GOOD MEDICINE —THE 9TH S.M.A. LECTURE

By R.C.K. Loh

There are duties which are difficult to perform and this relates to every position in our society; and there are duties associated with public professional life, from which no man can assume to himself the right to ignore, even if it is born out of feelings of diffidence and insufficiency. So said someone many years ago when he was asked to hold office. I am afraid I have to confess to you that it is with such feelings and misgivings that I have ventured to accept, at the behest of my colleagues in the S.M.A. Council, the 9th S.M.A. lecture this year.

The S.M.A. Lecture was initiated several years ago as a result of the concern of the Council of the S.M.A. about reminding our medical profession and educators that something more was needed than just the teaching and the grasping of the academic aspects of medicine. I was on the Council then and therefore am to some extent a prisoner or perhaps a victim of my own doing. The Council was of the opinion that a complete doctor must not only be well grounded in the art and craft of diagnostics, therapeutics and prognostics, but also in the humanistic and liberal aspects of the philosophy of the practice of medicine.

To ensure a balance of interest, a specially endowed lecture was instituted and I would like to recall the previous lecturers and their subject matter.

1963 Dr. Gwee Ah Leng
"Advertisement and the Medical Profession"

1964 Dr. B.R. Sreenivasan
"Infamous Conduct in a Professional Respect".

1969 Dr. Gwee Ah Leng
"Medical Education in Singapore—the Past and the Future".

1971 Mr. Yahya Cohen
"Association—Profession and Adaptation"

1972 Prof. Phoon Wai On
"Priorities in Medicine"

1973 Prof. Khoo Oon Teik
"The Drug User and I"

1974 Prof. Khoo Oon Teik
"Ethics of Human Transplants and Experiments"

1975 Dr. Ho Guan Lim
"The Limits of Medicine"

All in all, you will see therefore that almost all these lectures have had something to do with medical ethics philosophy, and with the progress of medicine and medical education in Singapore, keeping therefore to the spirit that moved the Association to endow this lecture. It will therefore not be surprising that during the course of this lecture, that perhaps some old ground will have to be covered again, but I make no apologies as I shall be attempting to restate certain basic principles governing the practice of good medicine.

I consider it therefore a great privilege to be invited to deliver the S.M.A. lecture for this year and I thank the President and Council of the S.M.A. for giving me this rare honour. They have been very kind and I undertake this assignment, with very mixed feelings, knowing and feeling the inadequacies of myself and yet I cannot help but accept because it does give me an opportunity to say a few words on a subject very important and uppermost in my mind.

What constitutes good medicine? I will endeavour to answer this to the best of my ability but obviously, whilst good medicine broadly embraces the profession in general and the individual in particular, it will be impossible, nor desirable and also to a great extent outside my competence to discuss both these aspects tonight in any depth. I will content myself almost completely with the latter, for to my mind, in the final analysis, a system of good medical care must depend on the individual persons in the profession who are an integral part of this system. With the more general aspect of medicine, I shall deal with only 2 sections which I feel need mentioning.

Good medicine, or good medical care can be divided as I stated before and to put it more explicitly, into 2 broad aspects.

1. Health care of the community by the community
2. Health care of the individual by the individual

The health care of the community is the responsibility of the Government, the medical educational bodies and to a larger extent the medical profession as a whole. It includes the teaching, the training of the doctor, the numbers that are required, preventive medical services, hospital care and post graduate training, and continuing medical education.

However the health care of the individual devolves on the shoulders of the individual doctor and I shall deal with this now. Of course the two aspects mentioned above cannot be completely divorced from each other. None the less there is much truth in the saying that good medicine means good doctors and good doctors live by the Hippocratic oath and by a code of ethics.

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As a stream cannot rise above its source, so a code cannot change a low grade man into a high grade doctor, but it can help a good man to be a better man and a more enlightened doctor. It can quicken and inform a conscience, but not create one. I am quoting tne International Code of medical Ethics adopted by the World Medical Association in 1949. I would also like to quote Dr. Charles Berry, Director of Medical Research and Operation NASA and Professor of Aero Space medicine, University of Texas and he presents a picture of the requirements of a doctor in the future—

"The physician of the future must have administrative, diagnostic and therapeutic assistance and he must have sociological inputs concerning the individual, his family and the Community. He must also be supported by technology which will enable him to be a health director of a given area. He will thus become the ultimate decision maker for the health care not only of his individual patient but of his area. He would thus achieve that level of thoughtfulness and logic which is difficult to come by in the present System. Most importantly, these changes will not take from the physician his humanitarian role as confidant and advisor to the sick."

Thus it is this humanitarian role that dignifies our profession and takes it out of the ordinary and gives it the quality that is, or at least should be the distinctive character of our profession. This then is the only justifiable reason for the traditional laudatory description of nobleness given to our profession. Robert Louis Stevenson was also particularly partial to doctors. This is how he described him in "Dedication" of his collection of poems "Under woods". "There are men and classes of men that stand above the common herd: the soldier, the sailor; the shepherd not unfrequently; the artist rarely, rarelier still the clergyman, the physician almost as a rule. He is the flower of our civilisation. So it is that he brings air and cheer into the sick room, and often enough though not so often as he wishes, brings healing." We are in a rapidly changing world and in Singapore, these changes have come so swiftly that the spirit of service, the hall mark of our profession, seems hardly visible or felt at all. We are caught in the urgency of our times. This urgency comes from a need for economic growth and survival. With it follows the ugly spectre of a mercenary and materialistic society and the medical profession, sad to say, has also become immersed in this changing attitude. It is not too late though. To our credit there are still some of us, both in the public and in the private sector, who still try to practise and maintain the highest ideals. The Hippocratic oath which they took when they started practice, still remains undimmed in their memories. The spirit of service still burns brightly in them.

It has been stated that the most essential inborn quality required by a doctor is kindness. This basic quality is therefore needed for this spirit of service to be recaptured and be maintained in each one of us. The basic quality of kindness is in every human being, in greater or smaller measure. The secret for those of us who are doctors or who are planning to be doctors is how to recognise this and to use it to the best advantage, by nurturing it by precept and example, in our relationships with those who are students during their training and in our practice as a doctor—kindness can be to some extent cultivated, like good habits. The cultivation of good habits is a slow and gradual process and has to be picked up from one's parents, environment, school, colleagues, teachers and place of work. (to quote our Prime Minister.)

Intellectual honesty, humility and a sense of compassion are other as important qualities of a good doctor. Out of all these qualities will be fostered a sense of keen interest in the patient's welfare and this will be the driving force that will carry the good doctor in good stead. With it he can establish a rapport with his patient so necessary for gaining confidence and trust. With this he will get the best response from his patient and will be able to establish guidelines for the total care of the patient in relation to the patient himself and his immediate environment. With this great stimulating force behind him, he will remain inquisitive and inquiring and will try to keep abreast of the latest developments in medicine. It will thus carry him through continuing medical education and to quote Professor Khoo in his Ransome oration, "who knows may even make excellence out of mere competence".

Compassionate care must be offered by those of us who are in the medical profession because it is through this that we can supply the right relationship in which people can meet and face their illnesses, their problems and in terminal cases, death and find meaning and purpose and be able to accept it. The medical care must be person centred.

We in the medical profession have been given the opportunity and training to preserve the creation that is life, and we must believe that each day is worth as much as any other day. Let us accept our challenge as physicians to make each day of life God gives to us and our patients mean as much and be as worthwhile as any other day, in sickness as well as in health.

It has been said many times over that the profession is in danger of losing its soul. This is most disturbing thought. Of course, the way things are, this is not altogether impossible. A recent S.M.A. leading article in its newsletter entitled "medicine in a world of changing values" has expressed this. The student who now chooses medicine as a career may be doing so for less than unselfish motives. He may believe that there is "money in medicine" or even if he is not as hardened and as cynical, and may choose to be a doctor because of lofty ideals, soon after graduation, he becomes disillusioned. He finds that compassionate and conscientious care, is not after a while, as exciting or stimulating as he first thought it to be. He soon marries and with it a change of per-

sonal problems, or an advent of new ones, and now the "honeymoon is over." The hard grind of everyday practice takes away all the glamour of his profession and he succumbs to choosing the easy road ahead—get rich quick type of practice followed quickly by a complete change in attitude to his profession and in his practice.

Let us consider some of the factors motivating a doctor in his relationships with a patient.

1. Patient care—an amalgam of professional knowledge gained from tradition, training and experience
2. Beliefs, religious and idealistic
3. Curiosity and quest for knowledge
4. Career advancement
5. Financial incentives
6. Spirit of Competition—success, pride and fame.

All these are important but the first is most influential and the second is most significant.

If the doctor has some beliefs, whether they be religious or wholly idealistic, these will inevitably act as a yardstick against which he can check his attitudes and motives.

It is of course possible to have a wholly altruistic approach, respecting completely the sanctity of life and having a well developed sense of compassion, without any strong underlying religious belief. Many, perhaps most doctors enter the profession with such values. Whilst these values remain, they too will have an anchor against which they can check their motives. The great difficulty is that self interest is a very strong persuader, and it is all too easy to forget idealism when there are other strong motivating factors. A built-in mechanism is needed against which we can check our motives.

Most of us begin our medical careers with high ideals of serving suffering humanity, coupled with a somewhat dramatic view of what medicine is all about. The drama rubs off little by little during training and in later practice and so do some of the ideals. The business of forging a career and supporting a family will inevitably influence or try to influence our attitudes.

Thus we can see that in the production and the maintenance of a good doctor who will then provide good medical care, we have got to start at the beginning—the person himself.

Are good doctors born or made? Or perhaps the question can be phrased differently—who should take up medicine? The ultimate aim is to help the sick. There is hardly a virtue which has not been suggested as essential in the make up of a doctor. As I have said before the most important inborn quality is kindness and this is found in all of us to a greater or smaller degree. The other qualities I have mentioned are compassion, intellectual honesty and humility which leads to curiosity and quest for knowledge. It is debatable whether these latter qualities are inborn. They certainly can be inculcated, nurtured and developed in every individual given the right environment and encouragement.

At present there is no system whereby a potential candidate for the medical school is evaluated as to these qualities stated above. Is he or she scrutinised closely by a carefully selected questionnaire or a special interview, conducted by a group skilled in psychology, sociology, perhaps theology apart from those associated with the academical side. It is my belief that too much attention is being paid to the academic prowess of the individual in the selection of those applying to do medicine. Personally, I feel that to practise good medicine one has to have equal quantities of good and sound common sense and kindliness. Good intellect not necessarily a brilliant one is essential, but especially one with good powers of weighing up the evidence, discarding the unnecessary and coming up with the right decision. A doctor must always be ready to pursue the truth, and this is another quality he must have. The educationist can detect the clever student who is able to pass examinations well. The ability to pursue the truth cannot be judged on examination results. It is a hidden quality and consequently many good applicants might have been refused entry to do medicine because of the inability to discern this. Unfortunately also a good number of those who decide to do medicine look upon it as either a career with a status or a career with a pot of gold to be collected in large doses along the way.

Having been selected for these qualities, during the undergraduate years, is enough attention being paid to the nurture and development of these qualities? Is sufficient time set aside in the curriculum for the exposure of medical students to special lectures designed for this purpose. And do their teachers and other doctors they come in contact with daily realise how imperative it is to show them the importance of this spirit of service along with compassionate care and treatment of the patient as a whole, in the practice of medicine.

In the medical curriculum of the last ten years, some steps have been taken to correct this glaring omission. The posting of students for periods of time to those in general practice is a most laudable assignment. It exposes students to situations which can never be duplicated in the institutions and the hospitals in which he is doing his training. The students learn to handle the patient with greater flexibility and learn the art of improvisation. He meets up with and has to tackle the personal problems of the patients as well as the patients' family and environment. He soon finds out that a good general practice is built up on other things besides just plain medical skill.

After graduation the young doctor usually does a spate of service in an institution and here he soon finds problems in trying to practise medicine as he

should do. The sheer volume of work he is called upon to do and the long hours he keeps makes it difficult for him to give the individual and personalised attention he thinks he should be offering to his patients. This is probably not helped by the example of some of his senior colleagues who have also succumbed to the system that prevails.

An extension of the G.P. posting of the medical students may be the answer to this problem. A period of time spent by the young doctor with the G.P. may be a useful way of showing him what general practice is like. I am quite sure a scheme can be worked out and I am also certain that there are sufficient G.P.'s in practice today willing to participate in such a scheme.

This idea need not necessarily be confined to those in general practice but can also include specialists in private practice as well. Those in training for certain specialties can very well do a short stint with their seniors in private practice for the very same reasons discussed before.

I am not suggesting for one minute that those in general or private practice have a monopoly on these good qualities or are in a happy position of being able to offer the person centered or personalised medicine I have described. Far from it, and we in the profession fully realise this as evidenced by the leading article in a recent S.M.A. Newsletter which I have mentioned before and an editorial in the New Nation. As stated in the leading article, "in the private sector he may wind up in the poorer housing estates where he has to toil from morn till night just to eke out a living. The problems he faces are innumerable—high rentals, keen competition, and undercutting of fees." Compromise sets in and the less than the best of medical attention given. The lofty ideals he carries out with him in private practice are soon diluted, mixed and finally almost completely washed away. However, as there is an inbuilt corrective factor this would have a resounding effect on his practice, because if a doctor's bread and butter depends on his good relationship with his patients, then there is no denying the presence of the motivation to practice good medicine.

Thus it would seem that there is a great need for the revitalisation of this spirit of service both in the private and public sector. This could come about effectively with the whole profession participating through the medical professional bodies, particularly the S.M.A. Courses in medical ethics, etiquette, doctor-patient relationships, doctor-doctor relationships can be conducted and repeated again and again. The expression 'a doctor with a good bedside manner' is often used and taken in a derogatory sense, but there is nothing wrong in having a good bedside manner as long as it is motivated largely by a sincere interest in the patient's welfare and accompanied by a sound competence in management.

We thus come to the next question: Just as important as the qualities of character, is the maintenance of standard of medical care and this can be equated largely to the competence of the individual doctor, whether he is a G.P. or a specialist.

Patient care will continue to be available to the public at several levels in the future as it is today, but optimum care of the present time can be and should be improved upon.

Quality care must be our aim. Any other form of care of intermediate quality or low quality almost bordering on quackery must be eliminated. The public demands capable and skilful doctors who have had excellent education and training, who possess knowledge of all that is new in medicine, who are ethical and restrained in their financial relationships. I am sure most if not all of us approve of these Utopian ideals but perhaps circumstances do not always allow all these to be fulfilled.

Is high quality care provided only by high quality doctors? This raises another question, do high quality doctors ever deliver mediocre care? Clearly poor doctors can give good care and over zealous doctors can deliver poor care. However for practical purposes it must be assumed that the quality of the doctor and the care he delivers will be on the same level.

Let me consider in some depth some of the possible consequences of not practising good medicine. The essence of the practise of medicine is in the interaction between patient and physician and that in a good medical practice there is no substitute for the conscience of the physician. In the United States, where public awareness of medical developments are well abreast of the times and in many cases far ahead because of poor and indiscriminate reporting, the public has come to expect a high standard of medicine. The average person's concept of what is possible medically is conditioned by the memory of miracle drugs, polio vaccine, organ transplant and other great new medical discoveries. The public expects the best possible medical care, but also wants it delivered in the style of a generation ago—that is the doctor appearing at home with a black bag and a stethoscope. Medical Art and Science rest like others on a legitimate use of the possibilities given to man. If the history of medicine has been a little free from error, negligence, one sidedness and exaggeration as any other science, in its main development it has been and still is, to the layman, as impressive, honourable and promising as for instance, theology —to quote Karl Barth.

The public also has come to demand that physicians never make mistakes. Thus we see in America, the development of "Consumerism" and an increasing litigious attitude on the part of the public in all aspects of human activity—including medicine.

The rash of malpractice suits have appeared in the USA and associated with high premiums for insurance and what is worse, the withdrawal of many insurance firms offering coverage with the doctor.

It has been said the fundamental cause in many claims is the poor rapport between patients and doc-

tors. A plaintiff's attorney has made comment that in investigating such cases he realizes that what the plaintiff is describing is not bad medicine but bad personal treatment and underlying the patient's complaint there is almost always a tale of his physician's rudeness, arrogance or assembly line indifference.

Let us hope that in our country such a thing will not come to pass and before conditions arise which may lead to such a chaotic and dangerous stage, the medical profession must be cognisant of the situation and act swiftly to prevent it.

Arising out of the development of consumerism, and this attitude may well be developing in Singapore, the medical profession must be aware of the need for moderation in its financial responsibilities with the general public. We are happy to see the growth of Singapore as a fine medical centre but this growth can be nullified by the lack of responsibility and restraint on our part in our financial arrangements with our patients. Otherwise we may earn some of the unfavourable quotes I am now going to make. Leonardo da Vinci didn't think very much of our profession and his words seem to reflect this. Strive to preserve your health and in this you will better succeed in doing as you keep clear of the physician, for their drugs are a kind of alchemy concerning which there are no fewer books than there are medicines—Leonardo da Vinci (1452-1519). A physician is one who pours drugs of which he knows little into a body of which he knows less. I abhor physicians—Horace Walpole. Medicine is a collection of uncertain prescriptions, the results of which taken collectively are more fatal than useful to mankind—Napoleon Bonaparte. Physicians and politicians resemble one another in this respect, that some defend the constitution and others destroy it.

Medical knowledge has doubled within a decade. The advances of medicine in the last 20 years have been tremendous. The public knows this and expects the doctor to keep abreast of developments.

How then can the profession meet these expectations. And here the situation involves the medical profession as a whole. As far as the specialists are concerned, a need for certification has been proposed, accepted, and it is hoped shortly that it will be introduced by the Academy of Medicine. The Academy also hopes that this will lead to the formation of a specialist register. General practitioners too have upgraded their discipline by forming a College and holding examinations. Already in other countries for example USA, the question, however touchy and delicate it may be, of relicensure and recertification is being studied. In fact recertification has been introduced in several states in USA, though at the present time, recertification can be regarded more as a merit badge, a nice decoration to have, but no real economic significance.

The question of recertification whether by a simple process of examination, or by individual participation in a variety of educational activities, or a physician's clinical records may be scrutinised by a special committee, will perhaps arise within the next decade. Whether it will be on a 5 year or 10 year period remains to be seen. Undoubtedly the first method will meet with determined opposition and perhaps the second and third method would be more readily acceptable.

In the final analysis, whether by persuasion or by legislation it is terribly important that the doctor's knowledge and skills must continually be improved upon. A term "professional obsolescence" has been defined in an article by Dr. Gill of the Australian Medical Association. In it he says it is a major cause of falling productivity on the part of the medical profession. The cause is multifactorial and like athero—sclerosis, starting in the early graduate years. Medical courses of today tend to educate today's student for today's needs. Courses are not flexible enough to incorporate new developments. In general, undergrade education does not motivate the individual to make continuous learning or inquiry part of his way of life. The stimulus to learning is a negative one, that is the need to pass the examinations. As a consequence, the only accepted method of delaying or preventing professional obsolescence, continuing education in graduate years, is not really accepted.

These statements are true and applicable to every society which expects good medical care. Continuing medical education has already started in Singapore through the Alumni, S.M.A., the various professional society, and Academy of Medicine and College of General Practioners. However it appears completely to concentrate on the academic and clinical advancement of the graduate doctor. Some emphasis too should be placed on the teaching of medical ethics and etiquette and the revitalisation of the whole profession in its efforts to meet the needs of the Community with the spirit of service. In this way, therefore, good medicine will flourish and continue to flourish in Singapore in the years ahead and perhaps then our profession will have earned the approbation given to it by the following—If ever the human race is raised to its highest practical level intellectually, morally and physically, the science of medicine will perform that service—Rene Descartes (1596-1650). The lawyers are the cleverest men, the ministers most learned, and the doctors are the most sensible.—Oliver Wendell Holmes (1809-1894).

Dealing with good medicine or good medical care in its large context and that is with the public at large, the community, and I like to touch on two aspects of medical practice and that concerns the fuller use of the medical facilities and manpower we have in this country. We have recently heard the Minister of Health take to task the Association in Parliament about it being partly responsible for the poor intake of good students who are locally born into the Faculty of Medicine and hence we have a shortage of doctors in Singapore. He has even said that if the shortage becomes more acute, it may be-

come compulsory for women doctors to do National Service like their male counterparts. The husbanding of all our resources is absolutely vital in our small state. On this I would like to say something.

(a) that there seems to be some degree of polarization between the public and private sectors of the profession. One party always seems to refer to the other group as "they". It is terribly important for the whole profession to think as one and act as one and to have the concept that whether we are in the field of private practice or public service, we are all serving the community of Singapore. Fortunately, this lack of unified thinking is much better than it use to be, and this is well seen in associations like ours, the Academy and other allied medical societies, in their representation on their highest councils and executive committees and in their programmes.

(b) *Women doctors*

I may be wrong but there has been a considerably high intake and output of women doctors from the Faculty of Medicine in Singapore. In the past far too many women doctors have dropped out of medicine within a few years of qualification in order to look after their husband and children and few ever returned to *full-time* work. Women do not look for nor should they be given any special treatment on grounds of sex when they compete with men at undergraduate or postgraduate levels on equal terms. Indeed many of the women who apply to medical schools are academically better qualified than men, and are probably well, if not better endowed with the innate qualities of kindness and sympathetic understanding. Thus women should make good doctors, but any woman doctor, particularly if she chooses to specialize in a prestigious specialty like neurosurgery or cardio thoracic surgery, will find she is competing with men who give or are able to give 100% of their effort to their work. If she is married, it is hardly possible, nor can it be expected that she can be totally committed to her work and bring up a family herself. Some specialties are less demanding than others, and these women doctors who are not prepared to give total committment to their work, could take up specialties like anaesthesia, psychiatry, pathology, radiology, E.N.T., ophthalmology and a varied number of other disciplines with enough choices to suit all desires. Married women need not be condemned to such "soul destroying", to quote the B.M.J. leader routine of contraceptive clinics, public and school health clinics. None the less, women who enter into the profession, should be prepared to spend more than just "part-time" in their chosen vocation.

Good medicine in the community in the end depends on the provision of good medical care by the medical community as well as good individual care by the individual doctor.

I have touched on some aspects tonight which I feel are important. Any lecture to such a distinguished and sedate body must have ingredients which are somewhat provocative, somewhat stimulating and not emotional. I have therefore tried not to be preachy and thus avoid the accusation of being smug, nor have I tried to be a prophet which is extremely dangerous, as you are well aware of the future of prophets in the Bible especially when in their own precincts or territory. If I have been dull, I must seek your indulgence but as I first said, there are some things which have to be said and repeated perhaps again and again to make sure that they are heard.