

EDITORIAL

Advances in medicine have benefited women in many ways. Fewer die in childbirth, they have control over their fertility — which translates to control over many other facets of their lives, and along with males they largely enjoy better health and longer lives.

However, some developments are proving to be mixed blessings. For example, advances in medical technology mean that gender can be determined before birth. For some parents, that means names can be chosen and blue or pink booties bought. It may also aid early treatment of some sex-linked disorders. But others will use that knowledge to selectively abort babies not of the desired sex. And with other techniques, the sex of a child can now even be chosen prior to conception.

These are exciting advances, but can have a sinister side, when they are combined with a traditional predilection for male children.

It was reported recently that 90% of parents using the services of a Hong Kong gender-selection clinic want boys.

The Economist recently reported that in the post-ultrasound era — in China, South Korea and to a lesser extent Taiwan and Hong Kong — the normal ratio of males to females being born is becoming skewed. For first borns, the ratio remains normal at 106 boys to 100 girls, but for second children in China, the ratio is 120.9 boys to 100 girls, and for third children in Korea, the ratio is 185 boys to 100 girls. In these countries attempts by governments to legislate against the practice have had no impact. Ultrasound, it would appear, has become a tool of sexism.

Where should doctors stand on all of this? Perhaps they are in a better position than governments to affect changes in practice and attitude. As wielders of the technology, at the very least, they are surely obliged to consider the ethics and full implications of their actions. As parents, community members, and doctor-politicians they must also make their views heard.

The Hong Kong Medical Association recently denounced the practice of sex selection for social reasons as “unethical, immoral and discriminatory.” Hopefully, it won’t be a voice in the wilderness.

But one thing is for sure — before women can become equal, they must first be born.

Lynne Laracy

COMMENTARY

Asian family doctors must prepare for change

by Professor Tony Dixon

In health care system around the world, significant changes are taking place in the role played by primary-care physicians. In the UK, there is increasing emphasis on the integration of primary, hospital and community health services in what is being referred to as a “primary care led national health service.” Market forces have been introduced, with budget holding by general practitioners, contracting out of services by hospitals, and systems of shared care. Economic control is now centered in general practice, with general practitioners being given the funds to manage the total health care of their patients and the ability to negotiate for specialist services on terms advantageous to their patients. From being in the back seat of health care — certainly as far as financial power is concerned — general practitioners suddenly find themselves holding the reins.

In the US, market forces have always played a prominent role in the direction taken by the health care system. Now “managed care” is the new buzzword, as attempts are being made to cap the ever-increasing costs of health care. Suddenly, integrated systems of care in which family physicians play a key gatekeeper role are seen as a way of controlling the costs of an expensive and wasteful system. In a system that has traditionally been specialist-led, and with most graduates electing to enter specialties rather than primary care, the change is revolutionary.

In Health Maintenance Organizations, family physicians are finding themselves in the majority and specialists are less able to attract patients in a controlled market.

While costs are important, they are not the only reason for advocating a more central role for primary care. Research has consistently demonstrated that in countries that have health care systems with a primary care orientation, there are also better levels of health, less use of medications, and higher satisfaction with the care provided. Changes in demographic trends and patterns of illness, the shift of health care into community settings and concerns about rising costs are all factors that suggest that the role of primary health care providers is likely to gain increasing prominence.

Asia will not be immune from these trends — although in a few areas the economic strength of governments may tempt them to ignore, at least for a while, the trends that have forced previous economic super-powers to reexamine their health care priorities.

Glittering hospitals and high-tech equipment are an easily seen — if misplaced — symbol of a government’s commitment to improved health care.

Investment in primary care, while it might make a lot more sense in the long run, is much less visible and much less dramatic. Change, however, is likely to come eventually. The lesson of recent history would seem to be that no economy, however powerful, can sustain runaway health care costs for long.

How well prepared are family physicians in Asia to take advantage of the opportunities that change will present? There is a good deal to be done, particularly in the field of education.

In undergraduate programs, it is important that primary care disciplines play a prominent role throughout the medical course, to counteract the risks of an over-emphasis on specialized hospital-based care.

Medical students need to be exposed to health care in community settings, not just in hospital wards. They need to have a sound understanding of the relative contributions that primary and specialist care can make, and how the integration of such care is vital to the interests of individual patients as well as society as a whole.

Postgraduate programs need to be developed to provide suitably trained family physicians. It is no longer good enough to suggest that students straight out of medical schools have the skills to deliver effective and efficient primary care. In many countries, a period of postgraduate training is now mandatory before a doctor can set up a general practice.

Programs of continuing medical education are also going to be important if family physicians are to demonstrate a commitment to lifelong learning and be able to adapt readily to changing circumstances and new knowledge. Together with opportunities comes responsibility. If Asia is to have systems of primary-care led health care, then education will have an important role to play.

Family physicians will have to show the willingness and skill to play a role in undergraduate, postgraduate and continuing medical education. Meanwhile governments will need to acknowledge the vital role that well-trained family doctors can play in health care systems and allocate funds accordingly.

Professor Tony Dixon is the new chair of general practice at the University of Hong Kong.

Q PATHOLOGY QUIZ



answers on inside back cover

The patient is a 26-year-old man who had a history of multiple exostoses which had all previously been shown to be benign. During a routine follow-up examination he was found to have a pelvic mass which was removed.

1. What do you think of the nature of the mass with respect to its size? Is the clinical history important?

2. Looking at the gross picture, what is your diagnosis?

3. What is the general behavior of these lesions? Is the location important?

Compiled by Dr John Nicholls, University of Hong Kong, Department of Pathology, Queen Mary Hospital, Hong Kong.

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