Of Learning Curves, Chess and the Art of Translation in Medical Ethics

INSIGHT

Of Learning Curves, Chess and the Art of Translation in Medical Ethics

JACQUELINE CHIN, VOO TECK CHUAN, NICOLA PEART & ROY JOSEPH

Across Asia, the implementation of medical ethics teaching is gaining momentum. While many medical schools in developed countries within Europe, America and the Pacific Rim have formalised ethics teaching within the medical curriculum and developed staffing, core curricula and teaching materials relevant to their social and cultural contexts, Asian medical schools may best be described as being at the stage of "capacity-building". Key research studies comprising "situation analyses" of the teaching needs of various Asian countries in the area of medical ethics have been undertaken in recent years (Miyasaka et al. 1999, Kasturiaratchi et al. 1999, de Castro et al. 2003).[1] All have pointed to the urgency of implementing medical ethics teaching in view of social changes including flows of medical technology to the region, radical changes in macro-allocation policies, the promotion of market economies and globalisation which pose serious challenges to accepted principles of justice and respect for persons in medical practice worldwide. However, medical ethics is a complex creature; teaching needs vary from country to country, depending on differing social conditions and distinct histories which influence the way that ethics finds expression.

In Singapore, the medical school of the National University of Singapore (NUS) founded a Centre for Biomedical Ethics (CBmE) in September 2006. It appointed Professor Alastair Campbell, an international expert in medical ethics who had established centres at the Universities of Otago (New Zealand) and Bristol (UK), as the CBmE's first director. Part of the Centre's remit is to develop a teaching programme at both the undergraduate and postgraduate levels in health ethics, law and professionalism. To this end, it was necessary to start identifying what ethical issues clinicians in Singapore face in their clinical practice. Simply adapting core curricula, cases and texts from other countries

was not wholly satisfactory. Singapore's medical practices are influenced by its unique cultural, social, religious, economic and political circumstances.[2]

We decided to embark on a survey of the medical literature on abortion, end-of-life care and organ procurement in Singapore because they seemed to raise important ethical challenges for clinical practice in Singapore and were therefore more likely to be discussed in the medical literature. Our aim was to collect and synthesise information on the ethical issues identified and discussed by medical professionals in Singapore, so as to construct a provisional picture of real-world medical ethics and its implications for teaching. Journal articles on each of the chosen topics were collected through a Pubmed search (using MeSH terms and/or other appropriate parameters) of the Medline database, as it is widely accessed by clinicians in Singapore and around the world. The abstracts were checked and articles identified by a clinician as purely technical or irrelevant (for example, articles not dealing with the topic area or clinical practice in Singapore) were excluded. The remaining articles (including those without abstracts) were retrieved and reviewed; articles that did not raise ethical issues or were authored by non-medical professionals (such as legal professionals and social scientists) were further excluded. A reiterative search using the same methodology was done for medical journals published in Singapore, namely the *Singapore Medical Journal* (published by the Singapore Medical Association) and *The Annals of the Academy of Medicine* (published by Singapore Medical Council), so as to uncover articles not captured by the Pubmed search due to limitations in the input parameters. As the data collected from academic journals turned out to be scarce, relevant media material — i.e. reports, forums and opinion pieces from the local newspapers — pertaining to each topic area and accessible in English was also retrieved from online databases (Straits Times Factiva, Straits Times LexisNexis Academic); news collected in CBmE's own online library since its establishment in 2007 was also consulted. It would be impossible within this space to usefully discuss the findings of this research; our aim on this occasion is to describe the process taken to *contextualise discussions of medical ethics found in the literature in order to grasp their significance*. This is a decidedly inexact and unsatisfying statement, but we hope that its sense will be clearer as our story develops.

The findings of our literature survey were initially puzzling from the point of view of the paucity of discussion of some traditionally problematic areas of medical ethics, for instance, a marked silence on the moral value of the foetus in the abortion literature, or indeed, the limited number of articles that addressed ethical questions at all in these controversial areas of medicine. For example, from 120 articles culled from Pubmed using the search terms "Singapore, abortion", published between 1964 and 2003 (our Pubmed search found no articles were

published on this subject in the last five years), only 19 discussed ethical issues, of which 15 were written by healthcare professionals. Of 71 articles culled using "Singapore", and any of the following: "terminal care", "euthanasia", "hospice care", "resuscitation order", "assisted suicide", "life support care", "palliative care", "advance care planning", "advance directives", "living wills", published between 1983 and 2008, 20 discussed ethical issues, of which 16 were by medical authors. Of 46 articles listed through the terms "Singapore, organ procurement", published between 1987 and 2007, 15 discussed ethics, of which 12 were by medical authors. It should be added that in many cases ethics was not the main subject of discussion. It often received only cursory treatment.

Do medical professionals in Singapore see few ethical problems in relation to policies on abortion, end-of-life care and organ procurement for transplant? Are the many ethical questions discussed elsewhere non-issues in Singapore? This relative silence in the professional literature on issues regularly raised in standard medical ethics journals and other literature worldwide was surprising, prompting our spontaneous speculation on a number of simple hypotheses, such as:

1. that medical practitioners in Singapore see ethical issues as beyond their remit to discuss, indicating a prevailing narrow view of professional identity — perhaps, that of the "competent technician"; or
2. that professional reticence about ethics reflects a social and political culture of consensus, where questioning is acceptable but disputation of certain kinds taken as unconstructive; or
3. that ethical issues are seen differently.

We felt that further investigation of social trends relevant to medical practice might yield a better appreciation of the phenomena disclosed by our research.

What we concluded was that professional reticence might at times be explained by the complexity of issues arising from rapid or even *grand* social change. In such situations, what might be revealed by the literature is a certain reluctance to engage with large and complex issues that are "better left to experts". Passing tentative commentary may indicate the beginning of negotiations with an "ethical learning curve". At other times, silence could reflect a pragmatic consensus about external constraints (social, economic, political) on professional practice that calls for adaptation rather than debate. More disturbingly, perhaps, silence could in some instances be due to a brand of secularism that views people's moral, religious or cultural commitments as private matters, or even idiosyncratic and irrelevant to secular public and professional reasoning.

By what route is understanding increased by setting issues within a broader context of reflection? Suppose that we begin with a broad (selective) understanding

of the issue of organ procurement. We know that significant advances in transplantation technology and immuno-suppression have made organ replacement a treatment option for more and more people. Due to a steady increase in the incidence of end stage organ diseases in developed countries, however, demand has outpaced supply. This has raised deeply complex questions about whether a better engine for organ procurement can be devised. Underlying it is an assumption that transplants — which offer a better outcome for patients if they succeed — should be privileged over other means of treatment, such as (in the case of kidney disease) dialysis. From general reflections of this nature, we then started to compare some details of the Singapore situation with those of other countries.

Singapore's deceased kidney donor rate was 5.8 per million population (pmp) in 2007,[3] slightly lower than that of New Zealand, which only reached 6.0 donors pmp in 2006.[4] Both rates are much lower than the UK rate, where 13.2 donors are registered pmp in 2007,[5] and far behind Spain, the world leader with 34.3 donors pmp in 2007.[6] Singapore's supply to demand ratio is as low as 1 to 10 for kidney transplants.[7] In developed countries, various strategies have been proposed in recent years to increase the rate of procurement of organs for transplantation, all of which have had to contend with the complex reasons that individuals and families present for resisting organ donation upon death. More urgently, the slow progress of such donation strategies has created a burgeoning black market trade in organs between developed and developing countries. In Singapore, likewise, recent media reports have exposed hospital conflicts with families resisting the rules under the Human Organ Transplant Act 1987 as subsequently amended, and also illegal procurement of organs by wealthy Asians receiving transplant surgery in Singapore. This has fuelled a serious debate about the creation of an "ethical market" in human organs to save lives, address exploitation and to protect Singapore's reputation as it seeks to become a hub for transplant surgery.[8, 9, 10] The surveyed literature had not caught up with this grand turn of events that could spell, among other things, a sea-change in attitudes towards medical tourism.

The new ethical issues in organ procurement are far more complex and uncertain than those of the last thirty years or so. Then, rapid infusions of new technology into medical practice required attention to skills training and accreditation, and discriminate cost-effective use of such technologies in the best interest of individual patients. Legislative changes that put in place a system of organ donation by presumed consent led to discussions about efficient procurement practices within Singapore, reasons for resistance to organ donation, fear of abuse of the brain death criterion and withdrawal of quality care, and public education for ensuring valid consent. However, the new emphasis on

transplant surgery and alternative systems of procurement to match supply to demand engender large questions about the price that society pays in pursuit of the learning curve of technological advancement: Should transplant surgery or dialysis be prioritised for best outcomes, and what outcomes are "best"? Can there be altruism on the scale that would make organ donation schemes work? Can a legal organ market overcome selective exploitation of patients, preserve social solidarity and, if extended beyond Singapore, meet with international approval? Can attempts to render such a market ethical be cost-effective and fair from the point of view of healthcare distribution?

What can medical ethics do if professional discussion has not kept pace with change? Robust professional participation in the face of these changes is critical to maintaining professional values and a climate of just healthcare. Here, medical ethics can help to plot the *ethical* learning curve of technological advancement, addressing such issues as the meaning of "quality outcomes", the just distribution of healthcare resources, and the role of the medical profession in protecting the health of all patients. It may at the same time help to promote clear-sighted vision of the range of practicable procurement schemes that may be acceptable or problematic from a professional standpoint.

Even as medical ethics seeks to methodically address these issues, however, ethicists, like many healthcare professionals in Singapore, should be wary of too sanguine an attitude towards the state's powers of intervention in medicine. It might do well to take seriously an attitude well-expressed by a former President of the Singapore Medical Association, Professor Arthur Lim, in a metaphor he offers of a chess player:

> A skilled chess player will have at his command many more options than an unskilled chess player. His freedom of action is limited only by his knowledge of the game …. A doctor may like to compare himself with a chess player, operating within a set of rules and limitations that the game imposes. His freedom of action increases in direct proportion to his knowledge and skills. He struggles for freedom to practice medicine ethically without restraints so that he can place the interests of his patients foremost.[11]

Such an attitude would seem apt in the face of a problem like population ageing with its attendant challenges of maintaining high standards of medical care at the end of life. Large scale social problems of this nature require coordinated planning that state authorities may be best placed to administer. The Ministerial Committee on Ageing (MCA) this year published a progress report on 39 recommendations to tackle the long-term issues of population ageing, which were prefigured in the literature that we surveyed. Their broad-based strategy, involving professions, community and government, has placed

strong emphasis on promoting healthy ageing, reducing the use of expensive acute care for the aged, and encouraging self-reliance in healthcare financing.[12] Real limitations on public resources (as was the case during the high population growth years of the 1960's) mean that it is sensible for all to accept a pragmatic consensus about social, economic and political constraints that demand social planning and rationing of services. In such contexts, as Lim urges, the doctor as "chess player" respects economic efficiencies while keeping an eye on equitable distribution and the welfare of individual patients.[13]

This point about perceiving inequity leads to another — which will be our final point. In the area of rationing healthcare resources for the aged and any other area of clinical medicine involving a duty of care to patients, the work of translating patients' wishes and physicians' values in ways that enrich our sense of the equitable or even the worthwhile in medicine is a skill that has often gone unnoticed. The tendency to neglect this meaning-making aspect of medical ethics might account for the lack of discussion of such questions as the value of the foetus, or whether public policy has set acceptable limits on the right of abortion. This finding was puzzling when we first reviewed the literature on abortion, since we had expected these to be pertinent ethical questions for a population where over eighty-five percent profess religious belief. In addition, there are definite views on when life begins and how human embryos may be treated to be found in the written responses of eleven religious groups in Singapore which responded to the Singapore Bioethics Advisory Committee's consultation of public opinion on the social, ethical and legal aspects of human embryonic stem cell research.[14] To explain this silence, a reflective contextualisation helped again to carry our understanding a little further beyond our speculations. Skittishness about public discussion of religion in Singapore is a result of the city-state's geopolitics and the relatively recent experience of race riots that threatened the dissolution of a newly independent Singapore in the 1960's. "Multiculturalism", according to state ideology, is based on equal recognition of religions under a secular state. It is supported by a strong legislative framework that plays a key role in forestalling religious extremism and inter-faith conflicts. Recently, however, a book published by the Institute of Policy Studies reported that "there is a belated but growing religious sector within Singapore's civil society that seeks to participate in the public policy discourse, and which draws on their individual religious value systems to inform their choices in the public realm."[15] This work of translation — drawing on value systems to inform choices in the public realm — can also enrich the practice of medicine. Again, how can medical ethics help?

In his inaugural lecture entitled "Lost in Translation? The Quest for Universality in Biomedical Ethics", the new director of CBmE, Professor Alastair Campbell, alluded to the "clash of civilisations" that has been an outcome of globalisation.

As the world becomes increasingly homogenised, the resurgence of fundamentalisms and nationalisms asserting the superiority of certain values and beliefs has heightened the insecurity of contemporary life. He then asked what this might mean for biomedical ethics in the Twenty-First Century, and expressed the hope and remit of the new Centre: that it might serve to establish "a richer understanding of our common humanity," no less.

> For medicine has been, throughout its history, one of the great moral enterprises of humankind. It is at its very heart and soul a moral endeavour — captured long ago in the words of the mediaeval Jewish scholar Maimonides — "May I never see in the patient anything else but a fellow human in pain". Thus, medical ethics is not some add-on to medicine, some afterthought, to be referred to occasionally when a crisis comes. Medical ethics is at the very centre of all medical care, its prime motivation and its *raison d'être*. This means that we have to be sure that the medical ethics of our day genuinely reflects the plurality, diversity and richness of our human race.[16]

It is worth entering a caveat, however, that the same instabilities of discourse that caused the present clash of civilisations can similarly infect and polarise healthcare decisions. Each society reaches for its own balance between silence and debate.

In summary then, the process of contextualising medical ethics is neither straightforward nor formulaic; while it may be arduous, it can be rewarding! Our ideas, expressing a set of aspirations for medical ethics, are clearly contestable; but we present them here in the spirit of dialogue and mutual exploration.

Notes

1. Miyasaka, M., Akabayashi, A., Kai, I. & Ohi, G. (1999) An International Survey of Medical Ethics Curricula in Asia. *Journal of Medical Ethics*, **25**, 514–521. Kasturiaratchi, N., Lie, R. & Seeberg, J. (Eds.) (1999) Health Ethics in South-east Asia. *WHO Southeast Asian Health Ethics Network (SEAHEN)*. Project Report, Volume 1, p. 9. This report (in three volumes) is available at http://www.hf.uib.no/i/Filosofisk/ethica/pub.html [accessed 24 September 2008]. De Castro, L., Sy, P., Alvarez, A., Mendez, R. & Rasco, J. (Eds.) (2004) Bioethics in the Asia-Pacific Region: Issues and Concerns. *UNESCO Regional Unit for Social and Human Sciences in Asia and the Pacific (RUSHSAP)*. Available at http://unesdoc.unesco.org/images/0013/001359/135911e.pdf [accessed 24 September 2008].
2. Miyasaka *et al.* (1999) have highlighted the non-universal, contextually specific nature of developing medical ethics content, arguing that fundamental changes in medical ethics in Western developed countries arose from specific social factors, including the emergence of a "novel moral view" of respect for patient autonomy, the development of high-tech medical technology and a shift in patterns of disease and disease-related death,

that are of little relevance for medical ethics in the developing world. The debates over "Asian bioethics" are an added complication that cannot be entered into here. Suffice it to say that the "embeddedness" of cultural and religious thinking in Asian countries is a significant factor responsible for the emergence of these debates. In addition, *all* modernising countries that are touched by diverse aspects of globalisation face acute questions arising out of the transition from traditional to modern practices of medicine, and countries of the Asian region are not spared in this regard.

3. This Singapore organ donation rate was emailed by the National Organ Transplant Unit, Ministry of Health (organ.transplantenotu.com.sg) on 21 July 2008 to T.C. Voo.
4. See http://www.donor.co.nz/donor/statistics/international_donor_rates.php [accessed 24 September 2008].
5. Transplant Activity in the UK official report 2006–2007. Available at http://www.uktransplant.org.uk/ukt/statistics/transplant_activity_report/current_activity_reports/ukt/transplant_activity_uk_2006-2007.pdf [accessed 24 September 2008].
6. Source: Organisacion Nacional de Transplantes (ONT), the official Spanish transplant organization. Available at http://www.ont.es/Estadistica?accion=1&id_nodo=19&id_estadistica=63&perfil= [accessed 24 September 2008].
7. Schmidt and Lim, *op. cit.* p. 2174.
8. Two Plead Guilty to Human Organ Trading in First Such Case in S'pore, *Channel News Asia*, 27 June 2008.
9. MOH to Probe Possible Lapses in Living Donor Transplant Programme, *Channel News Asia*, 30 June 2008.
10. Two Indonesian Men in Illegal Organ Trading Case Jailed and Fined, *Channel News Asia,* 4 July 2008.
11. Lim, Arthur S. (1998) *Patients' Interest First*, World Scientific Publishing, Singapore, p. 70.
12. This report may be downloaded at http://www.mcys.gov.sg/MCDSFiles/Press/Articles/03-2008.pdf [accessed 24 September 2008].
13. Lim, Arthur S., *op. cit.*, p. 67.
14. For these views, see the BAC's Report on *Ethical, Legal and Social Issues in Human Stem Cell Research, Reproductive and Therapeutic Cloning*, available at http://www.bioethics-singapore.org/ [accessed 24 September 2008].
15. Eugene Tan, Keeping God in Place: How Religion is Managed in Singapore, in Lai, Ah Eng (Ed.) (2008) *Religious Diversity in Singapore*, Institute of Southeast Asian Studies and the Institute of Policy Studies, National University of Singapore, Singapore.
16. Alastair V. Campbell, "Lost in Translation? The Quest for a Universal Biomedical Ethics", lecture delivered on the occasion of the inauguration of the Chen Su Lan Centennial Chair of Medical Ethics, Yong Loo Lin School of Medicine, National University of Singapore, 21 September, 2006.