EXTENDING A DOCTOR'S REACH THROUGH PUBLIC SERVICE

Text by Dr Roy Joseph

The Singapore Medical Council's (SMC) Physician's Pledge begins with: "I solemnly pledge to: dedicate my life to the service of humanity; give due respect and gratitude to my teachers…" The Ethical Code in SMC's 2016 Ethical Code and Ethical Guidelines (ECEG) lists 22 directives, all of which, when complied, results in service of the highest order to the sick and the healthy. All physicians become aware of this imperative very early in their training, often within the first year of medical school. A quick look at the membership and leadership of organisations with a strong public service ethos will reveal a disproportionately high number of medical practitioners.

My entry into public service

I was led to this noble activity from young: at home by my parents; in school by my Cub and Boy Scout Masters; in church by pastors; in medical school by my teachers; and as a practising physician, by the numerous opportunities that my seniors, our health system and its administrators have made available. However, physicians are often so caught up in caring for individual patients that the needs of other patients, the healthcare system and that of society, are either not recognised, ignored or seen as someone else's business. The practice of my subspeciality of neonatal paediatrics is unique; because in almost every encounter with a baby who is sick, the doctor has to serve the needs of at least two others: the parents. Paediatric practice hence is a crucible from which the value and imperative of serving others becomes internalised and valued.

My service with the National Medical Ethics Committee (NMEC) began in 2005 as a member and from 2009 as its chairman. This was after a period of serving on the National University Hospital Clinical Ethics Committee. The NMEC was appointed by the Director of Medical Services to advise the Ministry of Health (MOH) on prevailing and projected ethical issues in public health and medical practice. An additional responsibility is to participate in the development of ethical codes of conduct for doctors practising in Singapore. The duty was quite formidable and soon, neonatal books in my library were being replaced by books on ethics. A week-long intensive course in clinical ethics at the Imperial College brought some confidence. My mentor in this endeavour was Prof Alastair Campbell, our first professor in medical ethics.

The experience was an eye-opener as it was the first time that I had to work with others who are not medical doctors to deliberate on matters, especially when their effects on an

individual patient were not immediately apparent. The intense discussions were stimulating. The multitude of perspectives present for each situation taught me the critical need for exercising patience, active listening and the art of ethical reasoning, and it enabled the development of skills in facilitating discussion, distinguishing positions taken from values held, negotiating, mediating and the forging of consensus. The mutual learning that took place among members and the camaraderie that developed were precious and memorable. However, much of this was accomplished "after hours" and with the sacrifice of personal free time.

As our referrals came from MOH, we obtained a ringside view of the issues that confront our administrator colleagues, the diligence and comprehensive manner in which these needed to be addressed, the urgency with which some situations needed to be ethically evaluated and the need for perspectives to be provided. Unlike interventions provided to a patient where the effects are immediately apparent, the opinions we provide often have a long but legitimate gestation period before its effects are visible through enactment into policy, regulations and operational changes that bring quality to our healthcare system. The joy and sense of being part of this change is immense and an important driver of continued public service. Equally vital is the understanding, acceptance and support that I receive from my clinical department and family members.

The scope of medical ethics

The spectrum of situations that we have had to evaluate is wide and usually ends with the offering of a view, recommendation of positions to be taken or the development of guidelines. Some that come to mind are: the remuneration and compensation of subjects of clinical trials; physicians' consent for their patients to participate in research; communication in advance care planning; medical futility; end-of-life decision-making; physician-assisted suicide; surrogacy; cryopreservation of oocytes; multiple fetal pregnancy reduction; in vitro fertilisation mix-ups; posthumous extraction of sperms; living and deceased organ donation; clinical decision-making in collaboration with patients; hospital ethics committees; public funding of high cost treatment of rare diseases; the practice of aesthetic medicine; the practice of psychosurgery; and the separation of conjoined twins.

Though the core of medical practice – the therapeutic relationship that we establish and develop with our patients – remains the same, the environment in which the practice takes place and the forces that will drive it are constantly changing and threatening the relationship. This is best described in SMC's introduction of their new ECEG: "… medical practice in Singapore has evolved to become more complex, with advanced technology, innovative communication means, new modalities of treatment, a wide range of organisational as well as business models…"

These new and evolving relationships and situations require careful and regular ethical evaluation. Physicians need to commit to this domain of public service and in so doing, share the ethical values of the medical profession with members of the public, help to strengthen society, and restore and promote individual health. ◆

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