From SMA News January/February 1985 Issue

Freedom in Medicine

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Editor's Note:
The following article is one of two papers presented at the 12th Council Meeting of the Commonwealth Medical Association held on 17 and 18 November 1984, and reproduced in the January/February 1985 issue of the SMA News.

It is an honour to address this distinguished gathering. The theme of this meeting, "Freedom in Medicine", is, of course not new. Notwithstanding, we can observe the truth of what Confucius meant when he said "wen gu er zhi xin". It means "each time we examine an old theme, we discover new ideas".

The question "To what extent are doctors free to practise their art?" is as old as civilisation itself. However, the answers have been constantly changing in the wake of social, economic and political developments throughout the centuries.

Perhaps I shall begin by saying something about freedom in general. We need not dispute that freedom must be qualified. Absolute freedom is a myth. Even leading proponents of liberalism in the nineteenth century, such as Locke and Rousseau, recognised the need for a compromise between liberty and restraint. These issues have invited questioning which is becoming more frequent, sharper with time, and is often hostile in nature.

In archaic societies, the doctor was regarded a supernatural figure as he grappled with the seriousness and mysteriousness of the forces of disease and death. In this situation, the patient entrusted certain freedoms over to the doctor to obtain some form of curative benefit. Such charismatic authority left the knowledge and competence of the doctor unquestioned.

Since then, social responses to the claim that doctors should have freedom in structuring their relationship with their patients so as to secure the proper medical benefits for the patient, have varied considerably. As social development gathered pace, particularly after the Industrial Revolution and the subsequent massive urbanisation, a growing number of moral, legal and political challenges arose, challenging the traditional authority of doctors over their professional activity. The Information Age has further altered the scenario. In contrast to the support for professional authority exhibited in the first part of this century, the last twenty years has seen a growing public concern for the rights of patients and for corresponding professional obligations. Constraints in medicine have come of age. And rightly so, I would say. But with age, other problems crop up.

I would like to touch on several areas pertaining to this theme, namely,

1) Ourselves – professional oaths and codes
2) Legal constraints
3) The economics of medical care
4) Healthcare financing
5) Government intervention

1) OURSELVES – PROFESSIONAL OATHS AND CODES

2000 years ago, Hippocrates formulated an oath that provides ethical standards and guidance for physicians. This has historically played a formative role in focussing doctors on the highest ideals of their profession. It continues to do that. But it was not until the first two decades of this century that medical councils were formed in western countries and other countries to oversee the professional conduct of medical practitioners. These medical councils established strict standards for medical ethics and education.

As I have mentioned, the first constraint comes from ourselves. We have come to recognise that to function as a credible profession, a code of ethics must regulate medical conduct. These rules and regulations have certainly restricted freedom in medical practice – and in the right direction too!

2) LEGAL CONSTRAINTS

The relationship between a doctor and a patient is subject to legal constraints. Today when the relationship breaks down and a patient sues a doctor he generally does so in tort or specifically in negligence and battery. This is of course nothing more than a manifestation of justice. It necessitates full communication between the doctor and the patient and deters malpractices. The law thus acts as the mentor of the doctor-patient relationship.

However, the fear of tort liability can render doctors so cautious as to refrain from taking the course of action medical judgement best dictates. If we do so, we will be failing in our mission. The point is that we have to strike a balance. It seems only right that as a patient is increasingly protected by a rising awareness of his "rights", that the doctor equally deserves, protection from litigious patients.

3) THE ECONOMICS OF MEDICAL CARE

The next constraint which is fast becoming a major concern is the cost of medical and health care. In our inflationary society, costs spiral. The population is ageing. Illnesses which are expensive to treat are on the rise. Technology and new advances enable doctors to keep patients alive. But these do not come cheap. Besides, the general mood in the past few years is one calling for reduction in health costs.

How do these developments affect the freedom in practising our art? Like it or not, the profession must make cost-effective decisions and must accept clear responsibility for effective and efficient use of scarce resources and limited funding. Ongoing technological innovations should not overwhelm doctors into confusing expensive, sophisticated treatments for quality care. Doctors must recommend the most cost-effective treatment.

4) HEALTHCARE FINANCING

The wider perspective of a national healthcare system places further constraints on freedom in medicine as well.

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How should healthcare be financed? This is a difficult question to answer. To reduce unnecessary medical expenditures, it is perhaps sound that direct financing from source be encouraged. Indirect financing, either by means of government taxes and subsidies or various insurance schemes, distance the consumer from his direct medical expenses, thus reducing the incentive to economise. A case in point is the escalating cost of healthcare in the United States, due largely to the provision of comprehensive health insurance schemes.

The last intrusion into the freedom in medicine I wish to touch upon is one from government.

Take abortion in Singapore. The longstanding belief that it is medically unethical to perform abortion was changed overnight by a stroke of legislation. Take professional secrecy. Doctors may be required by law to reveal information obtained in the course of their professional practice, if it is considered in the public interest to do so, such as drug addiction. I do not intend here to go into the merits and demerits of these legislations. The point i wish to make is that today we are living in situations where political and community considerations may, and often do, cross paths with our professional ethics.

These questions raised give issues of conflict of duties. There needs to be a balance between the rights of the individual patient and the needs of our nation. But the rapid changes in Singapore will bring with it more social transformation and doctors must learn to adapt to further constraints to freedom in medicine.

Part of community

What could we as professionals do in the midst of these constraints upon our freedom? One thing we must realise is that we are part of the community. In matters that affect the practice of medicine, we should formulate and present logical, considered arguments to win over the community. As long as we keep the public interests in mind, we will be taken seriously and will be able to better fulfill our social obligation as the healers of the community.

POLITICS AND AFFLUENCE

Financing of healthcare by governments also shoots up its costs. In Britain, the government politically fixes health expenditure for the National Health Service each year. The result is alarmingly long queues of patients waiting for treatment.

Lest I be accused of being unsympathetic to the needy, I must add that direct finance is beyond the means of a good number of patients. The Singapore government's answer is a savings scheme with which healthcare can be financed directly from source and yet is within the reach of the majority of the patients. Such a savings scheme, however, still carries a major weakness. There will be chronically ill patients needing long periods of medical care. The cost of maintaining these patients can itself be enormous, not considering the loss of income of the patients. The medical savings of the patients can be easily exhausted. Who is going to pay for the patient then? One naturally turns to the government. However, with the ageing of the population, this category of patients can be expected to rise. This will become a major social liability for which the government, the community, and doctors must jointly be responsible. Perhaps, a cheaper way of looking after these patients, one which does not involve an extensive use of expensive acute hospital beds, can be devised. Perhaps paramedical groups can play a part. Perhaps, the doctors can care for these patients on a semi-voluntary basis for a nominal charge. Whatever the scheme we may devise, this problem will soon preoccupy us. Doctors must help. But whether doctors volunteer or legislation is introduced, this major problem will soon be an additional constraint on freedom in medicine.

It has struck me that we, in this part of the Commonwealth, are in a unique position.

Despite centuries of civilisation, Asia did not have the political stability for economic and medical progress. Even today, modem surgical and medical techniques only reach a small percentage of Asia's massive population. On the other hand, many countries in the Far East and South-east Asia achieved significant economic growth in the past decade. International economists predict that these countries will continue to have the greatest economic growth in the world in the coming decade. We should therefore surely appreciate the tremendous effort and determination of the leaders in these countries in making available opportunities for enterprise and progress. Yet, not too long ago, in the practice of medicine itself, these opportunities were either restricted or even non-existent.

Before the Second World War, local Singaporean doctors, no matter how brilliant and qualified began as assistant medical officers in the civil service. They were to remain as assistant medical officers until they retired. In contrast, the British doctors who worked here started as medical officers and attained rapid promotion to consultancy and other senior positions.

Although not all countries have fared well in the post-colonial era, for those which have fared well, opportunities and the corresponding freedom in medicine are now only limited by the resources available and the organisation of the medical service. This has placed a tremendous responsibility on the leaders of medicine.

5) GOVERNMENT

I hope that medical leaders in these countries will urgently seize every possible opportunity to exploit this extraordinary freedom in medicine.

GAME OF CHESS

Freedom is strangely argued to be interlinked with intelligence, wisdom and skill. It has been compared to a chess game. In response to moves and counter-moves, the chess player's freedom of action is related to his skill and intelligence and knowledge of the game. A skilled chess player will have many options and may even make a significant move in a difficult situation not only to strengthen his position but also to reverse his position. He may be said to have greater freedom compared to a less skilled player.

Doctors and medical organisations may like to compare ourselves to chess players given a set of rules and the limitations within which we can work. Freedom of medicine is as free as we are able to apply our intelligence, wisdom and skills to the situations which confront us. ■