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"Not To Be Ministered Unto, But To Minister"

C H Chew

Let me thank the President and Council of the Singapore Medical Association for inviting me to deliver this 1998 lecture. As the President informed me that this lectureship is awarded in the main to eminent and distinguished members who have contributed significantly to Medicine and the community, it is thus with much hesitation and sense of humility that I accepted this responsibility.

Prologue

As I contemplated this present age, I considered the challenges facing the medical profession arising from rapid changes in society and in science and technology. It came strongly to me that the motto of the Alumni Association of our medical school embodies the timeless foundation of medical ethics and the true calling of our profession. Very aptly, the 75th Anniversary of the Alumni Association will be celebrated in Singapore shortly.

Changes in science and technology are resulting in new techniques in diagnosis, treatment and medical breakthroughs. These changes bring about tremendous excitement for development. Likewise, unprecedented accessibility to information is providing all reaches of society with vast knowledge and new levels of awareness. However, while much of this can be beneficial to mankind, the medical profession as well as society is now and will increasingly be faced with a variety of complex and difficult problems. In all these, there is grave danger of confusion and contamination. It is in this context that the motto of our Alumni – "Not to be Ministered unto, but to Minister"– is a rock regarding our profession. It provides precious reminders of our governing principles that ours is a calling and not a trade. To quote Sir William Osler, "The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head." Central to the doctor's calling is integrity. To quote Dr Johnson, "Integrity without knowledge is weak and useless. Knowledge without integrity is dangerous and dreadful."

To understand the dimensions of these fundamentals, we can consider more deeply the Greek root word of Minister – *Diakonia* that encompasses a wide set of philosophically related actions linked to our true calling as doctors. These actions include not merely service but rather service with humility; the active expression of care, compassion and charity; service with a determination to heal; an awareness and attitude of kindness to the needy; and certainly through example – a regard and concern for fellow doctors; and an interest to promote knowledge through teaching. The inference that is vital to these actions is that the minister ie. the doctor in this context, never operates under jealousy, selfish ambition, competition nor motivation on the basis of material benefits.

It is interesting that this same word used to describe the doctor is also used for the highest political office in government leadership implying similarly, a high expectation of those who would hold such positions of responsibility. Let us not overlook the application of minister as also referring to pastoral ministry. Indeed, in keeping with past tradition, we know of several colleagues in Singapore who are holding responsibilities as doctors and the clergy, lay or ordained. (In 1981, a close colleague and friend who succeeded me as Medical Director, Tan Tock Seng Hospital was called shortly after to be the Anglican Bishop of Singapore. Today, Moses Tay is also the Archbishop for the region – no doubt an exceptional example). Society looks to and depends upon such for constancy, reliability and reference in the midst of change and uncertainty.

The Historical Evolution of Medical Ethics

Some aspects of medical ethics are fundamental and timeless. However, as medicine does not and cannot stand still, we have to address changes while reaffirming what is fundamental. Therefore, it is helpful for us to review the historical evolution of medical ethics.

Since its earliest recorded history, medicine has held to high standards of ethics, conformity of which has been a hallmark of a good doctor and safeguard to the patient's welfare. Ethics is grounded on sound moral, religious and philosophical ideals. Doctors hold to certain special ethical standards that are determined by the nature of their decisions and personal relationships, characterising the practice of medicine. Thus ethics in the context of medicine concerns itself with the moral principles that underlie the doctor's obligation to the sick and to society.

Amongst the first existing documents that mentioned the priest-physician are from the Egyptian papyri in 1600 BC and writings about classical Chinese physicians dating around 3000 BC. Such

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documents outlined methods of establishing diagnosis, guiding decisions on whether to treat and for choices of appropriate therapy. As long as doctors followed the rules, they were held non-culpable even if the patient died. After this, Babylonians devised an elaborate code of laws for practitioners of medicine and even set fees according to the social status of the patient. The Judaeo-Christian tradition is also rich. Under this tradition, medical ethics was derived from the Divine Law (more commonly known as the Ten Commandments). It also emphasised the close relationship between medicine and religion – the primacy of respect for human life regardless of estate, ethnic group, wealth, position or geographical origins. The ancient Greeks as exemplified by the legendary Aesculapius, stressed the equality of service to rich and poor (Fig 1). And in the Hippocratic Oath, which has been the touchstone of our profession for over 2,500 years, we see how strongly the responsibility of doctor to patient is held.

Fig 1 – CCH at the Ascelepion in Pergamum where Galen in the First Century practised and taught, resembling the facade of College of Medicine Building.

Fig 2 – Dr & Mrs C H Chew at Plazuela De Maimonides, Cordoba, Spain. Spain was under Islamic occupation during his days.

As we move from the Mediterranean and Asia Minor to present day Asia we have much document on the teaching of doctors to uphold a wholehearted devotion to compassion and care. Chinese medicine with a heritage of over thousands of years established similar precepts – a canon of medicine written sometime between 200 BC and AD 200 holds that "the physician should have mercy on the sick and pledge himself to relieve suffering among all classes. Aristocrat or commoner, poor or rich, aged or young, beautiful or ugly, enemy or friend, native or foreigner, educated and uneducated, all are to be treated equally. He should look upon the misery of the patient as if it were his own." From India, we have an oath of initiation into the medical profession as follows: "Day and night, thou shalt endeavour for the relief of patients with all thy heart and soul. Thou shalt not desert or injure thy patient, even for the sake of thy living." These statements contain much that is similar in emphasis with the ethics of Hippocrates.

Nearer our times in this millennium, Moses Maimonides – the Jewish physician-philosopher highly respected in Islamic Egypt where he was domiciled sometime during AD 1135 – 1204, integrated various major medical canons of his day into a common document which remains influential to this day (Fig 2). Let me quote his prayer of a physician, "Endow me with strength of heart and mind. So that both may be ready to serve – the rich and poor, the good and wicked, friend and enemy. And may I never see in the patient anything else but a fellow creature in pain."

In Britain, it was only in 1520 that the Royal College of Physicians of London drew up the code for physicians. In the United States, in 1847 following the founding of the American Medical Association, a similar code was established. In 1948 after the Second World War, the World Medical Association adopted the Declaration of Geneva that represented a revision of the Hippocratic Oath. Many similar declarations were also established from that time. And since 1995 in Singapore, we have the Singapore Medical Council's Physician's Pledge taken by newly registered medical practitioners. With this rich heritage in mind, let us look at how a doctor is to apply himself to the various dimensions of relationships facing him in his calling today.

The Doctor-Patient Relationship

Primary Goals and Principles

Central to the delivery of healthcare is the doctor-patient relationship and the principles that govern this. These include beneficence, honesty, confidentiality and trust. The doctor's first responsibility is and always will be to his patient. His primary goals are therefore to treat and cure where possible; to help the patient cope with illness, disability, and death; and to bring relief in suffering. In all instances, he must help maintain the dignity of his patient. All the doctor's acts towards these ends stem from the nature of this relationship. Because of

his specialised knowledge in medicine, there are special obligations in how the doctor serves his patient's interest. Ethical behaviour towards patients furthers these goals, strengthens this singular relationship, and promotes the wider relationship between the profession and society.

Patient Consent and Autonomy

In most medical encounters when the patient presents himself to a doctor for consultation and care, consent can be presumed. In this regard, this is inextricably linked to respect for autonomy of the patient. Indeed, respect for the autonomy of the patient requires that doctors recognise the right of patients to make their own decisions about medical treatment. Effective consultation is based on continuing communication between patient and doctor, and the provision of relevant information by the doctor in such a way as to enable the patient to make an informed decision. Plainly stated, information must be given in terms that the patient can understand. This is an important ethical obligation. Relevant information should include the nature of the patient's medical condition, the objectives of any proposed treatment, treatment alternatives, and the risks involved. The thoughtful doctor communicates with the patient in a warm, comfortable and open manner that conveys competence, loyalty and respect for the patient in an attitude that engenders trust and confidence.

Patient Confidentiality and Dignity

Another fundamental tenet of medical care is confidentiality. It is a matter of respecting the privacy of patients and upholding of dignity, encouraging them to seek medical care and to discuss their problems candidly. Thus, the doctor must not release information without the patient's consent. However, confidentiality is not unconditional. There are circumstances, under which confidentiality may have to be over-ridden, such as to protect individual persons or the public. Examples include warning sexual partners that a patient has venereal disease, HIV infection, or a serious infectious condition, or to disclose information when required by law. Before breaching confidentiality, the doctor should make every effort to discuss and explain all the issues involved. The process of breaching confidentiality and explaining issues to the patient should be done in a way that minimises harm, stress or embarrassment. Respect for confidentiality also means that doctors should not comment on the health of individuals without their expressed consent, for instance those who are responsible in the care of well known public personalities.

Confidentiality is becoming increasingly difficult to maintain in the era of computerisation and proliferation of information technology. For example, the transmitting of patient information through faxes or using the Internet can be both indiscreet and widespread. Another example would be in the sharing of patient care amongst numerous medical professionals and institutions. Thus, the doctor should be aware of these increased risks of invasion of patient privacy, and apply sensitivity and wise judgement to help ensure confidentiality.

Advance Medical Directive (AMD)

One of the early pressing issues which the National Medical Ethics Committee addressed, was the care of patients who were incurable and terminally ill. Today, modern technology is able to sustain essential physiological functions and technically prolong life in the final stages of terminal illness. Sometimes it does no more than prolonging the process of dying. A doctor has a duty to sustain life. But he has no duty – legal, moral or ethical – to prolong the distress of a dying patient. Where there is little or no chance of survival, aggressive treatment should never be automatically instituted. Invasive procedures, respirators and cardiac resuscitation, are all supportive measures meant to assist a patient through a critical period towards recovery. To use such measures in a terminally ill patient when there is no hope of recovery is not good practice and it also prevents the patient from dying with dignity.

The Committee felt following wide-ranging consultations that there would be a need to allow patients to make advance medical directives to instruct their doctors to withhold or withdraw life sustaining treatment when they are terminal and incurably ill. The AMD allows the patient to continue to exercise autonomy when they are unable to express their wish. The directive is a formal and for over a year now a legal document, which removes any doubt, the patient's wish to die naturally and with dignity.

AMDs are best made when the patient is in good health and doctors, especially family physicians, should routinely raise the issue of advance planning and discuss with sensitivity and in depth the implications and consequences involved in the decision. All this will have the effect of strengthening the doctor-patient relationship. This was the reason why it is so important to have a doctor, preferably a patient's family or personal physician as one of the two witnesses. (This matter was discussed *in extenso* at the meeting of the Medico-Legal Society last week).

Medical Risks To Doctors

Traditionally, the ethical imperative for doctors to provide care has always over-ridden the risks to the treating doctor even during epidemics and in the treatment of life-threatening infectious conditions. In recent times, with better control of such risks, doctors have practised medicine with risks as a diminished concern. However, potential occupational exposures to new conditions such as HIV infections, multiple drug-resistant Tuberculosis, and viral Hepatitis require re-affirmation of our ethical duty to treat. Nevertheless, doctors must evaluate the risk of becoming infected both in their personal lives and in the work place, and put in place proper precautions to minimise undue risks within the boundary of duty. Evaluation of risks should not be confused with the medical imperative that it is unethical to refuse to treat a patient because of a medical risk or presumed risk to self.

The Doctor-Doctor Relationship

The doctor on entering our profession, shares with all his colleagues a commitment to care for the sick. The traditional bond between doctors is a powerful aid in the service to patients and must never be used to personal advantage.

Teaching

Teaching is part and parcel of the doctor's calling that reinforces the bond between colleagues. The very title, doctor, from the Latin root word *docere* – to teach, implies a responsibility to share knowledge and to impart information. This sharing includes the teaching of clinical skills and reporting of results of observations and scientific research, and the teaching of medical students and other healthcare workers. In keeping with this practice, the use of secret remedies has no place as this runs counter to the principle of service for the wider good. In this regard, the doctor's responsibility also includes communicating clearly with and teaching patients that they are prepared properly to participate in their care and the maintenance of their health.

Many years ago in the farewell address at the retirement of Professor Sir Gordon Ransome in 1975, I identified two prerequisites for a person to be truly great: "First, he should be a good man in the fullest sense of this commonly abused adjective. The second is that the man must multiply himself so that he leaves no vacuum. Alas all too many otherwise great men have failed to do!" Sir Gordon was an exceptional example of a teacher, for his disciples are many and they include professors, heads of departments of medicine, directors of medical services and even heads of civil and university service. Indeed, a fundamental function for all of us, especially of teachers in the university or institutions, is to be exemplary role models to our younger colleagues and successors.

Consultation

No doctor can be expected to be competent in all aspects of medicine. Furthermore, experience in practice cannot be acquired except over a period of time with exposure to different conditions, patients and observation of treatment alternatives. Certainly, experience cannot be compressed because medicine is complex both as a science and an art. Therefore, a doctor should never hesitate to obtain assistance when required in the care of his patients or seek consultation when this is requested for by the patient or concerned parties either openly or tacitly. Under certain circumstances, multiple consultations may be required. Indeed, the welfare of the patient must always be paramount in the consultation process. Misplaced pride has no place in good medical practice and can only compromise care of the patient.

May I quote a passage I made again of my former chief, Professor Ransome: "In person he was very kind and gracious and treated every patient regardless of station with the same thoroughness, humble in all ways and always prepared to learn from others including the lowly houseman, giving credit magnanimously when due and ready to admit his own mistakes." I am gratified that Dr Wong Heck Sing also quoted this passage in his 1997 SMA lecture when he spoke on role models (Fig 3).

The Impaired Doctor

With the recent amendment to the Medical Registration Act brought into operation on 3 April 1998, it has become a legal duty for any registered medical practitioner who attends to a colleague who is unfit to practise by reason of his mental or physical condition to inform the Medical Council. Indeed I would put it to you that it is an ethical duty for doctors who find themselves impaired for any reason, to refrain from assuming patient responsibilities which they cannot discharge safely or effectively. Every doctor is responsible for protecting patients from an impaired doctor, and similarly for helping an impaired colleague by ensuring he receives appropriate advice and treatment. Fear of being wrong, fear of embarrassment, or even of possible litigation, should not deter or delay identification of an impaired colleague nor of submitting oneself to obtain help if one is impaired. In such cases or when in doubt, it may be helpful to discuss the issue confidentially with a senior member or his peers. Impairment may be a result of habit-forming agents or from psychiatric, behavioural or neurological disorders. While undergoing treatment, the impaired doctor is entitled as with other patients to full confidentiality as in any other doctor-patient relationship.

Professional Courtesy

In keeping with our Hippocratic tradition, it is heartening to note that many doctors in varying measure still elect to offer professional courtesy to colleagues. Professional courtesy is demonstrated by the waiving of professional fees. However in the true spirit of this act, both doctor and patient should function without feelings of constraints on time or resources. The receiving of such courtesy should not be taken for granted but rather recognised as a unique and noble hallmark of our profession.

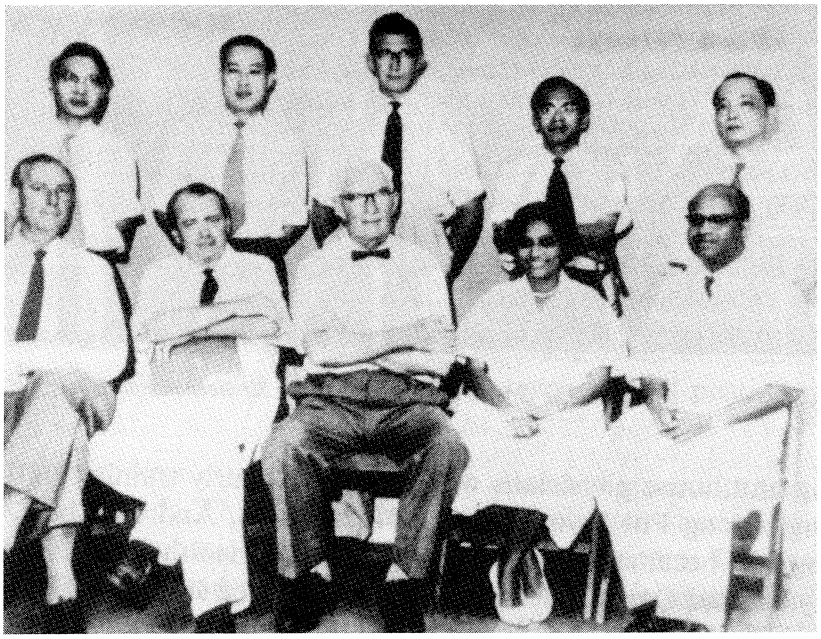

Fig 3 – Medical Unit I: Professor Ransome and his staff.

Criticism of Colleagues

It is not only harmful but also unethical for a doctor without good evidence to disparage the professional competence or behaviour of another colleague.

Similarly, it is unethical to imply by word, gesture or deed without good evidence, that a patient has been poorly managed or mistreated by a colleague. Such improper behaviour especially when used to induce a person to become one's patient, or to further one's professional or personal standing, is grossly unacceptable. All this goes against the doctor's fundamental calling to minister to the community.

The Doctor-Society Relationship

The standard of medicine practised in Singapore continues to experience a high degree of approval and respect from society. However, this is not unqualified as expectations continue to rise. Criticisms come more freely as society becomes better educated and more exposed to wide-ranging views towards medical treatment and the role of doctors.

Accountability

The professional prerogatives now enjoyed by the doctor are conferred by society. In turn, the doctor is responsible and accountable to society for his professional and moral actions. He holds as it were a franchise granted by society – the rights, the privileges and duties pertinent to the patient-doctor relationship. Never forget that these can be withdrawn by society if not exercised responsibly and with prudence.

Like any good citizen, the doctor should strive for the well being of society and should work towards ensuring the availability of adequate medical care for all individuals. In this regard, we must necessarily be aware of and appreciate the economics of medical care to ensure that care is provided in the most efficient and equitable manner. Effective medical care and practice therefore requires not only scientific knowledge and mastery of skills as well as the art of taking care of the patient, but it also must be guided by appropriate sensitivities to social and economic issues and the needs of the community as a whole. Ideals must be tempered by what is practical and what is available. However, in the changing environment of healthcare delivery, there is often tension and competition among doctors, health insurers and healthcare institutions. These parties should collectively commit to prioritise and share responsibility for ensuring that the ethical foundation of primacy of the patient's welfare is not undermined. Never allow the steady commercialisation of medicine or pressures of the marketplace affect adversely our professional calling. In the latest Singapore Medical Council Report, the President in his forward stated: "Medicine is demeaned by referring to our patients as customers." I fully agree with Professor N Balachandran that we must resist "these adverse trends lest we lose the trust of our patients".

Conflicts of Interest

The nature of relationships and trust vested by society in the doctor poses unique challenges to apply wisdom and moral strength in the areas of conflicts of interest. When conflicts arise, the moral principle is clear: welfare of the patient must at all times be paramount and the doctor must insist that an appropriate level of care takes primacy over financial considerations that may be imposed by other institutions or by the physician's own practice, financial investments or arrangements. Thus, the wise call is for the doctor to avoid any business arrangement that might because of financial gain, loss or inducement, influence his decisions in the care of his patients. In this regard, it must be emphasised collusion with any healthcare provider for personal gain is morally reprehensible. With these principles in mind, the issue of investment by a doctor in hospital or other facility in which the doctor practises or to which he refers patients and in turn receives a reward may create unnecessary complexities. In any case, the patient should be informed of such interest where they apply.

The acceptance of gifts or subsidies of all types from the healthcare industry for personal benefits by a doctor is unwise. While following the London College of Physicians' guidelines, "Would I be willing to have this arrangement generally known?" We should also ask, "What would the public or my patients think of this arrangement?". Doctors must critically evaluate medical information provided by retail persons, advertisements or industry sponsored medical programmes. In addition, doctors with ties to a particular company should disclose their interest when speaking, lecturing or writing about a company product.

Doctor and The Media

Commentary by doctors on medical subjects within the areas of expertise can help keep society properly informed. In this sense, doctors should regard interacting with the news media as an obligation to society. However in this era of rapid communication and intense media interest in medical news and professional opinion, it is incumbent upon all medical professionals to approach public pronouncements with caution and circumspection. Opinions expressed should be balanced. Because the impact of media is widespread, special attention should be given to ensure that such announcements be presented in a language that does not invite misinterpretation, cause for speculation, undue elation or alarm. For example, an announcement of early findings, couched even in the most careful terms, is frequently reported by the media as "a breakthrough". It is perhaps more prudent to have these matters discussed only after they have been accepted and published in peer-reviewed medical journals. Care must be taken against falsely raising public expectations.

Continuing Medical Education (CME)

CME has been, as many of you know, an abiding interest to me. With the increasing pace of change in the art of medicine and technology, any body of

knowledge can be rendered quickly outmoded and irrelevant. Thus, CME must be a life-long process – ie. a continuum from undergraduate through post-graduate education and, for some, even beyond retirement years. In this age of scientific and technological advances, it is not uncommon for doctors to lose sight of and becoming slack in honing skills in the art of medicine and patient care. However, it would be as unwise and less than responsible for doctors to ignore and not endeavour to keep abreast with new medical technology and treatment methods.

Doctors must be cognisant of the fact that society is increasingly educated and demanding, and thus have rising expectations of doctors to keep pace with change. In Singapore, throughout the year there is no dearth of accredited CME programmes to suit all doctors – doctors in training, family physicians and specialists – organised by the Academy of Medicine, the Graduate School of Medical Studies, the College of Family Physicians, the many medical bodies, specialist societies and hospitals. In addition, there are well structured training courses and programmes which are required for post-graduate examinations and certification by the recently established Specialist Accreditation Board. The existence of these will no doubt enable the high standards of medicine in Singapore to be maintained and strengthened even further.

Ten years ago, the Singapore Medical Council introduced an incentive scheme to promote voluntary participation by doctors in continuing education. Since CME is widely available to doctors in Singapore to meet the demands of our changing environment, the time with a decade's experience has perhaps arrived for participation in CME to be made mandatory. This will ensure that all doctors are kept refreshed and updated in their knowledge and practice as a commitment to society.

Epilogue

As stated earlier, there are some aspects of medical ethics that are fundamental and timeless. However as we have seen, medicine and its practice environment have changed tremendously. Many still yearn for return to the simplicity of the past. Such is of course not possible. Nevertheless, as long as we hold true to the mission and spirit of ministering to the sick and to our fellow men, we shall be able to overcome all the challenges to our calling with confidence.

In closing, let me quote from Sir William Osler when he delivered 'The Master Word in Medicine', a lecture to the University of Toronto in 1903:

Of learning, that you may apply in your practice the best that is known in our art, and that, with the increase in your knowledge there may be an increase in that priceless endowment of sagacity, so that to all everywhere skilled succour may come in the hour of need.

Of a humanity, that will show in your daily life tenderness and consideration to the weak, infinite pity to the suffering, and broad charity to all.

Of a probity, that will make you under all circumstances, true to yourselves, true to your high calling, and true to your fellow man.

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