Whose Medicine Is It, Anyway?

When I was first asked to pen an article for *SMA News* touching on differences between the practice of medicine in the United Kingdom and Singapore, my first thought (being the altruistic humanist that I am) was "...and put my job at risk? Bugger that!"

Nonetheless, here I am – two months and repeated (less than convincing) reassurances regarding absolute anonymity and free lunches later – putting my neck in the noose.

THE GOOD, THE BAD…

I won't pretend that my medical indoctrination (pardon the pun) and two years on the job in the UK have made me a better or more knowledgeable person. In truth, the NHS (National Health Service) is neither perfect nor the lumbering near-terminal retard that it has been painted to be. The same can be said about healthcare systems across the world: all have their strengths and failings, and the UK – *and Singapore* – are not exceptions to this rule.

Here, I'm committing the journalistic equivalent of the projectionist's nightmare – this is not what we came to see. This is not what you (and big brother) want to read.

I'll gloss over the good – we all know that we have many reasons to be proud of the Singhealth/NHG conglomeration. We've got more hubs than an automobile, more bells and whistles than a locomotive, and spin-doctors who're employed to sing our own accolades in ways far more inspiring than a rapidly-expiring foreign returnee could ever possibly hope to match. Gosh dang it, the system is medi-DHL: fast, efficient and actually *delivers on the same day*. Enough said.

I'll gloss over 'my bads' – frustrating teething-problems I've encountered as a Medical Officer in a 'foreign' land, including differences in med-speak, drug names and medical equipment. Apparently the prevalent attitude is that 'culture shock' is desirable and information is absorbed through the ether rather than communicated between individuals. I can't help but wonder how much smoother things would go if – like many of the A&E departments in the UK – the powers-that-be realise that ignorance is after all the default state of doctorhood, and create a departmental hand-over ring-binder detailing "every moronic question you will ever ask, and those you'll never think to ask". Ah yes, and a glossary of all the various acronyms we seem so attached to, including puzzlers like "JCIA", "SQA" and "PDCA".

…AND THE DEFENSIVE

On to the meat.

One of the most striking features about home has been how defensive practitioners are – both in practice, and attitude.

Over in the UK, there is a strong sense that doctors, nurses and patients are all on the same team working towards a common objective – healthcare – even despite Labour's best efforts to bring the NHS to its knees. It's something we regularly placate irate Mrs Joneses with, whilst patting them on the shoulder: "Don't be angry with us dear, we're on your side, really. If we could, we'd 'scope you tomorrow, instead of in eight weeks..."

Sure, there were dark and stormy nights in Casualty when semi-inebriated and/or personality-disordered patients and/or druggies higher than Wacko Jacko on Mount Everest (bundled in by way of some well-intentioned Good Samaritan with peanuts for brains) would lash out verbally or even physically at us, and caring-doctor facades sure melted away in a hurry as Senior House Officers and security staff brusquely turfed them back into the cold, or tackled them to the floor. It wasn't so much a case of "Us versus Them" but more of "Everyone versus The Twat".

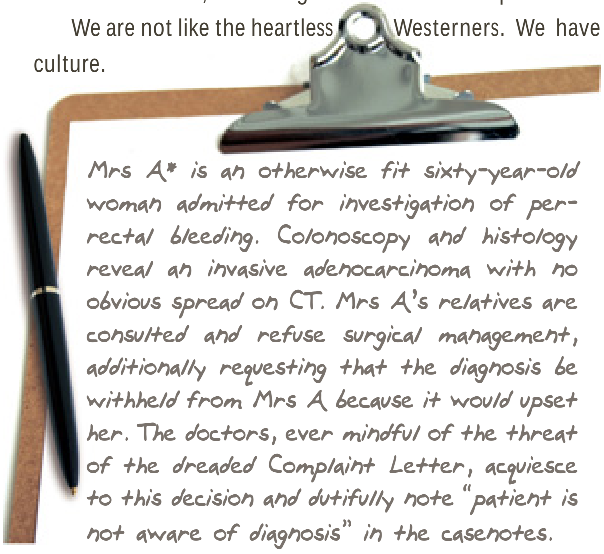
By and large though, the unending tides of Mrs Joneses were understanding, and very occasionally, even *friendly*. Sometimes, *too friendly*... But that is another story.

After watching the umpteenth eagle-eyed Singa-parent (in the UK, such nutters earn choice descriptions in patient casenotes like 'anxious ****', 'bordering on aggressive' and 'offensive') demand a second opinion from a (by implication) more competent doctor, and the zillionth stony-faced relative dictate to the team that his/her (fully compos mentis) mother is *not to know* the Truth about her diagnosis, I can't help but wonder what makes Them hate – or perhaps fear – Us so? And whose fault is it anyhow?

CULTURAL DIFFERENCE, LAH

My colleagues assure me that the one-size-fits-all universal solution to the many questions I am fast learning not to ask is thus: "Cultural difference, *lah*." So I guess that must be the problem.

We are not like the heartless Westerners. We have culture.



Mrs A* is an otherwise fit sixty-year-old woman admitted for investigation of per-rectal bleeding. Colonoscopy and histology reveal an invasive adenocarcinoma with no obvious spread on CT. Mrs A's relatives are consulted and refuse surgical management, additionally requesting that the diagnosis be withheld from Mrs A because it would upset her. The doctors, ever mindful of the threat of the dreaded Complaint Letter, acquiesce to this decision and dutifully note "patient is not aware of diagnosis" in the casenotes.

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About the author:

The author is a twitchy paranoid individual who appreciates his privacy and wants to keep his job for some strange reason.

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Filial piety is an inherent part of many Asian cultures: unquestioning obedience bordering on worshipful reverence is a norm; yet strangely at some point, a subtle role reversal occurs, during which the family unit assumes most responsibilities for their elderly and infirm, leaving them free to enjoy their golden years and pass on in peace. That's the theory at least. We all have families and recognise how flawed family-based decisions can sometimes be when making assumptions about another person's wishes. This is most apparent post- (or peri-) humously when dividing up the bereaved's possessions and estates.

Perhaps the people most qualified to make life-or-death decisions are neither paternalistic attending physicians nor overprotective and potentially incompetent families, but those for whom the death itself is terribly personal and terminally final. In other words, our patients.

Mrs B is an eighty-year-old Caucasian woman found to have a colonic tumour on CT scan. When approached by her family to conceal the diagnosis from her, the attending House Officer politely but firmly informs them that the surgical team's ultimate obligations lie with their patient's welfare, and not her family. Mrs B's Consultant tells her the scan findings the next day on the morning round. She takes the news badly, initially denying her diagnosis frantically, then flailing out in anger physically and emotionally at her family and hospital staff.*

DEALING DEATH'S HAND

Let's face it. There is no good way to deliver a death sentence, nor to receive it. Some say that it is not so much death we fear as the process of dying; but sometimes, the insinuation alone is enough to wreak devastation upon an individual's psyche. Even the noblest of men and women react poorly when first hearing the fatal words: "You have cancer."

It's actually a well-documented phenomenon. Kubler-Ross[1] describes five stages to the normal grief/bereavement process, encompassing denial, resentment, bargaining, depression and acceptance. It is through acceptance that we die with grace and dignity, but sadly, not all of us attain it in the limited time we have on earth – much less those who fall in the dark, in pain and suffering to a known (let's face it, it's their bodies – they know.) but unspoken and un-thought of foe.

In her final days, Mrs B seizes the chance to make peace with those around her, and to say her last farewells to those she loves. She also embraces religion, and meets with her lawyers to divide her estate between her children. When death arrives, she will, at least in part, be prepared.

CULTURAL MYTHS

Perhaps our role as doctors in medical disclosure is neither to play omnipotent Guardians at the Gates of truth and mortality; nor to grovel obsequiously and turn forelock-tugging customer-care attendants who live only to serve (it's strange but many of the doctors I've encountered are an odd oxymoronic blend of the first two traits); but to be empathic and honest messengers of our clinical findings – no matter how unpleasant.

The simple truth is that given the same scenario, *most of us as physicians would want to know*, whether we admit it or not.

We'd know when information was being withheld from us – and quite probably be outraged ("What do you mean I'm not allowed to look at my casenotes? They legally belong to me!" is a catchphrase patients in the UK occasionally buttonhole startled junior doctors with.), partly because of the breach of professional courtesy, and largely because, unlike our lay-patients, *we know better*.

And it's not because we think differently from the way we assume our patients do. Our MBBS's don't make us *that special*.

In a study regarding disclosure of new diagnoses of cancer to 246 Japanese patients aged forty to fifty[2], the vast majority of patients (85.4%) wanted full disclosure

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(that is, detailed information regarding prognosis and survival), 11.3% of patients wanted partial disclosure (that is, basic, general information about prognosis and survival) and only 2.9% of patients wanted non-disclosure.

CULTURAL TRUTHS

It's not hard to see why we make the decisions that we do. The ever present threat of the dreaded Complaint Letter, with the more unpleasant looming shadow of that all expensive lawsuit means that we are often loathe to displease our ~~masters~~ patients and their relatives. In the case of the dying, those that remain behind to plague us are unfortunately, the relatives.

It's true that patients and their relatives do not behave the same way as they do in the UK – there is less of an interest in medical awareness for one. Perhaps it's a good thing that we have less of a 'sick culture' (and here I don't mean claiming barely justifiable MCs) in Singapore, or perhaps not. There are fewer patient self-help and advisory groups, and there certainly isn't a patient base backing a powerful and impartial medical association lobbying for patient welfare, the way that the BMA (British Medical Association) does.

Though the BMA is often accused of being a white elephant, it does stand for something. It staunchly defends doctors wrongfully accused of negligence, but is also quick off the mark to deregister those it finds guilty of unforgivable medical or ethical offences. It gives an impression of fairness and this attracts the trust of patient groups.

I would be most surprised to see the Singaporean equivalent of the BMA lobbying in Parliament for shorter on-call shifts on behalf of junior doctors and in the interests of patient safety, and being supported by both doctors and patients.

CHANGING 'CULTURE'

Perhaps I have been away for too long, and acquired too many decadent Western ways. It still turns my gut to face down relatives demanding that their parents be denied knowledge about the cancer that will eventually eat them up from the inside, and have to smile sympathetically and intone the mantra: "Of course we won't tell." This, too, shall pass, according to many of the senior doctors who are themselves foreign graduates. Yet I can't help but wonder how malleable 'culture' is, and whether new cultures of medical awareness can be forged in our people tomorrow, by the healthcare providers of today. Perhaps the only thing protecting our medical culture of fear and ignorance, and holding back change... is us.

In conclusion, I'd like to thank *SMA News* for giving me an opportunity to vent my spleen here (a mistake I'm certain they will not soon make again...) and to pose a question:

Whose medicine is it, anyway? Ours? Theirs? Or... all of ours, doctor and patient alike. ■

Cases do not refer to specific individuals.

References:

1. Kubler-Ross, E. On death and dying. New York: MacMillan Publishing, 1969.
2. Miyata, H., Tachimori,H., Takahashi, M., Saito, T. and Kai, I. Disclosure of cancer diagnosis and prognosis: a survey of the general public's attitudes toward doctors and family holding discretionary powers. BMC Med Ethics. 2004; 5:7.