Future Directions of Clinical Epidemiology in the Philippines

By Dr. Ernesto O. Domingo

Dr. Ernesto Domingo is a practicing gastroenterologist. He was the Chairman of the Department of Medicine of the University of the Philippines College of Medicine when he served as the first sponsor of the first clinical epidemiology unit in the Philippines. He also served as board member of the International Clinical Epidemiology Network (www.inclentrust.org) from 1989 to 1997. He remains committed to clinical epidemiology, practicing it in the performance of his various tasks as Chancellor of the University of the Philippines Manila from 1988 to 1994 and currently as a gastroenterologist and health policy consultant. This talk was delivered at the 25th anniversary conference of clinical epidemiology on July 30, 2009 at the Pan Pacific Hotel in Manila.

Greetings!

I would like to start with a disclaimer. What I will suggest as the future direction of clinical epidemiology is only one of the many directions the discipline may pursue. I will not feel disrespected if what eventually gets adapted comes from someone else. A decision like this must be collegial and adopted only after an exhaustive and perceptive, not to mention evidence-based, collegial debate.

Take the Department of Clinical Epidemiology (DCE) in particular. We, in the DCE, can take the cue from the University. The University's direction in the next century, though still tentative, is the product of a yearlong assessment by personalities from within and outside the institution. As of now, while still a work in progress, the three pathways identified look elegant in their simplicity and clarity. I like to share them with you because the DCE's future directions must reflect those of the University.

First, the University must be a research university, meaning, its orientation must be research and graduate education.

Second, it must raise the quality of public discourse on national issues by providing quality data and information relevant to the issue under discussion. While the University's advocacy function is not waived, its clarificatory role takes precedence.

Third, the University must prepare every student for leadership responsibilities.

Having set the terms of reference, I will now proceed, as best as I can, to tackle the task you have given me. There is a Tagalog aphorism or adage that is quite familiar to all of us here. It says that "*ang hindi lumingon sa pinanggalingan ay hindi makararating sa paroroonan*." While this aphorism is generally understood by most as indebtedness, I suggest that it can also be interpreted as looking back to the past for guidance to the future. Hind sight is always 20/20. So permit me to briefly review the DCE's past and who knows, we may be able to define the future.

In 1983, Kerr L. White, then Deputy Director for Health Sciences of the Rockefeller Foundation, visited the Philippines as head of a delegation whose purpose in coming over was to sell a concept and a program to academic leaders in the medical profession. His boss in the Foundation happened to be Dr. Kenneth Warren, the man with whom I did most of my researches on schistosomiasis and who eventually became a dear and valued friend. Dr. Warren instructed Dr. White to contact me first, naturally. The result of this encounter was recounted by Dr. White in his book entitled "Healing the Schism, Epidemiology, Medicine and the Public Health".[1] Let me quote verbatim from his book, "Another example of the importance of making epidemiological principles and skills available to clinicians in their day-to-day work is provided by Professor Ernesto Domingo, then Chairman of the Department of Medicine."

I failed to understand him initially – "relationship of epidemiology to clinical medicine?" In fact, when I first heard the term, I thought it was an oxymoron. My reaction will become clear as I proceed with the account of Dr. White. To proceed, let me further quote: "Domingo described the adverse effects on past generations of medical students of boring epidemiology lectures unrelated to clinical problems..."

Let Dr. White proceed, quote, "Gradually, Domingo grasped the concept, became the initial sponsor of his own University's Clinical Epidemiology Unit (CEU) and now is one of INCLEN's (The international organization of CEUs, see www.inclentrust.org) most ardent supporter."

The lesson I learned from this encounter is never dismiss an idea simply because it is Greek and foreign to you but also seems outright ridiculous.

After I was converted to the idea of clinical epidemiology, it now became my responsibility to convince others. And so, I talked with the then UPCM[2] Dean Gloria Aragon to convince her of the soundness and importance of the concept of clinician-public health specialist and to persuade her to allow me to set up a CEU in the Department of Medicine. I succeeded on the latter but on the former I am not sure up to this day because her last words were "*O sige, i- set-up mo kung talagang sa palagay mo ay importante yan*." ["*Set it up, if you really think it is important.*"]

The lesson I learned from this incident is, the inevitability of advocacy if we want something to happen.

With the creation of the CEU, the most critical phase of its

development loomed large. The organization is only as good as its members so the task of selecting the first batch of trainees in clinical epidemiology was the make or break move. I was very deliberate in selecting people and with a little luck I correctly picked on the best bunch of young internists who upon their return sealed the success of the project.

Some of them or many of them are here in the audience.

The lesson I learned, not original really, is that investment in good people will reap you profit a hundred fold.

With the first batch of clinical epidemiologists at the helm of the unit, things happened in rapid fashion. They readily committed themselves into the undergraduate and postgraduate training programs. They helped the clinical departments develop clinical epidemiologists from their own staff. Most important of all, while they themselves were engaged in research, they also helped improve the quality of research in the institution principally via the honing of skills in DME (design, measurement and evaluation) of the current and would be researchers. With the push provided by the CEU, the quality of research protocols, research output, critical analysis and interpretation of data and scientific paper writing moved irreversibly forward, spilling into the professional medical societies. The new discipline eventually caught the interest of academic institutions. In no time at all, with the help of the Department of Science and Technology (DOST) and the Philippine Council for Health Research and Development (PCHRD), CEUs sprouted in major universities throughout the Philippines -- De La Salle University, University of Santo Tomas and Cebu Institute of Medicine. With this track record, it was not surprising the CEU at the University of the Philippines became one of the first research and training centers in Asia. A few years after, it became the Department of Clinical Epidemiology, one of the basic departments of UPCM. DCE and the new CEUs begun to be viewed as a resource center (both public and private institutions availing of their services) not only in the Philippines but also in the world.

With the full knowledge of your past as the Filipino aphorism suggests, you can now set your sight on new directions, new pathways into the future.

To me, there is one inescapable answer to the question, for what are we doing all these things? If it is not for our people then all achievements are hollow. Indecent self-indulgence really! Therefore, I challenge you to get involved in the promotion of universal health care, the single most important health problem in our country, the absence of it I mean.

Why you in particular? To answer that, let me use unabashedly an American example because an uncared for American is no different from a medically deprived Filipino. The American Recovery and Reinvestment Act of 2009 provided $ 1.1 billion to support "the development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies, including thorough efforts that - - - conduct, support, or synthesize research, that compares the clinical outcomes, effectiveness and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders and other health conditions. The Stimulus package given to this type of research recognizes the primal importance of the output in developing prognosis and policies that enhances the attainment of universal health care." [3]

Commenting on the recommendation to intensify comparative effectiveness research, Dr. Kevin G. Volpp, writing in the Journal Perspective said "If comparative effectiveness researches' full potential for improving the population's health is to be realized, such comparisons must go beyond those between medications or devices; it must also study medication or devices in comparison with behavioural interventions, either alone or in conjunction with other approaches."[3] In addition, since many diverse aspects of care delivery have a direct effect on patients' health outcomes, we should assess policy-based interventions and their relative effectiveness in improving health.

Now, let me ask you. The comparative effectiveness research referred to in the Recovery Act of 2009 and expanded in scope by Dr. Volpp, is this not your bread and butter? Is it not definitely in your alley?

Therefore, you are in a very good position to identify the path towards universal health that stands the best chance of succeeding.

In closing, may I again quote from an article in the New England Journal of Medicine entitled "A Time for Revolutions – The Role of Clinicians in Health Care Reform".[4]

"Placing professional responsibility for health outcomes in the hands of clinicians, rather than bureaucrats or insurance companies, must be the ambition of any new structure. Clinicians must educate both policy makers and the wider public about appropriate levels of care."

That clinician is the clinical epidemiologist.

Join us now in our advocacy for universal health care.

Thank you.

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[1] White K. "Healing the Schism, Epidemiology, Medicine and the Public Health" New York: Springer-Verlag New York, Inc. 1991; p 212

[2] University of the Philippines College of Medicine

[3] Volpp KG., Das A. Comparative effectiveness – thinking beyond medication A versus medication B. N Eng J Med. 2009 Jul 23;361(4):331-3

[4] Darzi A. A time for revolutions — the role of clinicians in health care reform. N Eng J Med. 2009 Aug 6; 361(6). Epub July 22, 2009