Preferential Option **for the Poor**

By Dr Tan Poh Kiang

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I learned through writer Philip Yancey that the phrase, "God's preferential option for the poor" was first coined by the early Catholic fathers to describe Jesus' bias toward the poor in the gospels. This clever description captures my passion and imagination throughout my medical career.

TO SERVE THE POOR OF SOCIETY

One of the things I was warned not to say during the entry interview to medical school was that I had wanted to be a doctor to serve the society. It was said that the interviewing professors were tired of such cliché. I do not honestly remember what I had said to make it into the medical faculty with average grades. However, I have always felt strongly that taking care of the poor must form one of the noblest reasons for being a doctor.

During the days of training as a student and a junior officer in the hospital, the way to serve the poor was to treat them royally as if they too were admitted into the "paying class". That was probably why postings (for medical students, house and medical officers) to the then government hospitals like Alexandra Hospital and Tan Tock Seng Hospital were popular, because they admitted a large share of the society's poor. It was not only because everyone wanted to pamper the less fortunate, there was also a larger pool of clinical cases the trainees could access without fuss. I remember feeling good whenever I gave away samples of expensive drugs to those who could not afford them. Somehow, people who have little wealth seem to display more gratitude toward their doctors, or at least they are more expressive of their thankfulness.

After leaving the government service, I worked in a couple of GP clinics where the boss granted me the freedom to charge as I saw fit. That was when I experienced the joy of waiving part of the fees for some patients with significant financial restrictions. The joy was of course, not similarly felt by my boss who was watching the bottom-line of the clinic's balance sheets. Notwithstanding some other reasons for leaving that employment, I recognised then that if I really wanted greater involvement in treating the poor, I had to start my own practice.

"If you are not careful, the poor can suck you dry," a well-meaning friend warned. I thought that was a very harsh judgment on the part of one who had been trained and involved in social work. This same friend offered two other pieces of advice: 1) work with the community social workers, and 2) recognise my own limits of help.

REALITY BITES

I plunged straight into my personal campaign to aid the poor in the HDB neighbourhood where I practise. In the first year of my clinic, my enthusiasm led to the creation of PWYCA (Pay-What-You-Can-Afford). I was delighted to be treating many patients who were paying a few dollars for treatment that would normally have cost them twenty or thirty dollars. I was finally doing real charity work with my medical knowledge and skills. The number of "poor" patients increased rapidly as a scheme like this needed very little advertising to get around a small neighbourhood.

However, my pride was dented when my clinic assistants reported that some of these "poor" patients were coming and leaving in taxis. A few flaunted thick gold accessories and carried handphones. It became apparent that not everyone who claimed he was poor was genuine. I abolished PWYCA, swallowed my pride and went back to the "drawing board".

This minor setback led to my work with the social workers at a family service centre within a stone's throw of the clinic. It began with a simple plan – any client accompanied by a social worker will be treated at the clinic for a token sum of five dollars. The need to charge a token sum was a result of my discovery of two phenomena when medical services are offered free-of-charge. Firstly, even the poor person suspects that less than high quality services are offered when he does not need to pay. Secondly, many individuals do not return for follow-up care because they are "*pai-say*" (Hokkien for "embarrassed") of their inability to pay. This plan is modelled after the collaborative work in the hospitals where the medical social workers take the burden off the clinicians in doing background search, interviews and making the decisions as to who deserved subsidised care.

SOCIETY'S UNSUNG HEROES

The world of social work is fascinating. I was privileged to be invited by the directors of the social service centre to be part of the monthly staff " brain-storming" meetings. Through impassioned discussions of cases presented by various staff members, I discovered that for many troubled

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families, financial poverty was not the only problem they faced. I began to understand that merely granting such families welfare funds or giving them medical treatment for a token fee did not even begin to make a dent in the huge obstacles that stand between them and a better life.

Many of the deeply entrenched habits are destructive (e.g. delinquency, truancy, gang involvement, chronic unemployment, physical and sexual abuse, alcoholism, glue sniffing) and not amenable to simple corrective measures. The disadvantaged of the society may know their plight but may have neither the skills (low education and poor insight) nor the motivation (content to be given financial aid or resigned to a "pre-destined hard life") to improve.

I walked into the world of the marginalised of society that I would otherwise have little contact with and thus no means to comprehend the depths of their struggle.

Social workers are a special breed of people. It is not only because they work really hard for really miserable remuneration, but they have hearts of gold to want to immerse themselves into the agonised lives of their clients, and in the midst of chaos, offer solace and hope.

Through my interactions with the social service centre's staff, I have developed tremendous respect for their devotion and their work. While there is a prevailing intent to remain objective (like doctors are taught to be when they treat their patients), none of the effective social workers I have observed can keep from having their elbows deep into the often-muddy waters of the cases they handle. Their emotional involvement is intense and exhausting while their rewards are often few and unapparent. They are often taken advantage of by their clients and frustrated at the same time by the lack of progress in the lives they try to influence. This may explain why the turnover of staff members is considerably high despite that particular centre's excellent work culture and environment. It is likened to the military special forces – the members do not last more than one or two tours of duty before it takes a terrible toll on their lives.

These society's unsung heroes wage wars against the social ills through long irregular hours (it is not uncommon for the staff members to bring their sick clients to my clinic at 9 or 10 pm). I make an extra effort to affirm the wonderful contributions these workers make toward a more stable society and welcome them to seek my medical help at subsidised rates.

PARTNERS IN HEALTH

Compassion is the fuel for help providers to continue to guide the society's disadvantaged out of the darkness. My collaboration with the social workers has confirmed my own calling to the practice of medicine. The problems that some of these troubled families or individuals face are complex and a multi-disciplinary holistic approach is needed to achieve success in the long haul. A recent incident epitomises such teamwork.

Herman is a 10-year-old boy from a family of four. The last time he was very sick, so were the other siblings (which is easy to understand given the lack of personal hygiene and a small crowded home). His social worker, Laura brought him to my clinic to seek help late in the night (about 9.45 pm). He was the last registered patient and while I was examining the patient before him, I could hear a din going on in the waiting room. When I finally decided that auscultation was close to impossible. I went out to check, only to find him throwing a tantrum on the floor.

I shocked myself and Laura when I raised my voice many decibels to chide Herman, "If you don't want to be helped, you can get out of the clinic! I don't need to put up with this nonsense!" My threat to use the needle on him worked to reduce his wailing to a tolerable whimper. It turned out that he was protesting against having to miss his football practices the next few days if he were pronounced sick. Just as he was about to leave my room, I relented and softened my voice, "Herman, I know you can be a good boy and that's why I am so disappointed in your behaviour tonight. I hope you have learnt a lesson tonight."

I thought little of that outburst until two days later, when Laura called to put Herman on the line with me. He apologised to me for his misconduct and promised not to repeat his antics. There was a small satisfaction that I had helped the social worker steer a young life toward a better path.

Just as we will never eradicate all the incurable diseases in this world, we will not alleviate everyone's suffering. Yet, even if only one person can be rescued from destructive social circumstances and set on the path toward recovery, the reward is good enough to continue to exercise our preferential option for the poor. ■