more demands on us to constantly be updated on the newest modalities of treatment options available. With these changes comes the legal challenges that we, as internists will inevitably have to face. Malpractice suits have become common-place in much of the West. In order to deal with this looming threat, it is necessary to improve best practices and ethical and professional approaches to patient care, whilst considering necessary legal defences that are needed to be in place in order to defend practicing professionals.

It would be wise to analyse the situations that cause patients to be dissatisfied. Sometimes this may be due to unavoidable circumstances that leads to pain, suffering or loss of a patient. But often it is due to mishandling of patients and poor communication with the patient, or the complete lack of it.

One of the key factors here is ineffective or lack of communication with patients. This could be due to time constraints, especially in the government sector. However, we must improve effective communication skills-this is very important to prevent misunderstandings. There are many little things we can do as professionals to improve our quality of care and build patient trust. For example if you are keeping your patients waiting, have your staff explain to them the reason why. If necessary apologize. Treat them with respect. Don't interrupt patients to answer phone calls, which is often what happens now-a-days, and you can get distracted and miss important points in history. Also, you must try your best to involve patients in making decisions about their own health. Sometimes this is difficult in our setup, as a large proportion of our population is not very knowledgeable, and do not have the means to gather the necessary information. Such small gestures and improved communication is necessary to build up healthy doctor-patient relationships. Your relationship with the patient is the most important factor in preventing law suits; but don't forget the documentation as what you write on the BHT will be taken as the gospel truth whatever happened in reality, As they say, "nice doctors get sued less often" And this doesn't just apply to the more attractive-looking medics either.

Empathy is very important. What is empathy? It is the ability to understand the feelings of another. It is not the same as sympathy. You have to be able to put yourself in another person's shoes, see their point of view. For this, you must have patience, and a good listening ear. Sadly, this is something that is slowly dwindling away in the modern set-up, with the commercialization of medical practice, and more reliance on technology, rather than face-to-face conversation and history taking.

Another important aspect is professionalism. More than a century ago George Bernard Shaw famously proclaimed that "professionalism is a conspiracy against the laity". I think this perception is clearly augmented in the public eye by the recent behaviour of physicians in Sri Lanka. There are of course many aspects to professionalism but the important attributes that contribute to it are specialised knowledge, competency, accountability, self-regulation, and most importantly, honesty and integrity. In my opinion when private practice enters through the front door professionalism tends to disappear from the back door.

I would also like to touch on the trends in medical education that we must shift towards, in equipping ourselves to face future challenges. Medicine is said to be a science as well as an art. The core or the essence of science is measurement, an art you cannot measure. We appear to shift towards quantification ignoring the art. It will be a good idea to introduce art subjects to medical curricula. Traditionally, medical education has been apprenticeship-based. So the trainee doctor follows their "Boss" the consultant, and hangs on to every word they say. If the boss is dissatisfied, well, you can't exactly yell "you're fired!" like Trump in *The Apprentice*, the reality show. However, at present, remnants of an apprentice model lingers on in clinical teaching. We need to improve interactions with students, and make teaching more of a two-way communication. Apart from focusing purely on medical knowledge and skills, I think it is vital that we also focus on enhancing soft skills like professional attitudes and interpersonal skills, which is sadly lacking to a great extent in our system. Concepts of professional ethics and appropriate behaviour I think should be integrated into medical training at both undergraduate and postgraduate levels. Although these concepts are introduced now into our medical school curricula, they are taught in a didactic manner. What is needed is role-play in real clinical scenarios; the real life situations which are more effective in changing student behaviour.

This makes continuing medical education (CME) and evidence-based medicine vital for practicing internists all over the world. At present in Sri Lanka there is no organized CME program for most doctors after graduate or post graduate certification. Some physicians

do keep abreast of new advances and skills but most do not. As you can see in this picture, half the seats are empty – this is the current state of CME programmes in Sri Lanka. In developed countries physician accreditation or its softer alternative re-validation is a must for a physician to continue in practice. As physicians, we owe our patients a duty as professionals to provide latest evidence based care. It is an ethical imperative. When you are a young budding medic you are filled with enthusiasm, but somewhere along the way some people lose that enthusiasm. In my opinion we at the College can start a program of CME, on a voluntary basis where credit or recognition is given by the College to Physicians. We may be able to collaborate with the PGIM and/or the Ministry of Health for this endeavour.

Nowadays there are guidelines published by various professional associations/organizations for the management of any disease or disorder under the sun. But guidelines are guidelines. True, they are generally evidence based but that does not mean that you have to tick all the boxes in the guidelines in treating patients. This has become a norm in western countries in fear of litigation. How are you going to explain to the judge that you have not followed the hallowed guidelines? You should be the master of the guidelines not its slave. Patient preference after informed consent should take priority in any decision you make. It is definitely a must to be up-to-date with current clinical guidelines, at the same time, you must realize, even with guidelines there is room for bias and human error.

As per postgraduate education, the current setup is that there is a tendency to move towards increasing sub-specialization. But the question is, has this really led to improved quality of health care? Or has it led to fragmentation of the system? In fact, it appears that sub-specialization has led to a less holistic approach to health care. It is more costly, and is also not widely accessible for the wider population. More often than not, we find that this system/approach to treatment actually ends up confusing the patient, as they are not really aware of which specialist they need to consult for each and every one of their ailments, and they end up seeing multiple specialists, who draw up multiple plans of care. This often results in less commitment to patients from multiple health care providers, poly-pharmacy, unnecessary costs of repeated investigations, and does not often change the ultimate outcome. As our patients rather than being referred go directly to consult a specialist, the gate-keeper at present is the receptionist at the private hospital or channeling centre. Common Scenario at present is "mokokda lede" if patient says "oluwe lede" he/she gets referred to the neurologist even though the headache may be due to a febrile illness, "ganu leda" gets referred to Gynaecologist. I know of an instance

where a patient with shoulder pain got referred to a Gynaecologist as the patient's relative said “ganukenekge ledak” to the receptionist. The best part of the story is the patient was treated for shoulder pain by the Gynaecologist. So ultimately nobody gets referred to the internal medicine specialist nowadays.

Internal medicine has been called the “cornerstone of every national healthcare system”. In the face of so many subspecialties, the lines drawn between each of them and internal medicine is becoming increasingly blurred. This is why the role of the internist needs to be redefined. Going forward, I think we as internists need to act as the co-ordinators of care, so that patient management occurs smoothly and efficiently. Follow-up with sub-specialists need to be streamlined and more focused on specific diseases that need very specific diagnostic and treatment procedures. This would save a lot of time, money and effort.

When speaking of ethical issues, I must also touch on the topic of private practice. I proceed with much caution, because this is a topic some might consider insane to even touch upon, but there, I will risk it, as I am retired now !! As a middle-income country, our government has done a remarkable job of maintaining a system of universal free healthcare. However, we find that sometimes due to financial constraints we must deal with a lack of resources. This means that there are instances that we cannot do our very best as clinicians for the patient within the public sector. Here, the private sector offers an alternative to those who can afford paid care, where patients are given access to more resources and often a more efficient service, with shorter lists and waiting times. There is also easy access to physicians as well as specialists through expedited appointments, and the opportunity for patients to seek a second opinion if they so wish. However, as has been seen all over the world, private sector health care has its host of disadvantages as well. Private medicine encourages doctors to make decisions on the basis of profit rather than need, which is a poor driver of clinical decision-making. Professionalism has often been compromised and unethical behavior promoted due to avarice for money. Private Hospitals implement systems that focus first on balance sheets, not patient welfare. It is well-known that some hospitals pay commissions to doctors who order tests or admit patients. And indeed, some doctors gleefully accept this unethical practice without any remorse. It can be said, in short, that “The business of medicine and the practice of medicine are at odds.”

Sometimes physicians exaggerate the disease condition to patients and convince them to play along. Because seeing more patients translate to more profit there is less time spent with each patient, which is dangerous. Often as some patients say “the doctors

don't seem to have time to actually listen to what we have to say, they just have time to order lots of tests and drugs and then move on to the next patient” This also means public-sector patients are neglected, the free services that they are entitled to often get delayed or postponed. Patients are unnecessarily pushed towards consulting specialists as it is more profitable for hospitals, but more costly for the patient. As someone once said “if there be an excess supply of doctors and they are paid fee-for-service” there would not be one womb or appendix left in the population!!! There is also a wide variation in practice standards and fees. There are many unethical practices, misinformation and misleading of the public. The CCP I think should stand strongly for the ethical practice of medicine.

Should private practice be regulated? Is this the solution? Poor public perceptions are often precipitated by our own unprofessional practices. I think it is wise for us to take the initiative and formulate the necessary regulatory policies within the professional community, rather than waiting till the situation reaches a point-of-no-return. A situation wherein the government dictates the terms of service, according to pressures from the public, may not bode too well.

There are advertisements claiming to cure complications of diabetics in half an hour. There are newspaper articles, which claim to prevent and cure complications of dengue fever with untested remedies. These are just two examples of what is advertised in the media ever so often. We physicians are all well aware of patients who discontinue their current treatment because of such advertisements. Sometimes their illness gets worse to a point where we cannot help or they die prematurely because of their belief in these remedies. There is a case heard in courts now filed by the Ayurvedic Practitioners demanding their right to prescribe western medicine. I just cannot understand why they need western medicines when they claim to have such potent remedies. Why do the western medical fraternity remain silent? Western medicine is now largely evidence based. Therefore, we are aware of our limitations and know that we are helpless against some of the illnesses that plague us. We tell our students that patient autonomy is one of the main principles of ethics and patients have all the right to choose whatever method of treatment they wish.

I think it is time for physicians to stop giving alternative medicine a free ride. There cannot be two kinds of medicine – western or alternative. There has to be only one kind of medicine and medicine that has been adequately tested and medicine that has been not. Medicines that work and medicines that may not work. Assertions, speculations, testimonials do not

substitute for evidence. All treatment should be subjected to scientific testing no less rigorous than that required for conventional medicine. In my opinion we play a very weak role in patient or public advocacy. This is probably because we as professionals feel we should look after our own affairs and not to tread on the toes of others. The alternative systems of medicine being so entrenched in our society, we may be afraid of the political backlash and negative public sentiment. But should we watch while patients get maimed and killed? We as physicians should have a stronger voice in media about this blatant misinformation and manipulation.

I am about to touch a controversial topic now, and that is concerning the relationship between the pharmaceutical industry and the healthcare services. This debate has been raging for quite awhile now. There are the arguments against the undue influence that big pharma companies hold over the profession. However, at the same time, the financial support and incentives given by these companies make a vast amount of valuable work possible, which would otherwise be out of our grasp. Events such as educational programmes would incur a burdensome cost if not for their support. Relationship with pharmaceutical companies is like doctor dancing with a porcupine who represents the pharma companies. Like the porcupine quills, the drug companies interaction with doctors are numerous and can be harmful if approached in a wrong way.

There are codes of conduct for pharmaceutical companies developed by the industry. Most if not all such codes prohibit companies from giving doctors inducements to prescribe their products. Many medical professional organizations in developed countries have their own codes and guidelines on interacting with pharmaceutical companies. WHO has published criteria for "medicinal drug promotion" and "code of pharmaceutical marketing practice". What can we conclude about the regulations designed to choreograph the porcupine dance? Drug companies, like porcupines, come in various shapes and sizes; some are fiercer than others, the relationship between doctors, academic institutions, pharmaceutical companies and medical journals will always be complex and interdependent. But we should not forget that the dance has produced some remarkable collaborations that has enabled the discovery and development of drugs we rely on.

The recent acrimonious friction between the doctors and the Ministry of Health has highlighted these issues. At present, funding of continued medical education is mostly by the pharmaceutical companies in Sri Lanka. Governments in developed countries have resources to allocate funds for CME. This is a distant

dream in our country with the government already constrained and overburdened by the provision of a free health service. So how can we maintain ethical practices whilst balancing the relationship with the industry? Resources offered by companies can be positively used for CME programmes and to improve services offered by physicians. As a professional body, the CCP must push for policies that regularize the use of such resources, and in order to do so, it may be more prudent to channel these resources towards professional bodies and organizations rather than the individual practitioners. This way, professionals can better maintain ethical practice, as there are no undue incentives offered directly to the individual, and there can be more transparency.

I have touched on many topics during this talk, which I thought were of timely importance as we celebrate 50 years as a distinguished professional body, whilst stepping into the future. I have talked about the many challenges we would have to face, including new demands on the healthcare services provided by physicians, our changing roles as caregivers, changing public perceptions and attitudes and the many legal challenges that we will inevitably have to circumvent. Also, as I have mentioned, there are many things we can do to overcome these challenges and continue to work towards providing the best care possible.

To this end, this year as I mentioned, we plan to introduce credit-based CME and CPD programmes, which we hope to achieve together with the PGI M/ Ministry. These programmes will help to ensure that our post-graduate trainees as well as consultants keep up-to-date with the latest modalities of care. It is my belief that the CCP must also be more involved in postgraduate education. At the moment the Board of Study in the PGIM has a representative of the CCP, but going forward, I think we must interact more with the other colleges and contribute more pro-actively in the formulation of PGIM prospectus and curricula. We hope to have discussions with both the PGIM and other colleges.

I also wish to lay emphasis on promoting ethical codes of practice. This is especially important in the face of diminished regard for our profession in the public eye in recent times. Preserving our code of conduct as physicians and the maintenance of professional attitudes in dealing with our patients as well as our colleagues was, and always will be crucial, and this need is felt now more than ever. Therefore, this year, we wish to raise more awareness about and promote ethical conduct and practices, amongst fellow physicians around the island, whom we will be reaching out to throughout the year via a series of planned workshops. I think we must discuss these ethical and professional issues and dilemmas more

openly in order to move forward. We hope to draw together multi-disciplinary teams to formulate a code of ethics regarding private practice, in alliance with other councils and colleges. As I have highlighted earlier, as a professional body we should initiate the formulation of policies and the defining of ethics related to how we should interact with pharmaceutical companies.

A greater role in public advocacy is also something we wish to achieve this year. Therefore we hope to conduct more public out-reach programmes this year. It is vital that not only doctors, but the public too should remain informed about the newer modalities of treatment and options available to them. A medical exhibition open to the public is to be held this year, in collaboration with the Ministry of Health and the Chamber of Commerce. The CCP can join with the Ministry of Health, the PGIM, the Drug Regulatory Authority and other stakeholders in advocating for the regulation of unethical practices and dissemination of false or misleading information amongst the public. Our advocacy for our field must always be grounded in our ultimate goals of improving the medical care we provide and the health of patients and the public – not any short-term gain for individual doctors or medical institutions. Trust is especially important in an increasingly transparent world, where a damaging reputation can be flashed across the globe via the internet in a few minutes. If we indeed become dominated by the profit motive alone independence of thought and conscience may be irrevocably lost. The profession and professionalism will be compromised. The essence of professionalism is its integrity – a sense of being beholden to use its knowledge for the greater good of humanity and in the service of truth.

As long as we as a profession hold on to this essence of professionalism – even, and especially, in an age of globalisation – we will survive and flourish, and we will fulfill our role in serving the patients of this country. I acknowledge that it is challenging to balance professional well-being with the interests of patients and the public; but we dare not abandon these aspirations.

I would like to end with a quote from William Mayo, one of the founding fathers of the Mayo Clinic:

“The Glory of Medicine is that it is constantly moving forward, that there is always more to learn. The ills of today do not cloud the horizon of tomorrow, but act as a spur to greater effort.”

I can see that many of you are fidgeting in your seats now, so I would like to draw to a close. Again, like I mentioned in the beginning, I feel deeply honoured and privileged to stand up here today as the president of this prestigious organization. How I came to be here, at this moment, well, it has been a long journey, and a much rewarding one at that. I wish to thank the teachers at my Alma Mater, Nalanda College. Also my teachers, and mentors at Colombo Medical Faculty and during my years of post-graduate training-excellent clinicians who helped me to develop my career and were guiding beacons. I thank the immediate past president, D. Nihal Gunathillake, for his leadership and excellent accomplishments during his tenure. I extend my heartfelt gratitude to the joint-secretaries of the CCP, Dr. Chamil Marasinghe and Dr. Barana Millawitane. Thank you for your tireless efforts. Also I would like to appreciate the constant support and hard work of all the members of the Council.