

THE TENTH SINGAPORE MEDICAL ASSOCIATION LECTURE 1977 The Doctor's Dilemma

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When we look around the world we live in today and compare it with yester-years which are still fresh in our minds, we cannot help but wonder what is happening. We are sometimes at a loss ourselves trying to cope with the rapid changes that are taking place around us. In the history of man and civilization, the twentieth century stands out significantly from at least two aspects: one, in the field of scientific and technological achievements, especially the enormous developments and advances in the intra- and post-World War II era and, two, in educational, ideological and economic change and progress, based on democratic and egalitarian concepts and policies. What is perhaps more interesting and challenging is the rapidity of the change in all fields in meeting the needs of the people belonging to societies steeped in social conventions, traditions and attitudes; a heritage of the old order and ways, developed over centuries in their respective culture. The attitudes have not matched the transformation in the environment and lifestyle, be it in the physical facilities and manifestations of home and city or dress, food environment or political and economic systems. Whereas fifty years ago most men lived in the country and off the ground for their livelihood, at least in developing countries, today the majority are living in towns and cities off the desk and their wits to get along in life.

In every walk of life, professionals, businessmen, sociologists, politicians or physicians included, this phenomena of change, rapid and often sudden, within one's own lifetime, has proven to be a fact of life. Parallel to this development, we have still sustained or are expected to sustain and conform to old values, standards, attitudes and approaches, only slowly giving way to required changes in conformity with the changing times. The effect of all these has had a traumatic effect on man and society, including the medical profession. It is not the change, for it is often for the better,

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but the suddenness and rapidity of it which has brought about troubles of re-adjustment in the life-style, values, habits, attitudes and happiness of man. No doubt, he has to sort himself out in understanding and keeping in line with this increasingly irreconcilable position of the old and the new, within and without himself. He is brought up in ethics and religion to believe in the good values and conduct of life but is caught in the active competition, if not rat race, for survival in an urban life, and this applies to the medical profession more than any others in any society.

I chose to speak today to this august body of fellow professionals on a subject which we would like to think is peculiar to ourselves in the society and the world we live in today—The Doctor's Dilemma. But from what I have said so far, it will be apparent to you that this trauma of the times does not only afflict us but all people, especially professionals who have been trained, if not disciplined, in conservative and traditional schools of scholarship and therefore find it increasingly hard to translate set values, ethics and discipline in terms of the reality of everyday life, including the practice of their profession. On the one hand we endeavour to conform to what we have been taught as being right and on the other, we have to accommodate the changing world and people that we serve and the conditions that govern ourselves and our livelihoods. There is no doubt in my mind that this experience is shared by all professionals in varying extents and degrees but our profession deals with life and sufferings of people, both physical and mental, and is therefore more affected by the changes in values and attitudes of our peers, society and people. The attitudes of people towards the physician have also changed with the rapid changes in the social and economic structure around us from one of respect, if not reverence to that of even mercenaries, in the sense that we are looked upon often as those who, like others, have to earn our living and are induced by largely monetary considerations and materialistic values.

The above generalization I have made may appear empirical, universal and to some extent superficial in its applicability. Professionals and physicians like all people are individuals, each with their own likes and dislikes, attitudes and values and fancies and idiosyncrasies. As for myself, and in this regard many of us who had taken to medical studies and practice, I would think that we were drawn to this arduous disci-

pline in our childhood or while at school through a sense of dedication to serve the cause of humanity, the noble service of looking after the sick and relieving human suffering. It may also be true that the social recognition given to doctors was singularly one of special position in society and possibly contributed to create an egoistic satisfaction of recognition and even superiority. In return for this, we went through many years of education in very competitive and trying conditions. On completion of our studies, we were welcomed to join the ranks of the public sector as physicians and teachers, given reasonable terms and conditions of service. The basic needs of salaries, housing and superannuations were provided and the essentials of life were assured us for our life-time. These were taken for granted and the need to ponder over our future and that of our family and children did not arise. In addition, we were given governmental and social recognition and this helped to sustain our enthusiasm and dedication in the discharge of our duties to our fellow beings. We were made to feel content and our services were rendered for no expectations in return. We were not made to feel the want for anything. As a result, the public sector managed to attract and keep the best in service and as would be expected, provided the leadership for the country in difficult and trying professions and expertise like medicine and some of its specialities.

It is obvious that in the rapidly changing times, this consciousness has been lost sight of and this psychological ploy of the government has given way to one of a simple and straight monetary yardstick in relation to emoluments on the one side and productivity and merit on the other—a managerial concept of cost-effectiveness that cannot quantify humanitarian inputs in a discipline like ours. The security of tenure of office, the privileges and perks effective in retaining professionals in a career service and the general social recognition and respect have been overlooked in considerations of policies governing attitudes towards the terms and conditions of service for professionals in general, especially doctors.

The change has gone to the extent of patients looking on us, not with regard due to us but with demands on our time and services, as a matter of right in return for our being paid for what we do for them. In fact, this is not basically wrong but it becomes a purely monetary consideration without the other special relationship that must exist in

any dealing between professionals and clients, especially doctors and patients. We have also been subjected to the inevitable cross-fires of politics and public criticism, often on good grounds but controversial in character, which in turn affect the morale and enthusiasm of our services as medical men in the community. Added to this, personal and professional frustrations in our being part of the overall bureaucracy and administration, subject to standard rules and regulations governing our official duties, have turned us into cogs in the wheel in our own attitudes and reflexes. Whilst as workers of the noble profession, responsible for inculcating values of selfless service and the sick before self, we are caught in the regulations that force us to turn the sick away because of monetary considerations.

I can recall my days as a house officer and trainee medical officer at the Singapore General Hospital about twenty years ago when with no extra monetary returns for extra duties performed, we worked round the clock often without sleep for 36 to 48 hours, and I can understand why I find it difficult to get such response, common in my time, from young house officers and trainee medical officers these days. Some of the reasons have been given earlier.

Let me move away from the sociological, economical and administrative problems and conflicts and try and dwell briefly on some professional aspects as they apply to institutional practice.

Medicine in the middle ages and for centuries thereafter was primarily an art of letting patients die with charity, hope and dignity. The hospital was considered the last whistle stop on the journey towards the Great Divine and the patients needed assurance that there was something beyond. Religion was part of the art of healing. Later on, the doctor was a man of university learning with perhaps some knowledge of astrology. A surgeon was an upgraded barber, familiar with the knife and able to perform operations. We have come a long way from medicine in the sixteenth century of dealing with plague, typhoid, smallpox, cholera and communicable and infectious diseases; from the preparation of concoctions from herbs; and from relying on saints, monks and incarnations for miracle cures. With the birth of this century, epidemics of communicable and infectious diseases which contributed to keep the population regulated were rapidly brought under control. Rapid advances in science and technology have given us a scientific understanding of

disease and more recent advances in knowledge and techniques have allowed us to look at systems that physicians twenty-five years ago would have dreaded to attempt. Mortalities have declined to below ten per thousand population in developed countries and many developing countries, including Singapore, and perinatal and neonatal mortality has also declined to below 20 per thousand. We have created new medico-social problems, one of reduction in loss without corresponding reduction in births, resulting in a massive problem of population and its effect on society. It affects all aspects of the community's needs: food, clothing, housing, health services, education, transport, sanitation, economy and environment. Deterioration in these poses new health problems and attempts to rapidly stem birth rates also create problems.

It took many years for demographers, economists, sociologists, religious groups, governments and international organizations to realize and accept the problems created by reduction in death rates without reducing birth rates and it took even much longer for the physician to recognize and accept the health and socio-economic implications of the man-created phenomenon, to which he was a major contributor.

The solution to the problem demanded his active participation. He is most suited as a trusted friend and counsellor to advise, educate and propagate new values and concepts. The nature of his education and training provides him with information required to convince the people of the need to change their values and attitudes. Yet he himself chooses to remain enshrined in conservative and traditional concepts and values of life. His involvement would have committed him to re-evaluate, re-orientate and examine his own beliefs and values. He instead chooses to follow blindly the easier conservative and traditional approach and values and has been slow to change. He has become caught in the highly competitive technical world of science and lost the social and humanistic aspects of medicine. He has become a scientist and technocrat but failed to appreciate his role as a trusted friend, counsellor, philosopher and community leader. He speaks of traditional values of life and morals and oaths of a physician but fails to place himself in the position of the patient. He fails to be realistic to the individual and community needs. He often becomes another super-technocrat and looks at an organ or system without often realizing that the primary fault is in the individual as a whole.

The conditions in institutional practice do not help. The fiscal regulations governing the physicians in institutions; the acute shortage of personnel and facilities, the large number of patients that have to be seen, and the rapidly dwindling dedication, enthusiasm and morale amongst physicians have made the practice of medicine very impersonal, objective and often incomplete. The patient-doctor rapport is not established and no more than a cursory examination is all that is possible. Such standards of practice are not acceptable to most doctors but they soon learn to perform miraculous "short-cuts" and with experience avoid serious mishaps. Whilst the student in training is taught to adhere to all that an ideal physician should be, he soon becomes disillusioned on seeing what happens in practice and before long, learns to adopt an attitude which is impersonal and a practice which, to put it mildly, is cursory. To teachers of medicine, this is very traumatic and hypocritical and before long, becomes frustrating.

The result of all this is that student's teaching gets disrupted by heavy workload, over-tired and therefore impatient and irritable doctors, and ambivalence and lack of conviction in the doctors. The position is not made easy by over-zealous administrators who interpret standing orders without any humanistic consideration, resulting in ill patients being sent home because they cannot afford to pay and because they are not Singapore citizens. How does a physician or a teacher of medical students expect students to uphold ethics and moral values of the profession where in practice this is not always possible. How does one inculcate in the future doctor the feeling that he is more than a technocrat and that he should deal with the patient's problem as a whole, be a trusted friend, a counsellor, an opinion setter and a philosopher. How does the physician develop rapport with the patient if he is to work under constraints of rigid regulations, time, facilities and, most of all, without appreciation and recognition. Personal considerations have been left to the last. At what point does personal self-sacrifice give way to the basic need for family life and happiness? It has been written "Thy reward shalt be in heaven" but to the permanently harrassed and overworked doctor, it has the hollow ring of the promise of tomorrow that never comes. The answer may appear simple and that is to leave institutional service but then you will be labelled as disloyal and lacking in dedication. It will be a defeatist attitude. Some are more tolerant than

others, some have other reasons for staying, but there appears to be no answer to the problem at present, not at least for as long as the medical services are part of the general administrative structure.

One of the basic concepts in the practice of medicine is the sanctity of life. In early times, it was easy enough to fall back on the basic principle that life was inviolable and that it should be maintained at all costs. This satisfied religious, moral, personal and all other considerations. With the passage of time, one has come to question the logic of adhering to this principle blindly. The exact definition of death has been demanded by lay people and doctors alike with the advent of transplant surgery. Whilst euthanasia has not been allowed yet, recent sensational cases involving patients on prolonged artificial respiration and other machines have excited the imagination of the public. Gender identity problems have caused patients to demand sex re-assignment operations, a procedure close to the legal definition of grievous bodily hurt. Decisions as to the definitions of life and on what is professionally, ethically and morally right are still matters of controversy and conflict.

To return to the theme of life and its sanctity, we now consider a different aspect, namely that of the unborn. The Papal Encyclical "Humanae Vitae" has held rigidly as it indeed must, to the sacredness of life. The pragmatists have found that ours is a shrinking world with the predictions of Malthus rapidly becoming more and more a stark reality. The traditional joint family system is being rapidly replaced by an urban nuclear family system. The male dominant, male economy dependent society is gradually but surely being replaced by an equal society. Women are becoming equally educated, enlightened and socially and economically independent. Segregation of sex at schools and socially is being replaced by a free mixture of sexes. Strict moral code and conduct applicable in segregated societies are rapidly breaking down. Whilst still economically dependent on the family, a 12-to-15-year-old today is sexually mature and it is difficult not to get emotionally and not infrequently, physically involved with associates of the opposite sex. Whilst sexual knowledge and experience did not occur until later and most times until after marriage, today pre-marital sex in the teenager is a fairly common occurrence. A recent WHO report states that more than 50 per cent of girls the world over experience sex in their teens. The report

continues, "The probability of coital relationship before marriage has increased as has the likelihood of adolescents experiencing their first coital relations during their early teens." A number of countries have reported a substantial increase in recent years in rates of birth out of wed-lock and in abortion, with adolescents constituting a significant proportion of cases. A doctor of twenty-five years ago would not have anticipated the social changes that contributed to liberal sexual attitudes and it must follow that it would be unrealistic to apply values of 800 to 2,000 years ago in our attitudes and practice of medicine and in dealing with the problems. It must follow that a physician should be aware of the social changes, about the changing attitudes and must be sympathetic, humanistic and pragmatic if he is to fulfil his role as a friend and counsellor. Yet this involves a basic principle and concept in the practice of medicine and must cause conflict and controversy. I remember that before the First Abortion Act in Singapore (1969) was mooted, the Singapore Medical Association held a symposium where it was discussed and there were many who expressed reservations on this. With the introduction and implementation of the law, the rest is history although the conscientious objector clause still holds.

There is an increasing problem of venereal disease and sexual promiscuity in the young and articles have appeared in the British Medical Journal regarding the position of the family doctor in juvenile cases—whether to inform the parents and if so, how this would affect the doctor-patient relationship.

In Singapore, the legal answer to this problem appears to be that the legal age for abortion is non-existent. What about the moral answer.

The Sterilization Act (1975) permits sterilization without husband's consent in a married woman above the age of 18 with or without children. Whilst the physician is legally protected, it does not absolve him from moral and ethical responsibilities. His responsibilities as a physician to the individual and family health and welfare extend beyond the legal protection.

These activities have led to ironic and almost to tragicomical situations, where one sees a doctor running parallel or simultaneous clinics for both abortion and infertility, yet trying at the same time to rationalize to himself the logic of doing so. With the decline in unwanted babies, childless couples can no longer have recourse to adoption and the

demand for artificial insemination of donor semen and sophisticated, time-consuming and expensive treatment for induction of ovulation and tubal surgery has increased. It is conjectural how long it would take before child-kidnapping (or child-napping as it is known in the United States) or "surrogate wives" as detailed in some magazine articles, will emerge in these desperate people.

I make no apology for what I have said except that it has been slanted towards Obstetrics & Gynaecology, a subject I know best; yet I am sure a lot of what I have said applies to medicine as a whole and to professionals in general.

In a subject of this nature, I think the time has come when we critically review our own position in relation to society and its needs and to re-dedicate ourselves to our first and only cause as doctors in making our only role that of helping the sick. It is dangerous if we join the rat race of survival and success. It is important for us to go back to our original objectives in taking to this profession and to sustain our dedication as that of one for a lifetime. I do not see any alternatives to this requirement in the best interest of our health and humour, let alone in serving the real needs of the people for whom we are trained to serve. On the other hand, it is obvious that governments who increasingly are determining the life styles of the people should place sufficient importance on the need to give adequate social and economic recognition and satisfaction to professionals, who are trained to produce the best in their respective fields and who are not in politics actively. This is particularly so for employment in the public sector, where they should fully review the terms and conditions of service for professional employees who should not be subjected to the overall civil service norms but be adequately provided the basic requirements of life in terms of shelter, food and retirement, and a good life in relation to others. Insecurity in any form is disconcerting to professionals in employment, especially when the welfare of their futures and families is at stake. More opportunities should also be developed for friendly and open dialogues between government and professional bodies to resolve both basic as well as minor difficulties and requirements and work together in bettering professional and national interests.

Public confrontations and controversies, merely tend to highlight issues without resolving them and generally bring about increasing misgivings, if not distrust, detrimental to professional

efficiency, personal enthusiasm and dedication on the part of doctors.

It is time for the Singapore Medical Association to re-examine its role and consider:

1. A proper research section to study and to put up matters on government-doctor relationships, doctor-patient relationships in relation to international history and practice and in the local context.
2. Working on new norms and forms of medical ethics and also possibly consider the rationale and maxima and minima of rates for medical services both in the public and private sectors and putting these up for

consideration by the Medical Council and the Government.

3. Actively and continually reviewing conditions relevant to the welfare and ethics of the medical profession and to have seminars and the like to broaden the base of such deliberations and knowledge and to put up suggestions to the Government and the University of Singapore from time to time on matters relevant to the medical services and profession in Singapore, to setting the profession in its proper perspective, to ensure its due recognition by Government, society and the people of Singapore.