CONTEXTUALIZING PATIENT-DOCTOR RELATIONSHIPS IN SINGAPORE

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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My inquiry examines the disjuncture between experiences of people with diabetes and biomedical discourses that support global capitalism within the two-tiered biomedically-based health system in Singapore. I use an institutional ethnographic approach, which is both a method of inquiry and an analytical process, to explore how relations of ruling are reproduced in specific relations between physicians and people with diabetes. As a subtext, I produced a critical autoethnography that critiqued my original research plans.

My inquiry documents the lived experiences of people with diabetes through interview transcripts (describing physicians), relevant texts (including historical and present political practices), fieldnotes of over three years as a participant observer within the Diabetic Support Group of Singapore (DSGS) and a journal of my Canadian expatriate experiences.

Diabetes is part and parcel of Singapore’s economic ‘miracle’ and the adoption of consumerism. People with diabetes experience a bifurcation of consciousness as it is challenging to comply with the government ideology of hard work while simultaneously following a ‘healthy’ diabetic regimen. Singapore’s local health care policies impose Western biomedicine within a two tiered system in which 80 percent of the population attend private for-profit clinics. Indigenous health practices are marginalized. A fiscal orientation inherent to contemporary global economics can be seen within patient-doctor interactions. For example, physicians are increasingly concerned about the accounting aspect of their profession and most people with diabetes tacitly accept this ‘revolving door’ efficiency.
Members of the DSGS, a support group for insulin-dependent diabetic families, express dissatisfaction with existing physician services while health professionals associated with the group tend to critique other aspects of the system. Rather than rejecting the biomedical health care system itself, group members claimed friendship and diabetic education as primary reasons for their attendance. A Freirian dialogue can be seen to be part of the social process of this group. However, from a critical feminist perspective, the DSGS can also be seen as responding to external social forces. That is, it has undertaken the least revenue-generating health work of psychosocial support and patient education thus salvaging biomedicine and smoothing the transition to consumerism in medicine.
ACKNOWLEDGMENTS

I will never forget my thesis journey, nor the people who helped me through this personally transformative process. I am exceptionally lucky to have had my sisters, Susan and Tracy, and my parents as steadfast believers in my skills as an academic. Without their vision, I may never have discovered mine. My partner, Paul, provided me with unending technological and financial support for the thesis work. More importantly, through his actions, he modeled to our children that my accomplishments as a student were as meaningful as his paid work. I have watched my (now) teen-aged daughters, Anna and Jamie, grow and mature alongside of my dissertation. I feel a deep sense of joy when I see their pride in me. They say it takes a village to raise a child. I have discovered that it takes the support of a family to produce a thesis. To my family, I thank you all.

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I am indebted to Professor Goh Lee Gan’s tireless efforts linking me to various health care providers in Singapore. These physicians, in turn, introduced me to people with diabetes attending their clinics. I wish to thank these individuals who shared with me their experiences as providers, or consumers, of Singapore’s health care system.

Many members of the Diabetic Support Group of Singapore (DSGS, a pseudonym) hold a special place in my heart as they allowed me not only to be a part of the group itself but also
the privilege of being a part of their lives. Thank you for sharing your world with me and, in many cases, becoming my friend.

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I. Overview of the Investigated Problematic

This thesis investigates the complex connections among government ideology and biomedical and indigenous health relations in the small post-colonial island republic of Singapore located in Southeast Asia. Singapore achieved its independence in 1965 and is considered a developed nation that is competitive in a Western-dominant, capitalist, globalized economy. By this I mean Singapore is participating in an economic structure where the flow of capital increasingly flows freely across national boundaries. There is an increased presence of multinational corporations in search of profit within the Republic’s borders. Part and parcel to this phenomenon is a corresponding social reorganization.

Singapore is populated predominantly by those who identify themselves as Chinese (77.4 percent), Malay (14.2 percent) and Indian (7.2 percent) (Singapore Ministry of Information and the Arts, 1996, p. i). Prior to Singapore’s independence, multiple indigenous health practices flourished, reflective of Singapore’s multiracial population. Western medicine, a biomedical approach to the treatment of disease, however, is currently the only official version of health care that is recognized by the Singapore government. With Singapore’s independence, indigenous health practitioners increasingly lost their status as healers among Singapore’s ‘modern’ people.

The dominance of biomedicine in Singapore is institutionalized within a two-tiered system, with 80 percent of the population frequenting privately run clinics and the remainder attending the publicly supported “polyclinics” or PCs² (Singapore Ministry of Health, 1994, p. 14). The private health care clinics range from large multi-branched operations with salaried physicians to solo independently operated clinics. Both types sell pharmaceuticals to their patients. The less expensive PCs also practice Western medicine and contain pharmacies.
Patients are responsible for health care costs. This is accomplished either indirectly, through various health insurance plans, or through more direct forms of payment. What experiences do patients have in this two-tiered system imported from the West? My research focussed on this question, using the example of diabetes.

As a result of Singapore’s rapid economic ascent, there have been increases of diseases of the West, that is, of affluence. Diabetes is one such chronic condition. Epidemiological studies point to the likelihood that adaptation of lifestyle habits of the West, coupled with a potential genetic predisposition of Asians, are contributing factors to the increased incidence of Singaporeans with diabetes (Cheah et al., 1985; Cheah, Wang & Sum, 1990; Goh, 1998; McManus, 1994; Thai & Emmanuel, 1996).

It is important to contextualize doctor-patient relations within political ideology in Singapore. Diabetes has been singled out as a problem by the Singapore Ministry of Health (MOH), thus centrally locating it within government as well as Western epidemiological discourses. For example, the findings of the MOH’s National Diabetes Commission were prominent in the 1993 supplemental edition of the Singapore Medical Journal. This report and other medical journals advocate patient education as an important component of the treatment of this increasingly prevalent condition. However, miscommunications in professional-patient interactions are viewed in these sources as being a one-way phenomenon. That is, in government and biomedical sources, people with diabetes are represented as either not being told by their physicians or not understanding how to manage their disorder. In either case, the relationship is assumed to be hierarchical with doctors cast as experts regarding the ‘best’ treatment for people with diabetes.

Diabetes, generally speaking, requires a high degree of patient participation in its biomedical management. Patients are inherently responsible for the implementation of health regimens prescribed by physicians within this model of health care. The best management of
### TABLE 1

List of Acronyms (in alphabetical order)

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>5Cs</td>
<td>condominium, car, cash, career, and credit</td>
</tr>
<tr>
<td>CPF</td>
<td>Central Provident Fund</td>
</tr>
<tr>
<td>DCCT</td>
<td>Diabetes Control and Complications Trial</td>
</tr>
<tr>
<td>DCOS</td>
<td>Diabetic Community of Singapore</td>
</tr>
<tr>
<td>DKA</td>
<td>diabetic keto-acidosis</td>
</tr>
<tr>
<td>DSGS</td>
<td>Diabetic Support Group of Singapore</td>
</tr>
<tr>
<td>EFPO</td>
<td>Educating Future Physicians for Ontario</td>
</tr>
<tr>
<td>HbA1c</td>
<td>glycosylated hemoglobin</td>
</tr>
<tr>
<td>HDB</td>
<td>Housing Development Board</td>
</tr>
<tr>
<td>IDDM</td>
<td>insulin-dependent diabetes mellitus</td>
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<tr>
<td>MC</td>
<td>Medical Certificate</td>
</tr>
<tr>
<td>MCP</td>
<td>Malayan Communist Party</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MS</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>NIDDM</td>
<td>non-insulin dependent diabetes mellitus</td>
</tr>
<tr>
<td>NUS</td>
<td>National University of Singapore</td>
</tr>
<tr>
<td>ORT</td>
<td>Orchard Road Type</td>
</tr>
<tr>
<td>PAP</td>
<td>People’s Action Party</td>
</tr>
<tr>
<td>PC</td>
<td>Polyclinic</td>
</tr>
<tr>
<td>PWD</td>
<td>people or person with diabetes</td>
</tr>
<tr>
<td>SAF</td>
<td>Singapore Armed Forces</td>
</tr>
<tr>
<td>SDU</td>
<td>Social Development Unit</td>
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<tr>
<td>SES</td>
<td>socio-economic status</td>
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<tr>
<td>TCM</td>
<td>Traditional Chinese Medicine</td>
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<tr>
<td>UKPDS</td>
<td>United Kingdom Prospective Diabetes Study Group</td>
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diabetes from a biomedical point of view typically requires varying degrees of lifestyle adjustments including certain changes in diet and exercise habits. Inherent to the biomedical model of physician ‘management’ of diabetes is physician knowledge regarding the possible types, timing and quantities of prescribed medicines. This role is deemed exclusive to physicians and is depicted as a necessary component of the optimization of both short and long-term health outcomes (Asian-Pacific NIDDM Policy Group, 1995; National Diabetes Commission, 1993; Kwan, Goh & Thai, 1998; Tan, 1992; Turner, Cully & Holman, 1996; UK Prospective Diabetes Study Group, 1993; Diabetes Control and Complications Trial Research Group, 1993; Worrall, 1994). This reductionistic view of diabetes has little regard for the social, psychological, or financial aspects of diabetes. People with diabetes frequently do not ‘comply’ to a prescribed biomedically-derived diabetic regimen. How does the phenomenon of ‘non-compliance’ look from the perspective of the people with diabetes?

The Diabetic Support Group of Singapore (DSGS) began as an informal grassroots group of people with diabetes and their families to address their life challenges associated with this chronic condition. This group also provided me with the opportunity to address issues including ‘non-compliance’ from a different perspective than what was presented in government and biomedical sources in Singapore. Members (or family members) have the form of diabetes that requires daily injections of insulin. Their experiences within Singapore’s health care structure leaves them dissatisfied with the provided health assistance. The social and educational activities within the DSGS are supportive, in contrast to the social relations within the various primary health clinics. The DSGS also has a role within Singapore society in publicizing the nature and prevalence of diabetes in Singapore. This support group was one of my points of entry into the diabetic community—and an important one, given their critical views. I also enlisted the support of biomedical physicians in providing access to patients attending PCs and
private clinics. Thus this research provides views of people with diabetes (as well as their doctors) from several locations.

II. Contextualizing Myself

In this thesis, which problematizes doctor-patient relations in Singapore, I locate myself within critical academic feminist and emancipatory theory. I provide an overview of these perspectives in the next section of this introductory chapter and in Chapter III. As part of this theoretical orientation to my research, I must point out that there is a need to contextualize myself to the inquiry.

I am a white Canadian woman. Since 1988, I have lived with my Chinese Canadian partner and our two daughters in Belgium, Singapore, Hong Kong and the United States as expatriates. With the exception of the United States, we chose to live within Western ex-patriate ‘communities’ and did not send our children to local public schools. The American-based multinational company that employed my husband assumed many associated costs of our privileged lifestyle. Singapore is touted as an attractive place for high-ranking employees of multinational companies to relocate (often with their families). Consequently, Western corporations’ profit-searching expansion is facilitated. In this way, we were a part of the corporate push towards a ‘globalized marketplace’ based upon Western capitalism.

Unlike other Southeast Chinese nations, the Republic of Singapore provides many opportunities for English-speaking researchers such as myself to communicate with local people, as English is one of the four official languages. Further, it is considered ‘modern’ and a newly industrialized nation. However, my transition to Singapore was not smooth. My bi-racial family life included discussions about our experiences of adapting to life in both Eastern and Western cultures. My outgoing nature precipitated informal conversations with indigenous peoples
(although only in English or French)—usually those working at repair/service/secretarial jobs or holding prestigious positions in corporations—regarding their perspective of their own versus Canadian/American ways of thinking and behaving. Through my ex-patriate years I felt myself change and acquire a kind of internationally ‘mixed’ perspective of life. As a result, today I firmly believe myself to be a more sensitive witness to how others view me, including when they do not understand my worldviews and associated lifestyle choices that differ from mainstream North America. It is important to consciously contextualize social relations of all types in order to foster improved communication and mutual respect.

My research journey began in Singapore with my exploring the field in search of the ‘best’ way for me to adapt my original inquiry proposal that was to have been completed in the Toronto area. Using a grounded theory research design, I had originally intended to generate a theory that would have helped explain the relationship between doctors and people with Multiple Sclerosis (MS). My epistemological position was not socially critical, rather, it was one based upon the postpositivistic premise that there is an existence of an objective social ‘reality.’

Through an ongoing analysis of my fieldnotes documenting both my personal and research-related experiences, I decided to change my inquiry focus from people with MS (which is not common in Singapore) to those who live with diabetes (where rates are increasing at substantial rates). As the non-Western-originating literature on patient-doctor communication was sparse, I began my inquiry with a survey. The quantitative results were intended to help contextualize and assist with the collection of qualitative data that was to have taken the form of follow-up, in-depth interviews. My experiences associated with the implementation of this grounded theory design in Singapore met with a number of unanticipated challenges.

My consciousness has been raised to appreciate the relevance of social context in influencing day-to-day interactions and that it goes beyond immediate circumstances. My awareness extends to how economic and political hegemonies influence local behaviour. To do
justice to my dissertation topic of contextualizing patient-doctor relations in Singapore, I needed to stretch considerably beyond my own Western-schooled and immediate ex-patriate experiences. The resulting critical, rather than explanatory, inquiry was informed by Smith’s (1987a; 1987b; 1990; 1993; 1999) “standpoint theory” where associated methods are considered part of an “institutional ethnography.” Smith’s ideas and corresponding research methods are briefly discussed in the following section (III) and in more detail in Chapter Three.

A detailed accounting of my experiences that led to this fundamental re-organization of my inquiry is included in Appendix A. My rationale for this somewhat artificial division between the ‘thesis proper’ and the contextualizing critical autobiography included as an appendix is to focus attention on the primary study, which is presented as the institutional ethnography of the relations between people with diabetes and their doctors. The critical autobiography is included to explicate the underlying social processes behind my fundamental re-organization of my data and epistemological shift to standpoint theory. I believe that my prioritizing the ‘inquiry’ over the ‘journey to the inquiry’ (although arguably an institutional ethnography in its own right) is an important feature to my ethically fulfilling my research promises to the inquiry’s participants.

III. Institutional Ethnography: A Socially Critical Investigation of the Problematic

The term “contextualizing” in the thesis title emphasizes that this research does not attempt to construct a theoretical model or reject a null hypothesis. The inquiry begins from the standpoint of lived experiences of people with diabetes and their doctors. It includes an analysis that problematizes personal relations of people who are not, nor intended to be, statistically representative. This is accomplished through an institutional ethnography that encompasses both a method of inquiry and analytical processes. Smith (1999) explains that an institutional
ethnography produces a type of "map" which provides "features of the world to find and recognize as expressions of the relations it draws, but [that] she has to look outside the map to find them" (p. 125). The purpose of this type of inquiry is not to explain relations in some universal sense but rather to discover what are the relations in a given moment.

Evidence is presented in the thesis of extra-local practices (such as a globalized market-driven economy) imposed upon local institutions (such as "for-profit" health care clinics in Singapore). Institutional ethnography explores the construction of extra-local relations as they are evidenced from the standpoint of embodied individuals experiencing them at the local level—hence the term "standpoint theory." This institutional ethnography critically explicates the varying social forces affecting face-to-face interactions between people with diabetes and their primary care doctors in Singapore.

Traditional research reports outline a statement of the problem that the investigator deems as needing to be 'solved.' This decision is argued to be relevant to an existing body of scholarly-sanctioned knowledge. The purpose of this kind of research is to systematically develop a universally applicable theory that helps explain objective and logical truths inherent to the problem. By way of contrast, institutional ethnographers do not wish to, nor do they claim to be experts at 'solving' social problems. Instead, they identify underlying macro relations as implicit or explicit social forces that enter and influence individuals' social interactions and experiences. This is accomplished by attending to the "everyday world" activities of inquiry participants (Smith, 1987a). As Campbell and Manicom (1995) state, "[e]xperience may be and is organized ideologically through ruling practices" (p. 8). The resulting analysis displays the ideological character constitutive of institutional practices. It acts as a 'pointer' to where social change is needed.

By using an institutional ethnographic approach to contextualize the lived experiences of people with diabetes (including those within the DSGS) and their physicians, I locate
important “generalizers of actual local experience” (Smith, 1987a, p. 154). The objectives of my dissertation resonate with Smith’s critical view (1987a; 1987b; 1990; 1993; 1999). The thesis focuses on the experiences shared and noted through participant observations. It also analyzes various texts surrounding people with diabetes, their physicians and the Diabetic Support Group of Singapore (DSGS). The goal of my inquiry is to display the ideologies found within the “relations of ruling” that are reproduced within the investigated experiences. As put forth by Smith:

The phrase “relations of ruling” designates the complex of extra-local relations that provide in contemporary societies a specialization of organization, control, and initiative. They are those forms that we know as bureaucracy, administration, management, professional organization, and the media. They include also the complex of discourses, scientific, technical, and cultural, that intersect, interpenetrate, and coordinate the multiple sites of ruling. . . .[They have an] essentially textually mediated character. (1990, p. 6)

Smith’s conceptualization of social relations originated within white, Western feminism. Although institutional ethnography is being applied outside of women’s studies, it is still Western in origin. For this reason, the theoretical perspective of the male Brazilian Paulo Freire was useful in my inquiry (1996; 1970/1997; 1973/1998; 1992/1998). Freire’s approach to learning about oppressed peasants’ experiences was dialogic and egalitarian. Like Smith, Freirians seek to understand social oppression through the eyes of the oppressed, through their reported experiences and through conceptualization of the problematic. The relationship between researcher/participant or teacher/pupil is intended to be egalitarian. This social equality extends to how and which ‘problems’ are examined. These research methods are atypical to most social inquiries.

Dissertations are typically written in the third person to reflect the epistemological tenets of the systematic pursuit of objective knowledge. In Smith’s words:

[Social sciences…maintain a sharp division between people’s experiential knowledge and objectified and authoritative knowledge of the expert. Experiential knowledge isn’t recognized as knowledge in the terrain of
professional, scientific, and other academic discourses. ...As I began to see the objectified methods of thinking and writing texts characteristic of the social sciences, I also began to see them as integral to the great complex of ruling relations operating in contemporary society at a level abstracted from the everyday/everynight particularities of our local worlds. In this context, the social sciences appeared as a systematically constructed consciousness of society which creates a synthetic standpoint, locating the reading subject outside the actual time and place in which she reads, and in a conceptual space isomorphic with that of the abstracted, extra-local relations of ruling of contemporary capitalist societies. (Smith, 1999, pp. 31-32)

In the next two chapters, I describe in more detail the critical epistemological framework upon which my inquiry is based. My inquiry is partly written in the first person to reflect my standpoint as a white, non-diabetic, Western female learning about the experiences of relationships between doctors and people with diabetes in Singapore. My dissertation examines how the imposition of an ideology that touts “West is best,” including a shift to its ‘modern’ medicine, affects the relations between people with diabetes and their doctors in Singapore.

IV. Chapter Organization

Second chapters in conventional dissertations are usually entitled “Literature Review” and summarize peer-recognized scholarly endeavours that precede the contribution to knowledge of the thesis. This chapter is traditionally viewed as the place to acknowledge prior research on the chosen topic. The literature devoted to relations and interactions between patients and their primary care physicians under the rubric of ‘doctor-patient communication’ tends to be orientated around the biomedical model of health care. Other pertinent literature that addresses social relations within primary health care can be viewed under the umbrella term ‘sociology of medicine.’ While these two bodies of work echo a lot of my findings, the use of institutional ethnography as a research and analytic strategy reveals linkages that may otherwise be obscured. From my perspective, these literatures are fundamentally deficient, with a few exceptions. For example, some symbolic interactionist or grounded theory research was useful in raising my
consciousness as to the relevant issues and understandings—usually physician centered—of the social problems associated with patient-doctor relations. I thus refer to some of these within the thesis wherever they assist in contextualizing the perspective, or worldview, of the inquiry participants.

Theses typically devote a chapter to a brief description of the methods used in the inquiry. My dissertation includes an overview of the institutional ethnographic approach in Chapter Three. The substantial Appendix A is a ‘thesis within a thesis’ which is my examination of the disjunction between my own lived experiences as a Western researcher in Singapore and what I was taught at academic institutions. The epistemological premise of my critical approach is fundamentally different from the perspective of investigator objectivity and universality housed within science and social science. I include this critical autoethnography of my inquiry experiences to show both how I reproduced the extra-local in the field and then took positions that challenged this reproduction. This reflective analysis opened me to institutional ethnographic approach taken in the thesis proper.

Conventional dissertations also contain two to four data chapters that are distinctly organized around ‘significant findings.’ The interpretations of these ‘objectively’ obtained findings are systematically accounted for in the “analysis” chapter. The concluding chapter is a synopsis that often recommends further study. My thesis deviates from this conventional organization where my epistemological position requires this. Specifically, Chapter Two critiques the biomedical and indigenous views of diabetes in Singapore noting where the imposition of this Western approach to health care is socially oppressive. Chapter Four provides a critical overview of the Singaporean political system within a global context, again noting where the imposition of a “West is best” ideology is oppressive. Chapter Five critically contextualizes the interactions between doctors and people with diabetes to the extra-local social courses of actions that enter these local relations in Singapore. This chapter also suggests that
activities within the DSGS contrast relations between doctors and people with diabetes by providing people with diabetes a more psychosocially supportive atmosphere. Chapter Six contextualizes the DSGS itself, and briefly explicates how the DSGS facilitates a local transition to consumerism in medicine. Chapter Seven provides the major arguments of the dissertation, summarizes each chapter and includes a commentary regarding the contribution of my inquiry.

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1 I chose to use single quotation marks—as opposed to italics or double quotation marks—to indicate an emphasis or the stopping of the flow of text. Double quotation marks are reserved for quotations (including specified terminology or phrases) from written materials (including transcribed interview data and written fieldnotes).

2 Table 1 summarizes acronyms used in the dissertation.

3 Diabetic Support Group of Singapore (DSGS) is a pseudonym.


5 In the Spring of 1999, my partner was laid off as part of corporate 'downsizing.' Within 'head office,' his international skills were apparently no longer valued.

6 Original author's emphasis.

7 Original author's emphasis.
CHAPTER TWO
DIABETES: BIOMEDICAL AND INDIGENOUS VIEWS IN SINGAPORE

I. Introduction

Singapore, a relatively new nation of the ‘first world,’ is experiencing an ‘epidemic’ of chronic diseases associated with Western lifestyles. Diabetes is one of these diseases. The first part of this chapter reviews the biomedical conceptualization of diabetes, placing it within the context of Singapore. The second part reviews the various critiques of the biomedical model that have been written by North American social scientists over the past three decades. Biomedicine is historically linked with capitalism in that healthcare profits are more important than health. Historically, increases in longevity have often been credited to biomedicine when improvements in sanitation were responsible. Biomedicine has also been critiqued as curative, hierarchical and dualistic; that is, the patient is objectified by the expert physician. Finally, indigenous health practices, which tend to be more holistic, are marginalized by biomedical practices. The final part of this chapter contrasts indigenous health practices in Singapore with biomedical approaches.

II. A Disease of Affluence Associated with Rapid Westernization

1. Biomedical view of diabetes

In biomedical terms, there is a pandemic of diabetes. Complications that are secondary to diabetes are considered one of the greatest sources of personal and state burden within society:

Globally, there were estimated to be approximately 135 million adults with diabetes in 1995. By the year 2025, the figure is expected to rise to 300 million, an increase of approximately 120 [percent]. Whereas the rise will be of the order of 40 [percent] in the developed countries, it will be 170 [percent] in the developing countries. (Global Burden, 1997, para. 4)
According to biomedical texts, there are a number of differing types of diabetes. As

McLaughlin comments:

The key to the problem of diabetes is in its proper medical name—diabetes mellitus—which actually means something like “fountain of sugar.” The name derives from the fact that people with this condition produce lots of very sweet urine because their bodies have lost the ability to control the level of sugar (or glucose) in their bloodstream. This loss may be total, as in people who have so-called Type I (insulin dependent, or IDDM) or partial as in people who have Type II (non-insulin dependent, or NIDDM). ...

[The glucose formed as a breakdown of digestion] needs the action of a hormone called insulin to get it into the cells. Any excess glucose is [stored]. ...Normally, insulin levels rise and fall as required to keep the level of blood glucose more or less constant. ...The pancreas [secretes insulin] and may stop producing...[IDDM] or produces insufficient or ineffective insulin [NIDDM]. ...

[If this happens] the cells don’t get their proper supply of energy [and the breakdown of fats will occur. This is a source of glucose that release ketones into the blood as well]....[T]he bloodstream becomes so overloaded that it can’t hold any more, and the excess is excreted in the urine.... Eventually [too many ketones] could lead to a serious condition called diabetic keto-acidosis [DKA], or diabetic coma. (1994, p. 7)

The biomedical causes of diabetes are unknown, although higher risks for contracting NIDDM have been observed in people who are overweight (McLaughlin, 1994, p. 14).

The biomedical treatment of diabetes requires a diabetic regimen that typically includes medication. NIDDM does not necessarily require tablets but those people with diabetes with the IDDM variety require insulin injections. Lifestyle changes such as healthy eating and exercising habits are described as important features of the regimen. Routine diabetic check-ups are suggested within the biomedical model and involve what should be regular, often monthly, doctor visits. Ideally, blood glucose levels are monitored and diabetic regimens are negotiated to best fit the person’s lifestyle and resources. This would typically include further patient education activities and the dispensing of medicines. Ideally this is negotiated within the realm of cultural expectations and resources available to people with diabetes. The informed physician is aware of the complex psycho-socio-economic-cultural influences upon the dynamic
conceptualization of diabetes by those who have this condition. This includes assisting patients in valuing the necessity of a diabetic regimen.

The prescription of medication is often, but not necessarily, warranted in the biomedical treatment of the NIDDM variety. The oral medications prescribed to people with diabetes have the NIDDM form. The effects of these pharmaceutical products upon the body vary from stimulating the pancreas to secrete more insulin to reducing the rate of delivery of glucose to the blood by the digestive system. The associated risk of a person with diabetes having a hypoglycemic reaction is much less for those with the NIDDM form of the condition as compared to the IDDM form.

People with the IDDM variety, by definition, require insulin injections. The number of injections is dependent upon the treatment objectives and the types of insulin chosen. As the body does not produce insulin, these injections artificially ‘match’ the blood glucose uptake requirements by the cells. These are highly complex biological processes. Some injected forms of insulin are considered “short acting” and begin their sugar uptake properties sooner than those considered “long acting.” The risk of a hypoglycemic “reaction” is most present in people who have IDDM because they might not eat enough food, or burn off too many calories by exercising, to warrant the amount (or type) of insulin injected. Since blood sugar regulation is such a complicated biological process, people with diabetes are often encouraged by their doctors to keep diaries of their blood glucose levels by using a home monitoring device called a glucometer.

Within biomedical wisdom, people with NIDDM should follow similar lifestyle adjustments, perform home blood glucose monitoring and take tablets. “NIDDM is not a mild form of diabetes. It is a serious condition leading to serious complications” (Endocrine and Metabolic Society of Singapore: Diabetic Management—A New Dimension, Fieldnotes, November 12, 1994, p. 1). People with diabetes with the NIDDM variety who have ‘borderline’
normal blood glucose levels can often 'treat' their diabetes in a drug-free fashion through lifestyle adjustments. People with the NIDDM variety of diabetes do not have the same risks of a dramatic hypoglycemic reactions nor diabetic keto-acidosis (DKA) coma as do those people with diabetes with the IDDM form of the condition. This lessened risk coupled with the typical absence of symptoms in the early stages of NIDDM probably explains why this type of diabetes is often not considered seriously by either people with diabetes and/or their physicians.

2. Associated epidemiology

There is an increased rate of chronic illnesses in Singapore. In 1992, however, this newly formed Republic still had a youthful citizenry, with 77.2 percent of the population under the age of 45 (Singapore Ministry of Health, 1993b, p. 7). Thus health challenges are different from the West, although the epidemiological trends are rapidly shifting towards chronic diseases, such as diabetes, associated with Western lifestyles. Diseases such as high blood pressure and diabetes are called "diseases of affluence." "More than half (58.5 percent) of the total diabetics detected during the 1992 National Health Survey were diagnosed through the Survey [that is, were identified as either new or unknown diabetics]" (Singapore Ministry of Health, 1993b, p. 9). Coupled with these sudden increases in chronic diseases, there is the expectation that Singapore's population pyramid will also eventually approximate Western dimensions. The prediction is that by the year 2030, there will be five times the present number of Singaporeans over the age of 60 (Mathi, 1997, p. 26). This statistic is seen as significant with regard to present-day health policies.

That youthful Singapore has not escaped the diseases of affluence is evident in the official figures:

The National Health Survey 1992 showed that 8.6[percent] of Singapore residents, aged between 18 and 69 years had diabetes. Indians had the highest prevalence of diabetes (12.8[percent]), followed by Malays (9.3[percent]) and
Chinese (8[percent]). For the age group of 30 to 69 years, which is the target population for...NIDDM..., the survey showed that 11.9[percent] of persons had diabetes.... A comparison with the previous National Health Survey in 1984 shows that there has been a sharp rise in the prevalence of diabetes mellitus from 4.7[percent] (among adults aged 18-69 years) in 1984 to 8.5[percent] in 1992. ...This rise...was most marked among Chinese whose prevalence had doubled from 4.0[percent] in 1984 to 8.0[percent] in 1992. (Singapore Ministry of Health, 1993b, pp. 12-13)

The majority of people with diabetes in Singapore have the NIDDM variety (National Diabetes Commission, 1993, p. S1); one local source claimed that “only 10 percent of Singapore diabetics have IDDM” (Poh, 1995, p. 25). The rates of diabetes are not the same across Singapore’s three racial groups. Although still most prevalent among Indians, the rate of increase of diabetes is greatest amongst the Chinese who make up the majority of the population.

III. Critique of Biomedicine

1. General critique of the biomedical model

There are varying ideologies supporting health care around the world. The dominant global ideology, biomedicine, has been under construction since the turn of the twentieth century. This scientifically-driven model of acute care carries with it the social inequities of its historical origins. Brown (1979) states:

The [Western] medical profession discovered an ideology that was compatible with the world view of, and politically and economically useful to, the capitalist class and the emerging managerial and professional stratum. (p. 71)

The organizational processes associated with a biomedical model of health care continue to flourish in a climate of advanced capitalism. The two have been historically linked:

By embracing scientific medicine, leading practitioners bolstered their crusade for a monopoly over the practice of medicine. ...[There was a] mobilizing [of] the power of corporate wealth in the social sphere, foundations brought unprecedented aid to the promotion of scientific medicine and to the reform of medical education. (Brown, 1979, p. 193)
Today, in industrialized nations this link between biomedicine and capitalism is strong. Harding (1991) argues:

> [A]t least since World War II doing science is part of the apparatus of ruling. Science generates capital in the form of information, ideas, and technologies that are used to administer, manage, and control the physical world and social relations. When human activities are divided in hierarchical ways, those who engage in “ruling class” activity can have only a partial and distorted understanding of nature and social relations. (pp. 94-95)

Harding’s above use of Smith’s phrase “apparatus of ruling” refers to

those institutions of administration, management, and professional authority, and of intellectual and cultural discourses, which organize, regulate, lead and direct, contemporary capitalist societies. (Smith, 1990, p. 2)

Within this context, biomedicine is part of the apparatus of ruling. Only in a state or insurance-supported system could the exorbitant costs of scientifically-based health care be assumed. In this way the inequities of power remain unchallenged by individual “users” of the health care structure.

Medical sociologists have long argued that national health improvements have historically been disproportionately credited to biomedicine:

> Historical epidemiological evidence overwhelmingly supports the conclusion that medical science has played a relatively small role in reducing morbidity and mortality. ...[The more notable improvements included] environmental sanitation measures--cleaning up the accumulated filth of the cities, assuring uncontaminated water supplies, and so forth.... (Brown, 1979, p. 219)

As was the case in the developed world’s history, the improved health of a nation is not as dependent on biomedicine as on sanitation. Singapore is no exception.

The acute care approach of biomedicine is narrowly technological and curatively oriented. It is a model that focuses upon the ‘micro,’ the human body, at the expense of the ‘macro,’ that is, the social context of diseases and illnesses. Brown (1979) discusses the historical origins of biomedicine and its dominance in America in 1900:

> While society benefited from more effective techniques against infectious diseases, people lost the benefits of traditional techniques and became
dependent on technological medicine. The propaganda of the reform-minded elite sold scientific medicine as the last word on matters of health and disease. Through their campaign, the medical profession excluded herbal methods of prevention and therapy that are only now regaining popularity. They also narrowed the scope of medical inquiry to reductionist concepts, all but ignoring the social and economic contexts of health and disease. (p. 95)

The biomedical model relies upon clinical applications of scientific research:

“Disease” tends to be seen, by professional and lay-person alike, as something “objective,” somehow in the individual or in the community, but separable from them, waiting to be identified and dealt with by the medical profession. (Macdonald, 1992, p. 30)

According to this duality, the body is conceived as being a distinct entity from the soul. This perspective can be traced to the writing of Descartes, a seventeenth-century philosopher and mathematician, who conceived of the human body as a complex machine:

The engineering model also leads to dualism, the division of the human being into discrete entities of body and soul. For Descartes, the soul is distinct from the body which it informs. (Macdonald, 1992, p. 39)

The biomedical model clinically applies the metaphor of the body as a machine and it has a dependence upon resource-costly technology (Rachlis & Kushner, 1989).

The doctor is cast as the professional who is trained to restore health by “fixing” the broken, or diseased, body part. In this way, this model is best applied to “acute” conditions:

The analogy of the body as a machine and the doctor as the medical scientist/engineer has proved useful to the development of certain aspects of medical care, especially in crisis interventions and in the treatment of acute clinical disorders. (Macdonald, 1992, p. 30)

A scientific view of events is fundamentally reductionistic in nature. Diseases are viewed as biological in origin and are researched via cause-and-effect models in the laboratory. Foss and Rothenberg (1987) refer to this as “biomedical reductionism.” The most common conceptualization of health care is one that envisages the “disease as a symptom of systemic disorder” (Foss & Rothenberg, 1987, p. 7). The “object” of medical investigation is not a whole person but rather a human body and its biological systems.
The role of the clinical investigator is to objectively and as systematically as possible, locate the potential cause(s) of ill health and select the best treatment/drug suggested by the research (and promoted by the “for profit” drug companies). The acute care biomedical model assumes that health is automatically restored once the offence to the body is removed. This view reduces the patient to a source of information to assist in the objective logico-deductive practice of clinical diagnosis. The social-psychological experiences or life challenges associated with living with an illness are of little practical relevance beyond providing the necessary data by which a diagnosis and treatment strategies can be derived by a medical professional. The patient’s “voice” is outside of the extra-local practice of biomedicine and not an integral part of “health care.”

Many exciting and life-saving medical treatments have been borne of this extremely costly curative approach to health. Such ‘miracles’ can be seen as the ‘carrots’ that drive the system: the hope that sicknesses may be passively cured with a “magic bullet” (Dubos, 1959). Besides the formidable and escalating costs of the quest for magic bullets, social inequity and access to this care become problematic. There are also iatrogenic (doctor or biomedically-caused) conditions that have precipitated suffering and yet more conditions to cure (Illich, 1976; McKeown, 1979; Bolaria & Bolaria, 1994; Rachlis & Kushner, 1989). Illnesses associated with drug therapies are euphemistically called “side effects” and medical professionals are taught that they are to be expected.

The acute care approach to healing has, by definition, failed when a condition is chronic because patients are not cured of their particular disease. The prevalence of chronic diseases, especially those associated with the elderly, are increasing due to the extended lives of those who might have otherwise died:

[There is a] changing disease profile.3 In the past, most illnesses were either minor and self-limiting or acute and fatal. Much illness today is chronic. Chronic illness is expected to last a long time, even over a lifetime, with
intermittent remissions and exacerbation of symptoms. The power of medicine to cure chronic illness is virtually nonexistent. (Clarke, 1996, pp. 311-12)

Biomedicine assigns doctors a curative role that they cannot effectively fulfil.

Western medicine is also a reactive approach to disease. Patients with chronic disorders are instructed to return to primary care clinics for treatments centred on symptom management. The health care structure is based upon the hope that ‘bio-science’ will find disease ‘cures.’ Physicians, in the meantime, tend to treat the symptoms manifested by chronic diseases in much the same manner as they would acute care disorders (Foss & Rothenberg, 1987, p. 106).

The biomedical, dualistic approach precipitates a bureaucratic arrangement of health care. Physicians are at the apex of the hierarchical organization of health professions. Bolaria and Bolaria (1994) state:

[The] emphasis on disease-centred and curative medicine has tended to undermine, at least until very recently, the public health and social aspects of medicine, such as healthy social environment, health education, promotion and prevention. Also, under debate are the composition of the health sector labour force and the hierarchical organizational structure of health care institutions. Racial, gender and class inequalities continue to permeate the health sector. (p. 2)

This “objective” expert approach does not consider the illness symptoms, that is, what a patient holistically experiences in a diseased state. The dualistic, scientific biomedical ideology and bureaucratic organization of health care encourages physicians to be considered ‘the’ best expert:

The division of human reality in this way: body/soul, has persisted in one form or another in medical thinking until our day and, however poetically expressed, is a simplistic, dualist and inherently deficient understanding of human reality. It is shown to be deficient and runs into difficulties as an explanation of this reality when dealing, for example, with some aspects of what is known as “mental” illness or condition described as “psychosomatic.” (Macdonald, 1992, p. 39)

There is an overemphasis on “objective,” scientific, highly technological and expensive testing and treatments within the biomedical model.
In summary, in contemporary capitalist societies, biomedicine tends to be uncritically viewed as the major route to health. This model of health care is part of the Western ruling apparatus that is informed by a capitalist ideology. Powerful institutions have maintained biomedical discourses as this is in their best interest. To do otherwise would necessitate a more equitable sharing of institutionalized power and resources. In addition, the role of this model in acute disease or accident management needs to be critically examined because the “voice” of other non-Western approaches to healing is conspicuously suppressed.

2. Patient objectification within Western medicine

Since the biomedical model presupposes that diseases are to be ‘cured’ by the physician, the person with the condition can be objectified as a type of disease “vehicle.” Yet it is illness experiences that bring people to health practitioners:

“Illness” refers to the patient’s subjective response to being unwell; how he and those around him perceive the origin, significance, impact and prognosis of this event; how it affects his daily life and behavior or relationships with others; and the steps he takes to remedy the situation. (McWhinney, 1991, p. 3)

Especially in the case of chronic disorders, as well as when the socioeconomic status (SES) of patient and physician differ substantially, there may be little congruence between the conceptualization of the ‘disease’ between physician and patient:

The patient’s definition of symptoms which are worrisome, his understanding of illness categories or syndromes and his views about bodily functioning go unrecognized. ...In every interaction of this type, the silent “statement” is made that the patient’s perceptions, knowledge and experiences have little significance; that his beliefs are not worth inquiring about; that his customary health practices are to be disregarded and his own health cultural tradition ignored. (Weidman, 1979, p. 86)

Different perspectives between patients and their doctors are a clinical challenge in the West. Generally, miscommunications are more likely when there are significant rifts in SES (Buchwald et al., 1993). Worldview differences are usually more pronounced between physicians and their
working class and elderly patients. Freidson states: "Unlike colleagues, lay clients do not necessarily share the professional’s universe of discourse" (1970, p. 109). In Singapore, physicians tend to be more Westernized than their patients and thus are of higher social status than their working-, or even middle-class patients. In non-Western cultures the situation is exacerbated when the physician is biomedically trained (Hahn, 1995). In Singapore, the ideologies of traditional healing methods and Western medicine conflict. Among those who are poor and/or the least Westernized, then, the conceptualization of health and health care may be fundamentally different between patient and physician. Finally, these patients are not surrounded by the technologies common to those persons who are familiar with Westernized employment and lifestyles.

Kleinman et al. suggest that in cases of chronic illnesses and/or diseases, "marginal" or "folk practitioners" are more often successful at reducing illness symptoms because of a more relative social closeness:

In part, this can be ascribed to smaller social class differential between patient and practitioner, an increased emphasis on "explanation," and a greater concordance between the explanatory systems of healer and patient. (Kleinman et al., 1978, p. 252)

Kleinman et al. state that healers are more concerned with the illness of a patient and take the time to listen and learn about the human experience of poor health:

[B]iomedicine is primarily interested in the recognition and treatment of disease (curing). So paramount is this orientation that the professional training of doctors tends to disregard illness and its treatment. Biomedicine has increasingly banished the illness experience as a legitimate object of clinical concern. Carried to its extreme, this orientation, so successful in generating technological interventions, leads to a veterinary practice of medicine. (1978, p. 252)

Kleinman’s pejorative use of the phrase “veterinary practice of medicine” highlights the magnitude, if not challenged, of the biomedical objectification of the patient. This is especially problematic when the ‘disease’ is ‘chronic’.
Freidson (1996) agrees with Kleinman’s perspective when he addresses the question of how “professional practices contribute to the unhappy experience of the patient” (p. 149):

The best way of beginning to answer this question lies in the recalling the distinction...between an object and a person. An object does not possess the capacity for understanding, and its behavior cannot be influenced by its understanding. When a person is treated as if he were an object, he will nevertheless behave on the basis of his understanding of that treatment.

...If the [medical] staff does not communicate to the patient the meaning of and justification for what is done to him, it in essence refuses him the status of a responsible adult or of a person in the full sense of the word. ...Explanation by the [medical] staff constitutes acknowledgement of the client’s status as a responsible adult capable of intelligent choice and self-control. (p. 149)

Although a more humanistic approach to health care, Freidson’s view does not go far enough as it is still an approach to patient education that is one-way, that is, from the expert teacher to the novice learner.5 On the other hand, a Freirian view necessitates a two-way dialogue between doctor and patient where each partner learns the other’s perspectives with a focus on the needs of the patient.

Diabetes is an especially challenging condition when the doctor conceptualizes it as a disease and the patient, as yet, may not feel ill. Within biomedicine, ‘good’ physicians hold the goal of ‘teaching’ patients how to maintain a diabetic regimen with the hope of avoiding short and long term complications. But this would not be the best approach for optimal patient-doctor communication within a more patient-driven paradigm of health care. According to a more enlightened view, at the very least, physicians might best begin by facilitating their patients’ awareness of the importance implementing the most practical biomedically-based diabetic regimens. Equally, physicians would learn about patients’ realistic capabilities, personal worldviews and health alternatives by listening to them. This would be the starting point for mutual education. It is where information regarding patients’ illness experiences might be voiced and ideas shared about best approaches to living with diabetes, as opposed to the ‘banking’ education techniques currently used in Singapore.6
The objectification of patients by biomedical physicians is an example of how the detachment characteristic of positivistic science is reproduced within local relations in Singapore. These social outcomes are a consequence of the organizational processes within biomedicine in an industrialized economy. The scientific ideology upon which the biomedical model is based seeks ‘objectivity’ as a marker of success. Professional and social hierarchies are also part and parcel of technological medicine. These organizational practices do not include a place for a two-way dialogue between patient and physician, as the latter is cast as the high status ‘expert’ who ‘diagnoses’ and ‘treats’ diseases. Dialogue takes time and is not perceived as “cost effective” within an economic view of health care management.

3. “For profit” ideology and biomedicine

The ideology of biomedicine is part and parcel of a capitalist economy; thus interactions between physicians and patients reproduce relations of ruling in advanced capitalism. Smith emphasized that “relations of ruling” come in many social forms including various bureaucracies and professional organizations (1990). I use this phrase to explicate that the social forces external to doctor-patient relations are varied and complex. Specifically, the use of medications as “magic bullets” is an example of the curative orientation of Western medicine. The idea that the use of pills and associated technologies are the goals of health care puts profit ahead of health. The hyper-focus upon pathology by biomedical professionals has thus monopolized spending of the health care research dollar. Critiquing synthetic drug trials, Rachlis and Kushner argue that

[t]he problem is that these kinds of studies are likely to greatly overstate the usefulness of the new procedure. They are popular however--particularly if there is money to be made. A clever public relations firm will take these early “promising results” and try for maximum media play. (1994, p. 107)
With an orientation towards health in which considerations of profit are paramount, fewer resources are directed towards activities surrounding health promotion and disease prevention activities. This is especially troublesome at the end of the twentieth century when morbidity rates associated with chronic illnesses are at an all time high:

[Efficiency might be substantially increased by more carefully controlling the allocation of resources among the different kinds of health services. More could be spent on prevention and less on cure, more on palliative care and less on aggressive surgical interventions toward the end of life, more on physiotherapy and less on orthopedic surgery, and so on. (Blomqvist, 1994, p. 6)]

Blomqvist’s view is more representative of a model of “health” versus the “disease-curing-for profit” approach inherent to Western medicine.

IV. Indigenous ‘Alternative’ Health Practices in Singapore

In stark contrast to for-profit Western biomedical practitioners are traditional healers of Malay, Chinese and Indian origins (Quah, 1977, p. 7). Some indigenous “healing procedures involve simple practices (steaming herbs, manipulating objects, etc.) and rituals which are transmitted verbally from generation to generation” (Quah, 1977, p. 7).

Tamney (1996) generalizes that

[t]he folk tradition presents life to be the result of fate and luck, although magical practices may improve one’s chances for prosperity, health, and a good family. ...The negative image of the folk tradition, especially among the more educated, is revealed in the comment of converts to Christianity. They described folk religion as “illogical” and “supersitious.” (Tamney, 1996, p. 41)

But Traditional Chinese Medicine (TCM) should not be confused with this folk

approach to health:

[TCM practitioners] make use of written experience on health matters, have a series of theoretical principles guiding their understanding of health and disease, and transmit this knowledge and related healing techniques and pharmacopeia through specially established schools. (Quah, 1977, p. 7)
The TCM model, unlike Western medicine, is not based upon a ‘disease’ view of the body.

Instead, TCM embraces a more holistic view as described by Lai and Yue:

All of man and nature are related to each other in a harmonious balance. Individuals must adjust themselves wholly to the environment and maintain this balance, since imbalance brings illness. ... People usually think of themselves as ill only when symptoms are evident. Their primary goal is then to get rid of the symptoms. They may have difficulty understanding the implications of chronic illnesses where symptoms persist for a long time and there is no absolute cure. In Chinese medicine, people may seek cures from substances which they associate with their own deficiency. For instance...[a] diabetic may eat an animal’s pancreas in the hope of cure. ... [This is] why traditional Chinese may have difficulty in regarding plastic capsules as a cure. (1990, pp. 78-80)

There is a conceptualization in TCM of “the phenomenological body of perceived experiences, the lived-body, that transcends the dichotomy of psyche and soma” (Ots, 1990, p. 21):

In non-western societies health traditions have a lively consciousness of the oneness of what the West has come to see as body-mind division and so of the spiritual dimension of health and disease. (Macdonald, 1992, pp. 39-40)

Illness is an embodied, experiential phenomenon. These subjective qualities are more valued within TCM:

Unlike Western medicine, TCM is not dualistic, and does not strictly separate emotions and physician functions: both are seen as the same phenomenon. ... Thus although TCM emphasizes physical symptoms (and treatments) rather than psychological ones, the practitioners are able to “read” these somatic symptoms as essentially an emotional message--and thus identify the underlying psychological problem. (Helman, 1990, p. 270)

From the perspective of holism, the Western paradigm of dualism is seen as ‘dwarfing’ a person’s ability to be aware of his or her body experiences. An example of dwarfing using the biomedical approach can be seen when certain illnesses are attributed to psychosocial origins and “treated” with psychodynamic interventions. Since the expression of emotion is discouraged among Chinese people and psychotherapy is not an accepted part of cultural norms (Helman, 1990), presumably this approach would not have the cathartic therapeutic effect it is known to
offer Westerners. That is, the ‘treatment’ may not achieve its desired goals because it does not have the cultural legitimation (Helman, 1990; Ots, 1990).

Conversely, TCM treatments are not (with the possible exception of acupuncture) considered therapeutic, and are sometimes considered dangerous by biomedical Western standards. Since TCM treatments do not conform to scientific research, they are not as valued as Western medical practices by the ‘modern’ Singaporean.

It is appropriate that critics of Western medicine problematize its minimal attention to disease prevention. TCM, by way of contrast, emphasizes preventative medicine:

In addition to the dichotomy of external symptoms versus internal symptoms in disease diagnosis which was conceptualized at such an early date [sixth century B.C], there was also a significant Chinese medical theory which emphasized preventative medicine over healing as the highest goal of medicine. (Wu, 1979, p. 4)

V. Conclusions

The ‘economic miracle’ of Singapore has brought with it diseases of affluence such as diabetes that are part and parcel of a consumer society. When conceptualized within a biomedical frame, diabetes is multifaceted, but is often linked with insufficient regulation of insulin production and glucose uptake at the cellular level. In TCM, a diabetic may be treated, although diabetes was not historically significant to Singapore. Singapore has imported a capitalist economy and its diseases of affluence. It has also imported the Western treatment for diabetes, thus buying into the curative paradigm of biomedicine. However, diabetes is chronic, rather than curable. Further, biomedicine has been critiqued for decades by Western social scientists as bringing with it hierarchy, dualism, objectification of the patient and the placing of profit-making ahead of health.
From feminist and postcolonial perspectives, biomedicine can be seen as the ideology of Singapore's colonizers. The relationships between people with diabetes and their doctors in Singapore can thus be seen as reflecting the relations of ruling, colonizers and colonized.

1 Original author's emphasis.
2 Original author's emphasis.
3 Original author's emphasis.
4 Original author's emphasis.
6 Freire's "banking" education technique is further discussed in Chapter Three.
7 A Malaysian healer is called a "bomoh" (Langley, 1997, p. 11)
8 This brief overview is centred around TCM. The traditional forms of health care are predominantly Chinese in origin due to the Republic's racial demographics. Folk healing continues within the Chinese, Malay and Indian communities (Quah, 1981, p. 149).
9 Original author's emphasis.
10 Original author's emphasis.
CHAPTER THREE
INSTITUTIONAL ETHNOGRAPHY: THEORY AND METHODS

I. Introduction

The work of Dorothy Smith and Paulo Freire provided the critical framework for this research. In problematizing the power relations of biomedicine in Singapore, my work draws on Smith’s idea of a “sociology for people” which would begin from the experiences of patients and analyze relations of ruling in encounters between doctors and people with diabetes. By this I mean that, I assumed the standpoint of the inquiry participants. I encouraged them to share their experiences and ideas about their lives with diabetes (or clinical experiences and ideas in the case of physician participants) on their own terms. I was careful to minimize any preconceived theoretical orientations that might hinder my hearing their stories. I did not assume to be a neutral investigator nor searched for a universal explanatory theory. Instead, I analyzed the many and varied sources of shared and observed information in search of a generalizing concept, or ruling relations, that would help me understand these specific micro relations.

Freire’s work, emphasizing the importance of consciousness-raising about the reproduction of power relations by oppressed peasants, was also useful in conceptualizing the agency of the patients and diabetic self-help group members in the realization of their own health. The writing of this emancipatory educator is relevant to my dissertation in two ways. The first is with the importance placed upon the value of egalitarianism of opportunity and the humanistic treatment of people which functioned as a sensitizing agent in my analyses. Secondly, the finding that the DSGS is claiming some of its power as consumers within Singapore.

After a review of the nature of critical theory, specifically in the work of Smith and Freire, I summarize my research narrative, emphasizing the paradigm shift I experienced upon
moving to Singapore and attempting to apply a grounded theory methodology derived in Canada. I describe my growing awareness of both my whiteness and of the academic discourses that I was reproducing in attempting to ‘survey’ my respondents. My consciousness-raising was achieved through journaling, taking fieldnotes and doing critical autoethnography. The fact that my husband was Chinese Canadian and my attempts to learn the language were met favorably by my interviewees, but I encountered many difficulties in the field because of the importance of ‘face’ in Singapore and because of the Singlish dialect, both are which are discussed briefly here. Finally, I summarize the methods used in this research, and introduce the participants, detailing the precautions I took to protect their identities in this thesis.

II. Critiquing the Social

1. General description of “critical theory”

There is no commonly accepted definition of critical theory. It is an umbrella term that refers to the texts of social investigators who are critical of the limitations of other research paradigms and the hegemony positivism¹ (and postpositivism) have over what is considered valid ‘knowledge.’ The term ‘science’ refers to the knowledge gained by positivists through an agreed-upon systematic, objectified research methodology of the empirical world. Critical theorists question the adoption of these methodological tenets for researching the social world:

   The rigorous methodological approaches of empirical inquiry often preclude larger interpretations of the forces that shape both the researcher and the researched. Empirical observation cannot supplant theoretical analysis and critical reflection. ...[T]he way we analyze and interpret empirical data is conditioned by the way it is theoretically framed. It is also dependent upon the researcher’s own ideological assumptions. The empirical data derived from any study cannot be treated as simple irrefutable facts. They represent hidden assumptions--assumptions the critical researcher must dig out and expose. (Kincheloe & McLaren, 1994, p. 144)
Critical theorists do not always agree about the best way to conduct research but are unified in their view that present traditions associated with postpositivism reproduce social inequity.

Kincheloe and McLaren (1994) help historically contextualize the evolution of critical theory:

*Critical theory* is a term that is often evoked and frequently misunderstood. It usually refers to the theoretical tradition developed by the Frankfurt school, a group of writers connected to the Institute of Social Research at the University of Frankfurt. However, none of the Frankfurt school theorists ever claimed to have developed a unified approach to cultural criticism.... Many academicians who had come of age in the politically charged atmosphere of the 1960s focused their scholarly attention on critical theory.... Impressed by critical theory's dialectical concern with the social construction of experience, they came to view their disciplines as manifestations of the discourses and power relations of the social and historical contexts that produced them. (pp. 138-39)

Kincheloe and McLaren (1994) continue with a comprehensive definition of critical theory:

We are defining a criticalist as a researcher or theorist who attempts to use her or his work as a form of social or cultural criticism and who accepts certain basic assumptions: that all thought is fundamentally mediated by power relations that are social and historically constituted; that facts can never be isolated from the domain of values or removed from some form of ideological inscription; that the relationship between concept and object and between signifier and signified is never stable or fixed and is often mediated by the social relations of capitalist production and consumption; that language is central to the formation of subjectivity (conscious and unconscious awareness); that certain groups in any society are privileged over others and, although the reasons for this privileging may vary widely, the oppression that characterizes contemporary societies is the most forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable; that oppression has many faces and that focusing on only one at the expense of others (e.g., class oppression versus racism) often elides the interconnections among them; and, finally, that mainstream research practices are generally, although most often unwittingly, implicated in the reproduction of systems of class, race, and gender oppression. (p. 140)

Findings by critical theorists are conceptualized as value-mediated: "Critical research traditions have arrived at the point where they recognize that claims to truth are always discursively situated and implicated in relations of power" (Kincheloe & McLaren, 1994, p. 153).

There is no search for an objective "truth" within critical theory as is often the case in positivist social research.
Using Guba and Lincoln’s (1994) typology, critical theory is related to other ideologies. It is seen as a blanket term denoting a set of several alternative paradigms, including additionally (but not limited to) neo-Marxism, feminism, materialism, and participatory inquiry. Indeed, critical theory may itself usefully be divided into three substrands: poststructuralism, postmodernism, and a blending of these two. (p. 109)

The important distinction between critical theory and more ‘scientific’ approaches is that the former is concerned with critique and transformation whereas the latter are concerned with prediction and control.

2. “Institutional ethnography: an alternative sociology”³

Dorothy Smith (1987a,b; 1990; 1993; 1999) critically investigates the oppression of women by beginning with their everyday experiences. Smith argues that there are institutionalized practices of excluding women. By listening to individual women’s experiences living within capitalistic culture, she was able to explicate how these macro relations affect their day-to-day lives. Smith (1987a) states that her work “began with the actual problems of doing research for women” (p. 214). This explains the epistemological term “standpoint theory” as knowledge is seen as originating from the standpoint of peoples’ experience:

[This] sociology...explores and explicates the actual determinations and organization of the actualities of people’s experienced worlds—not, of course, as to the particularities of their experience, but as their experiencing participates in and is shaped by that organization. (Smith, 1990, p. 3)

Smith’s institutional ethnography is:

a strategy that takes as central that women should speak from themselves and their experience and that the communities of their oppression are to be discovered in a discourse that can expand their grasp of their experience and the power of their speech by disclosing the relations organizing their oppression. (1987a, p. 215)
Smith argues that women's "cultural and intellectual world" was "assembled in textually mediated discourses and from the standpoint of men occupying the apparatuses of ruling" (1999, pp. 1-2). The goal of institutional ethnography is to discover evidence of macro, or extra-local, relations within local embodied experiences. This is accomplished by examining the intersections, or disjunctures, of "extended social relations of ruling through" people's lived experiences (Smith, 1990, p. 5). The objective of the institutional ethnographer is to look for these intersections or experiential contradictions. Smith refers to these as a "bifurcated consciousness" (1987a, p. 6).

George Smith (1995) comments on the importance of problematizing the everyday world in sociology:

[K]nowing in this everyday world is reflexively, rather than objectively organized. In this view, objective knowledge is no longer "the truth," but a form of knowing used to rule society that contingently, but inextricably, incorporates the standpoint of men. Thus, her feminist critique of objective knowledge, and hence of standard sociology, requires an epistemological shift. ...[This shift must] embrace the standpoint of those who stand outside a ruling regime;... (pp. 21-22)

Dorothy Smith is also referred to as a standpoint theorist. According to de Montigny (1995), Smith "outlined a Marxist strategy that explores the social organization of everyday experience" (p. 14). Harding cites Smith to "argue that not just opinions but also a culture's best beliefs--what it calls knowledge--is socially situated" (Harding, 1991, p. 119). The aim of standpoint theory is to make visible the influences of social organization upon lived experiences and not the prediction and control of generic social events.

Smith's method has been used by researchers in a variety of fields as an alternative sociology, not necessarily grounded in women's experience, but grounded in experiences of people. As McCoy (1999) points out, Smith has "in recent years been referring to it as a sociology for people" (p. 250). My thesis is an example of this approach. It does not focus
exclusively on the experiences of Singaporean women, but on the experiences of Singaporean patients and self-help group members, in contrast to discourses of biomedicine and capitalism.

Smith (1999) argues that by critically examining the everyday experiences of people, the various and often unrecognized influences of these experiences may be explicated. She sees inquiry of this kind as

not treat[ing] experience as knowledge, but as a place to begin inquiry. The aim of inquiry is not, as in established sociologies, to explain people's behaviour, but to explain to people the social—or society—as it enters into and shapes the lives and activities. (Smith, 1999, p. 96)

The role of the investigator becomes to make “sense” of the everyday experiences of the inquiry starting with apparent “contradictory practices” (Townsend, 1998, p. 46). The researcher traces the

social processes that connect the work being studied with the work of others.... These social processes are organizational in that they routinely organize what can be done in everyday practice. (Townsend, 1998, p. 21)

The inquirer's skill becomes the ability to discover evidence of relations of ruling, such as those found within social organizations and institutions, within the face-to-face relations being investigated.

Smith (1987a) refers to the concept of “ruling relations” as one that “grasps power, organization, direction and regulation” (p. 3). Walker (1995) summarizes:

These relations are exercised in social forms: in the talk, reporting and accounting procedures, documents, and categories of professional and bureaucratic practices; in the ideological forms in which objective knowledge is constructed by intellectuals; and ultimately when necessary by the use of force to maintain power. (p. 78)

An institutional ethnography makes visible ruling relations by discovering their extra-local practices within the investigated local experiences:

Exploring the ruling relations, discovering the interrelations and intersections of organization as a product of inquiry, can in principle begin anywhere. ...This sociology is of the same lived world of which it writes; it aims at producing a knowledge of that world which is itself in and of the social. It is
committed to inquiry and investigation, to finding out "how things are put together," and hence to producing knowledge that represents the social as it happens. (Smith, 1999, pp. 82, 97)

By problematizing a social phenomenon according to those experiencing the challenges (or oppressive states or difficulties), the "barriers for social change" (Townsend, 1998, p. 48) may begin to be dismantled. The tasks surrounding consciousness-raising of those in power and of those experiencing the problematic, can begin from the outcome of an institutional ethnography.

3. **A method of consciousness-raising: Paulo Freire's emancipatory education**

While my thesis is an institutional ethnography of patient-doctor relations in Singapore, I found the work of Paulo Freire (1970/1997; 1973/1998a; 1996; 1992/1998b) important in focussing on the agency of the oppressed. In addition, Freire’s work is situated in South America rather than North America. Freire, initially not including gender, wrote about the political importance of education for the oppressed peasants of Brazil. His work is that of an emancipatory educator. Freire wrote to raise the consciousness of his nation’s people about social inequity. Freire’s lifework was directed towards the potential for social change through "education for critical consciousness" (Freire, 1973/1998). His humanistic views have had far-reaching social and pedagogical ramifications.

Freire critiques what he called a “banking” style of teaching:

Narration (with the teacher as narrator) leads the students to memorize mechanically the narrated content. Worse yet, it turns them into “containers,” into “receptacles” to be “filled” by the teacher. The more completely she fills the receptacles, the better a teacher she is. The more meekly the receptacles permit themselves to be filled, the better students they are.

Education thus become an act of depositing, in which the students are the depositories and the teacher issues communiqués and makes deposits which the students patiently receive, memorize, and repeat. This is the “banking” concept of education…. (Freire, 1970/1997, pp. 52-53)

One of Freire’s main ideas is that the liberator, who wishes to educate the peasant to ways of alleviating their oppression from those with power, has to be careful to not simply reproduce the
oppressor's powerful position (Freire, 1970/1997, p. 112). If oppression were reproduced, the only difference between an old and new regime would be the level of compassion for the perceived needs of the peasant.

A two-way dialogue is seen as necessary in order for the liberator to best learn how the peasants envision their lives (Freire, 1970/1997, p. 149). Freire (1992/1998) states:

> [E]ven when one must speak to the people, one must convert the “to” to a “with” the people. And this implies respect for the “knowledge of living experience” of which [Freire] always speak[s], on the basis of which it is possible to go beyond it. (p. 26)

Passivity of the oppressed must be avoided in order to achieve a “critical consciousness” that is integrated with reality (Freire, 1973/1998, p. 44).

Freire argues that, in relational terms, peasants “housed the oppressor.” These oppressed people believe themselves unable to effectively enter into a process for social change. By housing the oppressor, people believe themselves to be only capable of functioning in their imposed social place within the nation's organizational processes. They see themselves as incapable of learning about others’ experiences with similar problems nor organizing themselves in ways that could improve their lives. Freire (1992/1998) argues that these self-limiting aspects of social inequities prevent Brazilian peasants from acquiring the cognitive tools to aid in the setting and achieving of the goals related to their social problems.

Housing the oppressor activities are related to the affective dimension of hopelessness:

> Their need to deny the humiliating truth, a truth that humiliates them precisely because they introject the dominant ideology that sketches them as incompetent and guilty, the authors of their own failures. And yet the actual “why” of those failures is to be found in the perversity of the system. (Freire, 1992/1998, p. 56)

This humiliation, or hopelessness, has a historical component that is grounded in previous attempts by peasants to freely solve their social problems (political oppression) which have been negated by the directives from those in power. This cycle of social oppression is self-
perpetuating when those who are oppressed perceive that any self-generated input for change is futile.

Freire speaks "of the raising of consciousness, of conscientização" (1992/1998, p. 104) as being required to break this cycle. He defines conscientização in *Pedagogy of the Oppressed* as "the deepening of the attitude of awareness characteristic of all emergence [from ignorance]" (1970/1997, p. 90). The goal of conscientização, later termed conscientization by Freire, is the beginning of critical thinking. He states:

Conscientization changes one’s perception of the facts, based on a critical understanding of them. ... A person who has reached conscientization has a different understanding of history and of his or her role in it. (1996, pp. 182, 183)

Freire’s perception of humanity is thus humanistic and egalitarian. From my perspective, this consciousness-raising is an important sequel to an institutional ethnography of doctor-patient relations in Singapore. How would this occur? Freire’s “dialogical method” provides some guidance.

The following excerpt is an illustration of Freire’s dialogic intercourse typical of a conscientization education practice. Freire asked 10 questions that only an educated individual might correctly answer and, in turn received 10 questions from a group of peasants. Neither he, nor the peasants, were successful at answering each other’s questions:

"Fine," I had told them. "I know. You don’t [know the answer]. But why do I know and you don’t?"
..."You know because you’re a doctor, sir, and we’re not."
"Right, I’m a doctor and you’re not. But why am I a doctor and you’re not?"
"Because you’ve gone to school, you’ve read things, studied things, and we haven’t."
"And why have I been to school?"
"Because your dad could send you to school. Ours couldn’t."
"And why couldn’t your parents send you to school?"
"Because they were peasants like us."
"And what is ‘being a peasant’?"
"It’s not having an education— not owning anything— working from sun to sun— having no rights... having no hope."
"And why doesn’t a peasant have any of this?"
"The will of God."
"And who is God?"
"The Father of us all."
"And who is a father here this evening?"
Almost all raised their hands, and said they were.
I looked around the group without saying anything. Then I picked out one of them and asked him, "How many children do you have?"
"Three."
"Would you be willing to sacrifice two of them, and make them suffer so that the other one could go to school, and have a good life, in Recife [a Brazilian city]? Could you love your children that way?"
"No!"
"Well, if you," I said, "a person of flesh and bones, could not commit an injustice like that--how could God commit it? Could God really be the cause of these things?"
A different kind of silence. Completely different from the first. A silence in which something began to be shared. Then:
"No. God isn’t the cause of all this. It’s the boss!"
Perhaps for the first time, those peasants were making an effort to get beyond the relationship that I called, in Pedagogy of the Oppressed, that the "adherence" of the oppressed to the oppressor, in order to "step back" from the oppressor, and localize the oppressor "outside" themselves…. (1992/1998, pp. 47-48)

Freire’s view of localizing the oppressor outside of the individual resonates with Smith’s idea of problematizing the disjuncture between experience and the discourse of ruling.

Freire’s work was to “critique and transform” society. hooks⁸ (1994) states that:

“Freire has to remind readers that he never spoke of conscientização as an end itself, but always as it is joined by meaningful praxis” (p. 47). Freire believed that “democratizing the power of choosing [educational] content” (1992/1998, p. 110) was required for the oppressed to begin to be truly liberated.

My experiences in the field better resonated with a socially critical perspective compared to my intended theory-generating inquiry. I kept detailed records and journals of my research activities from the beginning of my research.
III. Critical Autoethnography: From Grounded Theory to Institutional Ethnography

1. My research narrative

My research is an accounting of my experiences that not only explores relations between PWD and their physicians but also contextualizes these social relations within the unique society of Singapore. However, that is not where my research began.

My inquiry had its foundation in Toronto. I intended to adapt my schooled, and Western, knowledge to Singapore. My experiences working at McMaster University’s medical school coupled with my volunteer activities within the Multiple Sclerosis (MS) Society, were the foundations of a research plan that I intended to complete in Southern Ontario. My plan was to adapt this research proposal to this Southeast Asian republic. My research was intended to be based upon grounded theory; I set out to typify the universal generic process of interaction between patients and professional relationship. Through triangulation of method and sources of information, I intended to devise an explanatory theory to contribute to an existing, Western-scholarly-sanctioned, literature regarding the interactions between doctors and those with MS.

My life led me to Singapore. The adaptation of my Western-laid plans was not a clean one. The results were an accumulation of observations, interviews and other insightful experiences. It was not until much later in my inquiry that I conceptually re-evaluated my inquiry as a whole. This occurred due to a nagging sense that my uncritical and Western based methods were not working as they ‘should’ in this Southeast Asian Republic. These inquiry experiences became data in and of themselves.

My intuitive response was that my survey would not ‘work’ because I was in Singapore; thus my decision to reconceptualize my work. I experimented with situating myself in the inquiry via critical autoethnography (Church, 1995; Bochner & Ellis, 1996; Richardson, 1998) and the details of my analysis are contained in Appendix A. Here is a brief summary of
my dissertation's history: I organized my inquiry activities into eight linear phases\(^{10}\) of activity which took place over four years in Singapore (1993-1997). It is a critical autobiography and is presented as an institutional ethnography in its own right. Evidence of organizing social influences upon my research activity are highlighted.

The first phase describes my original Toronto-based study. I had arranged a grounded theory design that included a methodological triangulation approach to theorizing the relationship between some family physicians and their patients with MS. Phase 2 critically recounts the methodological challenges associated with the relocation of my family from Toronto to Singapore. Life in Singapore during this time-frame of the Summer of 1993 to the Spring of 1994, proved to be more difficult than anticipated. During Phase 3, I experienced the interrelationship between gaining access to informants within the Singaporean medical community and informally exploring the "field" during the Spring and Summer months of 1994. In Phase 4, I met my Singaporean "mentor" and other medical, and academic, key informants during the period between the Summer and Fall of 1994. The process surrounding my decision to select diabetes as the chronic condition is described.

During Phase 5 (Fall 1994-Fall 1995), I began my inquiry examining the relations between people with diabetes and their physicians. Again, these research plans were based upon a grounded theory design using methodological triangulation. My first pilot activities of the survey construction included being introduced to members of the DSGS who, within this capacity, acted as key informants and pilot participants. I describe my meeting government officials and the process by which I was intending to gain access to public and private primary care clinics when distributing the 'true' questionnaire (that is, the non-pilot version). My activities were centered on how I might best adapt this quantitative instrument to my Singaporean participants. Adaptations became ever-increasingly complex: various formats of the survey were constructed depending upon the clinic type, patient questionnaires were translated
into Chinese and all surveys were to be planned to be read aloud to the participants with their responses audiotaped and transcribed. These realizations led to the decision to perform a second pilot of the survey. In addition, I increased my participant observer role at the DSGS without a clear rationale for the many fieldnotes except an intuitive sense that this knowledge was increasingly important.

Phase 6 (Winter 1995-Spring 1996) was a time that I performed my second pilot activities with a more diverse group of participants--including unilingual Chinese (with an assistant). From a positivist perspective, the survey posed many challenges that I theorized to be due to language differences, differing cultural perspectives, and the inexperience of abiding by the tacit 'rules' of completing such instruments. My response to these challenges in the field better reflected those from an institutional ethnographic standpoint. I acknowledged the enthusiasm with which many participants responded to my questionnaire. Against the rules of survey completion, I encouraged them to share their stories and perspectives with me. These interviews were taped and transcribed with the survey requirements placed in the background (although these were completed to the best of my ability during the interviews). My activities at the DSGS continued to be varied and documented as fieldnotes.

During Phase 7a (Fall 1996-Fall 1997) I 'entered' the survey 'data' onto a statistical computer program. Coupled with the multiple sources of knowledge I was acquiring about the relations between people with diabetes and doctors in Singapore, I held fast to my intention of revising the second piloted questionnaire to an improved version that I would use in the real study. At the same time as above, I undertook an increasingly critical perspective of my participant observation of the DSGS (called Phase 7b). It was at this time that my sources of knowledge and what I took to be institutionally valid sources of knowledge created a bifurcation of consciousness that I could no longer ignore. I undertook a fundamental reorganization of my data as part of my epistemological 'conversion' to the critical approach of institutional
ethnography. In my journal, now summarized in Appendix A, I describe gestalt-like experiences that ultimately precipitated a personal type of “paradigm shift” (Kuhn, 1970, pp. 108-110).

My worldview, upon analyses of my experiential data, changed from a reductionistic one that embraced an objectified form of knowledge acquisition to one that does not presume an omniscient investigator nor universality of research findings. The epistemological basis of my inquiry became one that explores the social from a particular place within existing relationships. Thus, I am not neutral in this endeavour and take care to locate my place, including degree of able-bodiedness and level of socioeconomic privilege and race within the inquiry. I do not assume to achieve objectivity nor intend to be ‘the’ overriding expert. My role as the investigator is to organize the multiple shared perspectives of participants and to relate their social experiences to relations of ruling.

2. **Original grounded theory approach**

The problem I intended to research in 1993 was the specific nature of patient-doctor interaction; I intended to do this by focusing upon patients with a particular chronic condition. My initial hypothesis was that physicians’ professional relationships with their chronically ill patients would be more strained than with those clients who presented with acute illnesses. I argued in my thesis proposal that there were two fundamental reasons accounting for this strain. The first had to do with the relatively high level of social-psychological stress associated with living with a health condition that did not go away. I anticipated that these patients might expect their physicians to assist in their managing these increased stress levels by curing the offending chronic illness.

In my original proposal, I suggested that the idea that curing is expected might also be found within medical schools themselves, as Western physicians are taught to view health through a biomedical lens derived from an acute-care paradigm. Clarke (1996) defined this
medical model as the belief that "disease...[is]...an objectively measurable pathology of the physical body, which is the result of the malfunctioning of parts of the body. Cure is through chemotherapeutic, surgical, or other "heroic" means" (p. 303). Implicit in this reductionistic approach to health is the view that physicians ‘fail’ when they are unable to ‘cure’ the patient. A chronic disease, by definition, is a physical condition that cannot be sufficiently removed by a biomedical approach to health care. I had postulated that the limitations of the practice of Western medicine might be perceived either at a conscious and/or unconscious level as physician failure and thus produce strain in the interactions between doctors and their patients.

In my thesis proposal, I theorized that there were two fundamental mismatches between the chronically ill patient health care demand and health provider services. First, there would likely be a generalized heightened patient frustration level associated with living with a chronic condition. Second, there might be the unrealistic expectation that the physician should be able to cure the patient. I maintained that this pressure to cure might be at an unconscious level and might originate from both the patient and the physician. The strains on the relationship warranted investigation with the goal of finding ways to reduce them. I postulated that this reduction would improve the relationships between physicians and their chronically ill patients.

3. Inconsistency between epistemology and field experiences

I had originally planned to adapt my MS inquiry to Singapore. I intended to examine similar types of patient-doctor interactions by using constant comparative methods advocated by grounded theorists, Glaser and Strauss (1967). My proposed research included a combined use of methods, an example of triangulation, to obtain more reliable and valid information on the phenomenon. I chose to simply change the type of chronic condition within my inquiry from MS to diabetes as a result of my exploration within the field and information from key informants.
I used both qualitative and quantitative methods in Singapore. As a new expatriate, I engaged in many life activities that felt foreign. I kept fieldnotes and reflected upon these experiences both informally in my journal, through the internet with my OISE supervisor, and more formally through papers presented at qualitative research conferences. I became a participant observer at a support group for diabetics who required insulin (a minority within the diabetic population) and kept fieldnotes of these experiences and observations. These participant observations were intended to facilitate the adaptation of my proposed research. I learned more about diabetes and the experiences of living with this chronic condition. I also developed relationships that I expected would help with my “accessing the field.”

I designed and twice piloted a survey that examined patients with a particular chronic condition and their relationship with their physicians. At the time, I did not question the difficulties that I had with the survey instrument as being due to its extra-local nature. I was driven instead to ‘adapt’ my survey to the Singapore culture.

The survey results were intended to be the basis of in-depth follow-up interviews with participating physicians and patients. I expected that my qualitative data analyses would result in emergent theoretical categories. These would have directed my future sampling choices until I was assured that I had reached a theoretical saturation for these “grounded” explanatory categories. The “theoretical sampling” would have helped ensure a kind of scientific rigor for my study that I would have argued to be as ‘objective,’ or ‘value free,’ as possible. These efforts were intended to have contributed to pre-existing theory advocated within intelligentsia regarding how, and why, doctors and their chronically ill patients typically interact.

I had unquestioningly accepted the necessity (and possibility) of investigator neutrality. I had learned many strategies to best collect as ‘objective’ data as possible throughout my hard and social science academic experiences at the various learning institutions I have attended. I was taught at OISE ways to design a doctoral thesis that would reflect this underlying
institutionally-sanctioned epistemology. Throughout my formal education I had not been made aware, or could not grasp, other scholarly ways of conceptualizing social life. I did not question the institutional and professional ideologies of Western academe nor understand that I was reproducing these in Singapore.

Guba and Lincoln (1994) state in their discussion of competing research paradigms that

[q]uestions of method are secondary to questions of paradigm, which we define as the basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways. (p. 105)

In my proposal, I argued that my methods were reasonably value-free. My original research was intended to best discover social variables which influenced the ‘true,’ universal, nature of health professional interactions. My inquiry was intended to be as objective as possible and my findings as independent of confounding variables such as ‘culture’ as possible.

I see in hindsight that my intuitive responses provided better insights into professional-patient relationships than rigidly adhering to the rules of consistency and objectivity required of quantitative methodologies. I experienced a disjunction between academically sanctioned quantitative methods and the unexpected responses of participants taking my survey. The people to whom I was introduced in Singapore wanted to share their stories in their own fashion. My survey work reached a crisis when I realized that it was not workable in any quantitative sense. My series of quantitative research experiences ultimately led me to question these institutionally encouraged ways of acquiring knowledge.

My fieldnotes and journal entries associated with the above disjunctures are considered data and are critically examined in this thesis. That is, I considered my personally lived, everyday research experiences to be data which were used to derive a second institutional ethnography, or subtext, of my reproducing many of the discourses of intelligentsia found within
Western academia. After becoming familiar with Smith's method of institutional ethnography, I realized that I was reproducing these scholarly relations of ruling, that is, scientifically-accepted approaches were the best ways to arrive at valid sources of knowledge. Subsequent to this, I reframed my research activities and rejected the aspects of my quantitative methods that were not working.

4. **Contextualizing myself to the inquiry**

One of the most powerful life lessons I have had to re-learn as an expatriate living in four foreign countries over eight years (Belgium, Singapore, Hong Kong and the U.S.) was that not all people think, experience, or view life the way that I do. It was only when I was no longer living in Canada that the experience of "being a Canadian," or a white "Westerner" became increasingly self-evident.

I discovered that my personal set of 'universal' truths that I had unquestioningly accepted were just that: personal. Other groups of people did not necessarily subscribe to the same set of truisms; their historical backgrounds, cultural experiences and day-to-day lives were often quite different from my own. An increasingly important aspect of my adaptation to life in a foreign country depended on my degree of understanding of both my own, and host's, social and historical context. Living and engaging in social research helped facilitate a keener awareness of my own cultural biases. I am situating myself in this dissertation, in a critical theory fashion, as an embodied investigator from a different race, culture, and often, socio-economic group from those I am studying. I do not profess to be 'disinterested' or 'value free.' I do not wish to essentialize the experiences of my participants. I do not know what it is to be a Singaporean with diabetes.

I acknowledge the privilege afforded me as a consequence of my whiteness. In a society where many consider Westernization as synonymous with modernization, I was clearly a
part of this money-generating culture-changing Western influx into Singapore. My Chinese-Canadian partner recounted examples of feeling that he was granted certain business advantages as a result of his Western passport. I reflected upon the varying influences that my being a white, Western academic had upon my being accepted by these physicians and people with diabetes. I do not know if positive research experiences were more a function of my being introduced by an esteemed professional or whether his choices of professionals influenced the results. They may have been influenced by my—although not always—positive status as a Canadian expatriate. Perhaps it was genuine interest in my research (which was the message that I received by the participating doctors). Whatever the explanation, it was privilege.

McIntosh (1990, p. 9) states that only white people are born with an “invisible knapsack” filled with a collection of various social privileges. These social advantages may be “unpacked” and used to facilitate life’s challenges as needed. This metaphor helped raise my consciousness to privilege. Although McIntosh (1990) is speaking of a North American context, her argument is relevant to the situation of colonizer and colonized.

My partner’s impoverished childhood and racist experiences in east-end Montreal had been, since 1974, infrequent topics of discussion in our marriage. In Singapore, when I began asking my partner his opinion regarding white privilege, I heard responses that made me realize that I was only “scratching the surface” of what it means not to be white and middle class. As McIntosh (1990) suggested: “I began to count the ways in which I enjoy unearned skin privilege and have been conditioned into oblivion about its existence” (p. 7). bell hooks (1994) states that it is an “historical moment when one begins to think critically about the self and identity in relation to one’s political circumstance” (p. 47). I now believe my conscientization (Freire, 1970/1997) was an integral part in my receiving enormous help in accessing the field, and securing the trust (and friendships) of many of the participants.
My inter-racial marriage seemed to be viewed in a positive fashion, although staring and occasional pointing to my family and myself in public was at times annoying. This seemed to happen less and less as my stay in Singapore progressed. Perhaps I no longer noticed or maybe the increased number of ex-patriates flooding into the area in the middle 1990s made my situation more commonplace. I became aware of more inter-racial marriages and my eldest daughter confided that she was identifying more with the experiences of Eurasians, as the expatriates were termed at her school, than either Caucasians or Chinese people.

Some inquiry participants seemed pleased that my partner was Chinese. Typically, I receive many personal questions. In Singapore I did not detect any social negativity as a result of my race beyond being teased by local Singaporean friends about my relatively large body size. I mostly noted a positive, but distinctly surprised, reaction when they discovered my partner was Chinese.

By marrying and having children with a Chinese person, I had perhaps ‘proven’ a kind of respect for the culture. I do not know. It was as if I had earned a sort of ‘extra collegiality’ that meant I was somehow distinct from most other white individuals. Given Singapore’s colonial history and the elite Caucasians that inhabited Singapore, coupled with my observations that most ex-patriates that I knew kept to themselves and did not foster personal relationships with local people, I am not surprised. I learned to casually mention my mixed-race family early in participant relationships as it was a useful icebreaker in my research.

This acceptance was not always my experience in Canada and I have encountered subtle forms of racism from the white community—social nuances that communicated to me that I might have chosen a more suitable partner. Within the Chinese Canadian community, during the late 1970’s, I was not welcomed. My in-laws-to-be were overtly distraught at our wedding plans but have since been very welcoming. Today, my children and I are cherished members of our extended Chinese-Canadian family.
During my research in Singapore, I was at first concerned that my white status may have worked against me as I was not an insider and could be seen as a potential threat. My presence might have, I thought, triggered resentment regarding Singapore’s ‘modernization.’ Ng (1998) reinforces the connection between colonialism and racism:

Racism (that is, the ideology of the superiority of one race over another) was used to justify the subordination of groups seen to be inferior. Thus, racism encompasses both the ideology and practice of inferiorizing groups of people on the basis of their perceived racial differences. (p. 23)

Perhaps certain resentments were historically linked to life under colonial rule. I thought that these negative feelings might appear when Singaporeans associated with Caucasians in contemporary Singapore. Or, I thought, perhaps the present Peoples Action Party (PAP) regime had facilitated a conservatism based upon authoritarianism so that people were wary of revealing anything to strangers. My continued experience was that strangers were reluctant to engage in conversation. Properly introduced individuals did not have this same guardedness, with many being quite enthusiastic and informative.

I had certain negative experiences while living in Singapore that led me to be concerned about the effect of my race upon my research plans. Other ex-patriates and I shared stories about situations in which local people would not speak with us. For example, in one case a woman literally ran away when I, a stranger, asked her for direction at a street corner. Another time, when my dog was collapsing in the heat and I called out to a woman for help, she looked away and crossed the road. Perhaps she was afraid of my dog. It is possible that these were examples of the impersonality of a hurried big-city life, although my sense was that avoidance was due to my race. Maybe the people who were reluctant to speak with me were reacting to my Western status, and the associated Westernizations of Singapore, in a different, albeit negative way. It may have been due to their concern that their English was sub-standard and that they might “lose face” if they spoke with me.
Some of my inquiry participants were unilingual Chinese and were interviewed by my assistant in my presence. Many of these typically elderly people ignored me altogether and paid close attention to my assistant. I assumed it was based upon our language, cultural and working class differences and that deference to higher status might have been at play. I do not know for sure. I did, however, always, without exception, receive a surprised—followed by a pleased or amused—reaction when I spoke a few words of thanks in Mandarin. The feedback regarding this phenomenon from my key informants was that most Westerners still do not bother learning any of the local languages. I showed respect for their culture even with my most effortless attempts to speak a few Mandarin phrases. I believe my enthusiasm and my non-Singaporean status rendered me forgiven for many social blunders. My assistant also shared with me that she found mentioning that I was married to an ethnic Chinese man helpful in securing participation in my inquiry activities. Overall, the feedback throughout the study was that I was an atypical Westerner and full of surprises.

IV. Language and Interaction in Singapore

1. "Face" in Singapore

I frequently broke unwritten social rules and experienced the negative effects associated with a Singaporean losing face during my first year or so in Singapore. Prior to my move, I would have argued that I had fully understood and anticipated this social phenomenon of face. I expected it to be synonymous to the social relations surrounding the phenomenon of mild insult or affront which I had experienced as a Westerner. Instead I learned that it was a powerful aspect of culture which could not only limit my access to the field but potentially influence my ability to maintain the interest and co-operation of the participants.

Craig (1993) defines face as
the measure of one’s internal quality, status, good name, and good character, but it is much more than personal pride; it involves the entire group (the family, the school, the neighbourhood, the work place, the city, and the country). Face keeps relationships intact. It preserves group harmony, and it promotes group solidarity. It measures the social standing of the person with the group—and the social standing of the group too.\(^\text{13}\) If one person loses face, the whole group loses face, so it is much deeper and stronger than a simple personal embarrassment. (p. 58)

This social phenomenon is not exclusive to Singapore (or Asia) but it seemed more important in this Republic than in white Canada. My understanding of the meaning of face had an influence on how I conducted my interviews. I learned to accept answers that often made no sense to me or that might be interpreted as evasiveness. My experience as a Westerner is that if a conversation (or interview) makes little sense, the confused party asks clarifying questions or repeats the question in the hope of a better understanding. But I discovered that if my Western perception was that a person was being evasive, it would be inappropriate for me to make this evasiveness public, as this would cause the person to lose face.

I reflected in my fieldnotes my understanding of the social processes that were occurring when I experienced communication difficulties in booking an appointment:

When I stated that I would like to make our meeting in January as I would be out of town the next week and that the holidays would soon be upon us I, again, felt this hesitation, this lack of communication. Was she baffled by my seemingly simple request? Perhaps she thought I was rude by not arranging my schedule to better suit her employer’s. I have learned by experience that to try and address the misunderstanding and try and get at the source of the difficulty, often precipitates further difficulties! If I communicate any level of frustration I sense a withdrawal from them, as if I have lowered myself to an individual not worth the time to bother talking to at all. (Fieldnotes, January 10, 1995, p. 6)

Another example documented in my fieldnotes occurred when I was making my interview scheduling arrangements with a PC doctor:

I [told him that I] wanted to come on a quiet time, like today, as well as a busy Monday or Saturday morning. He smiled and didn’t respond. I said “of course I may not be able to during this pilot part but hopefully sometime during my study I would be allowed access at these busy times.” He smiled but did not respond. (Fieldnotes, April 3, 1996 p.4)
I knew not to push further. This doctor would have lost face if he had overtly refused me unlimited access to his clinic and I would have probably discovered that I had done something wrong.

I have found that Singaporeans, as in the West, could appear evasive if they did not understand what I was saying. They would lose face if they were not seen as intelligent enough, or fluent enough in English, to understand what was being asked. A variation of this occurred when I appeared to make no sense to them—which was different from not understanding the words that I was saying—and they became uncomfortable. I theorized that this lack of social comfort was a form of loss of face because the Singaporean was reluctant to point out my confusion—this would bring about a loss of my face.

This type of miscommunication happened to me many times with repair people at my apartment during my first few months in Singapore. I would discover, after the fact, that whatever I was asking of them might have been logical in Canada but was not in Singapore. I would sense withdrawal but would rarely be told that whatever I was asking made absolutely no sense in Singapore. Many times I would only have insight into these social dynamics a year or two later using the perspective of experience.

Dr. Sykes, a physician from England who was practicing in Singapore, explained to me that paraphrasing your question with a tone that indicated it was a new question was a communication technique which had helped her in the clinic. She said:

Chinese Singaporean[s] cannot be overtly “wrong” in a conversation as they would lose face. She quickly added that this does not mean one cannot sway their “wrong” opinion. Not at all. Rather, the talent lay in successive statements with which the individual can agree all the while leading to a “logical” conclusion—the very point you were trying to make—where everyone can comfortably agree. (Fieldnotes, January 10, 1995, p. 6)

She found that her patients would not lose face and be forced to admit that they did not understand. Although manipulative, this approach was presented as being a useful tool in
communicating with local patients. I discovered it to be a useful, 'last chance' approach when
dealing with miscommunications in Singapore. The drawback has been that it takes more time to
communicate effectively. The result can be a kind of 'floating about' in a sea of wordy
nonsensical discourse or segments of silence.

2. **Singlish: What is it?**

I learned of the term "Singlish" shortly after my arrival in 1993. I misunderstood the
term to mean a style of speaking, an accent which could be easily interpreted with practice. Some
describe Singlish as a unique form of English in the same way that a New Yorker speaks
differently from a Torontonian. Travel books and "how-to-live-in-Singapore" ex-patriate
manuals often refer to the existence of Singlish with vague pejorative tones. In this way I
maintained the belief that Singlish was "only" an accent.

During my first year I became increasingly aware that Singlish was a dialect of
English which was steeped in Singaporean culture. Negotiating appointments with physicians
and interviewing elderly people with diabetes regularly met with assorted miscommunications. It
became apparent to me that if a working-class person could speak English it would be Singlish.
An educated person could usually speak Singlish but only in a relaxed informal setting--and
typically not to Westerners. In this context, Singlish follows the same rules as slang usage in
English.

With practice, I became better sensitized to the possibility of multiple meanings
assigned the same English word or phrase. I worked at remembering, during my interviewing, to
ensure that participants were indeed saying what I was interpreting them to say. I also attempted
to catch myself before I unwittingly spoke any Singlish, for I did not want to offend any
individual. Later, when listening to my tape-recorded interviews I could hear the Singlish in my
nuances. I also marvelled at what I understood during the interview as my present-day Singlish skills have declined.

I experienced Singlish to be a kind of condensed form of English reflecting the “to the point” structure of Malay and Chinese. Shelley (1995) states:

Singlish is definitely not a pidgin. It is the English language with the sound of the Malay and Chinese tongues; it has the fundamental form and structures of the English language with a few aberrations of grammar and often with improvements to its parent. . . . (p. 110)

Once I was more familiar with its usage, I found it to be an efficient communication tool.

Some examples of Singlish include the terms “again” or “say again” which translate to “I beg your pardon” or “excuse me.” Another commonly heard term was “lah.” It has no overt communication purpose and is usually attached to the end of phrases as “eh” is similarly used in Canadian English. I noted that the more relaxed or familiar an educated Singaporean appeared with me the more “-lahs” crept into his or her speech. The use of this expression can be highly distracting especially when a Westerner is working hard at deciphering the accent. With practice I learned to ignore “lah” and concentrate on the message content.

Certain terms often contain more information than what a Westerner might expect. Examples of this are the terms “can” and “cannot.” Shelley (1995) points out that

[n]ewcomer[s] to the region should be aware of its relaxed and imprecise use. If it is used in answer to the question “can you fix my car radio” [and the response is “can”] it could mean that the responder can actually do it, but it could also mean that the technician does not want to displease you and though he’s not quite sure, he’s going to have a go at it. (p. 33)

The most challenging aspect of Singlish for me was its linguistic structure. An example of was interviewee misuse of the continuous tense. An example of this, “I am having a gastric ulcer” might be argued as more accurate than English, but it was confusing to me in the context of participants sharing the history of their illness. Another grammatical challenge was the misuse of the pronouns “he” and “she.” For instance, “She asked the woman if he could buy
them lunch.” I have found this practice coupled with the misuse of the continuous tense, especially challenging to decipher the person’s meaning without any loss of face.

Examples such as these presented me with many communication obstacles. I found these experiences to be more than a simple language challenge. Clashes of expectations in interactions during my first year in Singapore, coupled with my lack of Singlish skills, often prevented me from truly understanding, and being understood by, many Singaporeans.

V. Methods Used in this Research

1. Participant observation, interviews and document review

The methods I used in my critical contextualization of the relationships between Singaporeans with diabetes and their doctors include participant observation, interview and document review. These methods are regularly used in institutional ethnography. I was a participant observer of the Diabetic Support Group of Singapore (DSGS) for three years. I attended various meetings, public functions and retreats. I usually took detailed fieldnotes either during the activity or afterwards at home. Throughout these three years I engaged in both formal and informal interviewing of DSGS members as well as the associated health professionals who were also members. The formal interviews were taped and transcribed.

In addition, I formally interviewed people with diabetes who were not members of the DSGS at three different primary care clinics. Their doctors, who were also formally interviewed, recommended these individuals. I did not speak informally with any people with diabetes who were not members of the DSGS, but did have frequent informal discussions with different physicians. Fieldnotes were taken during these conversations. All formal interviews were taped and transcribed.
Another research method used to make visible the ideological aspects of ruling relations is detailed examination of associated texts. I examined locally produced literature from within the medical academic community regarding diabetes and doctor-patient communication. In addition, I collected articles throughout four years from *The Straits Times*, an English language newspaper on any health or health care related topic. These articles are considered to be data documenting the ideology of the government of Singapore. I also include as data the political perspective of former Prime Minister Lee Kwan Yew from his approved biography by Kwang, Fernandez and Tan (1998). An autobiography of a Singaporean with diabetes who poignantly examines her life during the first few months after being diagnosed with insulin-dependent diabetes mellitus (IDDM) is also critically examined (Poh, 1995). This is not presented as detailed textual analysis but rather is provided as a context for my inquiry.

2. **Participants and confidentiality**

To ensure participant confidentiality within the thesis, I use pseudonyms to identify key informants and inquiry participants. When the focus is upon their social role and/or how I came to meet them, I take precautions in order to secure their anonymity. I make some modification to their assigned pseudonym when describing the contextualizing features of our meeting or their particular roles within the Diabetic Support Group of Singapore (or health care community). This is to avoid linking confidential opinions provided in other areas of the thesis to contextualizing features that might reveal the identity of the participant. Table 2 contains a list of pseudonyms organized according to the various types of participants. Names are placed in categories in order to provide background information about particular participants. Categories are given a general title when the number of participants are few and when they might otherwise be identified within Singapore’s relatively small health care community.
Table 2

List of Cited Pseudonyms According to Participant Category type

<table>
<thead>
<tr>
<th>“Types” of participants:</th>
<th>Pseudonym2</th>
</tr>
</thead>
<tbody>
<tr>
<td>“specialist”</td>
<td>Dr. Lee*</td>
</tr>
<tr>
<td>(endocrinologists, medical academics and MOH physicians)</td>
<td>Dr. Chua*</td>
</tr>
<tr>
<td></td>
<td>Dr. Tang</td>
</tr>
<tr>
<td></td>
<td>Dr. Teo*</td>
</tr>
<tr>
<td></td>
<td>Dr. Ong*</td>
</tr>
<tr>
<td></td>
<td>Dr. Kong</td>
</tr>
<tr>
<td></td>
<td>Dr. Lip</td>
</tr>
<tr>
<td></td>
<td>Dr. Hum*</td>
</tr>
<tr>
<td></td>
<td>Dr. Sim*</td>
</tr>
<tr>
<td></td>
<td>Dr. Chin*</td>
</tr>
<tr>
<td></td>
<td>Dr. Yong*</td>
</tr>
<tr>
<td>“Health care professionals”</td>
<td>Lai Sim</td>
</tr>
<tr>
<td>(nurses, and diabetic nurse educators who are not affiliated</td>
<td></td>
</tr>
<tr>
<td>with the DSGS)</td>
<td></td>
</tr>
<tr>
<td>“General practitioners”</td>
<td>Dr. Sykes</td>
</tr>
<tr>
<td>(private or public primary health clinics)</td>
<td>Dr. Chiew</td>
</tr>
<tr>
<td></td>
<td>Dr. Shih</td>
</tr>
<tr>
<td></td>
<td>Dr. Zhong</td>
</tr>
<tr>
<td>“Diabetic Support Group of Singapore health professionals”</td>
<td>Sue*</td>
</tr>
<tr>
<td>(general practitioner, three nurses, podiatrist, dietician,</td>
<td>Paul</td>
</tr>
<tr>
<td>and social worker who are closely affiliated with the</td>
<td>Sasmam</td>
</tr>
<tr>
<td>support group)</td>
<td>Yew Soon*</td>
</tr>
<tr>
<td></td>
<td>Wai Mun*</td>
</tr>
<tr>
<td></td>
<td>Janet*</td>
</tr>
</tbody>
</table>
### "Diabetic Support Group of Singapore members"

(includes those people with diabetes who directly interacted with me or I named in my fieldnotes)

<table>
<thead>
<tr>
<th>People with Diabetes</th>
<th>Nancy*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orchard Road Type</td>
<td>Jane</td>
</tr>
<tr>
<td></td>
<td>Kate*</td>
</tr>
<tr>
<td></td>
<td>Mr. Aw*</td>
</tr>
<tr>
<td></td>
<td>Vivienne</td>
</tr>
<tr>
<td></td>
<td>Emma*</td>
</tr>
<tr>
<td></td>
<td>Gary</td>
</tr>
<tr>
<td></td>
<td>Yee Pak</td>
</tr>
<tr>
<td></td>
<td>Emily*</td>
</tr>
<tr>
<td></td>
<td>Jia Ling*</td>
</tr>
<tr>
<td></td>
<td>John</td>
</tr>
<tr>
<td></td>
<td>Lin Yee*</td>
</tr>
<tr>
<td></td>
<td>Pauline*</td>
</tr>
<tr>
<td></td>
<td>Gopal*</td>
</tr>
<tr>
<td></td>
<td>Anna*</td>
</tr>
<tr>
<td></td>
<td>Hope*</td>
</tr>
<tr>
<td></td>
<td>Sarah*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People with Diabetes</th>
<th>Mr. Salleh</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDB Type</td>
<td>Mrs. Ng</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People with Diabetes</th>
<th>Mrs. Lee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polyclinic Type</td>
<td>Mrs. Goh</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People with Diabetes</th>
<th>Mr. Kausalya</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mr. Hu</td>
</tr>
<tr>
<td></td>
<td>Mrs. Chen</td>
</tr>
<tr>
<td></td>
<td>Mr. Lau</td>
</tr>
</tbody>
</table>

1 This is not a comprehensive list of all participants. These include only those which were cited in the dissertation.

2 Certain participants were given two pseudonyms to ensure that contextualizing features were not cross-referenced to interview contents. These pseudonyms are flagged with asterisks (*).
The category “specialist” includes endocrinologists, medical academics and Ministry of Health (MOH) physicians. The “health care professionals” category refers to participating nurses and diabetic nurse educators who are not affiliated with the DSGS. The “general practitioners” category includes those who practice in either private or public primary health clinics. The “Diabetic Support Group of Singapore health professionals” category refers to the general practitioner, three nurses, podiatrist, dietician, and social worker who are closely affiliated with the support group. “Diabetic Support Group of Singapore members” includes those people with diabetes who directly interacted with me or who are named in my fieldnotes. Another example of a general category used to ensure anonymity is the reference to the Caucasian American, Canadian, Australian and British ex-patriate participants as all being “Western.”

I chose the more personal pseudonyms to be consistent with participant ethnicity, and level of social formality that I encountered in the inquiry. For instance, Dr. Lip is coded as a specialist, addressed as “doctor” and given a Chinese family name. The use of Christian names, such as Linda, is common and is thus included here. The sex of the pseudonyms is also representative of the number of men and women in the study, but may or may not accurately reflect that of specific participants, as a further measure of confidentiality.

VI. Summary

This research is guided by the theoretical framework of Smith’s alternative sociology and Freire’s writings about the agency of oppressed groups. Freire’s view of localizing the oppressor outside of the individual resonates with Smith’s idea of problematizing the disjuncture between experience and the discourses of ruling. In my research, I begin with the experiences of
diabetic patients and self-help group members and explore the disjuncture between these experiences and those of the Singaporean government and spokesmen for biomedicine.

In this chapter, I summarized the process through which my consciousness was raised about my particular location with respect to my research; through critical autoethnography, I was able to move away from a grounded theory approach to the critical methodology of institutional analysis. My institutional analysis of biomedical relations of ruling in Singapore is based on participant observation, biomedical and newspaper document analysis and interviews with patients and diabetic self-help group members. A second institutional analysis of Western academic relations of ruling as I experienced them is contained in the critical autoethnography in Appendix A. Important in my consciousness-raising as described here was my appreciation of the importance of ‘face’ in Singaporean society and my location vis-à-vis the participants in my research. My difficulties with language were also outlined in this chapter. Finally, my informants were introduced and the ethical precautions that I followed in citing their interviews were described here.

Chapter Four provides a historical context for the results of the participant observation, interviews and document analysis which appear in Chapters Five and Six.

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1 Positivism is a paradigm that assumes an apprehendable reality that is “driven by immutable natural law and mechanisms” (Guba & Lincoln, 1994, p. 109). Postpositivism assumes reality to exist but that it can “be only imperfectly apprehendable because of basically flawed human intellectual mechanisms and the fundamentally intractable nature of phenomena” (Guba & Lincoln, 1994, p. 110).

2 Original author’s emphasis.

3 McCoy, 1999, p. 250.

4 Original author’s emphasis.

5 Original author’s emphasis.

6 Original author’s emphasis.

7 Original author’s emphasis.

8 bell hooks does not chose to capitalize her name.

9 I provide a detailed critical autoethnography in Appendix A.

10 These eight phases were linear except for phases seven and eight which occurred during the same time period (Fall 1996-Fall 1997).

11 My husband’s mother tongue is Toisan and Cantonese. Today he speaks fluent English and is functional in French and Mandarin. He learned Mandarin in Singapore from our family tutor and through his many travels to Tai Pei, Taiwan and Beijing, China.

12 Although in my experience, inter-racial couples were more often composed of Asian women and white men.

13 Original author’s emphasis.
CHAPTER FOUR
SINGAPORE'S POLITICAL SYSTEM IN A GLOBAL CONTEXT

I. Introduction

The purpose of this chapter is to sketch the unique socio-political history of this tiny island state. I will argue that Singapore's current relatively Westernized orientation compared to other Asian countries is related to its unusual history. I discovered two contrasting texts that provide perspectives of Singapore's political system. The approved biography of Singapore's ex-prime minister Lee Kuan Yew by Kwang and others (1998) contains many original speech and interview transcripts. It describes and provides a rationale for government actions throughout Singapore's then 33-year history as an independent state. The biography also responds to external criticisms of the Singapore government made mostly by the West. Contrasting with this source is Tamney's book, The Struggle over Singapore's Soul (1996), which is a critical account of Singaporean society by an American sociologist. It is part of an "international and interdisciplinary book series" published in the West, and is based upon eight years of research while the author was employed at the National University of Singapore. This book was comprehensively critiqued in the book review section of The Straits Times by a visiting doctoral student at the Institute of Southeast Asian Studies (Gomez, 1997). Gomez is a student of the Department of Political Studies at the School of Oriental and African Studies in London who claims that his book is a "fairly accurate account of politics and society in [Singapore]" (p. 25). The book's author, Tamney, is currently re-patriated and a faculty member of Ball State University in Indiana.

I found the descriptions of events in these two books, although originating from such differing perspectives, relatively congruent. Thus these two references are key in my description of Singapore's history and political regime. I include Lee Kuan Yew's rationale in an effort to
minimize an exclusively Western-centric orientation but also to identify key aspects of the Singaporean political context for my observations in the chapters that follow.

I also include, in the third section of the chapter, qualitative data that illustrates discourses about the ‘non-Western-like traits’ of Singaporeans. These are presented in order to contextualize the analysis of social relations in Singapore, which appear in the last section of the chapter. As this chapter will illustrate, the history and government activities of the Republic are relevant to my research. These aspects of context are necessary to the central purpose of the thesis, that is, a general, and historically inclusive, contextualization of the relationships between people with diabetes and their doctors as well as the activities of the DSGS during the period of my inquiry. This contextualization also serves as an illustration that Singapore is neither a completely Western nor Eastern society (Tamney, 1996, p. 82). The chapter concludes by briefly describing and critiquing the health care system in Singapore.

II. Geography

Singapore is a small island republic situated in the rain forests of Southeast Asia 137 kilometres north of the equator. Tamney (1996) describes it to be “an island city-state, about three times the size of Washington, D.C.” (p. 1). It is located at the southern tip of the Malaysian peninsula to which it is linked by a kilometre-long causeway. It is 13 time zones ahead of Toronto and has approximately 12 hours of daylight per day regardless of the season. Singapore is located outside of the ring of volcanoes around the Pacific Ocean called the “Pacific Rim of Fire.” Consequently, Singapore does not experience the frequent and costly natural disasters such as earthquakes, volcanic eruptions and high typhoon winds of nearby Indonesia or the Philippines.
The 647.5 square kilometre republic (including the surrounding tiny, often uninhabited islands) is a busy seaport. Today, Singapore has a skyline symbolizing its economic success within the extra-local relations of a Western driven capitalistic marketplace. A 1996 government publication states that

the World Bank classifies the population as “one hundred per cent urbanised.” Almost 90 per cent of the 2.99 million people live in high-rise housing estates on one-sixth of the country’s available land.” (Singapore Ministry of Information and the Arts, 1996, p. 3)

This urbanization and economic development has occurred rapidly since 1965 when Singapore obtained sovereign nation status. Tamney (1996) quips: “When I first lived there beginning in 1968, Singapore was a poverty-stricken country. Today it is a land of Gucci” (p. 1). The requirements of consumerism within a capitalistic society are well met in Singapore.

III. History

1. From British colonialism to Lee Kuan Yew’s government

It is important to contextualize present-day Singapore historically to demonstrate that, although apparently quite Westernized on the surface, it remains Eastern. Singapore’s history is unusual given its small size, its recent, and rapid, economic development and its multi-racial and multi-ethnic origins.

Singapore’s recorded history, before its colonization by the British in 1819, is sparse, but its economic and political ties to the United Kingdom have been important:

When Sir Stamford Raffles first set foot on Singapore in 1819 it was a quiet Malay fishing village with no more than 150 inhabitants. From its early colonial days as a trading post, Singapore has undergone a remarkable change to become a bustling metropolis of nearly 3 million people. (Seow and Lee, 1994, p. 149)
Singapore was a trading station for the British East India Company and was leased from local Malay rulers. In 1824 the country was under the exclusive control of the British. Its attraction was economic as it had a strategic shipping location. It was located astride both the north-south seaway between China and the Indian Ocean/Cape of Good Hope route to Europe, and the east-West seaway between India and China or the Dutch East Indies. This provided the British with a valuable entrepôt port as well as a strategic location to capture a share of the rich East Indies trade. Its location also enabled the British to extend their rule over the Malayan states. (Tan, 1986, p. 43)

Initially, Singapore was unlike many countries subjected to imperialist control, as there were few indigenous peoples to oppress with Western economic and political power. Instead the multiethnic workforce was imported:

Immigrants from China and India, attracted by this island city, came to engage in trading activities; there was plenty of work for labourers, artisans, shopkeepers, farmers and domestic servants. ...It is also no secret that the British favoured the immigration of the Chinese, who were described by one source as “a hardworking and money-loving people.” (Tan, 1986, p. 44)

I find Tan’s above reference to the immigrant Chinese as “money-loving” pejorative. The use of this phrase illustrates how those in power viewed these individuals. This energetic pursuit of money is still an important feature of the national ideology upon which this capitalist state in Singapore was built. It is significant that this ‘money-valuing’ trait is seen by government as a Chinese, and not a Malay, characteristic.

Tan (1986) points out the “combined restraints of law, religion and family ties ... [as well as] the destruction with floods and famines, rampant in the mid-nineteenth century” (p. 43) were the cause of emigration from China. There were many different Chinese dialect groups immigrating to Singapore:

[A]nother significant characteristic was the divisive and fragmentary nature of the Chinese community. From various parts of the south-eastern provinces of China came Hokkiens, Teochews, Cantonese, Hainanese, Hakkas, and other dialect groups—with their own distinctive tongues and temperaments. Each
dialect group had its own customs and more, and was organized into a different occupational and class hierarchy. (Tan, 1986, p. 60)

But these Chinese people did not intend to permanently live in Singapore:

The Chinese emigrant was unique because he2 saw his departure as only a temporary solution to pressing poverty and deprivation at home. ...He did not judge himself by the standards of the society but by the standards and values of his homeland. (Tan, 1986, p. 47-8)

Singapore’s early lack of social integration may have reflected its many dialect groups. More likely, though, it was the result of socially oppressive British forces that did not make the new immigrants feel at home. Colonial rule continued until Singapore was occupied by the Japanese from 1942 until 1945, at which point Singapore became a crown colony. Singapore’s economic and political subordinate position had, once again, reverted back to Britain. There was, just prior to this, a large influx of migrants from China and the Indian subcontinent. This slowed down gradually, and the period of history around Singapore’s independence was characterized by a very young population, with those below 20 years of age making up 52.2 per cent of the population in the census year of 1957. (Seow and Lee, 1994, p. 149)

Singapore’s social demographics by the end of the 1950s were thus diverse, especially when the distinct differences between the numerous Chinese dialects are considered.

Singapore’s first prime minister, Lee Kuan Yew,3 was a survivor of World War II Japanese occupation who left Singapore to study law at Cambridge in England. In Singapore, Lee had been a part of the privileged class with many social and educational opportunities. It is likely that he led a relatively comfortable lifestyle when poverty was the norm in Singapore. This changed during the Japanese occupation. Later, in Britain, he experienced racism and, unlike in Singapore, he was not a member of the elite class nor was he part of the working class.

In Lee’s approved biography (Kwang et al., 1998) it is clear that his personal and contrasting experiences with oppression propelled his vision of an independent state. These
included his social oppression under the British throughout his youth and his horrible war experiences under Japanese rule, coupled with the realization, which came while he was studying at Cambridge, that the British are not inherently superior to Singaporeans:

It was in England that [Lee] began to seriously question the continued right of the British to govern Singapore. The Japanese Occupation had demonstrated in a way nothing else could have done that the English were not a superior people with a God-given right to govern.... [Lee is quoted as saying] “I saw Britain and I saw the British people as they were....[I]t was pretty tough. They treated you as colonials and I resented that. Here in Singapore, you didn’t come across the white man so much. He was in a superior position. But there you are in a superior position meeting white men and white women in an inferior position, socially, I mean. They have to serve you and so on in the shops. And I saw no reason why they should be governing me; they’re not superior. I decided, when I got back, I was going to put an end to this. (Kwang et al., 1998, p. 31)

Lee became Prime Minister when his People’s Action Party (PAP) won Singapore’s first general election in 1959. Britain had granted a degree of independence by this time, with the civil service gradually given over to local rule (Tamney, 1996). In Lee’s account, his divergent lifestyle experiences were the catalyst for his single-handed leadership of Singapore to independence and eventual economic prosperity.

2. **Singapore during the Lee Kuan Yew government 1959-1990: The People’s Action Party**

a. **Pre-independence**

Singapore’s rapid rise to its economic status as a newly industrialized economy caused it to be ranked (per capita) in 1996 as the ninth richest country in the world (Kwang et al., 1998, p. 83). Tamney (1996, pp. 173-181) views this as the result of Lee Kuan Yew’s “Asian-style” democracy—that is, its authoritarian application of the Western ideology of conservatism. The objective of this section is to briefly describe the activities of Lee’s government prior to Singapore’s independence in 1965 and social changes since that time.
The PAP was originally an alliance between Lee and his colleagues (the nationalists, who were English-educated professionals) and a leftist group, some of whom were procommunist (Tamney, 1996, p. 4). The PAP, under Lee’s leadership, negotiated Singapore’s independence from Britain in the period before 1965. The PAP’s goal during these first years was to create a democratic socialist state (Kwang et al., 1998, p. 78). This dissertation is not the venue to describe or analyze the complicated inter-relations between the Malayan Communist Party (MCP), communist guerrillas and the newly forming state of Singapore. It should be noted, however, that the late 1950s and early 1960s were not peaceful or politically stable in Singapore. There were public riots associated with the communist movement although the British prevented communist-influenced groups from gaining political power in the region (Kwang et al., 1998; Tamney, 1996). In Lee’s biography, the communist defeat is portrayed as a PAP victory. Lee’s political power grew:

The PAP’s defeat of the communists by a combination of force and the use of open argument ranks as one of Lee’s finest political achievements…. Lee’s political strength grew manifold. He and his colleagues could claim the moral and political authority to govern independent Singapore…. How Lee and the PAP defeated the communists and became political giants in the eyes of Singaporeans is hence of immense importance in understanding the history of modern Singapore and how it was able to make the transition from a political hot spot to one of the world’s most peaceful and stable countries. (Kwang et al., 1998, p. 60-61)

In 1961, within the PAP itself, there were difficulties that ended with “as much as 80 percent of the PAP [being] kicked out” or voluntarily leaving (Tamney, 1996, p. 5). The PAP, in the process of engaging in the aggressive management of its political opponent—including the “detention without right of trial of more than 100 leftists…had begun its public housing program and expansion of the school system” (Tamney, 1996, p. 5). Lee’s strategy of making significant economic improvements within the lives of Singaporeans while authoritatively
disarming his political opposition was probably a key reason that his actions met with little social criticism.

Lee subsequently successfully campaigned for a merger with Malaysia. There were disagreements regarding Singapore's financial contribution to the merger. As a result, “the two major races in Singapore” were in a “conflict [which] pitted the political leadership of Singapore against that of the federal government in Kuala Lumpur” (Kwang et al., 1998, p. 67):

In 1963 the PAP, with popular support, arranged for Singapore to gain independence from Great Britain and to become a part of Malaysia. This union lasted only two years. ...In 1965, Singapore was asked to leave... ...Race riots in Singapore in 1965 were blamed on Indonesian agitators. Anti-Chinese violence occurred in neighbouring Indonesia and Malaysia during the 1960s. During those years, and even in the following decade, the Singaporean Chinese felt threatened. ...After gaining power Lee abandoned the PAP's commitment not only to democracy but also to socialism. The party devoted itself to creating a society that would attract foreign investment. (Tamney, p. 1996, 6-7.)

The PAP ran Singapore's unicameral government without any effective and often no opposition. Its goal, upon achieving independence in 1965, was to design a society from the "bottom up" that would become a developed nation.

The economic ideology upon which Singapore was constructed is a microcosm of the relations of ruling in a globalized marketplace. The participation of Singapore in a Westernized marketplace illustrates a local application of the world-wide domination by capital. Singapore's reproduction of global ruling relations within its borders maintains extra-local power and subordinates the practices of Singapore's indigenous people.

b. **Authoritarian government and racism: "Democracy Asian-style"**

In his book, Lee is candid about his party's authority within Singapore and argues that this use of power was necessary for the country's rapid economic growth. Singapore's rise to
wealth from poverty "is attributed to [g]overnment planning" (Tamney, 1996, p. 59). Kwang et al. (1998) state that:

Despite the hard line he took with opposition figures in Singapore, Lee was to say often that he was not against the idea of a parliamentary opposition. ... [H]e would contend that those who aspired to the job in Singapore were not up to it. (p. 146)

Lee justifies his use of force in dealing with a particularly vocal political opponent by arguing that the maintenance of his modernizing national ideology required it. Describing his disposal of one opponent while still acting Prime Minister, he is quoted as saying:

There are two ways of playing this. One, you attack the policies; two, you attack the system. [This opponent] was attacking the system, he brought the Chief Justice into it. If I want to fix you, do I need the Chief Justice to fix you? Everybody knows that in my bag I have a hatchet, and a very sharp one. You take me on, I take my hatchet, we meet in the cul-de-sac....That kind of an opposition, if you do not check, it will degrade the system. (K.Y. Lee, cited in Kwang et al., 1998, p. 146)

Tamney (1996) points out that the Singapore government was, and is, "unusually powerful" (p. 195), with the ruling party "routinely [bringing] civil or criminal charges against opposition politicians" (p. 63). Canadian Judge Paul Bentley agrees with Amnesty International that there is a "disproportionate use of civil defamation suits by the government" and that the threat of defamation suits "affect[s] freedom of expression and peaceful democratic discourse" in Singapore (1997, p. 5). Tamney attributes the government's power to the "weak local bourgeoisie, Singapore's small size, the relative affluence of the population, the PAP's lack of corruption, and the Government's financial resources" (p. 195).

Lee claims the PAP's power was, and is, deserved and necessary to Singapore's continued economic development and he maintains that the elite PAP were, and remain, inherently the best people suited for the job. Lee made his elitist, paternalistic rationale clear throughout his years as Prime Minister. Regarding the differences between the abilities of the
races, Lee states: "I have said openly that if we were 100 per cent Chinese, we would do better. But we are not and never will be, so we live with what we have" (Kwang et al., 1998, p. 181).

The Singapore government does have a "Group Representation Constituencies" policy to ensure the representation of the minority races (Singapore Ministry of Information and the Arts, 1996, p. 51). This policy is intended to placate non-Chinese communities in the face of structural racial discrimination. However, the Chinese are favoured by being depicted as the major contributors to Singapore's economy.

Tamney (1996) elaborates on the construction of Singapore's national ideology built upon Lee's political conceptualization of Chinese culture:

Business and the [g]overnment value Chinese culture because, in their eyes, this culture embodies puritanism. Hard work is valued for its own sake, pleasure is denied, and discipline is the sign of being civilized. In addition the PAP includes a strong family and patriotism in its version of Chinese culture. (p. 167)

Although Singapore's population is 14.2 percent Malay and 7.2 percent Indian (Singapore Ministry of Information and the Arts, 1996, p. i):

The [g]overnment does not recognize anything distinctively Malay that is worthy of emulation nor does it acknowledge any profound conflicts between Malay/Muslim culture and capitalism. This silence prevents Malays from being able to defend themselves and prevents others from understanding who the Malays are. In Singapore there is not an atmosphere of mutual cultural respect. Finally the dominant ideology emphasizes that each individual is responsible for her or his own fate. But if "underachievers" are to blame for their problems, why are they worthy of compassion? (Tamney, 1996, p. 110)

Lee acknowledges that Westerners construe these beliefs as racist, but rationalizes his victim blaming: "With human beings, you can give everybody equal opportunities, but the results will not be equal because they are of unequal abilities" (Lee, K.Y., cited in Kwang, 1998, p. 154).

In contemporary Singapore, "the public image of Malays is [still that] of a backward people who lag behind in educational and economic achievement" (Tamney, 1996, p. 98). Lee felt that if
every person in Singapore had an equal opportunity in life, the results for society would
ultimately be negative. As Kwang represents Lee’s position:

[Lee believed that equal opportunities raise] false hopes, and furthermore, by
promising men [sic] equal rewards, they often resulted in some choosing to opt
out of the game altogether. He was also acutely aware that Singapore’s small,
fledging entrepôt economy could ill afford such indulgence. (Kwang et al.,
1998, p. 159)

Lee argues that the PAP’s policies were necessary “for the times” and the “Asian context.” Lee
maintains that he brought Singapore to a level of civilization in 30 years that took Britain “300

Despite these policies, the PAP managed to avoid rioting along racial lines after
independence and associated governmental policies are still in place. However, by Western
standards, it is essentially a dictatorship:

No group or organization can criticize important policies without running the
risk of being charged with engaging in politics, which would result in the
banning of the group and, depending on the nature of the dissent, might lead to
the arrest of its leaders. …Public protests are not allowed because it is argued
that such signs of disorder would jeopardize prosperity. (Tamney, 1996, pp.
61-62)

Another way the PAP deals with potential unrest among the Malays is through a government-

The rationale for keeping such strict control over race relations is also related to economics:
Singapore must look safe and be attractive to multinational investors. The actualizing of a
globalized marketplace are thus part and parcel of Singapore’s racial oppression.

In summary, PAP policies have been created to serve economic goals. “Public policy
is dominated by the desire to win the worldwide economic competition. The appeal of this goal
cuts across racial, ethnic, religious, class and gender lines” (Tamney, 1996, p. 193). The values
seen by the PAP as necessary to advance Singapore’s economy are “hard work, thrift, [and] an
emphasis on education” (Kwang et al., 1998, p. 177). In this way, a welfare state approach is rejected as potentially undermining the work ethic necessary for economic growth. One look at Singapore’s postmodern skyline demonstrates that, when measured in visible economic terms, Lee Kuan Yew realized his political vision.

c. **Social improvements during independence and their consequences**

**Personal affluence.** The social improvements experienced by Singaporeans since 1965 have been significant:

> During the 1980s economic growth resulted in a relatively affluent country in which people no longer needed to be preoccupied with having food, shelter, and a sense of personal security. Singapore is becoming a white-collar, middle-class society. The result is a population with changing attitudes and values. Quality of life is the issue, not economic survival. (Tamney, 1996, p. 18)

Singapore’s Gross Domestic Product, in 1965, was US$970 million, which had increased to US$34.5 billion by 1990 (Kwang et al., 1998, p. 108). In 1996, the unemployment rate was an enviable 2.7 percent. The Housing Development Board (HDB) was established in 1960 with the aim of providing low cost housing. These high-rise towers are communities onto themselves with the ground floors filled with shops and businesses, hawker stands and grocers, as well as small primary care physicians’ surgeries, or practices. By 1996, 86 percent of the population lived in HDB flats and only nine percent were confined to public housing (Singapore Ministry of Information and the Arts, 1996, p. 190). The towering HDB complexes ensured that land, a scarce commodity, was used efficiently. In his book, Lee talks of how associated technologies, such as affordable elevators, facilitated attaining this standard of living. Currently, Housing Development Board flats range in price and size depending upon their location and level of luxury. There are no inner city ghettos and, relative to neighbouring Southeast Asian countries, Singapore is affluent. Ninety percent of Singapore’s HDB-dwellers own their flats.
The positive social outcomes and governmental legitimacy corresponding to this high level of national wealth should not be underestimated. Within living memory, Singaporeans were virtually uneducated and living in poverty. The activities of the PAP are credited with rendering Singapore an economically successful nation. It is reasonable to assume that there is little will to openly criticize a government that is doing so well financially, especially among the Chinese. Neither do the inequities required to achieve this economic goal appear in government discourse.

**Personal safety.** The Republic’s borders are defended by the Singapore Armed Forces (SAF) that include male civilians who have served a two-and-a-half year, compulsory full-time service (Singapore Ministry of Information and the Arts, 1996, p. 103). The threat of racial or communist-related violence is not the actuality it was during the 1950s and 1960s but the PAP’s strict laws are still enforced with swift and, at times, questionably harsh punishments. This practice is promoted by the government as making the streets exceptionally safe. It has also precipitated international criticism surrounding human rights. These strictly enforced rules have also, coupled with the nation’s wealth, permitted the maintenance of a clean city that sports the reputation within the tourism industry as a “Garden State.”

**Education.** Another social improvement implemented by the PAP is the public and secondary school system. The government’s goal of the creation of a workforce best able to meet the labour demands of a global marketplace necessitated a better-educated people than existed in Singapore in the 1960s. Singapore’s school system rewards continuous rote learning over evidence of critical thinking skills. High grades are valued, especially within the Chinese community, with out-of-classroom tutoring becoming the norm of the middle and upper classes. Parental pressures on children to get ahead of their peers in the quest for securing a high rank in the education system is intense. Elitism is structurally fostered:
Streaming takes place at the end of primary four, based on the pupils' performance in the core subjects of English, mother tongue and mathematics. [The rationale provided is that pupils are streamed to maximise their potential. (Singapore Ministry of Information and the Arts, 1996, p. 215)

The wealthy are advantaged in this system because, in addition to affording private school tuition, they are capable of sending their children abroad for a university education if their offspring do not succeed in securing a place in a local post-secondary institution. The social hierarchy is self-perpetuating and advantages the ethnic Chinese people.

**Multilingualism.** In addition to recognizing the importance of basic education of the people, Lee decided in 1965 to gradually introduce English as a second language within the school system. Today, English is still viewed as the “language of commerce,” again reflecting enactment of the extra-local ruling relations of the Western marketplace. Lee states in Kwang et al.’s (1998) biography:

> The big decision was made in 1965—we had to make a decision. We decided to do it by evolution, not by suddenly deciding, “Right, English is the working language and we’ll also learn our mother tongues.” I think there would have been riots. The Chinese would never have accepted that. So we said, “We leave things as they are. Don’t change it. But parents can decide.” Whether you want to go to a Chinese school where you can learn English (as a second language), or to an English school and learn Chinese or Malay or whatever. Or to a Malay school and learn English, or a Tamil school and learn English. (p. 134)

English is thus seen as a necessity by the PAP for Singapore to become, and remain, economically competitive.

**Emancipation of women.** PAP rhetoric emphasizes family life as the building block of the Republic’s economic success. At the same time, the government facilitated women’s entry into the workforce in order to directly assist in the building of Singapore’s economy. During the 1960s, there were thus government campaigns to encourage smaller families but these were
reversed when the birth rate declined in the 1980s. However, these media messages encouraged only the educated to have more children:

Educated women are most likely to be the ones who postpone marriage to pursue higher education or a career and they also tend to view motherhood in terms of quality rather than quantity. They want to be mothers but not to [have] too many children. Unlike most of their mothers and grandmothers, they do not measure their personal fulfilment solely by their roles as wives and mothers. While many still would like their children to look after them in their old age, they no longer expect financial support from them. (Wong and Leong, 1993, p. 22)

The observation that educated women in Singapore were less likely to have as many children and to marry later in life, just as in the West, was a concern to Lee. Subsidized childcare and paid maternity leave was provided by the government as a stimulus to keep Singapore’s women having children while they were working (Tamney, 1996, p. 120).

The government advocates more children, but only for the “educated” couple:

Since 1983 specific financial incentives have been given, mostly in terms of income-tax deductions to working parents, for the purpose of encouraging them to have more children, according to their economic means. One of the early measures involved a cash grant of S$10,000 to working mothers of one or two children who undergo sterilization, provided both husband and wife do not have secondary-school education and their combined family monthly income does not exceed S$1,500. …[T]hose with a secondary-school certificate or higher education, could claim, in addition to the usual child deduction, a further 5 per cent of their earned salary for the first child,…to a maximum of S$10,000. (Republic of Singapore, 1985, cited in Quah, 1994, pp. 137-138)

The government regularly institutes policies and media campaigns in areas that would be considered unconventional or inappropriate to Westerners. An example of this is the role of the government as ‘romantic matchmaker’ through the activities of the Social Development Unit originating in 1984. The mandate was to help bring potential couples together through such activities as talks, cruises, dances and social outings (Tamney, 1996, p. 122). Again, the
government's interest is dictated by economic considerations. It is only interested in 'matching' economically contributing individuals to meet and (hopefully) propagate.

As I have said earlier, this prime minister is elitist and was concerned about the increasingly disproportionate percentage of Singaporean youth coming from what he viewed (in a racist manner) a 'less desirable', that is, 'poor' genetic stock. Economically disadvantaged Singaporeans were encouraged, and still are, to have smaller families. The "Small Families Improvement Scheme" provided funds to qualifying “low-income couples [in order] to upgrade themselves by keeping their families small so that they can concentrate their resources and attention on their children” as stated in a government flyer (Small Families Improvement Scheme, 1997, p. 2).

Childcare in Asia is more often the duty of the grandmother when compared to the West. However, “the three-tiered family— that is, grandparents, parents and grandchildren all living together—is far less common [than it used to be in Singapore, and] presently account[s] for only 14 percent of all households” (Wong and Leong, 1993, p. 28). Singaporeans appear to be adapting to less traditionally Asian family organization. Live-in domestics from overseas, usually young women from the Philippines, are common in the middle and upper classes. Tamney (1996) states that these women are poorly paid. In his words, “in the early 1990’s, there were about 50,000 foreign maids in Singapore [and] the use of these foreigners underscores the lack of rewards in housework” (p. 124). By devaluing running a home and looking after children, the government facilitates the objectives of inducing women to directly contribute to the Republic’s economy by undertaking paid work. Those women whose services are viewed as a cheap source of labour, such as the elderly or foreign women, perform the work that might have been done by more economically-valued members of the society. In this way, the organized
practices of a capitalist economy have clearly altered traditional organization of local family life in Singapore.

The wage gap between the sexes is still large, although according to Wong and Leong (1993), it has been steadily decreasing. In 1993 this gap was 30 percent, with the presence of the infamous ‘glass ceiling’ a distinct obstacle to personal career growth for women. Wong and Leong (1993) maintain that this is “because of men’s attitudes towards women, which in some cases affect their chances for the further training and job enlargement that lead to promotion” (p. 54). Tamney (1996, p. 134) states that there are no laws against sexual discrimination at work.

In 1961, a Women’s Charter was created by the PAP that stated that

the only legal marriage for everyone, except Muslims, is a monogamous one; ...husband and wife have equal rights and duties in running the home, in safeguarding their marriage and in caring and providing for their children; ...a married woman has rights, like an unmarried woman.... [T]he sole ground for divorce is when the marriage has broken down beyond repair. (Wong and Leong, 1993, pp. 81-82)

As in the West, the divorce rate in Singapore is on the rise. “In 1991 more than twice as many couples filed for divorce than in 1981” (Tamney, 1996, p. 125). He attributes this to “women [previously] suffer[ing] in silence” (Tamney, 1996, p. 125). The government attempts to ‘correct’ increasing rates of divorce by imposing HDB eligibility to better accommodate married couples. Thus the government’s influence upon local ‘independent’ and ‘free’ family decisions is exerted through its economic power to withhold fiscal privileges from those who choose personal arrangements that do not support its capitalist ideology.

On the surface, feminist issues appear to be better addressed in Singapore when compared to sister Asian states. But, tragically, marital rape is still not a crime. Tamney (1996, p. 133) points out that many women view themselves as liberated, since they enjoy many freedoms unknown to their mothers’ generation. At the same time, they must contend with traditional
chauvinist attitudes which dictate that they must not be ‘too successful’ and threaten potential, or existing, husbands. Tamney argues that

these same women, after marriage, will tend to be dominated by their husbands, who will, for instance, decide whether they will work. In addition, once they are married, the women are enmeshed in extended families who will attempt to control them. (1996, p. 133)

Women in Singapore are thus in a period of transition. They are typically working outside of the home, increasingly exposed to Western feminist thought and thus experience more choices than in recent history.

**Health care.** The improvement of the physical health of Singaporeans from the early days of the Republic to the present can also be linked to its economic prosperity. Improved social hygiene practices and more accessible health care coupled with other factors related to economic betterment such as the availability of nutritious foods, can be seen as responsible for the Republic’s improved health. Accepted indicators of a nation’s health are life expectancy at birth and infant mortality rates. In 1957, life expectancy of a female in Singapore was 65.2 (male: 60.3) years (Singapore Ministry of Health, 1993a, p.2). In 1996 it had risen to 78.7 (male: 74.2) years of age (Singapore Ministry of Information and the Arts, 1996, p. iv). In 1950, Singapore lost 80 infants per 1,000 live births whereas in 1992 this figure became one of the lowest in the world: 5.0 per 1,000 (Singapore Ministry of Health, 1993c, p.3). It further declined in 1996 to a rate of 4.0 (Singapore Ministry of Information and the Arts, 1996, p. iv).8

Leading causes of death in Singapore have also changed, illustrating the health benefits and associated costs of modernization:

The principal causes of death have changed from those caused by infections, e.g. Tuberculosis, malaria, diarrhoea, to the chronic degenerative diseases, e.g. cancer, heart disease, stroke, diabetes and injuries which are mainly due to unhealthy and unsafe lifestyles. (Singapore Ministry of Health, 1993a, p.4)
These statistics illustrate how Singapore's present health challenges are associated with its newly industrialized status.

Health care policies copy neither the British nor the American model. Lee believed that for Singapore to survive in the long term, a multi-tiered health system was required. This is in part due to his recognition that there would be an inevitable demographic shift from disproportionate youth representation to that of the more aged society presently faced by Western countries. Prime Minister Goh Chok Tong pointed out the PAP’s view of health as a personal responsibility, in 1992, during his speech launching the National Healthy Lifestyle Campaign:

Going against conventional wisdom the Singapore Government decided that the “free healthcare” philosophy, however well-intentioned, was flawed. Far from reducing demand for healthcare, it increases it, simply because healthcare is free and the individual is not motivated to stay healthy. We decided instead to make “personal responsibility” the cornerstone of our healthcare system. [Singaporeans are personally responsible] to stay healthy and to pay at least part of the medical expenses, when healthcare services are used. (p. 19)

The general health of the nation is secured in such a way so as to require payment from those who can afford health services and to provide basic care to those who cannot afford them. The National Healthy Lifestyle Programme espousing both educational objectives and associated governmental support measures for Singaporeans to improve personal health began in 1992 (Singapore Ministry of Information and the Arts, 1993, p. 251). A critique of this contemporary health care structure is made in Chapter Five within the context of an examination of PWD-doctor relations.

d. ‘Modernization’ and inequitable access

To summarize, the predominant theme of PAP’s ideology of modernization is a conservative one. Government policies are made with the intention of developing the Republic’s economy. Quality of life issues appear to be seen by the government as secondary. They are
assumed by the PAP to be positively related to Singapore’s economic progression in a globalized marketplace. Singapore’s ruling apparatus directly opposes the more egalitarian model advocated by Paulo Freire (1970/1997, 1992/1998). The PAP’s governing methods do not include consciousness raising of the equivalent of Freire’s peasant, that is, the uneducated Singaporean. In fact, Lee was quite blunt in expressing his views regarding the lack of responsible political awareness or abilities of the working class:

So when people say, ‘Oh, ask the people!’ It’s childish rubbish. We are leaders. We know the consequences. You mean that ice-water man knows the consequences of his vote? Don’t tell me that. That’s what Western journalists write. (quoted in Kwang et al., 1998, p. 134)

Lee’s approach has brought positive social changes, although his means have been prescriptive and paternalistic.

Freire cautions that revolutionaries having the best intentions for the peasants—and clear ideas regarding the implementation of their liberatory ideologies—should not become another type of oppressor themselves (Freire, 1970/1997, p. 147). According to Freire, oppressors are still oppressors even when they claim to be working in the best interests of the people. Lee’s PAP (even subsequent to his official retirement in 1990), is an oppressive regime within Freire’s conceptualization of an egalitarian democracy. This is due to the minimal input regarding governmental policies by the citizens who are directly affected by these decisions.

IV. Contemporary Political Ideology in Singapore

1. Singapore in the 1990’s: A less authoritarian PAP government?

The 1990s brought a reorganization of the PAP and less of an authoritarian style (Tamney, 1996). Lee has stepped down from the premier’s office, now becoming a key consultant to Prime Minister Goh Chok Tong. The government’s role has evolved towards
maintaining, versus creating, Singapore’s industrialized nation status with a focus upon
technology in the global marketplace. Senior Minister Lee transitioned out of the PM’s office to
avoid Singapore spiralling downward due to no effective leadership. Lee had anticipated that an
industrialized, more educated Singapore would require a more relaxed governing style (Tamney,

2. State involvement in the personal affairs of Singaporeans

Despite a relaxation of governmental control, Singapore would still be considered
authoritarian by Western standards. Tamney (1996) states that

Singapore’s dominant ideology is basically a variant of Western conservatism. …The Singaporean version differs from the Western form of conservatism in the degree to which the former empowers the elite and dissuades dissent. …However, although the PAP is authoritarian in theory, it is not in practice. While the Government reserves the right to do whatever is necessary to achieve its goals, the actual exercise of complete control is not one of these goals, because the leaders believe the people would resist a truly authoritarian regime. (pp. 180-181)

The above resonates with my expatriate, privileged experiences, and my observations of
governmental presence whilst living in Singapore. I acknowledge that I do not know the
worldview of others, especially non-Chinese indigenous people in Singapore.

One source of information available to me regarding local political activities came
from the English daily newspaper, The Straits Times. It was significant in raising my
consciousness to such issues. I examined, collected and organized newspaper articles relevant to
my inquiry. Singapore’s eight daily newspapers (three in English) are owned by a single holding
company (Singapore Ministry of Information and the Arts, 1996, pp. 275-6). Tamney elaborates:
“[T]he company controlling the newspapers has a history of appointing retired senior civil
servants as chairmen [so that] the [g]overnment indirectly controls the print media” (p. 61). In
my dissertation I treat my quotes from *The Straits Times* as data and not ‘knowledge’ acquired in any academic sense. Often I view these as governmental texts that facilitate my interpretation of the policy or political objectives of the Singapore government.

Tamney (1996) refers to Singapore as having an “Asian-style” (p. 57) democracy. Asian culture is typically viewed as one that looks after the “interests of society [and that these] tak[e] precedence over the rights of the individual” (Tamney, 1996, p. 62). The political opinions I heard from local people, although few in number, all concurred. Singaporeans I met were not personally concerned that their or my behaviours or speech were worthy of examination or suspicion. I was teased by a couple of key informants that “I worried too much.”

Singapore’s greatest assets in the 1990’s global market revolve around technology. Rodan (1998), an Australian professor of politics, had posted a critical article entitled “The Internet and Political Control in Singapore” at the Web address which I located via www.gn.apc.org. This home page states that it is “a Web site where Singaporeans are invited to read and discuss issues which concern them--a Web in and away from home.” Rodan states:

> In any evaluation of the impact of IT [information technology] on authoritarian political structures, Singapore presents itself as a fascinating and essential case study. Here we have one of the most comprehensive strategies for the development of IT anywhere in the world, supported by huge state-led infrastructure investments. Indeed, Singapore’s policymakers are committed to the transformation of the island economy into an information hub, trading in areas [information] rather than commodities. Yet Singapore’s authoritarian leaders have no intention of surrendering political control in the process. Certainly they recognize the existence of some tension between their economic and political objectives. ... What seems clear in all of this is that forsaken profits and stiff legal penalties have been more effective in fostering self-censorship than earlier methods of intimidation. (p. 2,4)

Although there may not be open criticism of a government that has brought wealth during the period of affluence, the increased presence of multi-national corporations—including the presence of executives and their Western families such as mine—together with local affluence
precipitates a heightened awareness of the unacceptability of an excessively aggressive
government. This decrease in public tolerance to an overtly authoritarian government is also a
function of increased global contact. Tamney (1996) discusses the notion of self-censorship as a
part of the Asian-style part of democracy, but clearly, increasing adoption of extra-local practices
have also supported a contradictory discourse regarding individual rights.

The Michael Fay case illustrates this trend. My family and I had been living in
Singapore less than a year when, in April 1994, the American 18-year-old, Micheal Fay, was
convicted of vandalism. He attended the same school as my children and throughout the events
leading to Fay’s conviction the local and international press, including Larry King’s talk show on
CNN—which was aired in Singapore—debated the use of physical punishment. We subsequently
received as parents of “Singapore American (private) School” children written notices regarding
the need to counsel our children to be cautious and to not assemble in large groups in public.
These were anxious times. Fay was sentenced to

six swift strokes of the rotan [cane] to be meted out. His parents and lawyers,
as well as human rights activists and newspaper columnists in the United
States, unleashed a verbal lashing at Singapore and its leaders. (Kwang et al.,

Tamney (1996) stated that “his punishment included a fine, a jail sentence” and a reduced “four
strokes with a rattan cane...[while] a doctor was present” (p. 175). In a New York Times
editorial, this reduction in the number of caning strokes was due to Singapore’s concession to the
Clinton Administration’s “campaign for clemency” (“Harassment in Singapore,” 1994). I noted
in the international presses that the term “caning” was often sensationalized to more emotive
terms such as “whipping” and “flogging.”

Lee stated that this was a “simple case of crime and punishment” (Kwang et al., 1998,
p. 193). Kwang et al. (1998) continues:
Not for [Lee] the fashionable liberal ideas of modern-day penology, which sought not so much to punish as to reform criminals, and where crimes were explained away by blaming...[them] on some failing of the system or society. He believed instead in the old-fashioned ideas of guilt and responsibility. ...In Oriental societies, Lee believed, people looked to the authorities to establish "order under the heavens." Good rulers were those who could do so effectively and fairly. ...[Lee] said repeatedly that, had the government backed down in the face of American pressure to rescind Fay’s sentence, it would no longer be able to impose similar punishments on Singaporeans. Nor could it govern effectively thereafter. (p. 195)

Tamney (1996) states:

The issue is social order, not individual rights. This attitude is believed to be just because all responsibility for deviance is attributed to the criminal, who therefore deserves the punishment. ...The fact that Singapore canes about one thousand prisoners a year suggests the punishment is not an effective deterrence in that society. As for Singapore’s relatively low crime rate, it has many causes including the traditional stress on obedience and family responsibilities, Singapore’s small size, and its affluence and low unemployment rate. No one knows the effect the harsh laws themselves have on the crime rate in Singapore. (p. 176)

Lee was Senior Minister at the time but was clearly active in the public eye regarding his elitist-based authoritarian policies. Lee’s economically-based view of the criminal rehabilitation model is that it is too costly and ineffective. The PAP government espouses a victim-blaming model; there is an underlying presumption that the accused did not take advantage of the opportunities provided and is personally responsible for deviant actions. Society is seen as not being able to "afford" Western liberalism.

The government, through the local press, used the Fay case as an opportunity to propagandize about how increased wealth has a price, that is, the increased potential for social problems characteristically associated with the West. One particular press report (Goh, 1994) identified three lessons entitled:

Lesson one: Don’t indulge your self and your family, especially young children and teenagers.
Lesson two: Compassion can be misguided.
Lesson three: Defend and strengthen family values. (p. 24)
Fay’s predicament was discussed for months within the ex-patriate community. I did not encounter, or overhear, much of the same among locals. One participant, Mr. Wong, was pleased I had two girls:

Mr. Wong: If boys, you have to be careful. Because not like Michael Fay, you know, Michael Fay—

Liz: Such a disgrace.

Mr. Wong: Going around, damaging cars and all [of this]—I don’t think they [referring to Americans] want to remember him.
(Mr. Wong, Transcript, November 27, 1994, p. 19-20)

Overall, Fay was not a major source of conversation between myself and local Singaporeans, inquiry participant or otherwise. Outside of Singapore it was entirely different. I felt a socially imposed role of being Singapore’s criminal justice system spokesperson. Even a Canadian customs officer solicited my opinion as I returned to Toronto for a visit. Living in Singapore during the Fay era proved to be a celebrity-of sorts time for many ex-patriates.

Throughout my inquiry I did not sense any fear of government repercussions from those participating in my inquiry. Neither did my day-to-day affairs cause me to believe that local people were anxious. I did sense a mindfulness of Singapore’s harsh government’s history coupled with an awareness of present-day criticisms in the Western press. I noted the following:

[M]any of my [Western] key informants laughingly stated that Singaporeans are afraid that their comments may be leaked to the government with the resulting unpleasant personal consequences. No one ever seriously stated that people really believed this—except that this “joke” was a common theme.
(Fieldnotes, May 2, 1995, p. 7)

I was generally not concerned about the absence of certain civil liberties and a harsh punitive system by Western standards. In a day-to-day sense, my freedoms were not curtailed—if anything, my personal freedoms felt enhanced due to the low crime rates relative to what I have come to expect of large Western cities. My being Western may have protected me. At the same time, I question the ideology and values behind the maintenance of the Internal Security Act that allows those who are accused of wrongdoing to be held in detention without right of trial. I did not fear for my children to the same degree that I now fear hate crimes, amongst other violence, that are commonplace in my present suburban home of Wilmette, Illinois. Western ideologies such as human rights in contrast with Singapore life-experiences were a common theme frequently discussed among ex-patriates. The low crime rate may also be related to the swift and harsh punitive system as well as the government’s curtailment of freedom to individuals suspected of potential wrongdoing.

In the winter of 1995, I had read a great deal in the local and international newspapers (both in Singapore and when I was overseas) about the American academic, Christopher Lingle. While working as a lecturer in European politics at the National University of Singapore, he wrote a commentary for the October 7, 1994 International Herald Tribune (IHT), where he “alleged that intolerant regimes in Asia showed considerable ingenuity in their methods of suppressing dissent. These included ‘relying on a compliant judiciary to bankrupt opposition politicians’” (“S’pore Govt Amazed,” 1995, p. 3). Dr. Lingle, amongst others involved, was found guilty of a contempt of court charge with the offending phrase considered a slight against the Singapore judiciary. An internet-posted-article by the U.S. Department of State regarding human rights in Singapore (1996) states:

Although the IHT published an apology for the article in December 1994, Senior Minister Lee Kuan Yew filed a civil libel suit. The IHT agreed in November 1995, to pay the Senior Minister $213,000 in damages, plus costs
for the civil suit. Lingle was separately ordered by the courts in April to pay $71,000 in damages, plus costs, to the Senior Minister. In at least the [example] cited above, the use of libel suits appears to have intimidated the press successfully. (Section 2(a), para. 9)

One newspaper headline, previously cited, read: “S’pore Govt amazed at US reaction” (1995, p. 3). This article pointed out that this trial was held in open court and that Dr. Lingle failed to appear. Justice Goh Soon Seng was quoted in The Straits Times (“No doubt,” 1995, p. 19):

The right to fair criticism is also protected by Article 14(1)(a) of our Constitution, which entrenches a citizen’s right to freedom of speech and expression. But this right is not and cannot be absolute. Anyone exercising that right must observe a corresponding duty of responsibility. No one is entitled under the guise of freedom of speech and expression to make irresponsible accusations against inter alia the judiciary, otherwise public confidence in the administration of justice will be undermined. (p. 19)

Dr. Lingle was fined $10,000, which, according to The Straits Times, he did not pay (“Lingle case,” 1995, p. 3). Pereira (1995) wrote a Straits Times article in the large “Insight” section of the paper that focused upon the meaning of the “law of contempt” (p. 24). The main point may be summed up by the following: “However, the criticism must not impute improper motives to the judges or allege that the judiciary is not fair” (Pereira, 1995, p. 24).

It is clear to me that Dr. Lingle caused the government a public loss of face by publishing his article in such a widely circulated newspaper such as the International Herald Tribune. Kwang et al. note that in Lee’s biography, he points out that he does not conceptualize the role of a free press in a democratic society in the same way as do Westerners:

The [U.S.] logic of its case was that where the media was free, the marketplace of ideas would sort the irresponsible from the responsible and reward the latter.

Lee would counter that, far from weeding out the irresponsible from the responsible, the marketplace of ideas in a multiracial society could, and did, lead to riots and mayhem. ... Few voters, surveys showed, rated press freedom high on their list of priority. ... The American mistake was to assume the universality of its system and values, Lee would assert in many interviews and speeches over the years. (Kwang et al., 1998, p. 217)
Again, my experience was that it was Westerners who were the most upset by government censorship.

Dr. Teo (Fieldnotes, May 9, 1997) commented that Singapore is a "unique environment" and that it had a "developed and a developing community" (p. 1) at the same time. Singaporean tolerance may be based upon an ideology of "two stages of modernization living in close quarters" that requires this type of firm leadership. This tolerance is certainly enhanced by the wider margin of personal affluence and a strong economy. Social improvements notwithstanding, I question how widespread these freedoms are. It appears that they are reserved for the few at the apex of the social hierarchy.

When conducting my inquiry, I did not feel comfortable discussing politics with newly-met participants when it was not the primary focus of my research. Thus my traditional research methods acted as a form of self-censorship as I anticipated that questions of this kind from a Westerner would be considered inappropriate. However, it was clear to me that relations of social oppression influenced people's personal lives by placing barriers to their making personal choices that are contrary to the national PAP-defined interests. The case of single mothers having difficulty obtaining permission to purchase government-funded housing discussed above is a case in point. Rather than discard the policy as non-egalitarian, priority is put on the mothers' inappropriate 'lifestyle choices' which must be 'corrected' to support of a strong, cohesive and traditional family unit (Tamney, 1996).

To summarize, the involvement of state in personal affairs is ubiquitous in Singapore with the rationalizing ideology being economic.
3. **Changing ideology of education**

Education is highly valued in Singapore and is very competitive. Many middle and upper-class children are tutored in subjects over and above their classroom activities in order to secure them a place within the relatively few colleges and universities in the state. Tamney (1996) points out that: "[foreigners are not likely to appreciate the significance of tutoring; about half of the primary school students and one-third of the students in secondary schools are privately tutored" (p. 78). At DSGS meetings, during tea breaks I heard about the costs of extracurricular tutoring of members’ children, some of whom were only 9 or 10 years of age. Children are continually reminded of their own and the Republic’s economic good fortune and the need to continue to work hard to secure a place in the streamlined education system. Tamney (1996) states that

[in 1983] Lee pointed out that human talent is for the most part genetically determined; he referred to foreign and local scientists in support of this belief. Lee also argued that since his [g]overnment had made the schools meritocratic, all the talented people must have been able to rise to the top. …New regulations gave priority in primary school registration to children who had an educated mother and two siblings. (p. 76)

The number of local post-secondary institutions, reflecting these elitist, structurally oppressive education policies, is relatively low. In addition, those families that have the financial means are able to send their children to universities abroad.14

Singapore’s school system has traditionally been authoritarian and not conducive to the fostering of critical thinking skills. As such, it is congruent with the more strict government ideology of Singapore’s earlier regime. Education practices in Singapore are consistent with Freire’s (1970/1997) notion of a “banking” approach to teaching, where knowledge from the expert is “deposited” into the student by the teacher (p. 53). This didactic approach encourages passivity in the learner. Lateral thinking and creative problem solving skills have traditionally
not been rewarded, but as the marketplace has changed and the best technological skills are those that encompass critical thinking, the schools in Singapore are reportedly changing. During the four years that I was living in Singapore, these new skills were touted by the government as being necessary to better meet the needs of a global marketplace:

Education Minister Rear-Adm[iral] N[ational]S[ervice] Teo Chee Hean said yesterday that Singapore had achieved most of its quantitative targets in primary and secondary schooling for all students, and emphasis would now shift to enhancing quality and creative thinking. …”

Our education policy will be guided by a future-oriented curriculum with a strong emphasis on harnessing the potential offered by information technology.” (Ghosh, 1997, p. 22)

The ideology is, again, wholly economically based. It does not place any value on personal development. The logic is that a global marketplace requires people to be independent thinkers so they must therefore be educated as such. Government policies thus encourage and support this objective.

4. **Government information campaigns**

There are many government-sponsored media campaigns that broadcast its ideology and activities. These include articles in the newspapers, on television and radio shows and interviews and media advertisements. The government rationale presented is usually economically-based. Some examples are amusing for the Westerner to observe. These include commercials put out under the National Punctuality Drive in 1993 with regard to the need for a civilized society to be on time for appointments and parties, especially weddings. The Courtesy Council in 1995 addressed the need to be polite to one another. It “announced that it was concentrating on RSVPs for parties” (Kan, 1995, p. 29). Other campaigns center around more obvious pragmatic issues such as the second “National Technology Plan.” The government also supported publicity about the need for Singaporeans to eat better, to live a balanced life and to
exercise more. These various programs were based on research findings such as the 1992
National Health Survey.

Prime Minister Goh said in his 1997 National Day Rally speech to Singapore that the
"Speak Mandarin Campaign"

had been successful in getting dialect-speaking Chinese to switch to Mandarin, but the focus should now be to promote Mandarin as the social language of the Chinese. ...[H]e reiterated the need to reproduce a new Chinese-proficient elite....(Chua, 1997, p. 1)

This was to better reach the government's goal of increasing the value of Chinese culture within Singapore. Mandarin is not indigenous to the provinces of China from which the Chinese Singaporean historically emigrated. However, it is the "official" language of the present-day Chinese government. I believe that this campaign is also part of a long-term plan to do business with the now more open market within China and to help reduce a complete Westernization of Singapore. One Reuter-based article with the headline "Genes and a Western lifestyle can kill Asians" (1995) ran in The Straits Times. This is an example of the government raising awareness about personal indulgence associated with a Western lifestyle:

When people became wealthy, eating more and exercising less, this tendency [of certain fats that predispose people to heart disease] turn[s] deadly. (p. 10)

This article reinforces the notion that West is not always best. There were multiple articles, media messages, and government information flyers promoting individual responsibility in the promotion of good health by appropriate lifestyle choices.

5. Contradictions in Eastern capitalism

a. "Kiasu" vs. "Going too far"

I have argued to this point that Singaporeans are given mixed messages from the government regarding its view of Western culture. Capitalism—and corresponding consumerism—
-and Asian-style democracy have promoted the expression "West is best," which is considered a truism:

Success is said to be measured by how much money one makes and the number and quality of one's possessions. In 1992 a locally produced television program presented the Singapore Dream: condominium, car, cash, career, and credit. [These become known as the 5C's.] ...Owning a home, a car, and the right shoes have become major sources of satisfaction and measures of success. ...Living in Singapore is organized around making money and acquiring things. But this is encouraged by [g]overnment policies. By defending capitalism, the leaders create an environment that rewards greediness and encourages consumerism. (Tamney, 1996, p. 44, 46)

Chain stores and restaurants familiar to me have proliferated throughout Singapore. Newly constructed air-conditioned malls were built along the prestigious "Orchard Road" during the four years that I lived there. I personally saw local food hawker stalls and other small outdoor businesses yield to the bulldozer of 'progress.' There were many foreign business executives, and their families moving to Singapore as a direct result of the economic globalization trend.

Western corporations were attracted to this republic's busy seaport. Ng (1998) states that globalization signifies the stage in capitalism whereby capital has developed the capacity to move beyond national boundaries. This has led to the restructuring of practically all industrial sectors in developing countries, and the concomitant reorganization of everyday life in both developed and developing parts of the world. (p. 23)

There was a building boom of private apartments as wealthy corporations sponsored many moves such as mine. The cost of living in Singapore is exorbitantly high by Toronto standards. The cost of a modest three-bedroom apartment in a middle-class area away from the downtown core bought through the government-assisted HDB program was approximately S$400,000. Our 2,800 square foot, privately-owned apartment near Orchard Road was worth approximately S$5 million \(^\text{15}\) in 1996. The rent was over S$10,000 per month, for which the U.S. head office of my partner’s corporation was responsible. Western grocery stores and chain stores increasingly became the norm in the mid-1990s, with local foods sold at hawker stalls cheaper and usually
fresher than in the air-conditioned grocery stores. (It did take a couple of years for me to
‘chance’ purchase meats that were hanging and freshly chopped in the tropical heat.)
Consumerism was everywhere. I frequently heard that shopping was, next to eating, the “national
pastime.” This meant that in my Sunday hikes along few, but beautiful, rainforest trails, I met
few of the three million natives. This was not the case when I waited in line for a restaurant table
or a shop cashier.

In keeping with my originally reductionist study paradigm, I did not discuss political
views with any participants except occasionally with some DSGS members whom I came to
know personally. In a particularly candid interview regarding Singapore’s history, present-day
political practices and the state of society Sue16 (a Singaporean health professional at the DSGS)
summed up what I had been hearing from others and reading in the papers:

Sue: Yeah. I don’t know... I’m not an expert at all, I can give personal
thoughts. But, ah, in Singapore there is a push to survive.

Liz: Yeah, there’s a hustle here.

Sue: It’s very strong. You find the same drive in Hong Kong, Taiwan—there’s
a push to survive. ...Singapore has zero resources. All we have—we had a
lucky break, location and a port. The only thing we have are people, right?
And if we don’t keep pushing, we won’t survive. In the back of everyone’s
mind, everyone knows that. So when you hear people griping, about school
system and all that... you [must] sit down and ask yourself “what options do
you have?” None. So actually if you can’t take the heat get out, get out. And
most people will not begrudge you. But the pace at which we drive ourselves, I
don’t—subconsciously. You know this “kiasu”17 thing?

Liz: Um hm!

Sue: It’s not so much to win you know, it’s not to lose. It’s to survive.

Liz: Exactly, to survive, to be ahead, basically so you are in front of the person.
It’s not to get there faster, it’s to make sure you’re in front of the person behind
you.
Sue: Yeah, yeah. So it's like when you say you are number one. We don't look at "okay we're number one," we look at "okay, where are the rest, how far down, what's the gap?"

Liz: So then why wouldn't they look after--within that mentality--their own? Do you see what I mean?

Sue: Okay. ...My own understanding [is that] what I've come, my conclusion would be, um, we've got to follow what happened in the early years. From independence [from Malaysia], which was '65. ...You are talking about a country that was left without a defense. ...Basically I think the assumption was, "okay, if Singapore was [left] on its own, [it] will not survive." And we probably wouldn't have, ah, except that we had quite a few good breaks.

...The only way to survive was to push on the economy, [to] work hard. So everything was working on a meritocracy. Work, work, work, achieve, achieve, get more, get more productive. So this "economic miracle" that the people talk about only came about because everyone jumped in and pulled in. Because it's survival. So when it's your individual survival, and you just pull it together you get national survival. It's a very...helpful force.

...Literacy here is very high. Everyone goes to the national service [military], [and] they're not complaining. They [are] used to [it]...You need it. They know we need it. It doesn't mean that it's popular, it's just accepted, it just one of those things you have to do, [in] a small country.

But when you keep pushing...you realize that certain things will suffer. And one of the things will be...[that] families are first. You are out climbing the corporate ladder, working more and more and more, and your family suffers. So what we are seeing in our teens is the result of what we started doing 15 years ago. We didn't give them any time. And now we are paying for it. If we don't do something drastic about it, these people are going to grow up to be really dysfunctional parents and it's going to be a cycle that just perpetuates.

So now, read all about it, "gracious society" [referring to national ad campaigns for politeness] and all that, it's really checking our step. ...You see, when you come to a meritocratic society, where you say, "okay, what you get is what you deserve." (Sue Transcript, June 12, 1997, pp. 11-12)

I had had a three-year relationship with this Singaporean health professional woman in her mid-30s by the time we had this discussion. She had developed a critique of Singapore's roots and the local social effects of the rapid development of capitalist ruling relations within the Republic.

According to this discourse, the overt governmental promotion of capitalism, and its corresponding heightened consumerism is responsible for "things having gone too far." In other
words, working parents are blamed for their spoiled and demanding children. Lee Kuan Yew himself concurs with this view (Kwang et al., 1998, p. 187).

The term “kiasu” is from the Chinese dialect, Hokkien, and technically means fear of failure or loss (Tamney, 1996). It represents the drive to financially get ahead at all costs. It is the energy behind the “5Cs.” Throughout my four years living in Singapore, I regularly spotted T-shirts sporting the phrase “Graduate of Kiasu University” and similar bumper stickers. It was a term regularly used by my ex-patriate and local friends.

The government perceived kiasuism as a necessary and temporary evil associated with modernization. Senior Minister Lee admitted in a Straits Times’ (“Singaporeans’ obsession,” 1996) interview that:

The obsession that Singaporeans have with money has to do with their newly-acquired wealth and will pass with time as they settle down and become a more cultivated society. ...In a way, he said, it was understandable for a number of Singaporeans, who just 20 years ago lived in a hovel with a hole in the ground for a toilet and now had S$2 million homes, to be obsessed about their new-found wealth and status. (p. 4)

My partner pointed out that the obsession with money exhibited by Singaporeans is no different from that of the West. The key difference may be that it is part and parcel of their new participation within capitalistic globalized marketplace.

Less tolerant government messages regarding excessive interest in the “5Cs” identify consumerism as being associated with the West. Thus, consumerism is not seen as acceptable; it is argued that consumerism will precipitate similar problems as are currently experienced in Western nations. This is another example of contradictory messages from the Singapore government.

Prime Minister Goh, in his 1994 National Day Rally Speech, is quoted in the Straits Times as stating that Singapore is changing:
Singaporeans are more preoccupied with materialism and individual rewards. Divorce rates are rising slightly. There are some single parents, and some increases in drug addiction and juvenile delinquency.

Societies can go wrong quickly. U.S. and British societies have changed profoundly in the last 30 years. Up to the early 60s, they were disciplined, conservative, with the family very much the pillar of their societies.

Since then both the US and Britain have seen a sharp rise in broken families, teenage mothers, illegitimate children, juvenile delinquency, vandalism, and violent crime. (p. 24)

The PAP argues that policies that are often considered “harsh” by Western standards are pro-active in intent. They are meant to avoid the “moral decay” of the West. The rhetoric is that the crime and violence problems in the West are a result of “too much freedom” for individuals.

Tamney (1996) states that

the moral crisis is blamed on one of the foundations of Western culture, individualism. ...Among the traits [the government sees as] to be avoided are: being individualistic and self-centered, not working hard, being suspicious of political leaders and limiting their power, state care of the elderly, casual sexual relationships, and single parenthood. (p. 17, 19)

Individual human rights are depicted as being overly emphasized in the West at the cost of the group or society. This ideology is presented as contrary to the Asian view of valuing the needs of the many over the needs of the individual.

The criticisms levied against the Singaporean government regarding its harsh punitive system are not locally ignored. They are ‘debated’ in the press. The PAP always seemed to be the ‘good guy.’ For example, government discourse would emphasize a need to be tough for the “good” or “welfare” of the group. The current level of authoritarianism is said by the government to be necessary to maintain order. Their role is to uphold “Asian” ways and values, which Tamney (1996, p. 97) points out as really meaning Chinese¹⁸ as opposed to Malay or Indian ways.

The government’s “Asian Values” campaign appealed to Chinese historical roots. For example, the needs of the group over the individual are valued as is the experience of a
paternalistic family life. While such trends also occur in North America, Singapore is historically different from its Western counterparts in experiencing very rapid change: “As a whole, the East Asian miracle economies grew more rapidly and more consistently than any other group of economies in the world from 1960 to 1990. ...This is a statistical miracle” (Mahbubani, 1997, p. 6). Clearly, the government of Singapore is attempting to marry the ‘economic miracle’ with strong Asian Values ideology. These relations of ruling are evidenced within local, and often contradicting, media campaigns.

b. Valuing family vs. queues for HDB flats

“Lee has blamed the decline of the West on the breakdown of the family” (Tamney, 1996, p. 147). Filial piety or a devotion to your parents was another ideology put forth in a government media campaign while I lived in Singapore. This valuing of the family is seen as an accepted Asian Value. The Social Development Unit (SDU) broadcasts media campaigns centered around the promotion of marriage and children for the “educated,” that is, more government-valued, citizens. As I have argued above, personal choices such as these are not as straightforward as the campaign implies. Structural incentives are placed in the HDB queue for the option of purchasing a new flat that is near the applicant’s parents:

First time buyers of HDB flats who want to buy a resale flat near where their parents live will be given help to do so.

A grant of S$30,000 will be credited into the [government-compulsory savings plan]. ...Unmarried mothers will no longer be allowed to buy flats direct from the HDB. They must get them from the [more expensive] resale market. ("$30,000 grant," 1994, p. 1)

This overtly sexist policy financially punishes those who do not comply to the “Asian Values” ideology of the government.

Tamney (1996) points out that “[i]n Singapore, as elsewhere, people like to live near the extended family but not with them” (p. 186). Prime Minister Goh is quoted as indirectly
recognizing this wish to have a private home when he stressed that filial responsibilities will be a legally protected right of the elderly:

Parents who brought up their children should in turn be cared for by them. They should have legal recourse to seek financial support from their children as a last resort. (Goh, C.T., cited in the The Straits Times, August 22, 1994, p. 1)

Personal neglect of the elderly was depicted as a Western evil that needed to be circumvented.

Tamney (1996) points out that there is a political motive behind the government advertising the need for filial piety:

Filial piety is also important for political reasons. If children respect and pay deference to their elders, such behavior will be the groundwork for developing a similar frame of mind toward the PAP leaders. (pp. 185-186)

Filial piety is not grounded in ethical or religious ideology. The subscription to this value by Singaporeans also helps alleviate the financial burden of old age homes and associated health problems by the state.

The long queues for the right to purchase HDB flats also act as a marriage deterrent. In a fundamentally contradictory way, the media is openly informative regarding these social challenges. The results of a particular Social Development Unit (SDU) survey state that:

“[M]any young couples might delay marriage for as many as five years while waiting for their HDB flat” (Leow, 1997, p. 21). Mixed messages--a kind of victim blaming--from the government seem to be a part of the fabric of Singapore life. I frequently heard about these long waiting lists in buying HDB flats and that private housing was prohibitively expensive while bombarded by government advertisements promoting the joys of family life. This is an example of Smith's (1987a) concept of a bifurcation of consciousness within local practices.
An illustration of the taken-for-grantedness of these housing shortages and their consequences occurred when Dr. Chua, a woman in her mid-30's, was visibly surprised when she learned the ages of my children. In my fieldnotes, I recorded how we shared a few experiences of our own regarding balancing career interests and our mothering roles. She seemed surprised my children were as old as they were. She stated that Singaporean women marry later in life as they must live at home if they are to afford university and other such luxuries. (Dr. Chua, January 10, 1995, p. 10)

Educated young people are openly encouraged to marry and have a family but face roadblocks in buying affordable housing due to government regulations. Observation of these conditions raised my consciousness about the level of privilege life had had afforded me. I had never perceived the age of my children as a testament to this privilege.

This example also illustrates the fundamental contradictions within governmental messages. This doctor is expected to go to university, to work hard after graduation—perhaps pay off student loans—and find time to meet a potential partner, buy a home and raise children. Billboards with young fathers kissing newborns or happy couples embracing a baby with the caption “Children. Experience the joy while you’re young” lined the hallways to a subway I regularly frequented in 1996.

V. Health Care in Singapore

1. Access to private, “for-profit,” clinics systemically facilitated

Privatization, including health care, is encouraged within Singapore. Phua (1991) states:

The Medisave scheme was the major financing method introduced to effect a shift away from a tax-based system to greater cost-sharing and to lighten the burden on government health services. ...[T]here were fears [in 1981] that increasing welfare spending would blunt the population’s incentive to work.
...[Heavily] subsidized Class “C” beds in all public hospitals [were provided]. Like the philosophy in public housing, government policy in health care had been to provide a minimum standard, but with higher income levels, standards would have to be improved to meet rising expectations and the level of subsidy would be reduced. ...In response to the rising costs of health services, [Prime Minister Lee] advocated that the private sector be encouraged to play a bigger role in health care provision in Singapore. Through competition, both the private and public sectors must become more efficient. (pp. 1-3)

Medisave joined up with the Central Provident Fund (CPF) which were compulsory savings plans for those who were employed. Medisave accounts were inaccessible to individuals except to pay “expensive hospitalization costs, within certain limits, of account-holders and their immediate family members” (Phua, 1991, p. 4). The intention behind this financial structure brought down by the government was that it would promote improved personal responsibility towards health.

But as in other sectors of Singaporean society, this promotion of Western ways has brought with it contradictions. For example, Phua (1991) suggests that leaving health care entirely to market forces is not the best plan:

A more balanced public-private mix has to be established instead of leaving matters to dominant market forces, given the peculiarities of the health sector. Hitherto, the private medical sector in Singapore has existed to cater for the up-market demands of the more affluent minority. ...The public sector has to ensure that its policies do not involve colluding [with] the commercial interests to generate cost-inflation for the population nor to provide unfair competition to the private sector. Privatization should not be used as a “quick fix” for cost-recovery or to avoid public accountability in critical areas. (pp. 38-39)

This critique suggests that the health care structure in Singapore is based upon an economic rather than a humanistic model. That is, the approach is intended to “reward” individuals who maintain good health rather than acknowledge the role that organized practices of biomedicine play in precipitating ill health.

A government report (White Paper on Health Care, 1993, p. 18) stated that it was best to “play it safe” and not use up Medisave funds too quickly and to harmonize this source of
hospitalization funding with other insurance schemes. There are various private insurance options including those under employer medical benefits. In addition there are MediShield (a disaster protection program) and the expanded MediShield II (which extends the limits to include more coverage and lowers the "already quite small" deductible). The report quotes the government as stating that the health care financing "is a hybrid of a totally regulated system and a free-market one" (White Paper on Health Care, 1993, p. 18). The key point is that the Singapore government facilitates personal savings and insurance plans to promote economic self-reliance in health care.

Those who are not as fortunate, that is, who are poor or have a chronic condition with inadequate insurance, have a financial safety net of public health care. This is to avoid inadequate health care or to avoid a family's financial bankruptcy. This system is problematic as it inherently "blames the victim" at a time when he or she has the least resources. Thus there may be a loss of face in attending public health care services that acts as a deterrent from overuse by those who can afford the private sector. Nonetheless, compared with other Southeast Asian nations, Singapore's present biomedical health care structure is accessible in some form to all.

This structure is based upon the biomedical view of health. It is economically logical. As is the case in Canada, health care spending is a serious problem. In these countries, the public expects these services for the disadvantaged to be financed by the government.

In Singapore, those with diabetes have an expensive chronic condition that is personally resource costly. Secondary complications associated with the NIDDM form of diabetes often occur after working individuals are retired and no longer have access to the contractual health care clinic associated with their place of employment. In this way they are victimized by a system that reinforces the notion that individuals alone are responsible for their health and should pay for any associated health care.
VI. Conclusion

Lee Kuan Yew's government candidly admits to being an elitist government. He and his cabinet had a long term vision. His focus on economic development has had spectacular results when evaluated from a financial perspective. Thirty years ago Singapore was impoverished, with its inhabitants living under the threat of, or actual rioting. People were poor and the prospects of obtaining adequate health care and other basic necessities did not appear until the PAP began its systematic and authoritative social reorganization.

The PAP is promoting, via social engineering, a society that is a combination of what are viewed as 'Eastern and Western traits' to best serve the government ideology of global competitiveness. There is legislated devotion to the state, with male attendance in National Service compulsory. Capitalism and an authoritarian form of democracy are present. Issues of human rights do not appear to be of primary concern to local people, but it is hard to say because such issues were not openly discussed with me. There is high rate of consumerism that is seen as a necessary "evil." The message through the multiple media campaigns promotes individuals to work hard but not to do so at the expense of family and health responsibilities. "Asian Values" are promoted as the antidote for the violence and "moral decay" that Singaporeans see in Western capitalist societies.

Most important for this inquiry is the rejection by the PAP of welfare state health policies and the establishment of a two-tiered health system in which the majority of patients seek care in private biomedical practices. In this way, patients are treated as consumers and urged to take responsibility for their own health care. There is a 'social safety net' of public clinics for the poor, but as in America, those with expensive chronic conditions such as diabetes may be victimized in this unequal system.
1 (http://windows.ivy.nasa.gov/earth/interior/RIM_of_FIRE.html)

2 This exclusively masculine referral is not entirely sexist reporting. These early immigrants tended to be male only.

3 Chinese names traditionally have their family names listed first, followed by their personal names. It is common to
   address people with all three of these names in this order, or Mr. Lee for more formal instances, or Kwan Yew for
   informal addresses.

4 This governmental power, sanctioned by the Internal Security Act, is still in existence today.

5 As quoted from Tamney, 1996, p. 81.

6 “Muslims in Singapore marry and divorce by Muslim law, which is administered by the Syariah Court. The
   Syariah Court hears matters regarding marriage, divorce, division of property, maintenance, and other things
   pertaining to Muslim law” (Wong and Leong, 1993, p. 87).

7 In 1991 the average Singaporean male life expectancy at birth was 73.5 years which surpassed Canada’s figure of
   73.3 years (Singapore Ministry of Health, 1993, p.2).

8 Canada had an infant mortality rate of 7.2 per 1,000 live births in 1989 and the U.S.A. had 9.7 (Singapore Ministry
   of Health, 1993, p.3).

9 In the population census of 1990, 54 percent of the population was between 15 and 44 years and 77.2 percent was
   under 44 years (Singapore Ministry of Health, 1993b, p. 7).

10 Original author’s emphasis.

11 Tamney (1996) points out that, according to Ian Stewart (1992), “as of 1992 about one thousand ‘vicious, hard-
   core gangsters and drug traffickers’ were in preventive detention” (p. 62).

12 The headlines were in this abbreviated form: “S’pore” referring to Singapore and “govt” to mean government.

13 Original author’s emphasis.

14 Assuming all obligations to the National Service have been met.

15 S$ refers to Singaporean dollars and is approximately equivalent to a Canadian dollar.

16 Sue is a pseudonym. Refer to Chapter Three for the rationale regarding the organization of the pseudonyms. In
   addition, refer to Table 2 for a list of participants.

17 “Kiasu” is a Hokkien term referring to a competitive need to be first in all aspects of life. It is discussed more
   fully later on in this chapter.

18 The PAP and its policies is Chinese-centric as outlined previously in the chapter. A clear limitation of my inquiry
   is the absence of these two significant minority groups. My participants were predominantly, but not exclusively,
   ethnic Chinese. I had informal contact with only two Malay individuals at the DSGS.
CHAPTER FIVE
INTERACTIONS BETWEEN DOCTORS AND PEOPLE WITH DIABETES
IN CONTEXT: RELATIONS OF RULING IN SINGAPORE

I. Introduction

The official health care structure in Singapore is based upon the Western biomedical model. This ‘choice’ is part of Singapore’s subscription to a health ideology that is seen as a necessity for an industrialized nation. The model, originating in the West, is familiar to white Westerners resident in Singapore who are the embodiment of the economic movement toward multinational corporate expansion. In Smith’s terminology (1987a; 1987b; 1990; 1993; 1999), this imposed health care organizational practice in Singapore is a “local” instance of the “extra-local” practice of Western medicine. This is part and parcel of the ideology of a globalized market-driven economy in Singapore.

With its independence in 1965, the government of post-colonial Singapore officially sanctioned biomedicine as the best approach to improve the health of the nation. This approval of exogenous health ideology by the local ruling apparatus forced traditional health practices to be defined as ‘outside’ of Singapore’s own ruling apparatus. Currently, non-Western medicinal practices persist in Singapore, but these are not conceptualized in government textual materials as legitimate ‘health care.’

Concurrent with Singapore’s economic ‘miracle,’ there have been notable increases of Western diseases. Diabetes is included among these “diseases of affluence.” Using an institutional ethnographic approach, I begin with the everyday experiences of people with diabetes and their relations with their primary care doctors. In this chapter, after reviewing the supporting discourse of these relations of ruling, I critically
contextualize these professional relations from the standpoint of experiences of physicians and people with diabetes. In this chapter and the next, I examine the everyday experiences of those within the Diabetic Support Group of Singapore (DSGS) and provide a critical contextualization of the support group's activity within Singapore society.

From these local standpoints, I trace the social processes in ways that best explicate relationships between doctors and people with diabetes. The analysis expands to make visible the ideological character of a globalized marketplace, and its effect upon Singaporean institutions (including health care) that are reproduced in local social relations. Evidence of the relations of ruling within local relationships between doctors and people with diabetes are identified here and were either observed or shared with me during the inquiry. When I discuss local social relations that are related to living with diabetes (or utilizing the Singaporean health care system), I am referring to these as local practices that stand within Singapore's ruling apparatus.

II. Diabetes, Biomedical Treatment and Lifestyle Discourse in Singapore

1. The Western pharmaceutical and technological industries and biomedical treatment of diabetes

The biomedical approach to treating diabetes is heavily dependent upon pharmaceutical and technological products and tests. As argued in Chapter Two, diabetes, especially the IDDM variety, is resource costly for people with diabetes in many ways. The most obvious are the direct financial costs associated with regular home blood glucose testing. These include a glucometer, pricey disposable test strips and lancets.
In addition, the relatively new laboratory blood test that measures "glycosylated hemoglobin" (HbA1c) was, according to Dr. Tang, the latest "gold standard" to measure patients' blood glucose levels. This specialist explained that the HbA1c laboratory test allowed the doctor to see a three-month average blood sugar reading. This meant that the patient could no longer 'cheat' as they could, and often did, with regular glucose testing. They could not appear to achieve target sugar levels with the use of the HbA1c test, by maintaining a strict diet a day or so before a doctor's appointment. This rationale was frequently shared with me as a justification for the regular use of this blood test during "regular follow-up" appointments.

The role of drugs in the biomedical treatment of the NIDDM form of diabetes is controversial. Experts disagree regarding the optimal degree of "aggressiveness," that is, regarding the amount of medication that should be prescribed. As previously mentioned, diabetes is often not treated at all because it is not diagnosed. Huang (1994) states that:

NIDDM should be managed more aggressively not in terms of intensive insulin therapy, but in terms of intensive diabetes management. ...Remember "mild diabetes" or "a touch of sugar" carries risk of complications. (p. 1)

In Huang's (1994) lecture, she points out the importance of strictness in achieving tight glycemic control. Unfortunately, this is more often achieved through adjustments in the levels of medications. Huang's point is that the attainment of a healthier lifestyle should be an important feature of the biomedical model of diabetes management rather than control by drugs.

Recent evidence from a large longitudinal study in the United Kingdom concludes that, under certain conditions, the long-term health risks of pharmacological
treatment of the NIDDM variety of diabetes are greater than those associated with higher-
than-normal blood glucose levels:

[T]hese [medications] may be found to be contraindicated if side
effects outweigh any clinical advantage. ...Individual therapies might
be shown to be more hazardous than beneficial. (Turner, Cully &
Holman, 1996, pp. 136, 144)

The implication of the results from this biomedical study is that the present quantities of
prescribed medications for people with the NIDDM type of diabetes may not be in their
best health interests. Dr. Tang stated that this scholarly article, referred to as the UKPDS,
was not well received within the pharmaceutical industry. This is understandable, as such
reports could precipitate reduced sales of diabetic tablets.

Another important long-term study (lasting 6.5 years) that addresses the
relevant risks related to “tight” blood glucose control for those with the IDDM form of
diabetes is known as the DCCT, or Diabetes Control and Complications Trial (1993).

This study argues the benefits of more aggressive insulin therapies:

Intensive therapy of patients with IDDM delays the onset and slows the
progression of clinically important retinopathy, including vision-
threatening lesions, nephropathy [kidney problems], and neuropathy
[nervous problems], by a range of 35 to more than 70 percent.
(Diabetes Control and Complications Trial Research Group, 1993, p.
983)

The controversy lies in the potential risks of hypoglycemic reactions by treating those
with the IDDM form of diabetes as aggressively as suggested by this study. This
approach is also very resource costly (more insulin injections and blood glucose testing),
risks more hypoglycemic ‘reactions’ and requires increased patient involvement.

As conceptualized within the biomedical model, diabetes requires different
intensities of pharmaceutical and technological interventions depending upon the
diagnosed type. These interventions are resource costly. They require varying levels of patient involvement and biomedical knowledge. In both cases, though, it is argued that healthy lifestyles promote the best overall chances for good health and are acknowledged as important.

2. **A ‘modern’ consumer lifestyle vs. negative health consequences**

A ‘modern’ lifestyle includes a high caloric intake with a disproportionate consumption of refined and fatty foods as described above. But meals from multinational Western “fast food” chains are especially popular and are associated with other symbols of wealth and modernity. An example frequently shared with me that illustrates the resistance to the consumption of healthier foods was the hesitation in switching polished (white) rice for the more nutritious unpolished (brown) version. The reason given me for this relates to the past when unpolished rice typically contained much grit. This food, especially with the elderly, is associated with poorer times and will not be considered as part of a lifestyle change. Rice is a culturally significant food in Singapore across all ethnic groups and tends to be consumed in its less healthy, polished form.

In addition to these changes in diet, there is an associated decrease in physical exercise due to the replacement of manual outdoor work with indoor jobs. Long working hours add to the low rates of physical exercise. Time becomes a scarce resource (even considered “as money”) and the cycle of the “need” for fast-, or convenience-, foods and poor exercise habits is complete. These modern practices, according to a “lifestyle” discourse, contribute to a national, overall increase of diseases of affluence. They also are considered a component of the rapidly rising rates of diabetes in Singapore.
The above activities are those associated with consumerism inherent to the economic ideology that is inherent to globalized capitalist market forces. I am referring to the drive of people to continually buy goods and services which profits multinational corporations. In addition to the need for profit, businesses-without-borders need to continually expand into market “niches” before these are acquired by the competition. The meeting of these fiscal objectives are ensured by advertising and media campaigns that render consumer desire for new and improved versions of goods and services high.

As reviewed in Chapter Four, the Singapore government touts hard work as an integral part of ‘Asian Values.’ Long hours of labour provide the necessary income to purchase products and maintain lifestyles that are increasingly seen by the population as ‘necessary.’ They are also the driving forces behind this Republic’s ‘developed’ status within international economies.

I noted many individuals’ activities that reflected governmental subscription to a globalized marketplace ideology. I frequently heard the expression “West is best.” Singaporeans tend to positively view many Western habits, as they see these as responsible for bringing them increased wealth. There is an enthusiastic acceptance of a modern consumer role and lifestyle. Individuals who contract diseases of affluence experience a disjuncture between the negative experiences of living with a chronic condition and enacting a modern lifestyle. A holistic, less frantic pace of life is a healthy lifestyle. This balanced lifestyle was mentioned at an endocrinology conference in Singapore, where experts complained that “invariably many patients cannot comply” (Endocrine and Metabolic Society of Singapore: Diabetic Management – A New Dimension, fieldnotes, Nov. 12, 1994, p. 6). This ‘non-compliance’ with a healthy
lifestyle is incompatible with Singapore’s organizational processes that reward the adherence to Asian Values. A ‘lifestyle’ discourse blames the individual rather than the prevailing ideology.

Dr. Tang explained to me that the need for a more balanced life is not just for people with diabetes, but for all individuals. By attending a professional meeting, he learned about the uncertainty concerning pharmaceutical diabetic regimens and secondary complications. What he did not see was that the ‘cure’ for diabetes, a ‘healthy lifestyle,’ is also imposed by the extra-local Western diabetic “regimens” conceptualized within the biomedical model. They are also similar to Singaporean activities and diets before the Singapore’s affluence associated with its entry into the global marketplace. Dr. Tang had learned that the basic diet regimen for people with diabetes in Singapore has not effectively changed since 1912, or pre-insulin days, and he believed that exercise can contribute to blood glucose fluctuations. The only proven effective treatment, according to Dr. Tang, was that “when you are deficient, you need insulin” (Transcript, October 12, 1996, p. 22). But he felt that overweight people with diabetes also needed to lose weight and eat a generally healthy diet:

If you are overweight, you might be told that you ought to lose weight because...you tend to fall ill more often. Your knees wear out sooner. ...[I] say, let’s look at the person as a whole. “...[A]re you overweight? Are you fit? Can you step? Can you walk properly?” ...[I am not saying “you need to lose weight] because of diabetes.” Let’s not make diabetes the fall guy. ...[That is], just because you have diabetes you have to exercise. But even if you didn’t have diabetes, I mean if you are overweight, or you are unfit, surely you live a lot better [if these are addressed]. Hopefully. (Dr. Tang SP3, Transcript, October 12, 1996, pp. 22-23)

This specialist espoused the most holistic view of health compared to other physicians with whom I spoke. He was notably insightful with regards to the personal lives and
health difficulties of his patients. Dr. Tang was quick to share illustrative examples of multiple challenges for people with diabetes, including financial and structural, which compromise their ability to live healthy lifestyles. His awareness of the social inequities associated with economic ideology was unusual even though he did not question lifestyle discourse. More typically in my inquiry, physicians did not at all problematize biomedical treatment and discourse about diabetes.

According to lifestyle discourse, contracting an illness is viewed as the individual’s responsibility. But behaviours associated with diabetic regimens, especially the healthy lifestyle components, are incompatible with behaving as a dedicated worker or energetic consumer. This disjunction is further exacerbated for the poor.

3. **Government advocacy of “modern medicine” as a necessity for a competitive industrialized nation**

Quah, a sociologist at the National University of Singapore (1977), states:

The modern health-care system comprises medical doctors, whether general practitioners or specialists, and all other health-care personnel, facilities, and equipment involved in work based on the principles and technology proper of Western medicine. (p. 6)

Quah points out that “the modern health care system in Singapore is, for the most part, a product of active government planning and intervention” (p. 5). The term “modern” medicine tends to be used synonymously with “Western,” that is, scientifically-based, medicine.

As outlined in Chapter Four, this Western-centric perspective reflects the location of Lee Kwan Yew’s policy decisions within a capitalist ideology. The radical shift to Western medicine is part and parcel of Singapore becoming more attractive to
multinational corporations (such as the social movement that my family and I were a part of) from the West. The building of government-supported primary health clinics and hospitals underlines the government’s rejection of existing traditional healing practices. Unilateral financial support of a Western-based model of medicine also illustrates Singapore’s entry into the increasingly globalized marketplace.

It is not surprising that, along with the many other social changes put in place by the PAP, the biomedical model of health care was embraced as an important step in Singapore’s progress or modernization. Medicine is the most powerful of health professions in the West and represents a compelling belief that science is the best route to a healthy nation.

Western medicine tends to have a higher status, and consequently a greater degree of influence on health policies than the more traditional forms of healing:

In most developing countries which are, by nature, undergoing a continuous process of modernization, the official definition of qualified medical practitioners refers solely to physicians trained under the Western medical model. (Quah, 1977, p. 6)

Weidman (1979) adds:

Since it emerged in the Western world, that social institution called “scientific” or “modern” medicine has been sanctioned internationally as being ultimately responsible for the health of national populations. Its legitimization has been an intrinsic part of the technological, social and political process called “modernization.” As such, it reflects the high value placed upon science, professionalism and complex medical technological achievements. Such sanction renders this health institution “orthodox.” All others remain “traditional” within the contexts of various historical processes. (p. 85)

Singapore is no different from other “developing” countries in its official endorsement of an exclusively Western medicine approach to health. A first step after independence was to bring Western medicine “to the people”:
Government intervention has produced results throughout the different phases of health policy since 1965. The initial task of the Ministry of Health after independence was one of reorganization. ... Already in August 1964, a network of 26 government outpatient dispensaries was decentralised ... [to] bring primary health care closer to the people. (Quah, 1981, p. 150).

Implementing Western medicine is part and parcel of Singapore’s entry into a globalized economy emanating from the West, as part of its “modernization.” The political and economic drive behind this switch is evident. The views, or experiences, of users of the health care system were not considered in the decision. Indigenous practitioners became marginalized by being avoided by the English-speaking “educated” Singaporean. This fundamental social change did not result from a Freirian dialogue with those most affected by it. Western ideologies that were part and parcel with capitalism were reproduced within Singapore’s health organizational process. This change was seen as necessity by the government in Singapore in order to secure its place as an industrialized nation.

4. **Biomedical texts and relations of ruling**

Primary care journals, in Singapore as well as in North America, predominantly focus upon the biomedical aspects of practicing medicine. These include articles that review the latest treatments or diagnostic strategies borne of scientifically based research. Articles on topics addressing social relations within health clinics regularly occur but are less frequent in number. Typically, these discuss issues of doctor-patient communication. They consist of biomedical text on issues such as ‘non-compliance’ by patients. Text dealing with the social issues surrounding the practice of primary health care make up a substantially lesser portion of the texts.
Biomedical literature tends to be uncritical of the biomedical model or power relations within health care delivery. An example of a critical topic might include how sexism and elitism are found in society and are reproduced within the health care structure. Bolaria and Bolaria (1994) state (in a non-primary care text) that in Canada there is a tendency for the health care needs of women and minority groups to be under “medical control and domination” (p. 2). Critical analyses of this kind are absent in primary care texts. I examined articles on “doctor-patient communication” and found them tacitly reflecting the biomedical perspective of health care (Bain, 1976, 1977, 1979a, 1979b; Rowland-Morin & Carroll, 1990; Beisecker & Beisecker, 1990; Barsky, 1981; and Beckman & Frankel, 1984).

I discovered the thread of doctorcentrism implicitly woven throughout the stated research purpose(s) and recommendations in these articles. In addition, doctorcentrism is inherently a part of the inquiry design itself. The power relations between doctor and patient are typically imbalanced and are tacitly maintained as such within the texts. Inequities are not usually described and doctor-patient relations are seemingly constructed as a commonsense arrangement. These texts illustrate the unequal power relations found within the biomedical model of health care. I am critical of the unquestioned premises of much of the research I reviewed, as there is a conspicuous absence of all interested parties’ voices, particularly those of the persons seeking medical care.

There appear no references within the biomedical literature that question the health care structure and the interconnectedness between it and other powerful social institutions. I did not locate any references that advocated a collaboration of research
perspective between scholars and people with diabetes within the health care structure including input to both inquiry objectives and related epistemology. The biomedical literature appears silent of the voices of people with diabetes although it dedicates many pages to articles about them.

I find the numbers of drug advertisements in these biomedically-oriented periodicals staggering. Most depict a humanistic theme of doctors prescribing particular branded medicines to reduce their patients' suffering. The implicit message sent to physicians through the glossy photos is that scientifically-based approaches in their practices are more important than their non-science activities such as the quality of their interpersonal skills. Drugs are a part of the science of medicine and are inherent to the biomedical model of health care. Drugs are considered curative, or as second best, symptom-controlling agents. Their selection, or use at all, is typically under physicians' control with little solicited patient input into this process. The influence of the pharmaceutical industry is high and reflects the economic ideology inherent to the ruling apparatus. In Rachelis and Kushner's (1989) book, which critiques this arrangement, they entitled a chapter: "The drug industry, or how to make money and influence doctors" (p. 91). Specific sets of information from patients are required for this matching-of-drug-type-to-disease aspect of the practice of medicine. Patient 'participation' is depicted as important, since they are the providers of the necessary clinical data so that the physicians can decide the best treatment plans. Nevertheless, social relation skills are portrayed as secondary to the clinical abilities required within the biomedical model of health care. This impression is supported by the frequency of drug advertisements coupled with the disproportionate literature dedicated to biomedical articles that outline
particular drug and other medical therapies or treatments. I could find no articles in the biomedical journals that explored patient-directed topics regarding clinical encounters.

Finally, the journal articles on psychological issues in the clinic, such as doctor-patient communication, are problematic in essentially two similar ways. The first of these deficiencies lies in their exclusive focus on inquiries with postpositivistic orientations to research. This epistemology is reflected through heavy reliance upon quantitative research methods, for example mailed surveys, and a seemingly apologetic tone for an inability to perform randomized controlled trials. Qualitative data are absent or is presented as secondary, either as illustrations of the ‘true’ interpretation of findings yielded by the statistical analyses or as ‘pilot data’ leading to quantitative research.

An example is a recent article in the *Journal of Health and Social Behavior* by Peyrot, McMurry Jr. and Kruger (1999) entitled, “A biopsychosocial model of glycemic control in diabetes: Stress, coping and regimen adherence.” This research used a random sample of people with diabetes who completed a questionnaire. These data were statistically linked with the results of a blood test (glycosylated hemoglobin or HbA1c—which provides objective evidence of the average blood glucose levels of an individual). There was no voice from people with diabetes in this study. Rather, the focus was upon the generalizability of the findings—even beyond the diabetic population—and the argument was that these data substantiated the provided explanatory model.

The biomedical literature reproduces the professional organization of western biomedicine by method of inquiry inherent to discourses of science as well as via substantive content. The texts exclude people with diabetes or they are objectified within
the biomedical model. Physicians read these literatures and in turn behave in ways that reflect these institutionalized processes within their clinics.

III. The Experience of 'Modern Medicine' in Singapore

1. Participant experiences of biomedical mismanagement in Singapore

I heard many instances of medical mismanagement throughout my interviewing. The most frequent problem shared with me centred on people with the IDDM variety who received inadequate medical attention just prior to their diagnoses. Sue pointed out:

I've seen the treatment prescribed by a few GPs. Some are excellent. Some are dangerous. [People with the IDDM variety of diabetes are being told by their doctors] ...to only take tablets. (Transcript, June 12, 1997, p. 30)

One of the reasons people with IDDM are more likely to be unhappy about being biomedically mismanaged is that complications can be dramatic and swift. Unlike diabetes of the NIDDM variety, if left untreated, DKA (diabetic keto-acidosis) and other complications can progress quickly, rendering the individual with the IDDM variety gravely ill. According to my participants, these complications are more likely to happen prior to diagnosis when the physician does not identify the sickness as diabetes.

The founding member of the DSGS experienced serious medical mismanagement causing her to lapse into a diabetic coma. She was not alone in her avoidable, near death experience. Another support group member shared the effects of her being misdiagnosed:

Sarah: [Singapore doctors] don't want to tell you too much, you know. ...They just say take this medicine, do this, do this, that's all. In fact, I
tell you, at the time [that I was first diagnosed] with diabetes, I was...given tablets. But what happened, when I went home, I took the tablet and [became hyperglycemic, i.e. experienced high blood glucose levels]. I don't know what happened that night. I was feeling very bad. And I was hospitalized immediately that night. And the doctor said "luckily I came on time. Otherwise--gone."—

Liz: You would have gone—[do you] mean you would have died?

Sarah: Yeah. Because I was feeling very bad.

(DSGS Focus Group, November 26, 1997, p. 21)

This DSGS member did not appear upset or angry about the medical mismanagement. She sounded resigned to her experiences and did not question the injustice of not being adequately diagnosed. Later on in the focus group, Sarah’s tone appeared the most frustrated when she referred to her physician not taking the time to properly educate her. Sarah’s diagnosis of diabetes should have been the IDDM variety. According to her account, her ill-informed physician prescribed a treatment plan that corresponds to the NIDDM variety, which nearly killed her. Another support group member had a similar experience. Pauline shared her frustration at not being heard by her GP. As was the case for Sarah, Pauline ‘paid’ for her physician’s error by going into DKA and requiring hospitalization:

Pauline: (voice very soft) Do you know [that] I went to the first GP that was treating my diabetes? She put me on tablets. And that was the first time I was diagnosed. What happened was that I [had] a lot of questions to ask. I really want[ed] to know. I want[ed] to manage it. And finally, every time I went to see her, I came prepared with all [of] these kind of questions. She told me one day, “Do you know we charge according to time? So if you take a longer time, you have to pay more.”

Liz: Ah—[pause]. So you felt bad?

Pauline: No. I was like, “So you are telling me I should read up?” And she said, “You are the educated individual, you should go and read up on things like—"
Liz: Did you keep that doctor?

Pauline: No.

Liz: Was that your last visit?

Pauline: It wasn’t my last visit because I didn’t know who to go to. All right, finally, I stayed with her until I went into DKA.... I went to the office [for]...my appointment and finally she was--she started getting nervous. She checked my blood [glucose level] and [found it] was very high. She said, “I think it’s time for you to go to a hospital.” (long pause, Pauline is visibly upset.)

Liz: [soft voice] It’s frustrating.

Pauline: Yeah. I was so angry with her. Okay. (changes subject) (Pauline transcript, September 28, 1995, pp. 33-34)

The sense of helplessness and anxiety associated with feelings of illness were clear in the above account. Not being given the correct treatment did not seem as stressful as the humiliation of being told by the doctor to not ask so many questions.

In Poh’s autobiography, she named her hospital physician “Doctor Whirlwind”:

I looked up at [the diabetic nurse educator]. I needed to know what “Doctor Whirlwind,” the one who was always very busy, never told me. “Tell me, what is diabetes exactly?” (1995, p. 24)

Although written in a light-hearted fashion, her message is clear: physicians in Singapore do not “slow down” enough to satisfactorily explain the nature of diabetes to their patients who have this condition.

Hope’s correct diagnosis of diabetes, also of the IDDM variety, arrived too late in her pregnancy:

I was, I was actually, my baby, actually it happened when I was alone. ....My baby was due...and I lost the baby. [repeating] And I lost the baby. And I didn’t know that I was having diabetes. [She describes her feeling of illness]. By the time I was rushed to the hospital, you
know, the nearest hospital.... The baby was already... there was no heart beat and they couldn't, you know, hear the heartbeat...... ...There was this doctor that came along and, well, she told me that my baby was gone, you know. And... she told me that I was having diabetes. Okay.

So what happened was, I remembered [after having the baby, the doctor] still came back to see me. Later on, you know, after the delivery, I [was told] to go back to her. But I didn't know what [for].... The amount she was charging me was based on how much time I had with her. I didn't know... anything about diabetes. She asked me to go back to her for a check-up. And I went there and I asked a lot of questions. The first time, she didn't want to tell me.

I take insulin. ...I went to...[a] bookshop to get a book on diabetes. Later on I found out so much about diabetes. The next appointment was with [this doctor]. I asked her [various questions]. I was having [hypoglycemic reactions] and I didn't know.... You know, I didn't know what it was. And she didn't want to tell me. She didn't tell me anything.

And the next time she also charged me--so expensive you know. And I asked the nurse, I asked her, “Why is the price, I mean the fee so high?” She said “because you spend too much time with her.”

(DSGS Focus Group, November 26, 1997, pp. 18, 19)

Hope’s shared grief with the focus group did not include reference to the needlessness of her poor prenatal care. Hope remained focused upon not understanding her diabetes. She reported frustration with her physician’s reluctance to educate her while charging high consultation fees. Hope did not question the cause of her inadequate medical attention.

In the above three narratives, Pauline, Sarah, and Hope do not overtly question the need for their physicians to be better educated regarding the diagnosis and biomedical management of the IDDM variety of this potentially fatal disease. Instead they shared their negative experiences in dealing with their physicians after the clinical mismanagement. Their reports focused upon high consultation fees or poor diabetic education. This is an illustration of how the extra-local is imposed on the local. These tragic “local” experiences did not precipitate any questioning of the “extra-local” hierarchical organization of physician power within the health care system. All three of
these participants, however, eventually switched to diabetic specialists (endocrinologists), making use of their ‘power’ as health consumers.

The lack of education by their physicians in managing their IDDM was also a source of frustration for some support group members even when their management appeared biomedically sound. Anna recounted her experience:

I was diagnosed [by] a GP and I was [given] medicine and never [told] anything. [mocking tone of voice] “It’s diabetes and take your medicine happily!”...I was [put on] pills....I was expecting [a baby]. I was not so lucky, I did not go to Dr. [named a popular specialist frequented by DSGS members]. I was referred to another doctor. It was terrible. He just gave me charts [saying] “these are the foods you don’t eat.” You know. Okay, injections twice a day, and then, nothing about diabetes. And I was expecting! This is very bad and I think I was with [this second doctor] for two or three months. I happened to be at my in-laws...[and] they [asked] me “[Do] you want to change doctors?” I changed...[recounts how happy she is at the above mentioned popular specialist]. (DSGS Focus Group, November 25, 1997, p. 37)

This woman did not sound emotional and was, in fact, mildly sarcastic (by Western standards) in expressing her frustration. She described her situation as doubly medically ‘mismanaged’ because she was expecting a child and should have received better diabetic education by her physician. As was the case with the other three members, Anna changed physicians.

2. Biomedicine and paternalism in Singapore

I heard many times at the DSGS that the continuity of health care service in Singapore, particularly in the PCs, was poor. This term refers to patients frequently switching physicians and/or clinics, rather than remaining loyal to a particular physician. My experience at one PC was that younger physicians completing their government service contracts were not directly requested by name or door number. People with
diabetes who do not read English also tended not to see the same physician. The full-time
doctor at the polyclinic did have his loyal patients with diabetes. These loyal patients had
learned that the system allowed for such requests, but this information presumably had to
be gleaned by the patients themselves.

The ability to ‘vote with their feet’ within health care presumably empowers
Singaporean health care consumers, since they can “take their business elsewhere.” And
they apparently frequently do. This practice, referred to pejoratively as “doctor shopping”
or “doctor hopping,” can be seen as signalling a fundamental dissatisfaction with primary
care services in both the public and private health care sectors in Singapore.

My impressions of the ideal type of doctor as viewed by Singaporeans is that
of a humanistic professional who nevertheless possesses many paternalistic qualities.
Emanuel and Emanuel (1995) describe a paternalistic physician as one who

ensures [the] patients receive the interventions that best promote their
health and well-being. ...[T]he physician presents the patient with
selected information that will encourage the patient to consent to the
intervention the physician considers best. ...In the tension between
patient’s autonomy and well-being, between choice and health, the
paternalistic physician’s main emphasis is toward the latter. (pp. 163-
164)

In their North American article, Emanuel and Emanuel (1995) argue that a paternalistic
approach from the doctor is only justified during an emergency situation and that
“[b]eyond such limited circumstances...it is no longer tenable to assume that the
physician and patient espouse similar values and views of what constitutes a benefit” (p.
172). In an article in The Singapore Family Physician, by way of contrast, Goh (1993)
expressed a different view: “Paternalism is traditionally frowned upon, yet it may be
appropriate if the patient is not in the situation to decide because he is unable to
understand or too young to decide" (p. 7). Many people with diabetes whom I interviewed appeared to equate humanism with paternalism when describing a ‘good’ doctor. The key qualities were described as “not rushing” and “listening” to the patient. This type of physician is depicted as generally knowing what is best for the patient with regard to diabetic regimen planning. Goh (1993) comments:

The doctor-patient relationship is in essence a balance of authority on the part of the doctor on one hand and autonomy on the part of the patient on the other hand. Each party exerts a varying degree of responsibility and control to the relationship. ...If the patient takes control (autonomous), the doctor needs to understand why the patient wants control; the doctor needs to set limits for the patient’s good and other considerations. (p. 7)

The doctor’s status as a professional grants him or her a higher ranking in the hierarchical relationship. In other words, I did not find that lack of patient autonomy was a complaint of people with diabetes in their relations with their physicians in Singapore.

Lai Sim’s view of doctor-patient relationships as a health professional (not associated with DSGS) was that her working-class patients would want physicians who were more approachable but would consider this to be unattainable. Lai Sim cautioned me to be aware that the doctors as well as the poorer, least Westernized patients would embrace the paternalistic social structure of primary care. She predicted that neither physicians nor patients would be ‘ready’ for critical feedback regarding relations between doctors and people with diabetes in Singapore:

Although people are very open about things and they will share some things with you, [n]obody wants to be put on the line...where fingers are going to be pointed afterwards [by people in power to physicians] and say: “Look, the communication between physicians and patients is abysmal. You’ve got to improve.” This is something the physicians won’t tolerate. And it is not just the physicians not tolerating it. It is also their--patients have such a strong belief in this, the physician being a God. It will be difficult....
Even the [inquiry] results. I don’t know. It might take years [for people to consider the relevance of the inquiry] because the patients themselves, they can’t--It’s like when you are a child and you believe in Santa Claus and then [you hear] “there’s no Santa Claus.” You say “No, there has got to be a Santa Claus.” That sort of situation. The patients themselves, they have a belief in [their doctors having this God-like status]--and they don’t want to have their “Santa Claus” taken away from them. Because no one knows exactly how to make them better. (Transcript, May 10, 1994, p. 2)

Dr. Zhong, an especially popular HDB physician, appeared to me an unhurried and candid individual. I formed the impression, by the stories shared with me regarding GPs in Singapore, that he was exceptional in his ability to retain patient loyalty and trust. These impressions notwithstanding, the reports and discussions with my interpreter and my own observations led me to see that his manner was subtly paternalistic. He did not solicit patient input into regimen planning. Rather it appeared that, in a fatherly manner, he ‘understood’ the various educational and socio-cultural contexts that influenced his patients and made allowances for these. But based on reports from patients with diabetes and my observations of these older people with diabetes, I determined that they did not wish a physician to negotiate their health care strategy. One such report regarding Mrs. Lee from my Chinese interpreter noted:

[Dr. Zhong] also asks her to eat fish. ...When the doctor said [to not] eat too much durian,² [Mrs. Lee] completely stopped eating it. [She said that] she can control herself very well [and is] not like some others who cannot resist. ...[Mrs. Lee always follows and obeys doctor’s advice--... [When asked about her input into a diabetic regimen Mrs. Lee responded that] she has never [given any input but that] she faithfully follows her GP instructions. [She added that Dr. Zhong] has never asked for any suggestion. (Mrs. Lee, Transcript Report, May 15, 1996, pp. 1-3)

This is not to say that Dr. Zhong was not sensitive to his patients as individuals and knowledgeable about their customs and beliefs beyond his own Chinese experiences. For
instance, he pointed out that he knew his Malay diabetic patients had difficulties during their daylight fasting times during the Islamic high holiday of Ramadan (Fieldnotes, May 15, 1996, p. 1). When we were discussing the average literacy of the patients in his practice, he comments:

I would say that the older ones [are] illiterate. Quite a big percentage of my patients are illiterate. ...Illiterate in the sense that they don't read and they don't write. ...But they are pretty intelligent people.
(Transcript, December 5, 1995, p. 3)

He pointed out that the elderly tend not to speak Mandarin and usually “speak all sorts of dialects. I am used to dialects, I speak something like four or five dialects. Maybe more, I don't know” (Transcript, December 5, 1995, p. 6). Dr. Zhong appeared to be the doctor type preferred by many participants in my inquiry. This professional exhibited many humanistic qualities that demonstrated his valuing the dignity of his patients. He respected his patients; however he did not educate in a Freirian dialogic fashion as there appeared no solicitation of his patients’ worldview regarding their diabetic regimen.

To summarize, it appears that many people with diabetes in Singapore may not wish to negotiate a diabetic regimen with their doctors as social equals. Rather, humanistic and altruistic qualities were mentioned as the most desired (or missing) personal feature in their physician. This paternalistic approach to health care reproduces the biomedical discourse that holds the tenet that ‘doctor knows best.’

3. **Stratified access to care in the dual public and private health care structure**

As explained in Chapter Four, in 1983, Singapore’s National Health Plan was introduced. These policies reorganized health care finances towards increased privatization of public hospitals and compulsory personal health saving plans (Phua,
Singapore’s present-day dual public and private health care structure is not a reproduction of any one Western model. It was intended to be one that learned from the mistakes of other nations that were seen as too dependent on the state for health care:

Since the existing Singapore system had evolved historically from the foundations of a heavily subsidized tax-based health service laid down by the British colonial government, there were fears that increasing welfare spending would blunt the population’s incentive to work.

(Phua, 1991, p. 2)

In addition, the National Health Plan had provisions for subsidized medical care for the poor: “[T]here would be limits to government subsidy for social services, as the policy would remain that subsidies are meant for those who cannot afford to pay...” (Phua, 1991, p. 9). This strategy was intended to best secure population health in the most economically efficient manner.

Between the years 1992 and 1996, the public sector reduced its financial support of primary health care from 25 percent to “about 20 percent” of the Republic’s total visits (Singapore Ministry of Health, 1992, p. iii; Singapore Ministry of Information and the Arts, 1996, p. 252). Between these same years, the provision of publicly financially assisted hospital care remained at 80 percent (Singapore Ministry of Health, 1992, p. iii; Singapore Ministry of Information and the Arts, 1996, p. 252). The remainder of health care services is provided within the private sector (Singapore Ministry of Health, 1992, p. iii; Singapore Ministry of Information and the Arts, p. 252).

In 1992, the person per doctor ratio was 830:1 whereas in 1995 it had decreased to 667:1 (Singapore Ministry of Health, 1992, p. 31; Singapore Ministry of Information and the Arts, 1996, p. iv).
Polyclinics (PCs) were described to me as “big multi-centres” located away from the core of the city. These outpatient clinics had many doctors in training who, according to Dr. Sykes, a general practitioner, had to “pay back their services to the government for three years” (Fieldnotes, January 10, 1995, p. 1). Dr. Ong, a specialist, stated that the “majority” of Singaporeans frequenting the “PCs are from the lower SES” (Fieldnotes, December 6, 1995, p. 2). This is consistent with the mandate of the PCs:

Public sector clinics, though only responsible for about one-fifth (18 percent) of primary health care patient-load in the country, provide care more to the elderly, the young and the lower socio-economic groups. This is in line with the mission of the primary medical care provision by the public sector. (Emmanuel, Tan & Choo, 1994, p. 88)

One specialist commented that the PCs are “very busy, tend to treat the elderly and can process up to 700 people per day” (Dr. Ong, Fieldnotes, December 6, 1995, p. 2).

In addition to this demographic difference, the disease profile within the PCs is dissimilar to that in private sector:

The disease pattern in [the] public sector has a much higher component of chronic diseases, which is to be expected since these diseases require long-term medication. Charges at government clinics are cheaper than the private sector. …Public sector primary medical clinics…manage a significantly higher proportion of “well” visits. (Emmanuel, Tan, & Choo, 1994, p. 88)

There is little available information on PC practices but one PC physician in a 1994 unpublished profile of his own practice noted that he “saw a total of 409 patients [or 74 per day in 5.5 working days] in one week…[with] the average length of a consult [being] about five and a half minutes” (p. 2, 6). This physician found that hypertension, diabetes mellitus and upper respiratory tract infections were the commonest problems seen. …Diabetes and hypertension account[ed] for about a third of patients seen. Not only are they very common, but they are both chronic conditions with potentially serious long term complications. (pp. 2, 6)
The PC that I visited was a medium sized, plain building away from the downtown core:

It was three stories high. It was an open-air building, that is, it was not air conditioned. It had many open, barred windows [with] fans whirling all around. ... It was bright and clean and sterile.

... Immediately to the right of the front entrance was the registration area, straight ahead was an information desk, past the registration desk were eight doors along the far wall with rows of attached chairs in front of them.

... Above a counter was a sign that read "registration desk" and beside it it had an electronic number board which stated "now serving #___" with the numbers changing with a loud electronic beep. The numbers were not in any order which could help the PC patients "guestimate" their waiting time.

Beside the registration desk was a sign which stated "clinic charges." ... There were approximately 60 chairs in front of the registration desk. ... The information desk had two women behind it who appeared to be nurses. They were passing out papers to a couple of people. ... The far wall was a series of closed doors, each with a name on the door—some said "consultation" under the name, one said "nurse practitioner" and a couple said "treatment room." The waiting area in front of each door— it was all one big open area—had 16-20 chairs that were attached in groups of four. The names on the doors were of the temporary type where the letters were removable.

There was an electronic mini board beside each door which stated "now serving #___" with a light that flashed and buzzed when it was time for the next in line to enter. (Fieldnotes, April 3, 1996, p. 1)

The PCs have various diabetic screening and education programs. PC doctors are encouraged to perform "opportunistic screening" such as a blood pressure checks. These doctors also encourage their patients to participate in the various health care opportunities available at the PCs (Dr. Ong, Fieldnotes, December 6, 1995, p. 3). The PC that I visited held various clinics on the second and third floor. There were informative health posters and information pamphlets that were mostly written in Chinese.

In 1991, approximately 46 percent of practicing physicians were in the private sector; by 1996, this had increased to 51 percent (Singapore Ministry of Health, 1993c, p.
Private GPs [treat] a much higher proportion (68 percent) of working persons than government clinics (37 percent). This could be related to contracts being awarded by companies to various private GP groups for outpatient treatment of their workers. Furthermore the cheaper consultation fees and medication charged by government clinics and their operations during “office-hours” make these clinics more geared to the needs of the non-working population. (p. 88)

I differentiated between “Orchard Road Type” (ORT) and “Housing Development Board” (HDB) private practices for two reasons. The first is that the ORT of private practice tends to be within the central shopping and business districts, often near the prestigious Orchard Road. The HDB private practices are within the HDB complexes described in the previous chapter, and are located away from the central shopping and business districts. The second reason for my differentiating between these private practice types is class-based. ORT practices are usually more expensive and have more luxurious environments than do those within HDB complexes.

HDB private practices account for the majority of primary health care visits.

The ground floor of the towering HDB apartment blocks were prime locations for these private physicians’ clinics. The HDB type of clinic tended to be solo or single partnered and less expensive than its ORT counterpart. The practice that I visited was tiny compared to Canadian standards. The only language I noticed was Chinese. Here are my observations of Dr. Zhong’s practice:

[T]he waiting room was more like an enlarged hall with a bench alongside the walls. On either side of the nurse’s station are two doors, one for each doctor. ...An electronic number showed in the clinic, like in a bakery. It blink[ed] and buzz[ed] when [the number] changed. A businessman, wearing a shirt and tie, sat and read the paper after having seen the doctor. A doctor [not Dr. Zhong] called to the desk to get
[some] medications from the nurse. (Fieldnotes, December 5, 1995, p. 1)

On a typical day Dr. Zhong sees between 50 and 60 patients at his HDB practice. The HDB type of clinic serves many of the non-English speaking local people. Dr. Sykes, the general practitioner, added that the elderly, women and children are most likely to frequent these small, solo or partner-based clinics (Fieldnotes, March 21, 1994, p. 1).

By way of contrast with HDB type practices, ORT primary care practices tend to have much larger consultation areas. I was told that many have salaried doctors who work from several satellite locations. These tend to be found within more prestigious centrally located areas that surround the Orchard Road shopping and business districts. Some of these private sector practices are so profit-oriented that they are registered on the local stock exchange. Multinational companies regularly have contracts with particular clinics but patients may select the satellite location. Physicians have to work within the financial limitations of the contracts and insurance plans that they negotiate as well as with the willingness of the PWD with less than total coverage to pay for the prescribed treatments and consultations. These corporate insurance limitations are discussed later on in this chapter.

The ORT clinic that I visited had 14 physicians on staff working five and a half days per week (a typical Singaporean workweek). The waiting area was very large, with three women working behind a work station. Here are my observations:

The waiting room had one central area with 12 seats in the form of [a series of] cushioned benches…. [In the middle of these benches was a child’s Leggo bench….There was a long hall at the end of the waiting area which had various doors with physicians’ nameplates on them. Between these doors were more of these cushioned benches in groups of fours and threes. I…figured there were enough seats for 15-20 people. (Fieldnotes, Thursday, February 8, 1996, pp. 1-2)
Some doctors could be seen from the waiting room. More commonly, though, a nurse instructed a patient in English to enter into the physician's office. At least one consultation room was not in use as I was permitted to conduct my interviews there. I never heard the calling out of instructions or electronic buzzers, as was the case in the other types of practices. ORT practices are more akin to those familiar to Canadians with the exception of their in-house drug sales and consultation payments.

Tan (1992) reports that

the recommendation of the Singapore Medical Association for a GP consultation has been revised in 1993 to $12-$20 for a short consultation and $20-$40 for a long consultation. (as cited in Goh, Cheong and Phua, 1993)

The consultation fee does not go directly into the pocket of the ORT physician but rather is income for his or her business against which expenses must be paid. 'Profit' from such practices is slightly higher, on average, than income from a locum:

The $6,000-$8,000 [per month] range corresponds to the prevailing gross remuneration rates of locums and $10,000 corresponds to the gross remuneration of established GPs and GPs who possess higher qualifications. (Goh, Cheong and Phua, 1993, p. 497)

As in the West, physicians and their salaries were frequent topics in the press. Both specialists and GPs were regularly described as leaving the public sector for the private sector in order to earn more money ("More Specialist Doctors Leave," 1994, p.2; Teoh, 1994, p. 3).

4. Power imbalances in interactions between doctors and people with diabetes

Inquiry participants who attended either ORT or HDB type private health clinics reported that they did not wish to go to these government-sponsored PCs because
they felt that the standards of care there were not as good as in the private sector. They also made clear that their time was too precious to be spent waiting to see a physician and to collect medicines. This “time is money” ideology was mentioned a number of times as a reason to not attend a PC. The perception of long line-ups was the most frequently cited reason for the avoidance of PCs.

These perceptions appeared grounded in reality. The actual consultation time varies between PC and the private sector. As mentioned previously in an unpublished profile, a PC physician saw 74 patients a day on average. Patient waiting times in the PCs were often reported to be over two hours in length but when I asked two ORT physicians how many patients they see in a typical day to which they both replied between 20 and 29 people. Waiting times in the private sector were reported to be “reasonable” and under a half an hour in length. The HDB physician stated that he typically sees over 50 patients per day. Patient waiting times at HDB clinics were also similar to those at the ORT clinics.

I was told that “common” people attended PCs. It is thus feasible that people with diabetes who were not attending these clinics might feel a loss of face if they were forced to attend a PC clinic. That is, the lower direct cost of PCs was reported to come with an indirect cost: loss of face and time. These are two prized resources for the Chinese Singaporean. On the other hand, my experiences observing my Chinese-speaking assistant interview people with diabetes in the PCs, coupled with our discussions afterward, did not lead me to the conclusion that the nine individuals attending public clinics in my study felt a loss of face. The two English-speaking participants, one elderly
man and the other a young woman, both stated that they were attending PCs over private clinics for financial reasons, but found the care to be acceptable.

I heard stories from, and about, people with diabetes who had switched to PCs from the private sector because they could no longer afford private care, or because their company package no longer covered their health care costs. Dr. Ong, a specialist, explained that 12 percent of the population has diabetes and that over 80 percent of these people with diabetes attend the PCs (Fieldnotes, December 6, 1995). These statistics suggest that most of those attending the public health sector were at one time accessing the private sector. This is because the public sector is responsible for only 20 percent of Singapore’s primary health care. Individuals who can no longer afford the familiar health care system must switch to the public sector when they are the most ill. They may pay less for health services but they face increased costs in terms of time and potential loss of face by switching to PCs.

Eighty percent of primary health care remains in the private sector. It thus appears that there are at least three deterrents to attending PCs. First, there is the prospect of loss of face by those who can afford private health care. Second, the perception that the quality of health care is proportional to the personal cost of treatment also seems effective in keeping middle-class patients out of the public health care sector. People with chronic conditions, such as diabetes, are ‘blamed’ for having inadequate financing for their ongoing health-related expenses. The health care structure reproduces the relations of ruling through its dual type of health care system, which minimizes the drain upon public resources while presumably optimizing the health of its workforce. Third, through advertising campaigns, the government preaches to the population about living a "healthy
lifestyle.” This capitalizes on the “traditional values of self-reliance and strong family ties” (Phua, 1991, p. 4). The ideology of self-reliance extends from the personal to the family and is an integral component of the relations of ruling. The social expectation of being “responsible” for one’s own, and one’s family’s, health and health care costs is an illustration of the extra-local practice of power. It appears to be the primary force behind the promotion of attending primary health care in the private sector.

In Singapore, language ability adds another cultural dimension separating physicians from patients. Physicians speak English, which is considered a language of higher status. Doctors frequently speak, or are conversational, in other Chinese dialects or languages, but there is no guarantee that the language of the patient will match that of their doctor.

Smith refers to the institution of education as having a “status structure [that] organiz[es] its internal relations [with respect to] sources of knowledge and academic standards” (1987b, p. 27). In a similar fashion, doctors’ levels of education, social Westernisms and multiple language skills contribute to their high social ranking in Singapore. This may also provide a social distancing with their poor and/or least Westernized patients. I discovered there to be an unquestioned acceptance of physician authority from those who possessed few Western mannerisms. The following are some of my observations and experiences that were shared with me:

Lai Sim, a health care professional not affiliated with the DSGS, recalled many patients who were reluctant to question their doctor’s authority and who would remain silent in their 10-minute clinical encounter. Sometimes these individuals saved their questions for the doctor’s receptionist. I learned that, at other times, those with little
education would bring a family member who was perceived as having a higher status.

This family member would be the one who directly communicated with the doctor on the patient’s behalf.

The mostly unilingual Chinese people with diabetes attending the government PC and HDB clinics that I visited did not appear to question their physicians’ authority regarding diabetic regimen decisions. This included their acceptance of doctors’ professional ‘right’ to lightly scold, or reprimand, non-‘compliance’ with his/her orders. Conversely, participants who frequented ORT clinics shared their impressions with whom PC doctors were often rude to their patients.

Gopal, a member of the DSGS, is a person with diabetes who frequents public hospital clinics and PCs. He used to attend an ORT clinic due to his company’s health insurance. After he was fired due to diabetic complications, he could no longer afford private health care. Gopal expressed his dissatisfaction with the personal treatment received in the public health care system. He gave an illustration of a fellow public hospital roommate who was in pain and who, allegedly, did not receive proper attention. This man did not directly ask for help and, according to Gopal, was given little respect within this public ward:

At night time [the man] cried and cried, asking for help [very animated]. No one dared to touch him. And [it] happened the sister [nurse] walked by…. [Gopal said:] “Sister, this gentleman [explains situation]....” She said “No, sorry, no instructions from the doctor, we cannot do anything [for the dirty dressing].” [Gopal] said...”go pat him or whatever and he will feel much better.” ...So they [went] and...did something for him. This gentleman cooled down. (Transcript, February 14, 1996, pp. 31-31)

Gopal was animated in his detailed accounts of how his roommate was not receiving basic care after five days. He did not question this man’s passivity with regards to the
situation but was critical of the hospital staff. According to Gopal, this man lay in the wards never questioning his right to request treatment. Neither, apparently, did the nurses question the authority, or, in this case, inactivity of the physicians.

Gopal differed from the ill man and the nurse, as he did not respect the Asian ‘value’ of not critiquing authority. It appears that those with the least power are thus socially oppressed within the health care system in Singapore. From a Freirian perspective, by not complaining about his lack of treatment, the ill man appeared to ‘house the oppressor’ and reinforced the status quo. But from a biomedical perspective, Gopal would have been depicted as the aggressor because he was critical of the system of decision-making within the extra-local practice of the power structure of the hospital.

Gopal was aware of the differences in social status between poor patients and physicians. He stated that he also received poor treatment and that this was intolerable. Although not highly educated, this person with diabetes spoke English, previously made a good living and had access to ORT level of health care. His experiences within the public hospital and related hospital clinics were not positive. He shared many of his frustrations with a professor at the hospital who took the time to speak with him. The academic explained that physicians do not socially engage with their working class patients. Here is Gopal’s account of this situation:

Because they are doctors,...[t]hey are very proud...[and] cannot accept what the patient ask[s] them. [If they responded, the doctors would lose face] because we are laymen. ...I don’t accept such a powerful thing. Because we understand, you see? ...They are no better. (Gopal, Transcript, February 14, 1996, p. 27-29)

Gopal suggested to me that physicians use working-class patients to vent their frustrations in order to alleviate some of the stresses of their jobs. “Their job is very
difficult. ... We appreciate [their challenges], but [they] cannot ill-treat [their] patient[s]” (Gopal, Transcript, February 14, 1996, p. 30). Physicians are awarded the most authority within the hierarchical health provider setting. In the public health system the social distance between themselves and their patients is at its greatest. Gopal’s account illustrates the inequity and potential for abuse by those in power.

Lai Sim, the health care professional not affiliated with the DSGS, expressed a similar view. She explained that physicians not only hold the most power within the primary health clinics but that many patients are reluctant to try and challenge this power differential:

Windows are opening up for [people with diabetes]. They are just so happy that they can actually talk to somebody [referring to their talking to Lai Sim about their experiences living with diabetes]. They said to me that sometimes they thought that they would love to question the physician but they had to find somebody that was higher in the hierarchy who was at the level of a physician. [This had to happen] before they could even talk to their own physician.
[This is] because they won’t feel comfortable to go on top of all of these ladders. So they are quite thrilled to be able to speak to me. And they’ll tell me so [many things] that they’ve never told a physician. And they’ll even tell me “don’t tell my physician because I haven’t told him this,” you know. (Transcript, May 10, 1994, p. 6)

This is another illustration of people with diabetes who are poor and/or least Westernized housing the oppressor. Lai Sim pointed out that the enthusiasm of poor patients in sharing their experiences of living with diabetes and their many questions demonstrate their desire to have such relations with their physicians. Paradoxically, this lack of sharing experiences of living with diabetes and questioning by the people with diabetes is part and parcel of poor patient ‘compliance.’

Lai Sim was one of a number of informants who insisted that patient education is done poorly with patients of low socio-economic status (May 10, 1994). The
counselling, if it existed, was usually described as brief and many times wrong things were taught. Patient education is seen as an important feature within a modified biomedical model. The objectives are to facilitate patient understanding, and valuing, of a prescribed, or hopefully negotiated, diabetic regimen. Lai Sim appeared open to patient input into the negotiation of a diabetic regimen but maintained that Western medicine was the “best” approach to “treating” diabetes. She believed that this was poorly achieved in Singapore with individuals who could not afford private health care.

Dr. Zhong, the private HDB clinic physician, described his experiences of providing PWD education. He pointed out that he tried not to ‘overwhelm’ the person with diabetes with too much information. His response to my questioning about how he organized his clinical time around such communicative activities was:

You see the problem with this [time challenge is]—that we fellows [referring to GPs] tend to, after some time [as practitioners] become a little bit more worldly wise. We give [people with diabetes] bits and pieces [of diabetic regimen education] as we go along. So we don’t spend a whole lot [of consulting time] in one chunk. If you give [the patient their education] in one chunk, they can’t remember [it] anyway, half the time. ...So we give them odds and ends as we go along. So in the end, they could get a whole picture. (Dr. Zhong, Transcript, May 22, 1996, p. 13)

In his view, this tendency for his patients to return to him personally enables his chances at guiding his working-class, unilingual Chinese patients towards a Western-adapted diabetic regimen. Dr. Zhong admitted that he does scold his patients but they tend not to disappear because “they know it is done for their own good” (Dr. Zhong, Transcript, May 22, 1996, p. 13). This continuity of care is an important dimension of ‘treating diabetes’ within Zhong’s modified biomedical model so that changes in health status may be more easily perceived and correctly diagnosed by physicians.
Although education is accomplished in a humanistic fashion in private clinics, this example makes the case that doctors are the link in the bureaucratic and professional organization hierarchy by excluding poor patients from decision-making in a comprehensive way. Although a gentle, unhurried man, Dr. Zhong's style was paternalistic and did not engage his patients in a Freirian-type dialogue.

5. Justifying relations of ruling by tolerating 'humanistic' physician authority

As described in the previous section, Gopal may be unusual among PC clientele in not quietly losing face when forced to switch to the public health care sector. He expected to be treated in a humanistic style regardless of the class of clinic. Gopal frequented PCs and public specialist hospital clinics for advice on his many secondary complications due to long-standing IDDM. He spoke of a specialist who became very angry when he did not comply with a nurse's instructions to purchase a glucometer upon discharge from the hospital:

It so happened [that] I went to [the hospital] pharmacy. [There] the pharmacist told me: “Why don't you come back and let the doctor see you first. Then you can buy the machine.” Then I said: “Good idea.” So after two weeks, I went back to the doctor. And immediately I went into his clinic and I said: “Doctor, I did not do my blood count,” [to which s/he replied] “Get out of my office now and re-educate yourself.” [Gopal using an angry tone of voice] (Transcript, February 14, 1996, p. 19)

Yew Soon, a DSGS health professional, confirmed that the particular physician to whom Gopal referred was noted for shouting at his/her patients. Yew Soon did not appear interested in pursuing my line of questions regarding this doctor. The role of the pharmacist as a viable health care consultant appeared ignored altogether by the physician.
Gopal objected to how doctors rushed him when he asked questions regarding his condition:

Of course, we patient[s]...don’t know anything. We need to ask. That’s why...today, many people’s lives [are] deteriorating. Why? Because of the relationship between the patient and the doctor. I think [that], most of the time [it] is the doctor that caused most of the trouble. (Gopal, Transcript, February 14, 1996, p.26)

Gopal’s English and level of education were not compatible with his physicians although he was Westernized in many ways. He had an awareness regarding his (consumer) rights as a patient and was vocal regarding these rights. He overtly questioned the lack of humanity in health care delivery (but never the power structure within health care). Physicians often chastised Gopal for not behaving in a compliant manner. He said that he was even thrown out of one consultant’s office. Perhaps this was due to the physician’s impression that this Westernized man should comply because he understood more than others who are less Westernized. More likely, the anger reflected his challenge to the authority of the doctor. Gopal did not appear to question the hierarchical arrangement of the health care structure nor the inherent rationale behind physician authority. Rather, he demanded that the social interaction between physician and patient be more humanistic.

The ‘right’ of doctors to reprimand patients was also tolerated by people with diabetes in ORT private practices as part of their doctors’ role in helping them maintain their diabetic regimen. Most of these people to whom I spoke did not like the term “scold,” although they accepted such behaviour, if it was ‘necessary’ and done in a humanistic fashion. This authoritarian practice was seen as a regular occurrence within the primary sector of primary care. However, I did not hear of any abuses such as those described by Gopal in this more affluent sector.
Nancy, a DSGS member who frequents ORT clinics, believed that “very few patients will talk outright with the doctors” and wondered if doctors want to have a patient who is talking or, you know, some of [the doctors], when you talk they are not interested, they don’t hear you. “Ya ya ya” you know. You get the message that [the doctors] are not interested…. It's got to be two way. [The doctors have] got to show the patient that [they] are interested in hearing what they have to say [and that they] are interested to understand why is it [that the patients didn’t follow the doctor’s] dosage or why they chose to switch. But if I'm not wrong, if [they] don’t have the communication level with the patient, [the patient] will still do it anyway. It’s just that [patient] won’t tell you…. “If I perceive that [my doctor] is not interested, okay, I will just answer [their] questions. [The doctor] didn’t ask me, I will not tell you what’s really happening.” (Nancy, Transcript, October 12, 1994, p. 28)

Nancy also pointed out that sometimes people with the IDDM variety of diabetes adapt their insulin dosages to best suit their activities without negotiating this regimen change with their doctors. Others confirmed this. When I asked if they usually told their doctor at their next routine check up, Nancy told me: “I think they will wait until the doctor asks them” (Transcript, October 12, 1994, p. 28).

It appears that patients are more likely to passively communicate their displeasure by not returning to a particular physician or by not adhering to their diabetic regimens than by direct confrontation (see Hayes-Bautista, 1976a and 1976b). This power struggle between physicians and their more Westernized patients, in general, does not appear to be an overt conflict. Rather, people with diabetes do not socially engage with physicians whom they judge to be ignoring their concerns. In addition, they may make adjustments to their insulin dosages but do not communicate such changes to their doctors. I was frequently told that when people with diabetes in the private sector are not satisfied with their health care, they typically drop out of care and switch physicians.
According to the biomedical model, this discontinuity of care contributes to long-term complications.

People with diabetes who attend private sector clinics tolerate mild scolding because they justify it as having a personally motivational feature. In this way, people with diabetes rationalize that they are better equipped to adhere to a diabetic regimen. Sasman, a health professional within the DSGS, pointed out that a humanistic physician can effectively use varying degrees of scolding as a tool to help with diabetic regimen compliance:

You see, the local patient here is very funny, you know. If you scold them, the next moment, they disappear. They get very upset with their doctor unless they know that the doctor scolds them [and that the scolding] is for their own good.

...[Sasman recounted a specialist friend who] scolds the young [patients but] not the older ones. The young ones, yes, if the [glycemic] control is terrible. He really gives [them] a tongue-lashing. Some of them really got it.

[Physicians] can be so strict. ...I can see his point. He has to sort of wake them up from their slumber. He always tells them “Ten years down the road, anything [can] happen [and that] he might not be around.” (Sasman, Transcript, September 8, 1995, pp. 12-13)

Sasman was clear in his opinion that people with diabetes must first understand that they ‘deserve’ to be reprimanded. The rationale is that a healthy lifestyle, even a strict diabetic regimen, is seen as especially important for avoiding complications from IDDM type of diabetes. The reason for the acceptance of ‘mild’ scolding is that people with diabetes do value and understand the requirements of a biomedical-based diabetic regimen and need ‘help’ with their role in ‘treating’ the condition. This implies that the power relations between Singaporean doctors and their patients with diabetes reflect the unequal social organization found in biomedicine. In this way, decisions regarding living with diabetes belong more with the physician than with the person who has the condition.
Authoritarianism alone, on the other hand, is indirectly addressed by people with diabetes through a 'boycott' of that doctor. The more pejorative term for this behaviour, "doctor hopping," suggests that it is not condoned within the system. Thus Westernized Singaporeans appear largely accepting of biomedical physician authority in treating their diabetes. Although relations are not egalitarian in nature, physicians are labelled as "good” as long as the health care is reasonable and can be rationalized as humanistic. But middle-class Singaporeans (as compared PC clinic patients) insisted that treatment from their physicians respect their personal dignity and individualism.

IV. Contradictory Health Discourses and Practices: Non-Western Medicine in Singapore

1. Traditional Chinese Medicine (TCM) alternatives

Although I did not directly observe this, I would expect that 'social distance' between the TCM practitioner and elderly and poorer patients may be less of a problem than with biomedically-trained physicians. In addition, although associated with the dominant Chinese, TCM is part of the culture and history of Singapore. As Kleinman et al. have argued for the Western situation:

For many chronic medical problems, patients' reported improvement may be greater after encounters with marginal or folk practitioners than with modern physicians. In part, this can be ascribed to smaller social class differential between patient and practitioner, an increased emphasis on "explanation," and a greater concordance between the explanatory systems of healer and patient. (1978, p. 252)

Few English-speaking interviewees stated that they participated in TCM or other traditional health approaches. However, they often mentioned that older family members, or some generalized Singaporean "other" do "believe" in TCM and folk healing.
Thus although TCM is not officially sanctioned by the government, its practice occurs throughout the Republic. As Wu observes,

[I]t seems popular from among all walks of life in Singapore to make supplementary use of [T]raditional Chinese [M]edicine, especially in the case of taking Chinese herbs and tonics to strengthen health and body. (1979, p. 2)

2. Government views of TCM

The status assigned to TCM practices in Singapore by government is that of registered businesses and not medical practices (Quah, 1977). This governing practice locates TCM in a market of buyers and sellers, thus further decreasing the status of TCM practitioners as healers, at least from the perspective of those who espouse the Western biomedical worldview of health care.

In 1994, TCM accounted for 12 per cent of the total daily outpatient attendance of the Republic according to a MOH survey (Tan, 1995, p. 25). Government sources are thus forced to acknowledge its existence. In The Straits Times, Senior Minister of State (Health and Education) Dr. Aline Wong was quoted as saying:

Traditional Chinese Medicine is part of our Asian culture. It is very much interwoven into the daily lives of a part of our population and is used by a section of our people as a form of medical care. (Tan, 1995, p. 25)

However, there is increasing government involvement, with a view of ‘protecting’ patients from non--or poorly--trained practitioners. In addition, there is a deemed need to control the quality of herbs coming from China.

One headline described the urgency for “tighter control on Chinese medicines” and included examples of dangerous practices under a sub-headline, “complications from
treatment range from allergies to death” (Tan, 1995, p. 25). One example cited under the section of the newspaper entitled “horror stories” described how “seven diabetics’ condition worsened after they were treated with tablets or herbs and had to be hospitalised” (Tan, 1995, p. 25). Newspaper accounts advocating further government involvement included a call for Chinese physicians to follow ethical guidelines (“Chinese Physicians,” 1996, p. 24). There were also “concerns over children using herbal cures” (“Concerns,” 1997, p. 2). By way of contradiction of government sources, though, the same newspapers contained articles pointing out the medicinal value of these herbal cures. One such example was the summary of a scientifically-based study of certain herbs at the local university. The headline claimed that “[r]esearch throws light on yin and yang equation in herbs” (“Research on Yin and Yang,” 1996, p. 23). Another example of positive coverage of TCM carried the headline: “Acupuncture for epileptics? More than three-quarters of patients in study showed improvement” (Wee, 1997, p. 26).

The socio-political issues surrounding TCM use in Singapore are complex. It is not Western and does not fit the dualistic conceptualization of health of the biomedical model. Its practitioners are not as yet under control of the government. Similar to the West where so-called CAM (complementary/alternative medicine) is not supported by the state, surveys have shown that the public is beginning to acknowledge TCM as therapeutic in its own right (Eisenberg, 1996).

3. Adherence to TCM and biomedical practice

The doctors in my inquiry were vaguely aware of the use of TCM and folk healing approaches to health by their patients. Unlike government sources, they did not
seem to perceive this practice as a ‘problem’ unless there was ‘non-compliance’ by patients to their prescribed medications. There did not appear to be many discussions regarding these non-biomedical approaches to ‘treating’ diabetes by either physicians or patients. This passive ‘avoidance of mentioning’ non-prescribed health practices can be seen as part of Asian social expectations regarding avoidance of conflict (Tamney, 1996, p. 131) and not overtly questioning authority. The invisibility of indigenous practices and discourses, though, can also be seen as part of the relations of biomedical ruling. Apart from their own personal upbringing as Asians, Singaporean physicians have no formal TCM education and are not encouraged within the health care structure to enter this dialogue. There is no allowance within the biomedical model for TCM or folk practices as biomedical and TCM paradigms of health and health care are very different. The local traditional forms of healing are outside of the practice of biomedicine and challenge contemporary professional organization of health care.

Lai Sim, a health care professional not associated with the DSGS, thought that when people with diabetes took TCM herbs in addition to biomedical medicines, no harm was usually done. It was when people with diabetes did not take their prescribed Western medicines that she viewed these non-Western health care practices as posing potential complications. Lai Sim emphasized that people with the IDDM variety of diabetes can quickly have tragic consequences. She explained that these individuals can die when there is ineffective patient education:

“Often they might be taking some other herbal medicines and they are trying [this practice] out on their own. They don’t tell their own physician about this. ...It can do harm. It just depends on how it’s used. If you marry the two and use the Western and Eastern medicines, there is rarely any harm done. But if they decide not to use any of the Western medicine and stick to the Eastern there can be a lot of damage.”
[The clinic where Lai Sim worked] had one family who had a very young girl, four years old, diagnosed with IDDM. They had such a hard time. They could not accept [that] the daughter had diabetes. They ended up taking her to China to some herbal medicine physicians who would be able to cure her with the herbal medicine and take her off the insulin. This is where, I mean, you can kill somebody. (Lai Sim, Transcript, May 10, 1994, p. 6)

In this account, the biomedical difference between the IDDM and NIDDM varieties of diabetes is evident in the speed with which complications, and their inherent seriousness, can occur.

TCM and folk remedies for the treatment of diabetes are commonly advocated among lay persons in Singapore. Mrs. Lee, an HDB patient, mentioned that she regularly experiences social pressure to supplement her Western medicine treatments with TCM herbs. This unilingual elderly Chinese woman pointed out that she stoically resists this social pressure from her peers (Mrs. Lee, English Transcript notes, May 15, 1996, p. 1).

More typically, I was told by people with diabetes who preferred TCM that Western medicine is 'required.' One such opinion was expressed during an interview that took place in an ORT practice with Mrs. Ng, a 70-year-old woman without a formal education. Mrs. Ng's form of diabetes was the NIDDM variety. She only spoke Chinese and, since my assistant was not with me, the interview was translated through her accompanying daughter. My Cantonese speaking transcriber translated Mrs. Ng's answers into English from the tape. She explained that Mrs. Ng was quite blunt regarding her views, often leaving her daughter apologetic or answering her mother's questions for her and not performing the translation. Mrs. Ng's worldview regarding her diabetes and high blood pressure was clearly not biomedical, although she was compliant to most of
her family's and doctor's requests. Mrs. Ng's daughter pointed out how Chinese herbs had 'caused' her mother's blood glucose levels to rise:

So [her mother] was telling some old ladies today "oh, you boil some Chinese medicine, it will help you control the salt." That [was when] things grew worse [for my mother]. ...[Later her] diabetic [blood glucose] check was very high. It came up to [an unacceptable glucose reading]. (Mrs. Ng, Transcript, March 2, 1996, p. 9)

Later on in the interview, Mrs. Ng stated that she does value and tries to implement her biomedical doctor's prescribed regimen. However, clearly Mrs. Ng exerts some resistance towards a biomedical regimen, as she takes various TCM herbs without first checking with her Western-trained physician. Ultimately, though, she respects the Asian value of not questioning the authority of her children or the Western doctor that they made her see.

Mrs. Goh, another HDB person with NIDDM, was less 'compliant' to her HDB physician's diabetic regimen than either Mrs. Ng or Mrs. Lee. Although younger than Mrs. Lee, she is far more involved in folk remedies and has tried other Western-practicing doctors, including those at a PC. She has always returned to her HDB physician, who she claims has been her and her family's primary physician for the past 20 years. The exception is her husband, who only frequents a TCM practitioner. Her conceptualization of diabetes is clearly not biomedical. Mrs. Goh admitted to being too busy working as a downtown provision hawker to attend to the many personal aspects of her life. Yet she takes the time and travels back to her old apartment area to consult this HDB physician.

Mrs. Goh's folk beliefs about her diabetic condition are illustrated in her account. She explained:
She went to ask “God” (she is a Taoist) through a Medium. The “God” told her she might have diabetes and asked her to consult a doctor. So she went to see [an HDB doctor] and [diabetes] was confirmed. Her condition initially was very mild, and had not affect[ed] [her] blood only [her] urine. When her condition became severe, she dared not visit the doctor, but instead took the Chinese herbs “Tungkwai” and “Xi Xart” as a supplement. [She found these] effective in controlling [her] diabetic condition. She boiled the two ingredients and drank the water. At the same time [she was] careful not to eat too much food. Later on, she came back to see the [HDB doctor] again as she was too busy to boil the drink. [Mrs. Goh] [subsequently] switched back to Western medicine in order to keep her condition [under] control.

...She d[id] not feel healthy [at the time of the interview]. [Mrs. Goh shared that] she has been taking Western medicine and [that] it makes her heart feel weak. She often feels breathless and her limbs have no strength. She makes a Chinese herb drink to strengthen herself up, about three to four times a week. She drinks it all day long, as [one would] plain water. (Mrs. Goh, English Transcript Report, May 15, 1996, pp. 1,4)

Mrs. Goh believed in the therapeutic effects of her herbal drinks but saw them as too time consuming to prepare in her busy lifestyle. Her long working hours away from the home prohibited her preparing these tonics. Mrs. Goh did not perceive Western pills as curative as they caused her to feel weak. They were a second best to her tonics.

My Chinese speaking assistant confirmed that many of the unilingual Chinese speaking people with diabetes were fatalistic in their views of personal health. In her notes about one particular PC participant, she commented:

[Mrs. Chen] attends a polyclinic [and has] no fixed doctor. One year, [she had] about six visits and [saw] about two to three [doctors]. [These were the] same doctors. Having diabetes is not a secret for Mrs. Chen. [She is not] bothered [by it]. [She sees] it’s a life-long illness. [She] honestly [does not] pay attention about food intake. “Life is short, it comes and goes, all fated, accept it, can’t be bothered.” (Mrs. Chen, English Transcript Report, April 10, 1996, p. 1)
This fatalistic view may be an expression of superstitious or folk beliefs. Mrs. Chen did not see her ability to question the authority of the process of life itself and consequently did not ‘comply’ with a ‘healthy lifestyle’ ideology.

4. **Critique of the marginalization of indigenous health practices in Singapore**

As I have argued many times, the NIDDM form of diabetes and other chronic conditions can be seen as a ‘side effect’ of Singapore joining the globalized economy. Preference for a holistic approach to health, characterized by less social distance between ‘patient’ and practitioner, potentially makes folk or TCM an attractive option for many Singaporeans with chronic disorders. Westeners who advocate “integrative medicine” also believe that visiting a TCM practitioner and consuming the suggested herbs—if of a pure variety—is a reasonable adjunct to the biomedical approach to diabetes. Such ecumenical practices appear wise in light of the potential side-effects or long-term complications resulting from certain drug therapies.

The Singapore government, promoting Asian-ness to Singaporeans ostensibly to forestall the moral decay associated with destructive ‘Western traits,’ may also be inadvertently taking steps towards encouraging educated Singaporeans to reconsider the potential benefits of TCM within their lives. But TCM is not, as yet, considered a complementary source of disease or illness relief by the government of Singapore. In a society where TCM is historically and culturally intertwined, the marginalization of indigenous health care practices can thus be seen as an oppressive act by the government. The professional domination of Western medicine within health care is reproduced within local relationships between doctors and people with diabetes. For people with diabetes
who have the least social status, this oppressive practice has the greatest consequences as Western medicine is the least familiar and tends to be more expensive. Specifically, people with diabetes appear not to engage or demand that their indigenous health beliefs be considered when ‘negotiating’ a Western diabetic regimen with their physicians. At the most basic level, extra-local relations of ruling are reproduced when physicians in Singapore ignore the existence of differing conceptualizations of health by their patients.

V. ‘For-Profit’ Biomedicine in Singapore

1. Selling drugs in the clinic

The pharmaceutical industry was identified by my informants as playing an influential role maintaining the “magic bullet” aspect of biomedicine within primary care. Patients with NIDDM were reported to be told by doctors to simply “take pills” with no mention of a correspondingly healthy lifestyle of a balanced diet and regular exercise. In 1995, Dr. Tang referred to hearing rumours that “pills are bad” was the message within the latest study by UKPDS8 (Transcript, October 12, p. 23). He sighed when he referred to “the pill lobby [as being] so powerful” (Dr. Tang, Transcript, October 12, 1995, p. 23). Even with this public declaration that taking pills for certain NIDDM might be contraindicated, Dr. Tang claimed that the influence of the pharmaceutical industry on doctor prescribing habits was not to be underestimated.

Revenue-generating activities such as clinical drug sales were associated by patients with greed, although, as in the West, patients were also blamed by both my medical and non-medical participants for ‘buying into’ a biomedical model by expecting to receive a prescription when they visited the doctor. It was frequently mentioned that
these sales are part of the Asian culture and are “expected.” For example, Dr. Teo, a specialist, informed me that the sale of drugs is an “Eastern practice behaviour” as “TCM practitioners] sell herbs” (Fieldnotes, February 26, 1998, p. 5). Dr. Sykes, a general practitioner, also described how patients “pressure” primary care doctors to prescribe some sort of pharmaceutical treatment. In her opinion, this pressure from the patient is a “can of worms” (Fieldnotes, March 21, 1994, p. 3). Dr. Sykes stated that: “the Chinese love or value medicines...[as a result of their consultation experiences] with their Chinese physicians” (Fieldnotes, March 21, 1994, p. 3). Both Dr. Sykes and Dr. Teo thus ‘explained’ selling drugs by reference to expectations built up within TCM. From their view, individuals consulting TCM practitioners receive herbal tonics just as those consulting biomedical practitioners receive synthetic drugs. When I spoke with Dr. Teo about the revenues associated with the sale of drugs in private health clinics, he informed me that the profit margin is about 25 percent of the list price (for both ORT and HDB clinics). This means that drugs bought at a clinic are cheaper than those bought at a pharmacy (Fieldnotes, February 26, 1998, pp. 3-4). Polyclinics also have “in-house” pharmacies that sell drugs. Dr. Ong stated that there is a policy of charging according to the duration of the medication prescribed rather than according to the costs of medicines. For instance, one week would cost S$1.20, with a maximum charge of S$6 regardless of the number of medications. The elderly are charged half price and pay no more than S$35 for two months including the consultation fee (Fieldnotes, December 6, 1995, p. 2). Thus the view that the sale of drugs is evidence that physicians financially take advantage of their patients came only from private sector patients. As a Canadian, I was not used to this practice and felt that it was a conflict of interest for the doctor.
Some of the conflicting views regarding the practice of purchasing a variety of drugs from doctors came up during one of the DSGS focus groups I attended in which the health professionals attributed the problem partly to patients. A couple of DSGS members agreed with them. Sasman, a DSGS health professional, elaborated on the mutual expectations between patients and physicians regarding a sale of some medicine with each consultation:

Sasman: A lot of patients haven’t come to terms with—if you don’t prescribe—they always think: “no charge.” So much so that all GPs will always give you some medicine.

Jane: Just to settle your piece of mind.

Paul (another DSGS health professional): They want something tangible, something tangible. [lots of agreement; some laughter]

Sasman: You see, I think it’s Asian mentality. When [a person] sees a doctor, they expect some medicine. If you don’t give them medicine, that means “no charge.”

Yee Pak: Yes.

Sasman: They don’t have this concept of consultation yet.

Yee Pak: Yes. Yes.

Sasman: But if they are seeing a specialist they know. “Okay,” you have to pay [for] the consultation, so much [for] medicine....But they see a GP they don’t [think this way]. So I’ve noticed that GPs love to load you with medicine. [noise of agreement]

Paul: Oh yeah!

Jane: Four to five types.

(DSGS Focus Group, November 25, 1997, pp. 23-24)

These physicians also contextualized selling drugs in the clinic as necessary in order for physicians to be taken seriously as a professionals. Dr. Teo, the specialist, emphasized
that patients may be reluctant to pay for "only" receiving a verbal consultation (Fieldnotes, February 26, 1998).

My own observations through the many and varied ORT appointments that I attended confirmed that most people left with a "little bag of something." Thus I see patient demand based on buying into biomedical capitalism and clinic prescribing policies combining to compromise the physician's professional autonomy in Singapore. The profit-orientation of some clinics; the consumer-orientation of Singaporeans; the physician's desire to cure through a "magic bullet;" and the influence of the drug companies through their advertisements--amongst other marketing tactics--all combine to ensure that drug sales are high within Singapore's primary care system.

2. For-profit ideology, 'accounting logic' and the practice of biomedicine

A profit-orientation clearly influences the organization of the health care structure in Singapore. Lai Sim (1994) has euphemistically described the private sector of primary health care in Singapore as "competitive." One large private biomedical practice was especially overt in embracing economic objectives when it became a publicly owned corporation on the local stock exchange. Physicians became salaried employees and the overall 'services' of the clinic were intended to be profitable to the stockholders. Smaller privately-owned primary care practices serve a different clientele, or in economic terms, "niche." Physicians in this environment were reported to be increasingly concerned with the accounting aspects of their work, rather than the 'professional' details of practicing medicine.
These ‘economic’ behaviours of physicians can be seen as local practices carried out as part of the extra-local organization of biomedicine. In the U.K., Broadbent and Laughlin (1997) refer to the increased role of accounting in attempts to develop controls over professional work. … The changes taking place are ones which we see as informed by “accounting logic” and which claim their legitimacy through the application of market-type controls. (p. 34)

This ‘accounting logic,’ which is part and parcel of a globalized marketplace for health care, can have negative implications for relations between doctors and people with diabetes. It “requires that relationships have to be reflected in financial terms and the danger is that the structure of relationships could be changed to allow this type of quantification” (Broadbent & Laughlin, 1997, p. 38). My informants repeatedly identified these trends in the private biomedical sector in Singapore. Patients labelled for-profit medicine as a social problem. And physicians expressed their frustration in trying to reconcile the many demands made upon them, even though they might not go so far as to advocate a holistic perception of health. “Accounting logic” health care practices can be seen to disempower health professionals:

[The] intention is to take away discretion from the professionals concerned… by seeking to define outputs and link financial rewards to these outcomes and in this they are representative of “accounting logic.” (Broadbent & Laughlin, 1997, p. 45)

It is impossible to make direct outcome linkages between the health care provided by physicians and the health status of people with diabetes. The “accounting logic” approach is blind to the socio-economic complexities affecting the ‘health’ of an individual.
In Canada, Muzzin, Sinnot and Lai (1999) discuss how large drugstore franchises disempower individual pharmacists:

Shoppers Drug Mart is a franchise corporation, but the pharmacist-franchisees no longer have their autonomy; they must follow accounting and other practices determined by head office and can be fired. (p. 303)

An illustration of similar professional disempowerment in Singapore occurred in the practice of Dr. Sykes, a salaried Western physician. In an interview at an ORT clinic she explained that she had the experience in a job interview where it was made clear to her that it was policy to prescribe a course of four days on antibiotics for the “flu.” [Dr. Sykes mentioned] that this was “standard”...and that it was important to keep the patient. [She had been told] that “they would go next door anyways.”

...[Dr. Sykes went on to say that] “a short course of drugs is silly, you don’t need an antibiotic for a sore throat”...and that a four-day course has no medical benefit. (Fieldnotes, March 21, 1994, p. 3)

These prescribing formulas precipitated an experiential disjuncture between what the employee doctors identified as their professional autonomy within a biomedical model of health care and expectations of their employers at a “for-profit” corporation. In this case, drug sales are a source of revenue for primary care clinics and doctors are expected to sell them, competing with their views of what is best for the patients.

3. Greedy physicians?

Rather than identifying the ways in which drug companies and the for-profit organization of Singaporean health care promoted practices that compromised health, many people with diabetes engaged in ‘doctor-bashing.’ For example, they complained that Singaporean physicians were overpaid. The
participants of one DSGS focus group discussed specialist remuneration a couple of times. One illustration of this is in the following interchange between Jia Ling and Emily, who both have the IDDM form of diabetes:

Jia Ling: [It] is very good money [being a] doctor.

Emily: Yeah, I think so.

Jia Ling: Because they don’t do much I can tell you. The control is in the patient, the doctor cannot do much for you. They cannot say “I give you this medicine. You are cured.” You are sort of improved [murmurs of agreement]. He can’t. It’s all in yourself. So they have very good money to earn, eh? I can tell you--

Emily: Yes, I think so.

Jia Ling: Every time you go, [it is] [S]$50, [S]$45. They don’t do much, they just talk to you. “How are you?”, you know, that’s all. [laughs]...

Emily: Yes, it’s true--know of this pastor, a church pastor, he was spending--per month--about [S]$2,000--because of his diabetic condition.9

(DSGS Focus Group Transcript, November 26, 1997, p. 30)

Thus while these stories of personal wealth accrued by physicians after clinic expenses may or may not be true, the perception that they are true clearly affects relations between doctors and people with diabetes.

There are also reports in the local academic literature about doctors within the private sector succumbing to fiscal temptation:

No one can deny that doctors, like everyone else, have a right to make a decent living. …The truth of the matter is doctors--their moral integrity and higher purpose notwithstanding--are human after all, and no different from others in their capacity to act in self-interest. Although the medical code of conduct adjures professional practice uninfluenced by motives of profit, doctors can, if they wish,10 act in such a way as to benefit their own purses more than their patients. (Lim, 1993, p. 102)
Lim sees physicians as part of Singapore's consumer society and claims that they are not "above" wanting high status items. Lim also points out the health care structure does not prevent such corruption.

These negative consequences of promoting consumerism in Singaporean culture coupled with the market structure of private health care were discussed in a newspaper article entitled: "Doctors today: Saints? Scientists? Shopkeepers?" (Veloo, 1997, p. 34). Veloo states:

Doctors say the main factor militating against good medicine today...is the "social fabric" that emphasises the dollar above all. In essence, their argument is that Singapore society is becoming more money-minded, and doctors cannot be immune from its effects. ...Associate Professor Goh Lee Gan...says that most doctors value the profession more than the dollar, and points to the large number in government service as an indicator of this. [Goh states:] "But we are slowly drifting towards a cold and mercenary kind of thing. You could put it as the three struggles: whether to be a saint, scientist or shopkeeper". (1997, p. 34)

Neither lay nor professional interviewees critiqued the health care structure itself, nor could such a critique be found within the lay or academic literature in Singapore. Instead a "physician blaming" approach by which doctors were expected to be "better" than the average Singaporean predominated.

An observation frequently cited as a reason for believing physicians were financially 'greedy' was that they saw too many patients in a day and did not spend enough time per patient. I was often told that doctors rush their patients. Emma stated in a DSGS focus group:

You can tell [by] the face of the doctor [that s/he is thinking] "You'd better ask [your questions in] as short [a time] as possible and get out of my clinic." [noises of agreement from others in the focus group]...You feel you are being chased, you know--[noises of agreement from others in the focus group]. (DSGS Focus Group, November 25, 1997, p. 39)
PWDs also tended to interpret impatience of physicians as evidence of a lack of caring.

As might be expected, health professionals themselves had a different view of this situation. For example, Dr. Zhong, the conscientious physician at an HDB clinic described above, tried to argue that for "cough and cold" patients he does not spend much consulting time, while for patients with chronic illnesses such as high blood pressure and the NIDDM variety of diabetes he "usually spend[s] a bit more time with [these] patients than most other doctors...[because he] thinks it is important" (Transcript, May 22, 1996, p. 12). Another health care professional explained:

Nowadays, the family doctors are the doctors [that have just graduated]. They are very young [and] before they get enough experience, they go and practice on their own. ...They have to see as many patients as they can so that they can pay the rent [and] pay their mortgage. Do you know what I mean? ...Oh, you'd be surprised that doctors are living at a very comfortable level. ...[Y]es, I can tell you that nowadays, doctors are the ones driving the Lexus, the Jaguars, the Mercedes... (Sasman, Transcript, September 8, 1995, pp. 19, 21)

Thus the capitalistic model of health care in Singapore, with its corresponding fee-for-service or imposed patient quotas, promotes a 'revolving-door' type of practice.

People with diabetes tended only to see that doctors are well-paid, and hasty with patients because of greed. And a few of their doctors agreed. People with diabetes and doctors did not appear to question the organizational processes influencing their everyday experiences nor identify these conditions as evidence of extra-local relations of ruling.

4. **Profit orientation and patient and physician education**

In addition to 'revolving door' practices and sales of drugs in the clinic, the perception that physicians were compromised by their 'shopkeeping' role was supported by the impression that physicians were generally poorly informed about diabetes. (See
the descriptions of misconceptions and misdiagnoses physicians made regarding IDDM and NIDDM forms of diabetes in Section III (1) above.) During the first DSGS focus group meeting, there was a discussion regarding the problem of the added sugars of many drugs, especially when prescribed for children. I was told that because sugar free medicines were often not “in stock,” sugared varieties were sold to people with diabetes. Prescriptions were allegedly not written for the sugar free variety because a sale might be lost! The view was expressed that physicians may thus not be educated enough to be fully aware of diabetic pharmaceutical needs (DSGS Focus Group, November 25, 1997).

Improved physician education regarding the management of all types of diabetes was, in fact, an objective recommended by the National Diabetes Commission (1993) in Singapore. A specific course was developed by the MOH for this purpose. Dr. Hum, an official at the MOH, informed me that this course was not well attended. Most of the doctors that I spoke with had heard of the course but had not attended. At the time of my discussion with Dr. Teo, the specialist, he informed me that the course had run five or six times with an attendance rate of about 30 GPs. He judged that it was not “very successful” because it was “too theoretical” (Dr. Teo, Fieldnotes, October 14, 1994, p. 3).

Lai Sim, a health care professional not associated with the DSGS, argued that people with longstanding diabetes were often ignorant of the basic daily regimens to optimize their blood sugar levels. She was candid in her negative evaluation of patient education by physicians:

Oftentimes the physician will just tell the patient what to do. There is not going to be a communication or an interaction. ... They tell the patients: “Take these two tablets, three times a day and come back in three months. And you go and see the dietician for this and go and see the nurse for that. Bye.” If you are lucky it will be a 10 minute discussion. It’s not a discussion, that’s not the right word. You know?
It's a one-way soliloquy from the physician. That's it. (Transcript, Lai Sim, May 10, 1994, p. 1)

Thus doctors, even by some doctors, were judged as failing to educate their patients with diabetes with regard to the ‘healthy lifestyle'—nutrition and exercise—component of the diabetic regimen. Their failure to educate can be linked to the perception that this activity is too time consuming and consequently not “profitable.” Further, physicians cannot teach what they do not know. And finally, as argued above, the “healthy” lifestyle that is inherent to good diabetic management is very difficult for their patients to achieve in modern Singapore.

Continuity of care is important to diagnosing and treating diabetes. Physicians are in a better position to note any subtle changes in health status or be aware of necessary screening procedures when they monitor the diabetes. A primary care doctor pointed out that only 10 to 20 percent of those people with diabetes present with clinical symptoms (Dr. Zhong, Transcript, May 22, 1996). He stated that he was the professional responsible for diagnosing diabetes for all of the people with diabetes within his HDB practice. I asked if he used a type of screening program and he stated: “I see them for some other thing and then...I ask some questions and I sort of pick them up. Through the family history, or those who became pregnant” (Transcript, May 22, 1996, p. 8). Dr. Zhong’s ongoing relationship with the people frequenting his practice facilitates more thorough history and education opportunities and contrasts with the accounts of the support group members that I collected.

Another problematic aspect of educating people with diabetes within the biomedical model revolves around dietary changes. There was generally a great deal of confusion regarding what foods are allowed. Of significance to the Singaporean was the
frequently reported misconception, by physicians and patients, surrounding the allowance of rice in a “diabetic diet.” Many reported that they believed that their consumption of rice should be significantly restricted. I was told that physicians were equally ill informed. This is notable, as rice is culturally very significant to Singaporeans. It is also a cheap source of food. Ideally it is consumed in its unpolished state but white rice is ‘allowed’ in a diabetic diet in reasonable quantities. Many participants either shared that they did not eat much rice at all, or were apologetic regarding their consumption of this food staple. This confusion regarding the eating of rice may be due to the fact that the literature regarding the treatment of diabetes is Western in origin.11 As such, there would be with little regard for the significance of certain foods within other cultures.

As stated previously, the Singapore government formed the National Diabetes Commission. This action recognizes a need for better doctor education in treating patients with diabetes. As illustrated by the above narratives, physicians can be unaware of the fundamental clinical difference between the IDDM versus the NIDDM variety of diabetes. In addition to this misinformation, people with the NIDDM type of diabetes do not receive adequate treatment because neither physicians nor patients take it to be a serious condition.

Health officials in Singapore are aware of this trend and are taking action to help offset the health problems associated with diabetes in the population. Education is noted as an “integral part of diabetes care” in a 1993 Guideline circulated to all general practitioners in Singapore. Also, through the offering of a diabetic training course, the government seeks to “educate the educators” of diabetes. This document includes sections on “meal planning” and “exercise” (pp. S7-S9).
In addition to better education of doctors, I was told of shortages of nurse educators, dieticians, and podiatrists and that there were not enough of these diabetic health care team members to support the physicians in their role as educators. The specialists to whom I spoke agreed that they refer their patients for this part of the program to these other types health care providers. It is not surprising that reports of no, or poor patient education by primary physicians are common. Doctors cannot give what they do not know themselves.

5.  **Maintaining the public-private mix by addressing inequities for patients**

One way the government encourages use of for-profit health care clinics is by placing limits on chargeable fees by doctors. Dr. Zhong felt that outpatient costs are affordable for most Singaporeans. He volunteered the following observation:

> And the government is just screaming their head,¹² you know. [The government is saying] “We want to curb [private outpatient health costs] and make sure the GPs don’t charge too much.” I think they are charging the bottom already. They can’t do anything more. Anyway, we ignore [the government]. (Transcript, December 5, 1995, p. 6)

The “for-profit” physician wishes to charge more money in order to participate more fully in a capitalist economy. But if prices in the private sector are too high, this drives patients to subsidized health care.

Consistent with making public care less accessible, switching from the private sector to PCs requires letters from past physicians. But three specialists explained how they advised their patients to work within the public health care structure in order to access subsidized care. Sasman, a DSGS health professional, explained that such access was not easy but that, at times, certain specialists who work in the private sector also hold
clinics within the public hospitals (DSGS Focus Group Transcript, November 25, 1997, p. 13). The procedure is for people with diabetes to go to a PC in order to secure a written referral to the public specialist hospital clinic where they can become registered. Dr. Tang remarked that “[he had] just sent someone to the polyclinic today.” He explained that a woman with the IDDM form of diabetes had been medically mismanaged, required expensive treatments and hospital stays to recover but could no longer afford his services (Transcript, October 12, 1995, p. 2). He was clearly frustrated with the patient’s gynaecologist who

continued to manage her right down to all her medications.... [Later, Dr. Tang] was called in an acute emergency to the hospital. ...So [Dr. Tang] asked the gynaecologist, “is this necessary?” (Dr. Tang, Transcript, October 12, 1995, p. 3)

He explained to his patient with IDDM that she required a doctor’s letter to bring to the PC. Dr. Tang explains:

So I wrote the report—It said, “go to the polyclinic.” Then I had to lower my profile [laughs]. [I] didn’t use my letterhead--[long pause]. ....It was a very very modest sort of report. [I didn’t] mention any names....It set out the goals. I said I would be very happy to, you know, help with the management. (Dr. Tang, Transcript, October 12, 1995, p. 4)

This specialist took the time and effort to send away a source of revenue for his ORT clinic. But one ‘side effect’ of his actions was that his patient clearly did not receive adequate patient education regarding management of her diabetes. Although she initially could afford private specialist treatments, she eventually could not. The extra-local practice of governmental policies that hold the individual financially responsible for local experiences of good “health” is reproduced in this example as she maintained her costly doctors’ appointments within the private sector. That is, the “lifestyle” ideology of health
being a personal, financial responsibility originated from the government and was imposed upon this woman regardless of her ability to pay the high amounts related to the mismanagement of her chronic condition. Her local experiences were especially notable, as the multiple social and structural barriers discussed in this chapter placed before her may have prevented her from accessing health care services. The ‘system’ had begun to financially devastate her until a humanistic physician helped her better “navigate” the health care system.

Dr. Tang told me that the level of financial compensation for private or public out-patient diabetic care by the government was remarkably low compared to in-patient care, because personal Medisave accounts cannot be accessed. People with diabetes carry less of the financial burden of their health care management if they wait until they are sufficiently sick with complications to warrant hospitalization. Dr. Tang was quite animated when he critiqued this negative structural influence on cost-effective health care access. The implication of this for people who were not financially well off, and who chose to continue to use the private health care system, was clear: this system promoted patients wanting to wait until they could be hospitalized. This specialist claimed that this was too expensive for society (Fieldnotes, September 12, 1994). Singaporeans are, on the one hand, repeatedly told through the media campaigns of the National Healthy Lifestyle to be proactive regarding their health. Yet the sicker they are, the less financial assistance they receive. The public hospital clinics and polyclinics are seen as a health care ‘net’ to catch those who are not adequately insured or cannot afford private health care. These individuals tend to be women, children, elderly and those with chronic conditions such as
diabetes. Such an approach serves to maintain a system of health care which is non-egalitarian.

6. **An inequitable system:**
   **Corporate influences on consumer health care choices**

Dr. Sykes, a general practitioner, pointed out that it was common for a person's employer, or union, to have a contract with a particular private medical practice. She added that "the employer will pick up employee medical bills when they see these specific family doctors...[although] only the employees themselves are covered and not their families" (Fieldnotes, March 21, 1994, pp. 1-2). In addition, these benefits typically no longer apply to an employee after retirement. Physicians are expected to make clinical decisions within differing lists of medical procedures and drugs. As is the case in the West, there is often a capping of costs by insurance companies.

Some participants complained about their physicians but did not switch practices because of the financial incentive of their particular corporate insurance policy. More often, I spoke with elderly participants who wished they could afford the physician they had seen while they were employed. Mr. Hu, a 63-year-old English-speaking retired accountant, used to attend an ORT clinic when he was working. His company had a contractual relationship with this clinic. Mr. Hu had been diagnosed with NIDDM over 20 years ago and had been satisfied with his health care at this private clinic. After retiring, he attempted to self-finance his visits to maintain this ongoing professional relationship but was ultimately unsuccessful. Our interview took place at a PC. He explained how he tried to negotiate a more affordable arrangement:
I was looked after by [my] company doctor until I retired. Then...I came [to the PC] and they gave me a thorough check. [The PC doctors] asked me [the name of the doctor who usually] looks after my diabetes. I said [the company doctor's name]. “Oh, I see,” [the PC doctor said] “He's a very good doctor.” But I told [the PC doctor] that I would like to [continue] to see [the company doctor] but he's too expensive.

...Every time I [would] go there, I [would] have to pay S$300. ...So the last time I saw him I gave him [a] list [of items and services]. Then he said [that] he can't cut any other expenses except the [consultation charge]...for S$150. He [will reduce his fee to]...S$75. Still it's expensive though. (Mr. Hu, Transcript, April 18, 1996.)

For a short period of time, Mr. Hu had successfully negotiated with his physician to pay a reduced consultation fee. He did not appear to me to be resentful that he could no longer afford ORT type of medical care. However, he did not manage to reduce the profit margin on medicines and associated technologies, such as a glucometer and testing strips, required for his NIDDM. The “for-profit” ideology inherent to Singapore’s health care structure thus resulted in a rupture in care for this elderly gentleman.

Another example of direct corporate influence on consumer health care choices is the requirement of medical certificates by many employers excusing work time lost due to illness. Dr. Sykes claimed that many employers only grant sick leave to their employees when presented with these physician-signed Medical Certificates (MCs).

“The government and employers require MCs from physicians when employees see a physician during working hours” (Fieldnotes, March 21, 1994, p. 3). The amount of leave time is decided by the physician. MCs appear to be a formalization of Talcott Parson’s (1951a) “sick role” within Singaporean society.13

The existence of MCs objectifies working adults, as they become powerless in deciding if they are well enough to work. Patients are treated as non-autonomous children within this regularly enforced practice. Newspapers carried stories regarding
Singaporeans lying to their doctors in order to secure a day off. Conversely, I was told that physicians were reprimanded if 'too many' MCs were distributed. These activities are economically based and are unrelated to health objectives. They support ruling relations in that lost worker time costs employers potential revenue.

More evidence of unchecked corporate power can be seen in unemployment discrimination or termination based upon the existence of a diabetic condition. Besides the obvious social inequity, the threat of firing causes individuals to take measures to 'hide' their condition. Especially in the case of the IDDM version of diabetes, such concealment is not in the best health interest of a person and tends to interfere with his or her ability to maintain a diabetic regimen. More important, people with diabetes who hide their conditions may not receive effective medical assistance if they become hypoglycemic at work. Sasman pointed out that these employment discrimination fears are warranted but that people with diabetes should not hide their condition:

To me, I think the patient takes [these experiences] as a social stigma. Well,...there are some worried that the employers...will always think that having diabetes is a kind of sickness. ...They don't want to let the employer know too much. They are so worried that it will affect their, you know, promotion, their future.

...I always tell them it's very important. Number one, "you have to manage your diabetes well. If you manage your diabetes well, then you [will not] have to hide [it] from [your] employer. But if you do not manage your diabetes well, [then] you cannot blame the employer for having preconceived ideas about your health.

...I find that if the patient is very willing to let her colleagues, her [employer], know, she or he will...accept the condition more.
(Transcript, September 8, 1995, p. 9)

When at work, though, people with diabetes cannot 'look after themselves' by eating something sweet if a significant hypoglycemic reaction occurs. As part of a vicious cycle, hypoglycemic reactions are more likely if a person with diabetes is not well 'controlled'
due to a poor ‘regimen,’ thus reinforcing employer fears that people with diabetes cannot perform their jobs effectively. These local experiences reflect the priority placed on revenue-generating activities by people as opposed to maintaining their health and well-being within Singaporean society. Coupled with poor public education, the mythical belief that those with chronic conditions such as diabetes cannot participate as contributing members of Singapore society is perpetuated.

7. **Disjuncture between experiences of people with diabetes being a visibly productive member of Singapore’s capitalistic society and ability to lead a healthy lifestyle**

The doctorcentric terms, ‘non-compliance’ or ‘cheating’ behaviour are examples of the indirect or passive ways in which people with diabetes might communicate to their physicians about their perceived or real inability to comply with a prescribed regimen. Specifically, people with diabetes do not always understand how to adapt the doctor-prescribed regimen to their day-to-day lives. People with diabetes may not perceive themselves as able to maintain, or afford, the often far-reaching corresponding lifestyle adjustments. Levels of education and conceptualization of what constitutes health also play a role in patient ‘non-compliance.’ It is impossible to implement a diabetic regimen that is not understood or valued. Some people with diabetes view a diabetic regimen as an irrelevant feature in their long-term plans for good health.

Mrs. Goh’s life illustrates her powerlessness to ‘comply’ with Dr. Zhong’s continued suggestions for a lifestyle that is more consistent with her health condition. She works full-time outside of the home as a hawker. She stated that she did not have the time, nor presumably other resources, to raise all five of her children and consequently
gave up two of them. Mrs. Goh's lack of education and inability to speak English—the language of those in power—may have contributed to her story not being heard by health care professionals during clinical consultations. In addition, this woman does not overtly question the authority—in a 'housing the oppressor' fashion—of the various physicians that she has consulted. Mrs. Goh's position within the Singapore societal structure requires her to work long and physically demanding hours to make a living. She does not, as a street vendor, receive company-sponsored health insurance, nor have much time to frequent the government PCs.

VI. Conclusion

People with diabetes receive mixed messages from the Singapore government. Individuals are depicted as being responsible for the impossible task of working hard (and being good consumers of products and services) while maintaining a physically and emotionally balanced self. Maintaining a diabetic regimen (e.g. frequent healthy snacking or a noon time walk) fundamentally contradicts being a productive worker who takes few breaks. A market-driven economy fundamentally opposes one that reinforces a more socially- (especially family-) balanced and embodied work existence. In order to achieve this there would also have to be less emphasis on consumerism.

The existence of diseases of affluence, such as diabetes, signals how people with diabetes and physicians reproduce the relations of ruling. That is, the health 'price' of an 'unhealthy' lifestyle is more pronounced for people with diabetes than for those who do not have a chronic health condition. The health care structure in Singapore supports the notion that its citizens are responsible, financially or otherwise, for their
health and health care needs. If they fall ill, they are to blame. According to this ideology, the multiple contributors to illnesses are not acknowledged nor compensated within ruling relations. Further, the health care structure organizes inequitable health services so that those who have the least economic power must utilize a paternalistic public system. These individuals are usually from three interrelated social groups: the chronically ill, the aged, and the unemployed.

Doctors are part of the oppressive ruling relations associated with a capitalist economy that prioritizes revenue-generating activities. In this way, physicians have a professional interest in the status quo. It is unlikely that a fundamental change towards a more egalitarian system will come from within the ruling apparatus. A Freirian dialogue may come from outside and the first step towards this may be, as in North America, a more critical ‘consumer’ approach to a health care system—as in the activities of the DSGS. The significance of the development and activities of the DSGS are assessed in the next chapter.

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1 As discussed in the previous chapter, Singapore is an indigenous local practice of many Western-originating relations of ruling. In reproducing the relations of ruling, Singapore’s multiple institutions, professional organizations et cetera subscribe to a Singapore “version” of these extra-local practices. These Singapore ruling relations held within the Singapore ruling apparatus are more often referred to in the dissertation with the understanding being that much of the underlying ideology are Western and are typically economic in origin.

2 Durian is a local fruit that is malodorous and extremely popular among local people when in season. It is also high in sugar.

3 A critical review of drug sales within primary care clinics is made later in this chapter.

4 The three PC doctors I spoke with varied with respect to the average number of patients seen per day: one stated it was between 10 and 19 patients, the second stated it was between 40 and 49 patients and the third doctor reported it to be over 50.

5 It may also be a form of denial as I recollect the many times that I have heard my diabetic father claim “you only live once” when socially excusing certain regimen-breaking behaviours.

6 I learned of the term “integrative medicine” at the American Sociological Association conference in 1999. Goldner (1999) states: “integrative medicine retains the beliefs behind alternative [non-biomedical] medicine, but combines Western and alternative techniques (e.g., acupuncture, biofeedback, chiropractic, homeopathy, massage)” (p. 1-2). Weil (1997) concurs: “Doctors do not collect and study cases of healing, or think about the body’s healing system. Yet ordinary people are increasingly interested in this subject. More and more, they are experimenting with health-restoring ideas and techniques that conventional medicine has largely ignored. The popular enthusiasm for alternative medicine has finally begun to
influence medical education, research, and practice. For example, I now direct a Program in Integrative Medicine at the University of Arizona, whose aim is to develop new ways of training physicians for the next century. We need doctors who work from the premise that the body can heal itself if given a chance” (pp. 3-4).
7 It is also important the TCM herbs are not part of cruel animal practices in their preparations.
8 Dr. Tang’s sources were correct. This UKPDS study has been cited and briefly discussed above (see Turner et al. for the 1996 article from this longitudinal study).
9 Dr. Tang, during a 1995 interview pointed out that for “pure ambulatory care” an uninsured IDDM in the private sector could expect to pay $1,800 a year. This figure included all of the relevant private specialist visits and home/clinical testing.
10 Original author’s emphasis.
11 For example the consumption of a certain quantity of bread as being ‘allowed.’
12 Presumably “screaming their head” is synonymous to “screaming their heads off,” meaning complaining very loudly and publicly.
13 Talcott Parsons (1951a; 1951b) referred to the “sick role” as what an ill individual assumes when he or she is unable to effectively perform his or her regular role in society. Parsons’s assertion was that a temporary place, or role, for the person who is sick in the social organization of a society needed to be theoretically assigned (Clarke, 1996). This was decided in order that sickness could be managed by those in power and that the return to the socially productive status quo was ensured.

Clarke reviews the four components of Parsons’s sick role with the first two being rights and the second two being duties of the individual:

1. The sick person is exempt from “normal” social roles.
2. The sick person is not responsible for his or her condition.
3. The sick person should try to get well.
4. The sick person should seek technically competent help and co-operate with the physician. (1996, pp. 18-19)

Parsons’s formulation of the sick role was primarily theoretical. It was not based on extensive systematic empirical investigation. There are a number of criticism of the sick role based on empirical analysis (Clarke, 1996, p. 19). His ideas are too simplistic. More important, there is little consideration of chronic diseases. The ramifications of individuals living with chronic diseases are beyond the scope of his universalistic and reductionistic model. I briefly revive the term here to best explain the controlling rationale behind corporations requiring MCs in Singapore.
CHAPTER SIX
DIABETIC SUPPORT GROUP OF SINGAPORE:
TRANSITION TO CONSUMERISM IN MEDICINE

Overview of Diabetic Support Group of Singapore (DSGS)

The DSGS is a volunteer organization that is officially under a larger charitable ‘umbrella.’ These charity groups play a vital role in providing social services that are prohibitively expensive to many Singaporeans. As previously described, the government considers life events, including health, to be the personal responsibility of its citizens. Minimal government support exists for the poor. Tamney explains:

‘Singaporeans who do receive state aid are referred to as “underachievers,” implying that whatever problems these people have are of their own making. . .Rather than providing greater social security, the Government is privatizing its provision. . .But the primary responsibility for showing compassion is being [left] to racial self-help groups. (1996, p. 91)

Wai Mun, a health care professional at the DSGS, adds:

In Singapore, almost all social welfare, or social assistance-type programs are carried out by... “Volunteer Work Organizations.” The government does not do direct service.

...The government has a regulating [and]...co-ordinating role. . .They also fund, in part, depending on whether the programs fit their bill. . .[T]he government is very soft in its approach. It’s not a hard line thing.

[The umbrella group] carries the funds for DSGS to date. Although, hopefully,. . .that will change. (Wai Mun, Transcript, June 12, 1997, p. 7)

Many individuals who cannot afford to best ‘look after’ activities of daily living, health, or psychosocial aspects of their lives are attracted to the multiple service groups under the Christian-based charitable organization umbrella in Singapore. Wai Mun, a DSGS health professional, said that DSGS receives “about one third” of its funding from the government. Thus the existing power structure is supported. That is, the bureaucratic policies that financially penalize individuals for becoming ill and/or unable to work can persist while some financial support is provided to charitable organizations. This is a “bandaid” approach as the government
has minimal responsibility for those individuals who are not economically successful at fully participating in Singapore’s ‘modern’ society.

Although the DSGS is technically ‘under’ a particular Christian charitable organization, its membership during my three years as a participant observer tended not to be comprised of people who were in financial need, nor even necessarily Christian. The stated objectives of this support group were “to build a community of care and support for people living with [the] IDDM [form of diabetes]” (Lin Yee, Fieldnotes, January 11, 1997, p. 4). I provide a summary of my participant observer activities at the end of Appendix A. This chapter is a critical account of the DSGS’s role as part of ruling relations in Singapore.

II. DSGS Experience: Questioning the Ruling Relations in Singapore?

1. Support groups as a response to health care dissatisfaction in Singapore

Wai Mun, a DSGS member who was a health professional, stated that the DSGS formation had a ‘grassroots’ beginning as it was formed in 1990, before the existence of the present umbrella charity group. Lin Yee, the founder, with the help of her ORT specialist, contacted others with the IDDM form of diabetes. Wai Mun recounted:

Lin Yee was going to her [specialist]...and saying “all we’re getting [from our doctors] is medical treatment. I want to talk to other people with diabetes. I want to have people who empathize with me.” So it’s a basic need, [a] social need. And the [specialist said] “good idea, here’s a list of all my patients.” And then [the specialist’s nurse educator] got into it and they rounded up [people with the IDDM type of diabetes] together.

All they had the first session was tea. No structure. Nothing. Just, “Okay, we all [have] diabetes. We have no idea what we’re doing but let’s meet and talk.” That’s all. (Lin Yee, Transcript, 1997, p. 14)

The emergence of the DSGS can thus be seen as Freirian in nature. Lin Yee was not satisfied with her experiences of health care and began a dialogue with her physician—an approachable member of the health care “oppressors.” There appeared a mutual consciousness raising between
Lin Yee and her specialist that went beyond the biomedical model inherent to his professional practice. Her specialist engaged in activities that were neither treatment-based nor revenue generating. He did not assume a socially controlling role within the support group. The meetings that occurred before I became a participant observer were unstructured and outside of the imposed extra-local doctor-patient clinical relations.

Lin Yee respected her endocrinologist who was helpful in her initial attempts to start a support group. Lin Yee had been disappointed to learn that an existing group, the Diabetic Community of Singapore (DCOS) catered mainly to the needs of people with the NIDDM variety of diabetes, as they were the majority. Wai Mun pointed out that living with the IDDM form of diabetes is very different from living with the NIDDM variety:

So you are talking about IDDMs, they are younger, they have insulin—which means needles. Okay. And in that it is very different from Type IIIs [NIDDM variety of diabetes]. The [NIDDMs] are older and...most of them don’t need needles, they don’t need insulin. ...Most of the problems [for people with with the IDDM variety]...are how to handle the needles [and the home blood testing] prick[ing].

It’s growing up with diabetes, adolescence, parent[ing]. What to do with children who have diabetes. The strain that they go through. [These are] very, very different needs [from those with NIDDM].

The commonality in diabetes is, to me, arbitrary. Actually what you are talking about [is a] label [that] people give you. But actually [it is] the personal struggles. The personal obstacles that you have to face are very different between [“IDDM”] and “NIDDM.” ...Also, for “IDDMs,” they are easier to work with in something like this. Because their need is very immediate. “If I don’t treat myself, I get hospitalized.” [“NIDDMs”] can go for weeks binging on Haaggen Daas [ice cream] and probably never go into DKA [diabetic ketoacidosis]. You just put on a lot of weight and...the doctor will chew you out and then [someday] you will get complications. ...There is no immediate feedback loop. (Wai Mun, Transcript, 1997, pp. 14-15)

Wai Mun pointed out that people with the IDDM form of diabetes are more likely than those with the NIDDM form to be seeking help to avoid complications.

Lin Yee found that the difference in age between herself (with IDDM) and DCOS members (with NIDDM), coupled with differing life challenges, made her feel increasingly isolated with her condition:
So I [found] myself very lost there. I [found] that I [was] in a sea of mostly older people, and most of them NIDDMs. And so I didn't find that there was any incentive for me to attend the meetings.... And also they didn't have really support groups at that time. They organize[d] meetings but these meetings were generally diabetes “talks,” [with] invite[d] speakers. I don't want that. (Lin Yee, Transcript, 1994, p. 24)

She was clear in her opinion about there being fundamental differences between the experience of NIDDM versus the IDDM form of diabetes. The DSGS was thus formed to address this void.

The typically informal nature of the DSGS speakers reflected this fundamental difference.

Unlike members of DCOS, DSGS members considered the activities before and after the didactic portion of the meetings as key reasons for their attendance at DSGS meetings.

In her personal diabetic history, Lin Yee partially explained her drive to assist other people with the IDDM form of diabetes. She shared with me her personal distrust of GPs based upon the life-threatening delay she experienced in being diagnosed with diabetes:

I had pretty bad experience[s] with the GPs, general practitioners.... And also, I think my, the way I have, the way I was diagnosed, [pause] bad [pause] bad experience with GPs. Actually, I was sick for one whole month. I went to GPs, and nobody diagnosed me. Nobody did the test and everything and until I lapsed into a diabetic coma.... I landed myself in the intensive [care]. I think I almost lost my life. [My endocrinologist] told me that. You know, any further delay in diagnosis, I would have been, [pause] it would have ended me.

So it's like after that, in fact, right now, we are also fighting. We are also pursuing this issue that GPs need to be—they need to update themselves.... It's not just me. I think talking among the group, I realize that mine is not the only story.... Most of them had very unpleasant experiences where GPs really don’t know....what's happening and can't treat [people with diabetes]. Or are unable to see...that...diabetes has its own [biomedical approach]—and you've got to [treat people with diabetes] differently. (Lin Yee, Transcript, 1994, pp. 7-8)

Lin Yee’s consciousness raising about problems of diabetes care within the health structure came after her primary physical health needs were met. She also wished to meet others such as herself.

Similarly, the predominant theme I heard from young DSGS members was the desire to meet other diabetics who were young like themselves. They expressed frustration that they were viewed by society as having an “old person’s disease.” They also wanted to learn more about managing and living with their condition.
Within the regular DSGS sub-group for the parents of children with the IDDM variety of diabetes, about one third were men. Neither the men nor the women were satisfied by the status quo vis-à-vis the health care system in Singapore. Psychosocial challenges, especially those associated with feeling alone, are not addressed within the biomedical model of health. As Seedhouse (1988) states, “the medical definition of health is not rich enough” (p. 35). Reactive biomedical treatment of diabetes includes activities aimed at reducing or eliminating the perceived (‘real’ or not) health problem, including when and whom a person consults for healthcare and advice (p. 252). But Lin Yee did not require any more medical information to learn to cope with her ‘disease.’ To this end, her specialist ‘volunteered’ his help outside of a biomedical paradigm of health care in which he had been trained.

Support groups are not common in Singapore and the DSGS began slowly. At first, Lin Yee observed that people were not particularly interested in joining her support group. The sharing of personal problems outside of the home is not typically found within Asian culture. Although the existence of the support group appears based on a Western-Christian model of fellowship and altruism, Singaporeans are Asian and remarkably private by Western standards. This is reflected in Poh’s autobiography when she recounts her desire to reveal her pain to a work colleague, Sis Soon Lan, but does not dare break the Asian code of stoicism:

Sis Soon Lan, upon reading the e-mail, you came over and said you wished to give me a hug. As I hadn’t gotten over my emotional setback, I had an impulse to seize the opportunity and run sobbing into your arms. Orientals will be Orientals. I have only myself to blame for not being liberal enough. It wouldn’t have been nice to make you anxious if I had cried, so I had to endure my pain by myself. (1995, p. 65)

Singapore is a society in transition and the DSGS, although highly Westernized in its approach to health, appeared culturally sensitive in that members did not overwhelm potential participants by being too openly personal.
Even with an invitation from their common endocrinologist, Lin Yee discovered that
people were suspicious of her motives:

I just want to know somebody who I can see in flesh and blood, who’s got diabetes, and survived it and doing well, who can have a child, who’s got married. I just want to know, “hey, that’s a model I can follow.”

But unfortunately, it’s really difficult and I think [my endocrinologist] tried his best. In fact, my first contacts were all from his patients. I mean he encouraged me to just get it going no matter how small. So, well, it was very slow moving, and, I know, you just have to literally beg people to come. As if you are doing them a favor, you know, organizing something for them. And sometimes, there is this suspicion. “What’s in it for you? Why are you doing this? I mean do you get paid for it? Why don’t you just—you’ve got enough problems of your own. Why do you want to help people?” You know, this general thing. There’s [the impression by others that you have] some other motive that you are pursuing by starting this group.

People can’t believe that you just do it. …I’m not saying that I’m purely unselfish… I do it for myself too. In the course of helping other people, I am helping myself. And I find my greatest motiviation is that these activities actually [help me with]…my [own] diabetes care, when I know that there are others who are looking at me. And when I know that, “hey I better be taking care of my diabetes, because if I don’t, then, others will take me as an example.”

I find that that is really—sometimes [it] scares me, you know, if I don’t [take care of my health]. If I get lapses, when I don’t test [my blood glucose levels] myself, you know. Then I say, “oh dear,” you know. “How am I going to share with my support group?”

So I arranged the meetings and I said, “hey, you know, come to the meeting. We are having visitors, inviting so and so to speak.” So, I’ll try and make it as attractive to them as possible. It’s not just talking [amongst ourselves] all the time. Sometimes, we invite dieticians, sometimes physiotherapists, so I thought that would be a good incentive for them to come because you are learning more about diabetes through management.

Like the way our support group is structured now, [it] is basically a friendship group. So, we don’t talk about diabetes all the time. Sometimes, we just have fun together. We play games together. One Saturday, you can see us at the Botanic Gardens just having good times, doing exercises. No diabetes talk at all.

We also are very non-threatening in the sense that, I think nobody wants to be judged and if you point an accusing finger, I think that’s one sure way, that you’ll never see them again. So I think there’s got to be a lot of acceptance and we know, I mean among ourselves we know who are those who actually don’t control their diabetes at all and they’ll eat anything, you know. They don’t do their [blood glucose] testing, we know, but yet we have to keep from evaluating them. In the group, we accept them and sometimes, for example, there’s a table laid out of food; much as we want to make sure that everything there is suitable for diabetics it is very difficult because we have non-diabetics who attend the meetings as well. So, if we see this diabetic getting into a piece
of cake that we know is bound to raise blood sugar, none of us point our finger.  
(Lin Yee, Transcript, 1994, p. 2-4)

Lin Yee’s philosophy of acceptance of DSGS members’ diabetic regimens (or lack thereof) contrasts with the critical evaluation of many physicians in Singapore. This socially safe and unrushed environment was a unique forum for people with diabetes to share their concerns and learn about the IDDM form of diabetes. The education topics also included areas pertaining to the psychosocial challenges associated with life with diabetes. Poh states, “Knowing about diabetes reduces the level of fear while encouragement rekindles the fighting spirit” (1995, p. ii). Physicians in Singapore usually ignored these personally important areas.

The DSGS is an atypical social response and nurtures the “Western” practice of questioning authority. Members’ questions are not radical and include: “What can I do to improve my health experience?”, “Who else has this condition?” and “Can you offer me more help in learning how to best live with my condition?” The growth of the DSGS reflects a fundamental dissatisfaction with Singapore’s health care structure. It also reflects an enlarging health related social movement that demonstrates a desire to look beyond modern medicine for answers. This, in and of itself, may be seen as a start to questioning ruling relations by local people living “everyday” experiences.

2. DSGS activities reflect desire for a more holistic approach to health

In biomedicine, diabetes is a condition that can be controlled (or, in the case of NIDDM, delayed in onset) but not cured in the acute care sense. It is a condition with which a patient lives. The conceptualization of diabetes as a ‘disease’ within the biomedical health care model reinforces the view that it is a negative physical entity. There are social psychological repercussions for people with diabetes associated with this way of thinking. Social psychologists argue that a person’s ability to accept his or her chronic condition as an integral part of his or her
sense of self (Charmaz, 1994). This acceptance was illustrated when Nancy disagreed with my referring to her having to maintain a “special diet”:

[I treat my diabetes with a] special diet in a sense [that it is a] careful diet. ...There is no--I think it’s not true. No special diet. ...I would say [it is]--a normal, healthy diet. [A] balanced [diet] which I think applies to everybody. So I won’t call it a special diet. (Nancy, Transcript, January 31, 1996, pp. 8-9)

Nancy emphasized that her IDDM variety of diabetes was part of her life.

Frank (1995) describes accepting physical limitations and associated lifestyle as being an issue that pertains to members of a “remission society.” He explains that these voices need to be heard by the dominant medical system:

[The term “remission society”...describes[s] all those people who...were effectively well but could never be considered cured. ...Members of the remission society include those who have had almost any cancer,...[or] diabetics...and for all these people, the families that share the worries and daily triumph of staying well.... (p. 8)

Parsons’s modernist “sick role” carries the expectations that ill people get well, cease to be patients, and return to their normal obligations. In the remission society people return, but obligations are never again what used to be normal. (p. 9)

But illnesses have shifted from the acute to the chronic, and self-awareness has shifted. The post-colonial ill person, living with illness for the long term, wants her own suffering recognized in its individual particularity: “reclaiming” is the relevant postmodern phrase. (p. 11)

In Parsons’s sick role the ill person as patient was responsible only for getting well; in the remission society, the post-colonial ill person takes responsibility for what illness means in his life” (p. 13).

This concept of a ‘remission society’ resonates with the experiences shared with me by Nancy, among others, at the DSGS. I discovered her to be highly integrated with regards to accepting the multiple challenges, including difficult patient-doctor relations, associated with her condition.

Other members aimed for this level of acceptance as life goals. In her autobiography, Poh (1995) concurs:

Live a good and healthy life. Don’t wait until the discovery of new technologies and new medicines, because you may suffer from complications and not be able to enjoy the blessings [of life]. (p. 95)
The activities at the DSGS reflect a holistic worldview of health. Yet the content of many events focused on the practical aspects of coping with the daily biomedical necessities such as injecting insulin or testing blood glucose levels. The underlying message was that the experience of diabetes should not revolve around the acute care paradigm of health but that there is much to understand and do in order to survive. It is of interest, however, that the conceptualization of this aspect of diabetic care within the DSGS is exclusively Western, with little mention of traditional Asian approaches to treating diabetes.

DSGS education activities themselves sometimes used the ‘banking’ approach critiqued by Freire (1970/1997). For example, lectures at the DSGS were typically done by ‘experts.’ This approach reproduces the hierarchical organization that places the social status and power of professionals above people with diabetes. I asked Wai Mun about the hierarchical format of teaching being contrary to the grassroot ‘spirit’ of the group. He explained that support group members had indicated that they wanted this type of activity. In this way the professionals justified imposing extra-local upon local experiences. These were solicited requests. Wai Mun stated that, unlike the NIDDM form of diabetes, there was a body of knowledge that people with diabetes “just have to know to survive.” He mentioned that the lectures help reassure the core members that they are up to date as well as helping newcomers become more aware of the parameters of their condition. These lectures provided welcome information and were an indirect form of social-psychological support that was absent within the existing health care structure.

When I maintained that perhaps a lecture was not the best way to accomplish this goal and that it was at too high a level of abstraction for some to follow, Wai Mun agreed. But he explained that the lecture format might be a place for newly diagnosed people with diabetes to ‘hide,’ yet still acquire some knowledge. ‘Banking’ style of education segments are thus justified as sensitivity to the expected forms of learning by people with diabetes who are not accustomed to the informal and often personal dialogues among members (including health professionals). But it
can also be argued that these formalized lectures are part of a professional discourse with which
'expert' speakers (especially physicians) are most comfortable and, consequently, for which they
are more likely to volunteer their time.

The use of multiple methods of providing the 'necessary' biomedical information
regarding the care of IDDM form of diabetes is a predominant theme of DSGS activities. This
does not imply that core DSGS members are not critical of the practice of biomedicine. As one
member commented:

Diabetes care in Singapore at this point in time tends to focus on the physical
needs. The clinical needs, not even the physical needs. More the clinical needs.
And they are finding that the complication rates and care are not really coming
down.

Considering the amount of money they are pumping into running diabetes
centers. [...] they are tightening up all the hardware, [that is] more diabetes
centers. Then they are pumping money into a bit more software now. Train
nurse educators. That's a good step [as] there is a severe shortage.
Endocrinologists, [we have] enough.

Then they are going to look at training GPs. That's probably needed as well.
I'm betting at the end of it, it still won't come down to much. Because that's
only a part of it. [...] It is not even the lifestyle of [people with diabetes that is
the biggest problem]. When you look at diabetes as something that someone
has to live with, then it becomes different. Then you are talking about social
conscious, emotional concerns, psychological concerns and that is not touched
on at all.

The paradox in thinking to my mind is that...the drug companies spend so
much effort getting smaller needles. The doctors are trying to get [fewer]
injections. I mean the GP tries to put everyone on as few jabs a day as possible.
But the motivated [people with the IDDM form of diabetes] go for more jabs.
They don't care [about] the needle. Sure, it's great if it's a smaller needle. But
even if it's a 14 gauge and [they] need to do it, they'll do it.

Because there is something more there driving them. What is it? They have a
reason to deal with their diabetes. [The health care structure] never touches
[this]. It is not just diabetes, it's any chronic condition that you have to deal
with. Anything.

...[K]nowledge does not equate to change in behavior. ...[Y]ou've got to
help them come to term with a loss. They've lost something. There is no point
in saying "no, you haven't." You have lost something. For the rest of your life
you have to be more careful. ...Certain things are going to be tougher to do.

So a lot of [their] dreams and aspirations go. ...They have to be helped
through that healthily. So they don't go into denial. Or they don't go into
depression. And, no, [in Singapore] there is nothing for [depression]. Zero.
(Wai Mun, Transcript, 1997, pp. 25-26)
Wai Mun is clear in his holistic view of health. He is aware of the powerful social forces in the health care structure but is not openly critical. The role of the DSGS was conceptualized as an attempt to fill these health care 'gaps' presently 'missed' by the existing system. This is parallel to Smith's (1987a, p. 174) mothers who reproduce the relations of ruling by performing the educational tasks that were missed by the educational system.

Unlike most patient-doctor interactions, DSGS activities reflect a holistic worldview of life with diabetes. Wai Mun pointed out the critical absence of attention to the complex psycho-sociological issues associated with living with the IDDM form of diabetes. Some members reported that they were not just receiving education regarding the mechanics of life with diabetes. Rather, they shared that they were learning to live with this condition. This meant that their conceptualization of diabetes was not something to hide. Rather they intended to construct their lifestyle, which included a diabetic regimen, in a spirit of acceptance. This did not mean resignation, but rather an acceptance of their diabetes as a condition of their existence similar to the requirement of oxygen as a human condition.

One DSGS objective is the involvement of the family within support group activities. Partners and children of people with the IDDM form of diabetes can be considered as 'having' the condition as well. Lin Yee explained:

You've got to make your diabetes a family thing, you know. So my children say, "Mommy, have you taken your insulin? We are going to have lunch." To them it is nothing. Or sometimes, they see me stealing a piece of [something forbidden and say] "Are you supposed to be eating that?" (Lin Yee, Transcript, 1994, p. 43)

There was a high involvement of family members of people with diabetes in all DSGS activities. This is notable as it acknowledges that a chronic disease of an individual family member affects the household. By including partners and children of people who have diabetes in DSGS activities, the social psychological and practical challenges of family life with diabetes are addressed. This characteristic of including family members in all activities was seen as central to
the philosophy of the DSGS. Staff members told me that it was an integral aspect of meeting the social-psychological difficulties of coping with diabetes.

The role of this support group in addressing coping with these life challenges was based on their belief that only people with the IDDM form of diabetes really know about their situation. As one member commented:

I think [it is] more that we have something in common, you know? Among us, we understand what it's like being a diabetic. ...Non-diabetics would not be able to identify the struggles that we have. (Yee Pak, Focus Group Transcript, November 25, 1997, p. 2)

This was repeatedly explained to me. I heard in many ways that the DSGS was foremost a friendship group. I asked what the difference was, then, between DSGS and, for instance, a tennis group. Jane said “I don’t think that I will be able to talk diabetes with my tennis group” (Jane, Focus Group Transcript, November 25, 1997, p. 2). Vivienne shared, “You know, when I was diagnosed, I felt quite lonely because I [had] never seen any IDDMs at all. And Lin Yee was the first one I met at the [diabetic information day]” (Focus Group Transcript, November 25, 1997, p. 8). She saw the founder of the DSGS as a “walking example, [who is] married with children” (Focus Group Transcript, November 25, 1997, p. 3). This level of social psychological support can only be provided by a person with this type of diabetes.

Diabetic education was depicted as a secondary reason for attending the DSGS. Kate made the point that the education was the foundation of being able to access practical support: “It is...the same thing, you can’t really tear it apart because if you’re going to provide support you need the information” (Focus Group Transcript, November 26, 1997, p. 2). John agreed that information was important but objected: “I can get information from the [inter]net. Books I can get anytime. But the emotional support is the most important thing” (Focus Group Transcript, November 25, 1997, p. 8).
The most frequently-mentioned emotional support was provided for those younger women who were concerned regarding their future abilities to conceive and deliver healthy babies. This was one of the concerns of the founder of the DSGS, who subsequently had healthy children of her own. Support group members cited her frequently as an inspiration and a source of hope for their own lives. Jane stated:

I think [that] basically, as long as all [the members have IDDM] in this support group, we already have a bond. We know [that] we have the same lows, we know we have the same highs. ...I think we all share the same thoughts.

Without the education we don’t know if, some of us, we really don’t know if we can get married. [Or if we can] have children. ...So it was when you come into a group like [this one] they give you support.

Lin Yee is a walking example, [she is] married with children. ...So they are all working examples, and we learn from them. As well, we get the social support and the emotional support. Everything. So I think that’s why the support group is so different [from other social groups]. (DSGS Focus Group Transcript, November 25, 1997, pp. 2-3)

Although emotional support is cited as an important aspect of the relationships that were formed as a result of being DSGS members, these encounters were personal and rarely discussed in my presence. At times, with certain newcomers, I could feel their anxiety. I sensed their reluctance in general and knew, through confirmations with core members that new members often did not initially wish to speak to anybody. But I was never privy to the personal details or included in meeting potential new members for the first time. Especially during the family retreats, I observed certain groupings of people made up of varying health providers speaking to those with less familiar faces. Often spouses were included in this conversation. Later, during the two focus group that took place after I had moved to Hong Kong, there was discussion about DSGS members being “down” or “depressed” in the past. There was no mention of anyone being in those states when I was a participant observer. My interpretation of this is that I had developed a close enough relation to have “depressions” referred to in the past tense or in the third person.
Some members who became ill with their diabetes reportedly stopped attending the support group because they did not want to lower the group's morale. For example, the DSGS founder said that a particular member, with secondary complications whom I visited in the hospital, felt that her complications “inconvenienced” her attending and that she did not “want to discourage the group” (Fieldnotes, November 5, 1997, p. 1). The founder also told me about a member whom I never met whose gastric pains were so bad that he “suffered in silence” and about whom the “group was very concerned. …By the sixth or seventh meeting he stopped [attending meetings] because he felt bad that everyone [became] uncomfortable” (Fieldnotes, November 5, 1997, p. 2). Lin Yee told me that the support group still had many challenges and things to learn.

There was reference to a particular support group member who was having significant emotional difficulties adjusting to his diagnosis during the first DSGS focus group that I organized. I was surprised to see how he was singled out as he was present at that focus group. Gary is a quiet college-aged man who seemed comfortable sharing his emotional difficulties of the past without ever calling them depression. Gary described how he was in and out of hospital because of his “lack of knowledge of diabetes.” He added,

[L]ater I joined the DCOS but it [didn’t] help me much. …I was discharged [from the hospital] on the third or fourth episode [of poor glucose readings] and I was introduced to the DSGS by my doctor. And that is when I nearly lost my confidence in life. …When I met up with [the DSGS doctor], that is when I gained back my confidence. [The DSGS doctor] counselled me and talked to me. [The DSGS doctor] is very nice. The first time we met was at [the] house of [a DSGS member who was at the support group. The DSGS nurse educator] took me there. I was still in my state, you know, keeping to myself, keeping quiet. (DSGS Focus Group Transcript, November 25, 1997, p. 12)

After this personal and slightly emotional disclosure, by Western standards, the mood changed in the room to a more festive one, typical of support group meetings. The hostess responded:

“Yeah, he is. I test[ed] him. He came in with sunshade[s] and did not talk the whole time [that]
he was there” (DSGS Focus Group Transcript, November 25, 1997, p. 12). The room filled with laughter. Gary’s mannerisms were still introverted. But his shy nature, such as wearing sunglasses and not speaking at a meeting, had distinctly changed. He not only attended meetings regularly, but was involved at many levels, including accepting my invitation to participate in my inquiry.

In summary, over the three years I spent as a participant observer, I saw that disclosing personal life details was uncommon at support group meetings. This was especially true with newcomers who often sat quietly. The level of openness demonstrated by core group members at the focus group meetings was a function of the high degree of comfort and personal friendships that had been fostered through the years. But I was more likely to witness any negative emotion regarding past traumatic experiences with physicians during the focus group meetings and in my one-on-one interviewing than at the DSGS meetings.

3. **Increasing empowerment of DSGS members**

Wai Mun said that support group members were seen as passing through three chronological stages. The first was termed the “crisis” stage. The role of the group, through the relationships formed by attendance at some meetings or other support group activities, offered a type of therapeutic support. The second stage was called “passive acceptance” and occurred when individuals attended varying support group sessions and began to actively participate in activities. The final stage was called “personal ownership.” At this time, the member would begin facilitating their own groups and taking a more involved initiative in the planning and attending group activities (Fieldnotes, March 16, 1997, p. 5).

Wai Mun stated that DSGS members were always planning and trying new things. They sought to adapt Western support group approaches in order to be more culturally sensitive
to Singaporeans. The feedback from the group was that the DSGS should remain a resource for the IDDM variety of diabetes:

At the moment we don’t have a precedent in the region [that has] anything to do with support [that is] culturally sensitive and culture-dependent. So I can’t go and just pick something from the States. …So we are on the early part of our learning curve. We’ve made a lot of mistakes and we will continue to do that as we try new things. So I would rather keep it on to a group, a more homogenous group, so we know exactly what their needs and struggles are. (Transcript, 1997, pp. 14-15)

Neither salaried ‘members’ nor volunteer health care professionals were authoritative in their mannerisms. As the support group grew, I noticed more sessions facilitated by core volunteer members who had the IDDM form of diabetes.

The structure of the DSGS was such that it encouraged, and formally trained, members to take a more active role in membership expansion. In this way the group grew to include members with different and varying backgrounds who were perceived as ‘missed’ by past efforts. I see the consciousness-raising type (rather than banking type) of education espoused by Freire in these DSGS activities. Those experiencing oppression within the health care structure are made aware of their abilities to define the problem according to their own experiences and are subsequently facilitated to reclaim control of their lives. These ‘problems’ within the health care structure were perceived to be poor education and little social-psychological support in living with the IDDM form of diabetes. The DSGS provides opportunities for members to become increasingly empowered within the group itself. But this empowerment does not necessarily include the questioning of ruling relations in Singapore.

4. **DSGS role in the conscientization of the Singaporean community to the prevalence and treatment of diabetes**

Lin Yee’s definition of her health problem was initially centred on “needing” to meet young adults with her kind of diabetes. Her experiences as the founder of the DSGS led her to
help organize educational activities at the community level. These included speaking at DCOS events and promoting the DSGS’s annual public information day. At this point, coverage of DSGS events began to appear in the press and references to the DSGS were part of news stories on diabetes. These provided an opportunity to give voice to this particular part of the “remission society.”

The impetus, and provided rationale, for the creation of the support group began with grassroots dissatisfaction with the health care structure. After the level of diabetic lifeskills and perception of medical care were perceived as satisfactory, a sense of being socially isolated as “diabetics-who-use-needles” persisted. Existing health care structures had, after all, been constructed for the education needs of those with the more typical, or NIDDM form of diabetes.

Many Singaporeans, I was told, still believed that a disease that required injections was a “death sentence.” People with the IDDM form of diabetes tend to be young and within childbearing years—or children themselves. The additional social burden of repeatedly having to educate family, friends and employers as to the facts surrounding diabetic regimens; about the ability to function normally—within the terms of their illness; and about the ability to have children provided a rationale for DSGS members volunteering at these public education events. Their assumption was that an improved public awareness of diabetes would lessen their practical and social psychological challenges.

These events also provided an opportunity for consciousness raising of those advocating a holistic conceptualization of the experience of living with diabetes. Public perception might be swayed to no longer view people with diabetes as ‘diseased’ people but rather ‘normal’ people who have a manageable, unthreatening health condition. The potential for discovering previously undiagnosed individuals was also realized at these events. The expansion of the DSGS membership could have been attributable to these activities.
The role the DSGS played in the consciousness raising of the Singaporean community as to the prevalence and treatment of diabetes also helped accomplish the government’s objective of increased diabetic education. Further, financial assistance was required for large events, and these activities thus provided venues for pharmaceutical and technological corporations to advertise their products. In this way, the ruling relations were reproduced as a revenue-generating activity (such as advertising) was part and parcel of this ‘free’ service to the community.

Despite being supported by government, DSGS participants were not completely silent regarding the government. They were candid regarding the government’s influence on the press regarding which health theme was promoted when diabetes did not receive as much attention from one year to the next. But, there was a tacit acceptance of the market-driven ideology that formed the practical parameters of their humanistic efforts.

5. DSGS as a transition to consumerism in medicine

During the first year of my participant observations I formed the impression that some doctors were, or might be, economically threatened by the existence of the DSGS. The DSGS represented some sort of competition—or perhaps was perceived as an unknown and potentially disruptive force. Wai Mun talked about the DSGS having a “niche,” insisting that they were not in competition with doctors: “[W]e try to reinforce what [people with the IDDM variety of diabetes] have been taught in diabetes centres and clinics. We don’t want to take over that function” (June 12, 1997, p. 18). The DSGS viewed themselves as being ‘complementary’ to the existing hierarchy of health care. One volunteer health professional explained that territorialism lessened once the DSGS became more “known” to individual doctors, and that their “stresses” or concerns about DSGS decreased (Paul, November 1997, p. 3). Certain public clinics had accepted DSGS information pamphlets and were informally ‘referring’ potential DSGS
members. By the time I left Singapore, there were plans to link DSGS with certain public hospitals. But in general, not much was said to me about the reaction of the medical community regarding the role the DSGS played in health care.

The DSGS does not have the overt intention of critiquing or dismantling the existing “for-profit” organization of health care in Singapore. It merely reproduces the intent of an administration that is fiscally-oriented as DSGS members complete the less valued, less revenue-generating work of diabetic education and social psychological support. The DSGS does not problematize the scientific nature of biomedicine itself (including associated professional organizations) nor its place within a for-profit ideology. The role of the DSGS as a transition to consumerism in medicine is at an embryonic phase. In direct competition with physician-educators, I witnessed core group members, as they attended the various social and didactic, “banking” style type of education, become increasingly comfortable with complex biomedical knowledge. One outcome of becoming cognizant of the disease and treatment processes was an increased sense of security and social power in doctors’ clinics. This power reduces the social distance between doctor and patient and potentially threatens the status quo. As DSGS built knowledge about diabetes, it fostered personal relationships and provided psychosocial support. Although presentations were somewhat repetitive about the basic facts of diabetes, members attending the support group meetings had an opportunity to keep up-to-date on treatments. This was described as empowering.

I was recently updated through electronic-mail that the founder is now salaried by the umbrella organization and holds a position previously held by a physician. In a Freirian style, this shows an increasing ‘ownership’ of the DSGS addressing the challenges of living with diabetes within Singapore’s existing health care structure by those who are directly affected by it. The DSGS has currently expanded their activities to include a diabetic medical supplies shop (that delivers). This has further helped attract potential members. In addition, specific social
gatherings have been successful at better attracting Malay Singaporeans. These recent developments support my observations of DSGS as a movement towards consumerism in Singapore that extends a marketplace ideology.

In summary, the existing health care system does not support the holistic health views of the increasing numbers of DSGS members. Although the DSGS is not intended to question the "institutional order" (Smith, 1993, p. 6) of Singapore's society, one result of educated and more confident health care consumers will be individuals who are more demanding of their health care providers. Singapore is in a transitional state with local people becoming increasingly educated and autonomous. Coupled with supportive experiences such as those within the DSGS, education may facilitate those with chronic health conditions in discovering their own social power so that they can begin to question their physicians.

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1 This is not surprising as Christianity, in 1996, was reported to be the religion of only 12.9% of Singapore's population.
CHAPTER SEVEN
CONCLUDING COMMENTS

I. Introduction

I begin this final chapter by addressing the three major arguments of my work. Following this, I present detailed chapter summaries concluding with a discussion of the notable contributions of my inquiry.

My first summarizing argument defends my selecting institutional ethnography as the best approach for me to meet the research goal of contextualizing doctor-patient relationships in Singapore. I locate evidence of how Singapore’s embracement of, and active participation in, a globalized marketplace are reproduced at the level of face-to-face interactions between physicians and people with diabetes. Secondly, I point out that the DSGS is an increasingly organized response by people with diabetes to Singapore’s various relations of ruling including such forms as governmental bureaucracy, health policies, and professional organization of health practitioners. Since support groups are not common in Singapore it began as a ‘standpoint’ from which I could learn about the ‘everyday’ experiences of people with diabetes. My third major argument explicates how, in addition to DSGS members’ experiences, other participating physicians and patients led to my discovering how the social organization of local interactions between people with diabetes and their doctors in Singapore reflect an extra-local organization inherent to the economic ideologies behind a globally-driven economy.

This concluding chapter succinctly reviews the dissertation in a way that provides an orientation to its importance and potential usefulness. For this reason, I include a brief summary of the text. This accounting also provides a recent framework from which I outline the contributions of my inquiry. Central to my argument is the following: if meaningful change toward equity within Singaporean health care is to occur, the consciousness of the oppressed and
oppressor alike must be raised to the social complexities associated with day-to-day life. An important example of the above is with regard to the near impossible challenge of meeting contradictory objectives of working long hours and living a healthy lifestyle. In this way, individuals who, in a monetary sense, ‘successfully’ participate in capitalistic society often fuel health care problems such as the increased rates of diabetes. My dissertation’s institutional analysis provides evidence of how Singapore’s participation within a globalized marketplace affects interactions between doctors and people with diabetes in Singapore.

There are three major arguments within my thesis. The first is that institutional ethnography is the best approach in contextualizing doctor-patient relationships. The second argument is that the DSGS represents an increasingly organized response by people with diabetes to Singapore’s relations of ruling. And finally, a profit-oriented health care system supported by the globalized medical industrial complex are reproduced by doctors and their patients with diabetes in Singapore.

II. Major Arguments

1. **Institutional ethnography and contextualizing doctor-patient relationships**

My inquiry used an institutional ethnographic approach that encompassed a Freirian perspective. The purpose of this inquiry was to critically contextualize relations between doctors and people with diabetes in Singapore. These were presented in my thesis in a way that explicated the (usually unrecognized) societal relations that shape and influence the recounted face-to-face interactions of people with diabetes and their physicians. I did not have the intention of generating an explanatory theory that accounted for this professional relationship. Rather, the purpose of my inquiry was to learn about the experiences and perspectives of people with diabetes and their doctors. This does not mean that interpretations of these experiences by
participants were taken at face value. By using institutional ethnography, I located these social interactions as part of the typically unnoticed forms of organizational practices. Globalized capitalistic market forces, local health care policies and the imposition of biomedicine upon Singapore’s previous indigenous health practices are all part of these relations of ruling and the ‘data’ of my study include salient contextualizing features of Singapore’s history, present political practices and contemporary society. My purpose was to explicate how these multiple forms of organized social power were reproduced in face-to-face interactions between physicians and people with diabetes in Singapore.

Unlike more traditional social scientific methods, institutional ethnography provided me with a freedom to learn about and follow-up areas of concern that were considered important by the participants themselves. I experienced an epistemological revelation in Singapore. By using the methods associated with institutional ethnography, I found a way for me to actively minimize the imposition of my white, Western-centric thought upon the ‘collected data.’ While attempting a ‘positivistic study’ in Singapore, I experienced a bifurcation of consciousness. I became aware that at the same time I was attempting this approach I was simultaneously acquiring knowledge that was socially relevant and participant-driven. I learned that an integral feature of institutional ethnography is the absence of the ‘objective’ investigator. Thus my difficulty in implementing my originally proposed, OISE-sanctioned thesis was related to the fact that my methods were uncritically housed within a social sciences tradition and did not yield the anticipated results in Singapore. My adaptations to the field, and ultimate discovery of institutional ethnography as a more viable and appropriate way to analyze my fieldnotes, interview transcripts and relevant texts provided the underpinning of the thesis itself (which is presented as an autoethnography in Appendix A).
2. The DSGS: An increasingly organized response by people with diabetes to Singapore’s relations of ruling

By questioning the taken-for-granted social structure of doctor-patient relations, I learned of a diabetic support group and was enthusiastically included as a participant observer. These experiences provided a context for my analyses and insights regarding the perspectives of people with diabetes regarding the deficits within the local health care system. I realized that the support group’s existence in and of itself was illustrative of Singapore being in a socially transitional state. To this end, the DSGS offered an important ‘standpoint’ from which I could begin to learn what it meant to live with diabetes in Singapore.

Support groups are not typical of Singapore’s indigenous social health practices nor were they common within the biomedical health care structure of the 1990s. The existence and continued growth of the DSGS was part of increasing dissatisfaction with health care experiences. The health views of DSGS members were more holistic than those supported within the government-sanctioned health care system. DSGS perspectives resonated with educated health consumers who valued more autonomy than was supported within Singapore’s health care structure. The DSGS was critical of the implementation of biomedicine and its activities reflecting a desire for a more holistic approach to health. However, the biomedical conceptualization of diabetes was Western, with little or no attention to potential support from indigenous health practices. The provision of friendship and biomedical information was repeatedly presented as the rationale for the group’s success.

Critical views of biomedicine expressed in the DSGS did not extend beyond individual doctors and patients or Singapore’s health care system. In other words, there was no open questioning of relations of ruling that included the effects of a Western-driven globalized market economy upon their experiences of living with diabetes. DSGS members performed less valued, less revenue-generating work such as diabetic education and social psychological support
not performed by physicians. However, the DSGS was a transition to consumerism in medicine in which many activities reinforced the status quo within the health care structure. Within the social context of Singapore, the DSGS reflected the sentiments of a more educated, wealthy society. With this increasing regard for autonomy and government accountability, I have argued, also lay the potential for consciousness-raising to the importance of challenging existing social inequities which hinder individuals from realizing their best possible health.

3. The effect of globalized capitalist market forces, local health care policies and the imposition of biomedicine on people with diabetes and their doctors in Singapore

As an institutional ethnographer, I used many sources and forms of information. More important, I facilitated participant-driven discussions and activities where I learned about what was considered important by physicians and people with diabetes. I met with government officials who provided me with their perspective of the ‘problem’ of diabetes in Singapore and how I might best perform my research. Various texts, both local and Western in origin, were critically reviewed to better contextualize the investigated relations to biomedical and indigenous health approaches. My analysis was critical of how globally-driven relations of ruling such as globalized capitalist market forces, local health care policies and the imposition of biomedicine were reproduced by people with diabetes and their doctors in Singapore.

It was readily apparent that Singapore was not ‘typically’ Asian or Western. This Southeast Asian republic had a unique colonial history. As a ‘developed’ nation, Singapore was also competitive within the contemporary marketplace. To achieve this in such a short period of time, I have illustrated how governmental control was utilized. Citizen behaviors that were economically productive such as self-denying, hard work and a consumeristic lifestyle were and are supported in government discourse and policy. Certain aspects of the West that were seen as assisting in this economic quest were and are openly embraced, such as biomedicine, while other
related social conditions, such as high crime rates and lack of filial piety, were and are criticized by the government.

The effect of globalized market forces are also evident by unquestioned adherence to a more Westernized, unhealthy lifestyle that facilitates this epidemiological shift towards such diseases of affluence such as diabetes. I have demonstrated how there is no acknowledgment by the government of the impossibility of simultaneously working long hours, being an involved caring family member and maintaining a healthy lifestyle.

The health care structure in Singapore is composed of the more common private, for-profit clinics and government sponsored ones. In this way, the less powerful individuals from lower SES groups and people with chronic disorders who cannot afford private health care receive biomedical attention. This reproduces the relations of ruling such that economics are the prime motivating feature because access to private, for-profit clinics is systemically facilitated.

In addition to the above health care relations, I have pointed out how indigenous health practices such as TCM are marginalized and denied an officially sanctioned healing role within Singapore. Instead, the status of these practitioners as healers is officially reconstructed by the government as ‘business people selling herbs.’ People with diabetes who subscribed to this ‘alternative’ health practice are, I am convinced, reluctant to discuss these activities with their physicians which was reported by my participants to further complicate health outcomes. Doctors are aware of this phenomenon but do not take the time to discuss their patients’ conceptualization of their diabetes.

The health care structure itself is intentionally constructed to be the most cost-effective organization to implement the practice of biomedicine. It is also the form of medicine familiar to Westerners working for multinational corporations and thus helps promote Singapore as a desirable place to relocate. The influence of capitalism is seen in relations between doctors and people with diabetes. Time is considered a costly resource with physicians’ social status
rendering their time as being more valued. Time consuming and consequently least revenue generating activities for physicians tend to be avoided. Unfortunately, such activities include diabetic education and the provision of social psychological support even though these activities are conceived as being crucial in the best biomedical management of this chronic condition. In summary the economic ideology inherent to Singapore’s health care structure is a local manifestation of the extra-local globalized marketplace initiated in the West. In addition, this is reproduced at the local face-to-face interactions between physicians and their patients with diabetes.

III. General Summary

Diabetes is a world-wide problem that is being maintained within existing health care structures, as in Singapore. In my exploration of the interactions between people with diabetes and physicians, I sought to explicate these in a way that exposed the extra-local influences upon them. Chapter One in my dissertation outlines the discourses constructing diabetes. I provide a rationale for how institutional ethnography is the best approach for explicating these relations. In Chapter Two, I critique the contrasting views of biomedicine versus indigenous health practices in Singapore. Chapter Three provides an overview of the theory and methods inherent to institutional ethnography, contextualizing this approach to Freire’s method of consciousness-raising as a way of providing agency to the oppressed. Chapter Four describes the Singapore political system in a global context and includes a problematization of my observations and experiences during my four years of living there. Chapter Five is where I present my analyses by outlining how the relations of ruling in Singapore are evidenced in the interactions between doctors and people with diabetes in context. Chapter Six is the place where the activities of the
DSGS are problematized and illustrates how this unique support group represents the beginning of a transition to consumerism in medicine.

In this final chapter I provide my concluding comments regarding the contextualization of the investigated patient-doctor relationships. Singaporean society as a capsule of how doctor-patient relations are enacted in a global capitalistic system where a) there is a drastic change in diet and lifestyle and b) there is a privatized or semi-private health care system that is part and parcel of the global medical industrial complex supported by the pharmaceutical conglomerate and the hegemony of biomedicine. Chapter Seven is also the place where I note my Freirian conviction to the practical aspect of my work. This text may serve as one of the first steps towards a kind of ‘dialogue’ towards the goal of more equitable health opportunities among Singaporeans.

IV. Contributions of My Inquiry

Freire’s dialogical approach as an educator provides guidance to my inquiry. Because the nature of my thesis is intended to be socially critical, I am sensitive to observed or recounted social inequalities and oppression. This information is inherent to my institutional ethnographic analysis. The results of my inquiry are intended to help raise the consciousnesses of those individuals affected by the social inequities in relations between doctors and people with diabetes. These include the ‘oppressed’ and the ‘oppressors’ alike, if meaningful change is to occur. I locate myself within critical academic feminist and emancipatory theory. The overall purpose of my thesis is to critique the hegemonic meaning of social relations between doctors and people with diabetes.

Although there is a large critical literature in medical sociology, I could find no analytical accounting of ‘patient-doctor’ relations from perspectives that contextualize these
recounted local experiences within ruling relations in non-North American settings. My dissertation addresses this void. This study also contributes to an increasing body of institutional ethnographic research outside of feminist scholarship. Works in this genre include de Montigny’s (1995) institutional ethnography of social workers within Ontario’s child welfare community. My writing, like his, includes a reflexive accounting of my own experiences and their role in my scholarly inquiry.

My chronic neurological condition coupled with the multiple health challenges of my two children with asthma has provided me with a great deal of first-hand experiences with health care systems within five countries. Quite recently I have attended a number of specialist visits with my unilingual Chinese mother-in-law in Montreal. I assisted with the language challenges and other social distancing features that interfered with the ‘family’s decision-process regarding a particular surgery. These many doctors’ visits do not render me a universal ‘expert’ on doctor-patient relationships. Instead they provide me with a passion and an experiential context from which I might more effectively interact with the people who agree to share with me their own personal standpoints. In addition, I put forth that these insights and genuine interest in participants’ stories help reduce any social or cultural distance that might impede my learning about what actually happens to people with diabetes in Singapore. In this way, I believe I am better equipped at “knowing a society from within” (Smith, 1990, p. 21). Unlike more traditional sociology that ‘explains’ people’s behaviour, I am more interested in finding out how the social affects people’s lives and activities (Smith, 1999, p. 96).

de Montigny also explains how institutional ethnography offers the best approach to produce an analysis that exposes the form of ruling relations within a social work setting. Another work using institutional ethnography by Townsend (1998) includes a highly readable explication of how Smith’s approach effectively allowed a problematization of the occupational
therapy profession. Townsend’s conclusions resonate with de Montigny’s: academic professionals are a part of the relations of ruling.

My inquiry includes similar explications and conclusions. It also reaches beyond white Western borders. Like de Montigny and Townsend, I contextualize myself in an autobiographical fashion to the ‘investigated’ community. I include details of life as an ex-patriate Westerner in Singapore and reflections of the effect my sex, race and bi-racial family life within this community. I consider these contextualizing features along with any other relevant information when I problematize ‘everyday’ doctor-patient experiences in Singapore. Unlike these institutional ethnographies, my analyses extended to the effect of a globalized marketplace upon the local experiences of my inquiry. In addition, the recounted experiences and explications are not entirely unique to Singapore and resonate with those within similar health communities in Canada.

Especially important to my inquiry is my choice of diabetes as a focus. This chronic condition easily lends itself to the quintessential ‘magic bullet’ mentality inherent to biomedicine. In addition, Singapore has rapidly risen and is considered within the business communities (and touted as such within travel brochures) to be one of the most ‘modern,’ that is Westernized, Asian countries. As diabetes is a disease of affluence and Singapore’s official health care structure is biomedical, it is an important location from which to view the imposed institutional relations from the West upon the Republic’s local social condition. My deconstruction of biomedical journals is also relevant within a Western context. Corporate influences upon health care practices should not be underestimated even within countries such as Canada that have a socialized health care structure.

Although I periodically mention areas where my observations and analyses parallel a North American context, the objectives of this inquiry are not to typify, therefore stereotyping, doctor-patient relations in Singapore. Although I am not advocating these as ‘the truth,’ I include
these references to certain Western contexts as a reminder that the lived experiences of 
Singaporeans within a particular health care structure based upon biomedicine can resonate with the lived experiences of individuals in other countries. Smith states that we “want to know more about how things work, how our world is put together, how things happen to us as they do” (1990, p. 34). Although the knowledge acquired regarding doctor-patient relations does not need to transcend geographical locations, my own experiences (and informally shared experiences from others) coupled with a general understanding of the health care structure in Canada provide me with a reference to flag similarities between nations. As this dissertation is defended at a Canadian institution, I believe that it is important to raise the consciousnesses of others towards some of these basic resemblances. However, it was not my intention to perform an institutional ethnography that contrasted two geographical locations.

I drew from distinct participant ‘types’ reflecting five general discourses. These included physicians (from differing clinic types--HDB, PC, and ORT) introduced to me by my mentor; government officials (with the outcome of our meetings shaping the design of my inquiry); people with diabetes (who are not members of the DSGS); health professional members of the DSGS; non-health professional members of the DSGS who are part of an emergent consumer class. These varying perspectives facilitated my ascertaining the organizational processes housed within their shared opinions and experiences.

I discovered a pervasive for-profit ideology within biomedicine in Singapore. As Western medicine is historically linked with capitalism, the valuing of profits over health is clear. Biomedicine has also been critiqued as curative, hierarchical and dualistic and not providing for two-way dialogue between patient and doctor. This patient objectification by the ‘expert’ physician is problematic. Within this context, it is apparent that the power imbalances between doctors and their patients with diabetes are more pronounced within public clinics. I argue that financial savings at subsidized clinics come at an indirect cost: loss of face and time.
The professional authority of physicians over their poorer, less educated patients is part and parcel of the extra-local relations of the professional organization of medicine within a society that supports for-profit health care.

Another contribution of my research is a critical examination of the often ambiguous relationship of the DSGS, the government and the medical profession. It appears to have a similar position to that of the cancer society within Canada’s ruling structure (Muzzin, Anderson, Figueredo, & Gudelis, 1994). The presence of DSGS’s salaried health care professionals illustrates the potentially uneasy and contradictory relationship of the DSGS with the medical profession. The evolution of the group to a more consumer-oriented entity at the same time that leadership by a salaried physician was replaced by a person with diabetes suggests that this contradiction continues.

An important aim of my work is to provide an analysis that might equip those participating in relations between doctors and people with diabetes (both extra-locally and locally) with those skills that are necessary to the critical witnessing of everyday social events. The Freirian view of localizing the oppressor outside of the individual resonates with Smith’s ideal of problematizing the disjuncture between experience and the discourses of ruling. This could occur as a consciousness-raising for those who are in a position of power and who are an integral part of societal institutions that are presently informed by oppressive ideologies. In addition, consciousness-raising may occur among those who house the oppressor and contribute to their own oppression. In my view, this increased awareness, coupled with a sense of personal (or more egalitarian use of existing) power, may evoke social change. This change would be toward addressing the needs of the many rather than the privileged and powerful few.

I do not state here that my conclusions and recommendations are in fact ‘best’ or universal in some sense. My intention here is to raise the consciousness as to the importance of becoming more self-aware of how face-to-face interactions reproduce capitalist ideologies.
inherent to ruling relations within a globalized marketplace. An increased mindfulness of the systemic barriers affecting the relations between physicians and people with diabetes is the beginning to their dismantling. In addition, I would hope that an analysis such as the one put forth in this dissertation could act as a beginning point for a dialogue that reflects a better awareness of people with diabetes and doctors regarding the complexities of their social worlds.

It is my hope that this dialogue could extend beyond individual physicians and patients to include a more organized social discourse with the intention of promoting the ‘best’ health for the ‘most’ people. This objective encompasses the goal of the provision of equal opportunities to existing institutionalized health care. It is also the beginning groundwork towards the arduous task of dismantling existing ruling relations that are based upon ‘accounting logic’ and tend to be insensitive to the social determinants of health. I firmly believe that further research such as this has the potential to raise the consciousnesses of those who can, and might, make equitable social improvements by challenging the ideological character of the organizational processes governing institutions.
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Endnotes
I. Spring 1993-Fall 1994: Introduction

This critical autoethnography provides the context of my inquiry. It begins with an explication of the social processes surrounding administering a quantitative instrument that addressed relations between doctors and people with diabetes in a non-Western location such as Singapore. I experienced gestalt-like transformations that ultimately led to a reconceptualization of my inquiry. I came to recognize that my intuitive parallel research activities fulfilled the requirements of an institutional ethnography.

Briefly, I moved from the postpositivistic tenets of the survey portion of my inquiry to the more socially critical methodology of institutional ethnography. I experienced a disjuncture between my research experiences and the professional organization within academe. These experiences were textualized in the form of personal journaling and self-reflective academic papers presented at qualitative conferences. This critical accounting of my epistemological transformation is an institutional ethnography in and of itself. It begins with my everyday experience as a Western researcher in Singapore.

My research methods were frequently adapted to reflect ongoing sociological insights acquired from the Singapore 'field.' The premise of this methodological flexibility was that it would facilitate an inductive approach to my contribution to grounded theory. The problematic centred on the experience of the questionnaire not 'working' in Singapore as received methodological literature suggested it should. In my best efforts to twice pilot the instrument, I became aware that I would have quantitative data collection 'problems' in the 'actual study.' I recognized that the piloting 'status' of a questionnaire's development was more methodologically flexible. This allowed me to reproduce the relations of ruling by not rejecting this quantitative aspect of my inquiry. As a response to the participants' reaction to the survey, I 'used up the slack' inherent in the quantitative methodological flexibility in the piloting phase. I
engaged in interviewing. I came to realize that in the course of adapting the quantitative phase of my study to best ‘fit the field,’ I had unknowingly been engaging in another kind of research.

II. Eight Research Phases

I use the metaphor of the layering of an onion to illustrate the types of research activities that sequentially occurred throughout these four years of research. Each “layer” or “phase” represents a series of activities directed towards a general research objective. This onion metaphor (illustrated in Figure 1) provides a schematic representation of the differing research activities that occurred within a particular time frame, or period. I provide a flowchart within each phase. The relevant theoretical or practical aspects making up these activities are labelled.

My experiences accessing the field, coupled with the challenges of implementing Western-derived research plans in Singapore are treated as data in and of themselves. These include my personal stories of meeting and forming relationships with key figures in my research throughout my four years in Singapore.

My research approach is consistent with Bochner and Ellis’ (1996) warnings that the ethnographer should not stand “above and outside what they study” (p. 19). They emphasize that the notion that social scientists could do so is an “illusion.” They claim that we can “use narrative to make sense of our lives” and that it may be used as a vehicle to “offer a critical analysis” of social experience (p. 33).

Eight sequential phases in my research (Figs 2-6; 8-10) are as follows:

Phase 1: Original Toronto-based study (Spring 1993)
Phase 2: Methodological challenges associated with relocating from Toronto to Singapore (Summer 1993-Spring 1994)
Phase 3: Interrelationship between gaining access to informants within Singapore medical community and informally exploring the “field” in Singapore (Spring-Summer 1994)
Figure 1
Natural History Onion: Seven Sequential Layers/Phases
Phase 4: Meeting my mentor and other medical and academic key informants (Summer-Fall 1994)

Phase 5: Patient-doctor relationships in Singapore: First pilot activities (Fall 1994-Fall 1995)


Phase 7a: Period of quantitative organization of the survey data (Fall 1996-Fall 1997)

Phase 7b: Participant observations of the DSGS increasingly from a socially critical perspective (Fall 1996-Fall 1997)

Phases One through Four describe my experiences adapting my inquiry from Toronto to Singapore. Phases Five and Six depict the many and varied experiences associated with my two sets of questionnaire pilot studies. In Phase 7a I critically review the process by which I recognized that the survey aspect of my inquiry had not been successful from a quantitative perspective. In Phase 7b I identify how the DSGS participant observation activities that I undertook during this time were made from an increasingly socially critical perspective.

1. **Layer/Phase 1. Original Toronto-based study (Spring 1993)**

   Figure 2 summarizes my original inquiry plans. My original thesis proposal was entitled: “Relations between some family physicians and their chronically ill patients.” I was a research associate on the Educating Future Physicians for Ontario (EFPO) project at the McMaster Medical School before starting my Ph.D. programme at OISE and I was responsible for interviewing and facilitating focus groups comprised of “local citizens” across Ontario. I was involved in analyzing questionnaire data. This survey was given to people who had a chronic condition or were disabled in some way. It was intended to address their experiences and opinions regarding the quality of physician care that they were receiving. I wrote the working paper entitled “Chronically Ill and Disabled People: Some Views on Their Expectations of Physicians” (1992). I was a member of the EFPO-Multiple Sclerosis (MS) Society working group that planned to construct a workbook. The purpose of this academic resource was to facilitate
Figure 2
Layer/Phase 1: Spring '93 Original Study
"Relationship between some family physicians and their chronically ill patients"

methodological triangulation

1. literature review

2. in-depth interview:
   - people with Multiple Sclerosis
   - family physicians

3. transcripts: tape-recorded clinical visits

theoretical sampling

explanatory theory
medical students' learning about how to help people with MS cope with the social-psychological challenges inherent to their chronic condition.

When I began my Ph.D. programme, I intended to complete a thesis which would “help provide insights regarding the nature of the relationship between family physicians and their MS patients” (Crowe-Joong, 1993, p. 2). I became a volunteer at the local chapter of the MS Society when I quit my EFPO job and became a full-time OISE student. I went on weekly home visits to chat with a housebound MS Society member. I intended, with the help of my contacts within this non-profit organization to utilize a

case study approach [in my thesis]... because the research question being investigated requires context-laden understanding of the relations between physicians and their MS patients. This type of investigation requires a depth of understanding not easily ascertained through survey data. The purpose of this research is to, through the content analysis of detail-rich qualitative data, identify any underlying theoretical constructs which could assist in the understanding of this professional relationship. (Crowe-Joong, 1993, p. 2)

My research plan was to accept the offer made to me by a home care consultant to introduce me to various people with MS within her local chapter of the society. I intended to ask the name of their family physicians after explaining the purpose of my research to these potential participants. I also intended to ask permission to contact doctors to invite them to join my inquiry.

My original methodology was based upon grounded theory and was qualitative in nature. According to Glaser and Strauss (1967), grounded theory is “discovered” when inductive strategies are used to construct a particular theory that explains a given social relation. This is achieved through a “constant comparative method of qualitative analysis” (Glaser and Strauss, 1967, p. 101):

The purpose of the constant comparative method... is to generate theory more systematically... by using explicit coding and analytic procedures'.... This method of comparative analysis is to be used jointly with theoretical sampling. (Glaser and Strauss, 1967, p. 102)

Theoretical sampling occurs when “sampling is on the basis of concepts that have proven theoretical relevance to the evolving theory” (Strauss and Corbin, p. 176, 1990). In this way the data is
intended to drive the theory building and be “more objective and less theoretically biased” (Glaser and Strauss, 1967, p. 34). Researchers who utilize a grounded theory approach make clear that sampling choices are ongoing and are based upon the analysis. Thus in grounded theory designs, the researcher does not know ahead of time which participants will be included in the study. Theoretical sampling of emergent features features that will enable the scholar to make better theoretical sense of the data is conducted.

In my original inquiry, I intended to tape-record appointments between participating persons with MS and their family physicians. In addition, I intended to become cognizant of the relevant scholarly literature regarding doctor-patient communication. I planned to request a follow-up in-depth interview from all participants based upon the insights gained from analyzing the transcripts of the taped clinical visits. This design allowed “methodological triangulation” whereby “the use of multiple methods address a research problem” (Crowe-Joong, 1993, p. 15):

The objective of this study is to identify and describe characteristics of the communication patterns between a sample of family physicians and selected patients. Transcripts of tape-recorded office visits as well as those from in-depth interviews with the participants, which include retrospective reports regarding the nature of the relationship between these participants, would be content-analyzed. (Crowe-Joong, 1993, p. 4)

My multi-method, grounded theory approach was organized around theoretical sampling. I had arranged with my key informant within the MS Society to be introduced to various members. These potential participants were to be individuals who possessed the qualities useful for theory construction.

The purpose of my inquiry was to “identify the categories of the communication patterns between the participants as well as to interpret these patterns as they reflect the features of these various doctor-patient relationships” (Crowe-Joong, 1993, p. 4).
In 1993, I did not question the universalism of the concept of generic communication patterns. I believed that, by providing evidence of the nature of professional relations in the form of grounded theory, I would be contributing to a body of knowledge aimed at improving these social relations. As I argued,

A qualitative study such as the one proposed is an important first step upon which to design research with long-term objectives of assisting in the development of an improved quality of health care. (Crowe-Joong, 1993, p. 3)

As can be seen in this statement, I did not problematize the Western model of the health care structure.

2. Layer/Phase 2. Methodological challenges associated with relocating from Toronto to Singapore (Summer 1993-Spring 1994)

The next layer of my inquiry involved adapting my thesis plans in such a way that it would be possible to continue my programme even though my family and I were moving half a world away from Toronto. Figure 3 is a flowchart of these challenges. My husband was offered a position that was at the Singapore branch of the multinational corporation where he worked. We discussed what an career opportunity this was for him. My husband was born in China and lived in Hong Kong until he was nine years of age before he immigrated to Canada. The chance of his rediscovering his cultural heritage coupled with the life opportunities it would offer our two girls then aged six and 10, were some of the deciding factors that led to our relocating. The financial incentive was significant and would offset my university expenses.

I later reflected in a paper that I presented at a Qualitative Analysis Conference in Toronto (1994) about how I had initially intended to commute from Singapore to Canada to do the interviewing portion of my thesis. The travelling costs were to be assumed by my partner’s employer as part of our negotiated package:

My original plans of continuing with my OISE-approved thesis proposal by commuting from Singapore dissolved once I experienced just how far sitting 27
Figure 3
Layer/Phase 2: Summer 1993 - Spring 1994
"Methodological challenges associated with relocating from Toronto to Singapore"

- Toronto <-> Singapore too far to commute
- Multiple Sclerosis rare in Singapore
- unsure of locally relevant focus for adapting inquiry

- completing original research plans
- family/home disruptions
  - no local mentor
    - academic
    - medical
  - inexperienced with local English dialect: SINGLISH

CULTURE SHOCK
hours on three planes crossing 13 time zones feels. I decided it best to keep to my original study plans with the exception that I would simply do the research in Singapore. I intended to continue my dissertation on patient-doctor relationships by seeking an introduction to the population of persons with Multiple Sclerosis (MS) through the local chapter of the MS Society. I would then invite certain theoretically sampled persons to complete my English questionnaire with some of these participants subsequently asked to engage in an in-depth interview or two.

My biomedical naïveté caught up with me. In short, Asians do not get Multiple Sclerosis. There was no MS Society for me to visit. This realization was difficult for me to assimilate. Just a few short months ago I had successfully defended my rationale regarding why I had selected MS as a focus of my research. It is a chronic disease that especially challenges the general practitioner as it is difficult to diagnose, tends to have vague symptoms that wax and wane, is often mistakenly attributed to stress and is a condition which has no cure within the Western acute care paradigm. I was attached to this theory-building descriptive study. Now what? (Crowe-Joong, 1998, p. 2)

The letting go of my institutionally approved research plans was an emotionally difficult process. I filled my scholarly work time with an OISE reading course. My thesis plans became less of a focus during these first few months of acclimatising to our new lives in Singapore.

Our family’s lifestyle and culture shock further challenged this time of adjustment. The period between the summer of 1993 and January 1994 was filled with day-to-day challenges. A large portion of my time was spent assisting my children in coping with life in the tropics. My eldest daughter was unhappy, as she was not admitted to the large American private school attended by the handful of friends she had made within our apartment building. She had to wait six months on a “foreigners” wait list due to her Canadian status. She regularly resisted acclimatising to the private British school’s system and its expatriate cultural nuances. My younger daughter adored her grade one class at the American school, which did not help her sibling’s adjustment. Unfortunately, we discovered my younger daughter’s asthma and eczema were exacerbated in the tropics. I had many patient, or mother-of-patient, -doctor encounters as a result of the frequent immunisation schedule, children’s illnesses and continued investigation of my own health condition.
My husband virtually disappeared into his work. He travelled extensively and was often away a couple of weeks at a time. He felt especially challenged with his poor abilities at conversing in Mandarin. We learned that this is the more commonly used Chinese dialect in China, Taiwan and Singapore. His fluent Cantonese skills did find their place in Hong Kong. We decided, in December, to hire a local Mandarin tutor to help our family learn this language.

I became aware, during these introductory months, that “Singlish” was the local English dialect that took some skills to master. I was initially disheartened by how difficult it was to understand, and be understood by the many shopkeepers, clerical and repair people that I was regularly encountering. It became clear to me that there was more to adapting to Singapore than acquiring this local dialect. I became increasingly sensitized to the cultural differences early in our posting, kept fieldnotes, and later presented a conference paper (Crowe-Joong, 1995) describing my experiences and observations of my life in Singapore.

One result of these scholarly and life challenges was my commitment to redefining my thesis proposal in such a way that it was a better fit with my new home. I decided I would complete a grounded theory social inquiry analogous to my original proposal except in Singapore. My challenge in 1994 evolved into a plan to discover which chronic health condition stressed patient-doctor relations in Singapore as I had postulated MS did in Toronto.

3. **Layer/Phase 3. Interrelationship between gaining access to informants within Singaporean medical community and informally exploring the “field” in Singapore (Spring-Summer 1994)**

Figure 4 is a flowchart summarizing my initial efforts at accessing the field in Singapore. This phase of my inquiry reconstructs experiences associated with “accessing the field” without any local institutional support. I began collecting local newspaper articles that referred to health issues and the health care system in the spring of 1994. I discovered that a
Figure 4
Layer/Phase 3: Spring 1994 - Summer 1994
"Interrelationship between gaining access to informants within Singaporean medical community and informally exploring the 'field' in Singapore"

- **Local news articles:** health issues, key players
- **Local university library resources**
- **Discussed research possibilities with:**
  - ex-patriate colleagues
  - personal physicians
  - Western physician of ex-patriate colleague

- **Names of local professionals conducting research in health**
- **"Cold" calls introducing self through voicemail**
- **Messages ignored**

- **Introductions to Western researchers working in non-health areas in Singapore**

- **Day-to-day life experience**

- **Heightened awareness of Singaporean culture/Singlish**

- **Diabetes often recommended as focus of my inquiry**
great deal of attention was paid to the chronic condition of diabetes in the press. I began to consider this physical disorder as a possible focus for my patient-doctor relation inquiry.

I had not been successful at finding any “Canadian connections” that might have served to provide contacts for me within the medical and/or academic community in Singapore. I decided to keep a journal of my experiences of adapting my thesis plans and accessing the field. I needed to “make sense” of my experiences as well as find a place to express my frustrations at having to “start from scratch” with no professional or institutional support. I had read that my observations of my own research experiences would help me note the extent to which the inquirer’s [my] biases influenced the outcomes. That technique is the reflexive journal, a kind of diary in which the investigator on a daily basis, or as needed, records a variety of information about self (hence the term “reflexive”) and method. With respect to the self, the reflexive journal might be thought of as providing the same kind of data about the human instrument that is often provided about the paper-and-pencil or brass instruments used in conventional studies. With respect to method, the journal provides information about methodological decisions made and the reasons for making them. (Lincoln and Guba, 1985. p. 327)

My journal provided a personal venue for managing the difficulties I had making sense of this foreign culture. It also became data in and of itself regarding my role as a ‘human instrument.’

An example of the stresses associated with my solo status occurred when I was not allowed an e-mail account in Singapore for my first year. The rationale provided was that I did not have commercial or recognized “research and development” status. The Singapore ruling apparatus supported commerce or educational practices within official institutions. Even though I was a Ph.D. student in Toronto, I felt discouraged to learn that I had no legitimate research status in Singapore.

I wanted to meet local professionals who might listen to my research ideas and provide suggestions regarding the best choice of a chronic condition relevant to Singapore. I felt that talking to my expatriate friends and my husband’s business colleagues was not the most direct way for me to access this medical community.
I decided that the library at the National University of Singapore (NUS) would be my formal starting point in ascertaining which academics were interested in similar types of research as mine. I thought that, if I introduced myself, they might become instrumental in my deciding how to best access the field. I was attempting to import my Western practices of accessing educational resources.

I yearned to develop similar relationships as those that I had left in Toronto but felt unsure how to begin such a venture. I was beginning to no longer feel like an academic and decided that I needed to visit a library. I wrote about this aspect of my natural history in 1995 and presented the experiences recorded in my journal from this period at a conference:

I drove to NUS myself and drove around for a while trying to figure out where I could park legally. I noted that simple things like this do not seem straightforward at all to me here. I parked and walked uphill to what I thought was the library. I had to ask directions and found myself in a sweat and hopelessly lost. I am not comfortable asking people for directions in Singapore as I always seem to get the feeling that I have broken some rule in speaking aloud to a stranger. I did manage to find the library and spoke with the Chief Librarian.... I filled in the necessary forms and received a Temporary Reader's Permit. I left her office thinking it was odd that I seemed to be the only visiting student she had ever come across.

I decided that I needed some sort of reference that stated the names of the NUS faculty and their research interests. This seemed to be a good place to start tracking down some potential colleagues. I wandered around the library looking for the reference area that might contain such a document. I felt very old and very white. Everyone looked like teenagers to me. I felt out of place. This was unusual as I have spent half of my life inside a library and tend to find it comforting and familiar—even at my age! I decided to ask the reference librarian for help. She appeared completely confused by my request and ended up getting a colleague who found the *NUS 1993-94 Directory of Current Research*. I sat at the reference desk and poured over this text writing down any information that I might find useful in this matchmaking quest. I wrote down the particulars on 12 NUS academics.

I sat and “graded” each of...[their]...areas of interest according to its relevance to my thesis topic. I decided to contact the top three in writing first, followed by a follow-up phone call. I remember hating this part and wished that somehow it could be easier. I have always said that if I wanted to make cold calls I would have gone into sales—and now here I was in the horrid position of having to sell myself. I was losing the faith. I had to do something as I could no longer say that I was still “settling in” from our family’s move to Singapore.
I wrote, and subsequently telephoned, a half dozen National University of
Singapore professors [including ones in academic medicine]. I did manage to
meet with [an expatriate member of a relevant] department... who chatted with
me for a quarter of an hour. ...
I found him to be personable but also felt that he felt he had little to offer me
specifically as he knew very little about qualitative research. What I needed
was a friend [with whom to share]... my research ideas and concerns. What I
got was a friendly chat and a distinct feeling that he "had a life" and was not
interested in any long term relationship with me. (Fieldnotes, October 18,
1993, pp. 3-5)

Paradoxically, making these 'cold calls' was useful. I left voice mail messages asking the six
professors to return my call. I was discouraged when, even with my introductory letter, not one
of the six took the time to contact me. At a later date, one of these doctors explained the reason
Singaporeans do not return calls to people they do not know. He indicated to me that local people
need to be introduced to a person or they risk "losing face" by giving their attention to a stranger.
This doctor, in an indirect fashion, gave me his reason for ignoring my telephone message.

I recognized that I was in a Catch-22 situation: I needed to be introduced to key
members of the diabetic and health care community in order to be able to do my research.
Unfortunately I did not, at the time, have any social or professional connections from whom to
receive this assistance. Learning about the importance of these introductions, or social
"permissions" to call was an important insight for gaining entry into the field. I learned of two
academics in the NUS reference manual who were involved in diabetic patient education studies
at the medical school and telephoned the departmental number provided in this text. Although
neither returned my call, I believed that my attempts to contact them were an psychological start
to my inquiry.

I had the idea that I should substitute diabetes for MS in adapting my original
proposed inquiry in the late winter of 1994. I realized that I needed to locate some local medical
professionals who would potentially be interested in facilitating my actualizing this research
proposal around relations between doctors and people with diabetes. I spoke with my, and my
children's, doctors. Our GP, although somewhat reluctant to take the time to chat, said that he had no connections for me but that I should call a certain professor at the medical school. He named one of the doctors I had read about in the library and had been trying to call. My gynaecologist also gave me the very same contact name and advice. I planned to keep on telephoning. I was taking action in trying to access the field.

A kind of domino effect occurred in these early field experiences. I talked about my research challenges to practically everyone with whom I came in contact. I soon realized that the closely-knit quality of the ex-patriate community might work in my favour. For example, I had found an indirect way, one that originated through my role as a parent, to be introduced to the medical and academic community:

I began to feel like a detective snooping around on an ill-defined case. I talked to anyone who would listen to me. More importantly, I listened and watched. Everything was relevant. I had left the ‘dark ages’ for the ‘brainstorming’ phase of my research. I was still experiencing twinges of guilt and often worried that I was still squandering my time. The difference was that my intuition was now telling me that things would fall into place and that my efforts would not wasted at all. I was learning to trust my instincts.

The boundaries between my ‘work’ and ‘regular life’ became fuzzier. Watching television, reading the newspaper, talking with shopkeepers became activities where I carefully noted sociological details [which I could analyze]. My life in Singapore was becoming a cultural puzzle that I attempted to solve.

Professional contacts began to materialize almost effortlessly. For instance, I discovered, while chatting with another mother on a school field trip, that she had a friend who was working full time at the National University of Singapore (NUS). It turned out, when I was later introduced to this individual, that she was a psychologist. I was happy to learn that, although not directly involved with qualitative research, she was willing to meet with me regularly and discuss my research ideas. Not only did we become close personal friends [but] she suggested [that] I meet some of her colleagues in her department who were doing, or had done, qualitative research.

One of these professors knew of a Community Group who had the Diabetic Support Group of Singapore under its umbrella and gave me a couple of contact names. He also told me of a Western doctor who was a professor at NUS's Medical school. This physician’s friend turned out to work part-time as a nurse educator at a local diabetic clinic. I discovered some faculty doctors who were interested in either qualitative research and/or diabetic research and spoke with them.

I began to notice the same names surfacing in many of these conversations and, with the permission of my key informants, called these individuals and
introduced myself. Often my calls were expected as my new colleagues had advised their friends to expect my contacting them in the near future. It was in this way that I met many...professionals who would become instrumental for my work. One of these new colleagues from the NUS's medical school has become my local 'unofficial' thesis supervisor and meets with me on a monthly basis. I had not only begun making professional acquaintances with whom I could share my research ideas and experiences; I was developing a series of key professional contacts within the medical and diabetic communities. (Journal, May 2, 1995, pp. 6-7)

Thus, sharing my academic challenges with an American mother volunteering alongside of me on a school fieldtrip turned into the key introduction I had been seeking. I met with her at her office and was introduced to a few of her Western colleagues. One of these contacts at NUS confided that he suffered from a chronic kidney condition and required regular medical treatments. His enthusiasm for my selecting diabetes as the chronic condition around which to centre my inquiry was infectious. In addition, he knew of a Singaporean professor whose wife attended DSGS meetings. He provided me with this name and telephone number. I learned again from this visiting professor that it is critical to be introduced in Singapore. I was advised not to surprise anyone with a telephone call. In this way I was to wait until he called his colleague and asked permission for my follow-up call.

This energetic key informant also gave me the phone number of a Western medical school professor who he thought might be of some help. When I asked about his calling ahead as a way of introducing me, he laughed and said not to worry. This professor was Western and could probably handle my 'cold call.' I was advised to explain the circumstances regarding my acquiring his telephone number.

My follow-up of these suggested introductions was ultimately fruitful. I received a telephone call at home from the academic with the kidney condition stating that he had spoken with his colleague whose wife was a member of the DSGS. I had been hopeful that I could interview this woman with diabetes, but she refused to speak with me directly. She stated that it would be best for me to contact the founder of DSGS. The enthusiastic professor passed along
the founder’s name and phone number. He explained to me that his local colleague had confided that his wife was too shy to speak with me. She had claimed that “she did not know enough.”

We discussed how I might handle the possibility that local people might be reluctant, perhaps even afraid, to talk to me about such personal matters as their health. Throughout the following month the professor and I spoke on the telephone a number of times and met a couple of times at the university. He shared with me the difficulties he had with interviewing business people for his qualitative research projects. I felt, coupled with my day-to-day experiences of seeing a kind of prevalent shyness, that local people might not be willing to confide in me. I was a Caucasian Westerner with no official status in Singapore. I was tall and blond and quick to laugh—loudly! I stood out wherever I went. I worried about this. I needed help in appearing legitimate. I needed to be introduced as someone who could be trusted. My Western professor friend reassured me to take it “one step at a time.” I had the name and phone number of the DSGS’s founder coupled with an ‘introduction’ to this woman from a DSGS member. It was a start.

One of my Western friends suggested I call her GP. She described her doctor to be a personable woman from the West who might be able to help. I called and met with this doctor within the week. Fortunately that morning there was a significant tropical rainstorm that kept her patients from arriving on time. We spoke uninterrupted for 45 minutes. She detailed the two-tiered health care structure in Singapore. This expatriate physician was salaried at a branch of a large, ORT clinic within the private sector. My GP informant became quite animated when she described her view of the significant extent to which capitalism had affected the practice of medicine. She appeared displeased that physician clinics competed for customers, or patients, and profited from the sale of medicines that they prescribed. She found there to be “zero patient education [by physicians]—[any] that comes [originates] from the girls outside” (March 21, 1994 Fieldnotes, p. 3). This key informant was referring to the receptionist who handled educational
activities (sometimes a trained nurse), who filled patients’ prescriptions and collected the consultation and pharmacy fees.

The GP informant reassured me that my inquiry into the experiences of people with diabetes and their doctors would be an important one. She said that there was “quite a bit of doctor education [by the government and in the literature] encouraging them to educate the diabetic patient to better handle their diabetes” (Fieldnotes, 1994, p. 4). She went on to say that continuing medical education was “done well here…[and that] the Singapore government is prepared to learn [in order to improve physician education]” (Fieldnotes, 1994, p. 4). Our conversation was cut short when patients began arriving. That afternoon, I typed the notes I had taken onto my computer adding any further observations or insights I had made. I sent this physician a copy of this report along with a thank-you note.

During this period, I discovered that informal discussions of my research challenges with contacts in my personal life facilitated accessing the diabetic/primary care field in a scholarly capacity. These activities, although unstructured in and of themselves, were part of the field exploration aspect of my more structured research plans.

4. Layer/Phase 4. Meeting my mentor and other medical and academic key informants (Summer-Fall 1994)

Figure 5 is a flowchart summarizing my meetings with key informants. During the late summer and fall of 1994, I met with some key informants, both medical academics and practicing health care professionals, who were instrumental in my adapting my thesis to Singapore. At this time, I began a long-standing relationship with a medical school professor, Dr. Chin. This individual became my local thesis mentor and introduced me to many future research participants. I spoke with other medical professionals who understood research from a basic
Figure 5
Layer/Phase 4: Summer - Fall 1994
"Meeting my mentor and other medical and academic key informants"

future mentor recommended from multiple sources → met with future mentor → regular meetings

- spoke with Western medical academic
- spoke with number of medical academics

- PWD - Doctor relations seen as important topic of research

- spoke of DSGS
- given textual references

- met endocrinologist
- invited to scientific meeting

- met Western nurse educator

- met nurse educator

Key: * indirect introduction (given permission to use name)
     # direct introduction (in person or prior phone call)

PWD = People with diabetes
DSGS = Diabetic Support Group of Singapore
scientific perspective. I found myself frequently explaining the ideas behind grounded theory and emphasizing the usefulness of qualitative research. It was unanimously agreed that the clinical challenge of encouraging people with diabetes to ‘comply’ with a diabetic regimen was not being well met in Singapore.

My grounded theory research perspective interested Dr. Chin. My research approach contrasted with clinically-based methods with which he was more familiar, but the survey part of my inquiry plan was consistent with such a scientific worldview. A naturalistic approach that assumes that methods used in the natural sciences can be used in the social sciences would suggest that hypotheses should be generated; and that the aim of social inquiry is to objectively explain a phenomenon (Guba and Lincoln, 1994, p.112). The survey portion of my research objectives was similar to research done by some of the academic health care professionals with whom I was meeting. We tacitly agreed that the resulting knowledge was intended to assist people with diabetes to ‘adhere’ to a health regimen. Much later, I came to see that this tacit assumption reproduce ruling relations through my research.

Concurrent with developing the plans for my survey, I kept a ‘natural history’ of my research. This records the chronology of my meetings with Dr. Chin, my Singapore mentor, and other key informants in these medical academic and diabetic communities. I contacted the medical school professor that my academic colleague with the kidney condition had “heard of.” This doctor was also an expatriate from the West. I left a voice mail message. My call was returned that afternoon. This medical school academic was quick to explain that he had no overlapping interests with mine. However, in our chat he commented that, in Singapore, patient education was probably “10 years behind the West.” He provided me with the names and telephone numbers of two colleagues within his department who were investigating diabetic education issues. I noticed that these contacts were the very names that I had copied from the NUS reference text and had written and telephoned. One of these academics had also been
recommended by two of my personal physicians. I was also provided with the name and phone number of a diabetic nurse educator and who he thought might be interested in speaking with me. I was careful to get permission from the medical academic to say that he had recommended that I speak with these colleagues. He assured me that that this would be fine.

I telephoned, and met shortly thereafter the nurse educator recommended by the above key informant. I found her to be enthusiastic about my research. She recounted experiences, observations and opinions throughout our hour-long discussion in a local café. A methodological difficulty we discussed was the issue of how I would be granted permission to interview people with diabetes and their doctors.

I telephoned Dr. Chin, the senior faculty member at the medical school who had been recommended by his Western colleague. I used the direct telephone line provided and was successful at reaching him on my first try. I identified myself as a Canadian Ph.D. student doing research with diabetics, adding that this particular Western colleague had recommended that I speak with him. He spent approximately 20 minutes describing the primary health care system in Singapore. He told me about the existence of the DSGS; some epidemiological background facts regarding the prevalence of diabetes and its negative effect on morbidity and mortality in Singapore; and the presence of the National Diabetes Commission as a response by the MOH to this health problem. He suggested that, since I was looking for any relevant local literature, I should speak to some contacts within the government who might allow me access to some of their recent statistical documents. He also gave me the contact number of a colleague who, whilst in private practice, was interested in diabetic patient education. I noted that this was one of the doctors I had been trying to contact.

When I described my intended study as qualitative in nature, he pointed out that medical professionals do not embrace this as the most valid form of research. He mentioned that qualitative research was "frowned upon" (Fieldnotes, 1994, p. 9). I further noted:
[Dr. Chin] feels that qualitative [research] does have a place and explains that the reason there was such a large number of quantitative studies in the past is due to the focus on disease whereas now, in primary health care, disease is but one of the parameters. Qualitative research is more in fashion now but in medicine it is...not recognized...[as]...readily. (Fieldnotes, 1994, pp. 2-3)

At the same time, I discovered that this academic physician was interested in learning more about qualitative research. I knew that this was something I could offer our working relationship. Throughout our chat he appeared interested in my ideas and plans and gave me numerous names of those who were key professionals in the health care community. He agreed, after we had met in person a couple of times, to be of ongoing help—a kind of mentor, or 'unofficial advisor.'

Along with a thank-you note, I mailed a report of our first telephone conversation and subsequent meeting. I brought a copy of these 'minutes,' as well as a short agenda, to our next scheduled appointment. I was surprised when he did not show up. The departmental secretaries were helpful in finding him. We met an hour later. I learned that he had expected me to call and confirm our appointment. My husband later shared that he was experiencing this phenomenon of the social necessity of reconfirming appointment times in the business community in Singapore. I discovered that appointments, including doctor's appointments, were not as binding a social contract as in Canada. Throughout the many dozens of meetings I had with my local mentor over the following three years, I faxed and telephoned various reminder messages. His response was always that of grateful surprise. It was not uncommon that he had forgotten our engagement and had to reschedule our meeting a few days later. I wondered if I was simply bumped for an activity of higher priority. I had a couple of other similar experiences with other participating doctors. I learned to expect appointments to be rescheduled or delayed. I always brought along reading material and felt relaxed during the inevitable waits.  

I learned that a significant portion of primary care appointments in the private sector were of the "walk-in" variety and I discussed the implication of this for my study with my new local mentor. If people with diabetes did not tend to make appointments, how would I arrange,
via the clinical doctor, to interview them? I was not as concerned with the possibility of people with diabetes (or physician) ‘no shows’ as I was worried about annoying those working at the clinic with my presence. Would I be in the way or seen as untrustworthy in some way? Dr. Chin did not seem too concerned with these potential stumbling blocks. We discussed the possibility of my sitting in a clinic’s waiting room for half a day at a time, with the permission of a physician. This seemed a reasonable option. I could observe the various activities in the waiting room including purchasing of medicines and paying of clinical fees by patients.

I had heard that “routine diabetic check ups” were often scheduled. I planned on letting participating physicians decide how I should come to meet two to three of their patients with diabetes. This built-in methodological flexibility would, hopefully, encourage physicians’ participation. I discussed with my mentor, and over the phone/email with my OISE advisor, how potential dates for me to come to the clinic might be suggested to these physicians. I planned on suggesting that I be at the clinic during the days when the most diabetic ‘well,’ or routine, appointments were scheduled. I decided that this methodological detail would have to be flexible.

Patton states that: “Often the best approach for gaining entrée is the known sponsor approach. ⁹ By this tactic observers use the legitimacy and credibility of another person to establish their own legitimacy and credibility” (1990, p. 254). Dr. Chin promised, during one of our late Fall 1994 meetings, to help introduce me to various doctors. In this way I intended to communicate that I was a credible academic and that doctors and people with diabetes could be persuaded to give me some of their time and share some of their personal experiences.

At the beginning of each of our first three meetings, I reviewed minutes of our previous get together. This practice helped clarify my understanding of the information that my mentor had shared with me. It was also a time where the spelling and phone numbers of the various contact names I had noted within the health care community could be corrected. This
written document was helpful for me during these first few months, as I had difficulty understanding local accents and did not spell these unfamiliar Chinese names and places correctly. I saw our meetings as further practice for my becoming functional in understanding, and being understood by, people in Singapore.

We decided to wait until I was ready to proceed more formally with my inquiry before Dr. Chin would introduce me to future participants. I had decided, by the late Fall of 1994 to construct a questionnaire which examined interactions between doctors and people with diabetes from the patient's perspective. The idea was that this instrument would help validate the importance of my inquiry within the medical community, as these scientists were more familiar with this type of research. My mentor had advised that my accessing the medical field with this questionnaire should proceed from the "top down." This meant that I should always begin by securing permission from the physician to interview within his or her clinic. I agreed that this would be necessary given what I had learned about the nature of the organization of social power within primary care. I did not have any personal connections with any people who had the more common, NIDDM form of this condition. Thus this decision was a pragmatic one. At the time, I did not realize how I was reproducing ruling relations by working within the physician-driven hierarchy and by utilizing a physician 'respected' methodology.

My decision, at the time, appeared to be merely pragmatic. The physicians maintained social control within their clinics and it was important that my research design acknowledge this paternalistic, hierarchical reality if I was to be granted access to potential participants in my inquiry. It was also possible that doctors were protecting their patients from unscrupulous researchers! The latter justification for physician gatekeeping also occurs within a Western context and is an important consideration for researchers when negotiating access to the medical field.
I followed up a contact given to me by my mentor and called a local endocrinologist in private practice. He returned my telephone call after I had left a few messages. He sounded gruff, almost angry, and wanted to know who I was and who had told me to call him. I informed him who had recommended that I contact him. Immediately, I felt the tension evaporate. I appreciated the power my mentor had in my being given a chance to explain my research objectives within the medical community. This endocrinologist agreed to meet with me at his Orchard Road office.

I talked with the endocrinologist for over half an hour. I was acutely aware of the extremes of attention I was receiving and the power status of Dr. Chin in 'opening doors.' I also wondered about my privileged position as a white Westerner and its influence on my receiving such positive attention. My Western status alone was not very effective when contrasted with an introduction from a respected community member. I later discovered that university professors tend to be granted more status than do medical doctors. The title "professor" was preferred over "doctor." I saw a positive reaction to my university-crested business card when I met this endocrinologist.

We discussed my being a Caucasian from the West and how this would affect reactions from potential participants. I remarked at how candid he and other Singaporeans were regarding discussions around race. He told me that people might be curious to talk with me. He explained that I might be seen as somebody safe to speak with as I clearly was not from the government and probably would not be seen again. This specialist thought that physicians, if not too busy, might enjoy being a part of a Western study.

I confided that I was having some trouble with accents and the Singlish version of English often used by working class Singaporeans. I admitted that I still needed to have some comments repeated in order for me to understand. I also knew, by the sometimes blank stares by local people, that I was not always making myself clear. He was supportive of my practice of
asking participants for clarification. He told me that he found me sincere and felt people would respond positively to me despite our culture and language differences.

This endocrinologist gave me a copy of the *Singapore Medical Journal* (1993) issue that was dedicated to "Guidelines for the Management of Diabetes Mellitus in Singapore" which contained the report of the MOH-appointed National Diabetes Commission. He explained that every GP in Singapore had received a copy of this local diabetic resource. He also talked about the clinical experiences of people with diabetes who did not manage their diabetes well and "people [who] drop out of care" (Fieldnotes 1994, p. 2). Both physicians and people with diabetes in my inquiry frequently referred to the practice of "doctor hopping." This endocrinologist referred to it as a "problem." We agreed that this was a key reason for the necessity of an inquiry such as mine.

I wondered about people with diabetes becoming more forthright in stating their concerns and abilities to 'comply' to a prescribed regimen if there was an ongoing clinical relationship. People with diabetes regularly frequent primary health care providers as a function of the chronicity of their condition and their continued need for prescribed medicines. It seemed logical that an ongoing association with the same practitioner might be the key prerequisite for the negotiation of mutually satisfying relations between doctors and people with diabetes. I learned, during our discussions that Fall, that 'compliance' by people with diabetes was viewed as a significant problem by the medical community. This specialist appeared sympathetic to the difficulties associated with living with diabetes. He thought that any study that theorized the nature of doctor-patient relations, such as the one I was planning, would be an important step towards its potential improvement.

I did not, during the Fall of 1994, question the capitalistic structure of Singapore society and its effect upon doctor-patient relationships; this was not an aspect of my research. I had not yet had a consciousness-raising as to the epistemological issues surrounding a more
critical research approach to social problems. I met with the endocrinologist again that fall and found him increasingly enthusiastic about my research. I regularly left with informative booklets and photocopies of articles regarding diabetes. He invited me to attend the 1994 Annual Scientific Meeting of the Diabetic Society of Singapore. He also mentioned that I would be on my own as he would be unable to attend himself.

This meeting took place in a large ballroom of a prestigious downtown hotel. I approached the specialist’s nurse educator during a tea break. I chatted with her and was later introduced to a group of other nurse educators. Two of these individuals crossed my path later the next year and agreed to be interviewed. I discovered one of them to be a regular and active member of the DSGS. Later that week, she unsuccessfuely tried to secure permission for me to attend one of their informal training sessions. The reason for the refusal was that they were not ready (or willing) for any outsider to observe their activities. I was increasingly aware of the challenge it would be for me to meet potential participating people with diabetes and physicians. I intuitively knew that I needed to keep meeting those individuals who were interested in helping with my dissertation. I sat and listened to speakers discuss the importance of diabetes today, and especially the future, in primary practice and tried to consolidated some of my biomedical knowledge regarding this globally important disease.

During another visit to this helpful endocrinologist’s office, I heard more descriptions of the Singapore health care structure, medical savings plans and the difference between the public and private primary care clinics. He was also critical regarding finance within the health care system. At the same time, I became increasingly aware of structural barriers preventing people with diabetes from achieving optimal states of health. I wondered about the personal experiences and perspectives of those with diabetes who chose to avoid primary health care visits. I was told it was cheaper for people with diabetes to wait until they were sick enough to qualify for a better governmental subsidy for their health care expenses than to consult a private
practitioner. I decided to include some questionnaire items that probed the influence of these structural influences upon health care choices.

The endocrinologist mentioned that I should contact the same government doctor as Dr. Chin had advised (Dr. Hum), and obtain the most recent government publications. I was also advised to write ahead and receive "clearance" before attempting to make an appointment. He suggested that I talk with Lin Yee, the founder of the DSGS, as Dr. Chin had suggested. I asked permission to use this endocrinologist's name in this important set of introductions when I approached members of the DSGS. He promised to telephone Lin Yee and secure her permission first. Intuitively I recognized that, even though members of this group had the rarer IDDM form of diabetes, it was imperative for me to contact them. However, I was unsure of their place, if any, within my proposed inquiry at that time.

I was invited, during the late Fall of 1994, to join a lunch between my key informant endocrinologist and a visiting specialist from the International Diabetes Federation. We met at a local hotel and discussed the 'latest research' in treating diabetes. These professionals told me that patient education was a critical feature in the treatment of diabetes and that studies such as mine were necessary. I learned more about the health care structure in Singapore and how the incidence of NIDDM was increasing at high rates, and along differing racial lines. I was told to get the latest statistics on these rates from the MOH. These endocrinologists stated that more information was needed regarding people with diabetes and their relationships with their primary physicians if improvements were to be made.

I was invited to join them that afternoon on their tour of a diabetic education clinic at the Diabetic Community Organization of Singapore (DCOS). This is a non-profit organization that, in addition to private sources, receives governmental financial assistance. It was located in a small hospital in an outlying area. There, we were given a tour of clinic and classroom facilities and introduced to a couple of nurse educators and a physician. There were no people with
diabetes present during our tour. I learned more about the clinical aspects of diabetes and the role of DCOS in providing various classes public education forums than about patients or relationships.

I later joined the DCOS myself and, throughout the following three years, received their newsletters and attended a number of their public education events held at prestigious downtown hotels. These DCOS seminars were large and didactically-focused upon the dissemination of biomedical information predominantly for the NIDDM form of diabetes. I was told that activities within the DSGS, also a recipient of some government funding, were less institutional and more focused on family and social-psychological issues associated with living with the IDDM form of diabetes.

This fourth phase of my research was completed by late Fall 1994. By the end of the period, I had a local mentor, insights from a number of key informants and, after telephone and e-mail discussions with my OISE supervisor and a December committee meeting, was ready to begin my 'adapted inquiry' in Singapore. At the end of this layer of research experiences, my plans were in place. Dr. Chin had given me the telephone number of a Dr. Hum at the government, whose name had also been suggested by a few key informants as an important contact. I hoped she would allow me access to their most up-to-date health demographics that I hoped to base part of my questionnaire. I wanted to discuss the draft survey items with my mentor, with the intention of checking for their validity. I also intended to ensure that the phrasing of the questionnaire items were such that English-speaking Singaporeans could best understand them. As well, I was increasingly confident that I would meet potential 'pilot,' and later on, 'inquiry' participants when my instrument was ready. I planned to refine the items based on the pilot feedback and then distribute these questionnaires. The follow-up in-depth interviews were to be based, in addition to my observations and familiarization with the literature, upon the statistical analyses of the survey results.
I felt, at this time, that I was at the same point of readiness as I had been in Toronto in the Spring of 1993. My first of two pilot activities, or Layer/Phase 5, had begun and I had an inquiry structure within which to place my findings, both formally and informally acquired, from the diabetic health care community. My consciousness had not been raised to consider that my difficulties were part and parcel of my attempts to meaningfully quantify social relations (Cicourel, 1964).

III. Layer/Phase 5. Patient-Doctor Relationships in Singapore: First Pilot Activities (Fall 1994-Fall 1995)

1. Methodological triangulation

Figure 6 is a flowchart summarizing my first pilot activities. This fifth phase of my research experiences involved reading the doctor-patient literature as well as developing and piloting the initial version of my questionnaire. I had intended “to obtain valid, reliable and neutrally derived, knowledge... by utilizing methodological mixes” in this phase (Crowe-Joong, 1993, p. 12). I adhered to the postpositivistic orientation advocated by Patton (1990): “One important way to strengthen a study design is through triangulation, or the combination of methodologies in the study of the same phenomena or programs” (p. 187). I intended to methodologically ‘triangulate’ my inquiry by incorporating literature, questionnaire and follow-up interview analyses.

I soon learned through piloting my survey that it would not work in the ways I had originally planned. The field experiences I had in my attempts to adapt my postpositivistic study were varied and time-consuming. These challenges were indicative of a disjuncture between my plans and inquiry experiences.
Figure 6
Layer/Phase 5: Fall 1994 - Fall 1995
"Patient - doctor relationships in Singapore: First pilot activities"

Key: • direct introduction

DSGS: Diabetic Support Group of Singapore
ORT: Orchard Road Type
HDB: Housing Development Board
PWD: People with diabetes
2. **My activities within the DSGS**

a. **Introduction**

During this phase of my inquiry I developed and maintained ongoing relationships within the diabetic community. I became increasingly aware of what it meant to be a Singaporean with diabetes. During Phase 5, I was also personally experiencing relationships with many doctors in the ORT clinics. Coupled with my improving skills at communicating with those Singaporeans who spoke exclusively Singlish, these insights led me to make fundamental changes to my questionnaire and the method that I had planned for its distribution.

My first interview of a person with diabetes took place in October 1994 with the founder of DSGS. I telephoned this support group leader at her home. She informed me that her endocrinologist had spoken to her about my research. I accepted her warm invitation to her home where she offered to share with me her experiences as a diabetic and as an organizer of a support group.

b. **Private home**

This was my first time inside a local Singaporean’s home. I had never been to this outlying residential area of Singapore. This area was not one of the more familiar ex-patriate high-rise and bungalow ‘ghettos’ that tended to be clustered around the various Western international schools.

I located the founder’s house nestled in a suburban area that had small, established homes next to the occasional new ‘monster’ residences familiar to many Torontonians. Her home was moderate in size by middle class Canadian standards. I later learned that a free standing dwelling with a garden, such as this one, was typically only afforded by upper middle class Singaporeans. The founder’s home was not air-conditioned. I found that my initial nervousness coupled with the tropical heat kept me in a perpetual ‘glowing’ state! The peaceful sounds of birds and saccades were ever present—alongside of her neighbour’s construction racket. Lin Yee,
a gentle and unhurried woman, granted me a two-hour unstructured interview. I audiotaped and later transcribed our discussion. I became aware of the differences between IDDM and NIDDM forms of diabetes and how doctors were frequently ill-informed in treating people with this chronic condition.

c. Influences upon patient-doctor relationships

We discussed how physicians, in the quest to maximize their earnings, limited their time with patients with diabetes. Lin Yee observed that Singaporeans tend not to “speak up” with their doctors. She believed that, perhaps, more diabetic nurse educators might help with this important “clinical education” function. I heard her opinions regarding the importance of what she termed “Western” traits, often associated with good quality patient-doctor relationships. She shared that she saw herself as quite Western in her expectations of her physician:

I always see myself as a, I’m also quite Westernized. So I have no problems. I like a doctor who can talk to me, relate to me on that personal level. But now I’m thinking about some of the people in my group, and I can see that they might have a problem if the doctor gets a little more personal. They might not open up or they might see that, “hey why are you delving into my personal life?” (Lin Yee, Transcript, 1994, p. 10)

Our discussion continued into its second hour. My informant’s enthusiasm for her support group was palpable.

d. My entry into the DSGS

The DSGS founder invited me to join their next support group meeting where there was to be a podiatrist speaking about foot care. The agenda also included plans for a discussion regarding preparations for an upcoming information day at a local hotel. We did not discuss my exact role as a participant observer. I gratefully accepted the opportunity to meet more people with diabetes. I wondered about lack of ‘representativeness’ of this support group in Singapore
as I was still thinking about the design of the survey portion of my inquiry, but I recognized the importance of learning more about the DSGS for my inquiry.

My activities within the DSGS were loosely connected to my outlined research proposal. Shortly after my interview with the group’s founder, I began what became the beginning of a three-year relationship. My multiple and varied activities during this ‘Phase 5’ were personally and academically significant to me. I believe that the group’s acceptance of me, which was at times quite enthusiastic, may have been in part due to my unhurried, unstructured research plans with the DSGS. I frequently reminded them of my inquirer’s role as I openly took field notes and regularly explained that, in qualitative research, ‘everything was data.’ I was also introduced to newcomers as a “DSGS member from Canada” who was doing Ph.D. research with their group. I found my experiences in the support group to be incongruent with the postpositivistic model I had been taught at various learning institutions as ‘valid research.’

3. Quantitative beginnings

a. Legitimizing function of questionnaire

My Singaporean mentor made it clear that in order for my inquiry to be seen as “legitimate research” by the medical community I would need some sort of quantitative method. My supervisor and my committee agreed to this “quantitative requirement.” This value placed on quantitative research by physicians is not a phenomenon unique to Singapore. Kleinman (1983) states: “Physicians tend to be negatively predisposed to qualitative ethnography, since it lacks the numerical indices and statistical values that they associate with ‘science’” (p. 543). I decided to design a questionnaire that would provide a general description of people with diabetes, their day-to-day experiences of living with diabetes and how they utilized the health care structure as well as their expectations and relations with their GPs. I began by piloting this instrument with
people who had diabetes. Based on insights from this pilot, I intended to construct and pilot another questionnaire for primary care doctors. After a non-parametric statistical analysis of these two surveys, I intended to engage in follow-up interviews with theoretically-sampled participants.

I was advised by my mentor to briefly summarize my updated research plan in writing (see Appendix B), ask my supervisor for a “Letter of Introduction” on university letterhead (Appendix C) and obtain official-looking business cards. I did as he recommended. Dr. Chin provided a similar letter (Appendix D) and agreed to personally call some “key” doctors in the community after I had piloted both instruments and was ready to begin my quantitative data collection.

To ‘simply interview’ within this medical community would likely not have been seen as ‘legitimate’ research. According to Dr. Chin, a purely qualitative methodological approach might have posed some serious access challenges. This was not a problem for me, since I also viewed the “quantitative phase” of my research in Singapore as an opportunity for me to build relationships with participating physicians and their patients with diabetes. The social interaction around questionnaire distribution would allow me a way to secure their trust. These activities would also have provided an opportunity to make people with diabetes and their doctors aware of the relevance of my inquiry to their primary care situation. I was optimistic that the follow-up interviews with physicians and people with diabetes, once they ‘got to know me,’ would be numerous and rich in detail.

b. Diabetes in Singapore

At this time, I was becoming familiar with the local medical library. I was learning about both forms of diabetes, IDDM and NIDDM, and reading more of the various literatures concerning doctor-patient relationships. Meetings with my mentor were regularly filled with my asking questions about the clinical realities of living with diabetes as well as the various “types”
of doctors and people with diabetes in Singapore. We discussed how certain diabetic realities potentially influenced social relations with doctors. We shared our views regarding how the chronic condition of diabetes might strain patient-doctor relations. I constructed many survey items, and a number of questionnaire drafts, around such topics of discussion.

I met the endocrinologist again. I continued consolidating my biomedical knowledge of diabetes and its biomedical management. In addition, I became increasingly sensitized to the demands made of people with diabetes, especially those who require injections of insulin. I heard from the endocrinologist that the incidence of NIDDM was increasing at “alarming” rates in affluent Asian countries such as Singapore. I theorized about the various factors that affected this relationship as did he.

Thus during this fifth phase, my inquiry held fast to the importance of the biomedical divisions (NIDDM vs. IDDM). I had many discussions with my supervisor concerning the relevance of these categories to relations between doctors and people with diabetes. We discussed the fact that the IDDM/NIDDM categories were biomedical, rather than sociological. We agreed during these long distance telephone discussions that I was to be sensitive to any systematic differences along this biomedical variable and to not arbitrarily exclude one type in my inquiry. I also planned to note which types of people with diabetes were invited by participating physicians to join my study. I intended, as a contribution to grounded theory, to see how data of this kind naturally presented itself. At this point, I planned on constructing an explanatory theory based upon data coupled with the detailed reflections provided by people with diabetes and their physicians in their follow-up interviews.

I initially conceptualized the DSGS (made up of individuals with the IDDM form of diabetes) as a group of individuals who were well informed in the area of diabetes, relations between doctors and people with diabetes and Singaporean culture. I openly solicited advice from them that would help me improve my sensitivity to the culture and communication styles of
Singaporeans. Support groups were uncommon in Singapore—a fact that eventually led me to hypothesize that the DSGS served as transitional to a consumer ideology of health care. In keeping with rules of survey design, I worried that DSGS members were not representative of either the local NIDDM, or IDDM, communities. I continued my participant observation and fieldnote-writing, although I was, at this time, unsure of the place within my thesis of this DSGS data.

I pointed out to Dr. Chin that there was very little current information about diabetes in Singapore and even less regarding relationships between people with diabetes and their doctors. Patient education, and thus patient-doctor communication, was an integral part of good health care advocated within the Western biomedical literature. The literature was filled with references to the often ineffective, or lack of patient education. Poor ‘compliance’\(^ {14}\) rates were viewed as problematic. My mentor agreed that this chronic condition was a good focus for my inquiry and that my study was a timely one. I drew a complex diagram (See Figure 7: “Model of a priori conceptualization of PWD [people with diabetes]- [DR] doctor relationships” which I can now label as postpositivistic) that outlined how I theoretically envisaged relations between doctors and people with diabetes in Singapore. Dr. Chin and I discussed the potential validity of my theory of these doctor-patient relations in Singapore. Our discussion regarding the content of the diagram gave me indications regarding the theoretical representativeness of various survey items.

The contents in Figure 7 of the model are not reviewed in my dissertation because they represent a developmental phase of a “theory-generating perspective” rather than an investigation of “how things work” in relations between doctors and people with diabetes within Singaporean society.
Two meetings with government officials

My OISE committee and I decided that it was important for me to have some basic and local epidemiological framework upon which to base my inquiry. My supervisor and I agreed with Dr. Chin that it was time to approach the government for their epidemiological statistics. I wanted to take the opportunity to inform the government of my research plans and to solicit their help and approval. My local mentor gave me the name and telephone number of a governmental contact, Dr. Hum, who might be helpful. He telephoned his contact at the MOH.

As I sat in his office, I realized that the contact was the same individual who was recommended by the endocrinologist referred to in this chapter. Dr. Chin set an appointment for me with Dr. Hum.

I subsequently hand delivered a ‘thank-you’ note to Dr. Hum that also confirmed our scheduled appointment for the subsequent week, a copy of the briefer version of my proposal and letter of introduction from my OISE supervisor. My impression of the government building was as follows:

The building was quite attractive with the front entrance possessing stately looking pillars not unlike the White House. The floors were marble... The government offices were behind double doors... (Fieldnotes, First government meeting, 1994, pp. 3-4)

The receptionist informed me that the government official expected me but that she was running late. I was escorted to a small conference room. A Chinese woman appeared, approximately 10 minutes later:

Dr. Hum shook my hand as I introduced myself and thanked her for meeting with me. We sat down. She said surprisingly little while I wrestled internally on how best I should proceed. We were both clearly uncomfortable. I felt an inaudible sigh of relief when we were disturbed by a secretary offering us coffee... I began by thanking her, again, for taking time out from her schedule to meet with me. I referred to Dr. Chin’s helpfulness with my research and that he, as well as [a key informant] had mentioned her name as an important resource for my work. I was not sure of her reaction and found her to nod almost imperceptibly. I was feeling more nervous and realized that I was beginning to talk faster. Not a good sign. I continued by asking her if she...
received my letter with the copy of my thesis proposal and the letter of endorsement from [my OISE supervisor]. She said she had, then began to look somewhat flustered as she realized that she did not bring this file to our meeting. She began apologizing and started to get up. (Fieldnotes, First government meeting, 1994, pp. 4-5)

Our meeting had started off formally and somewhat uncomfortably. I was hesitating in assuming a leadership role in our discussing the purpose of my visit. As Dr. Hum had the more powerful position, I was expecting her to address the requests that I had made in my letter in her own way. I did not, at this time, consider my status-by-association with my mentor and as a Western Ph.D. candidate to be important. I believed that she may have forgotten that I wished to access any relevant government documents:

I decided that the best way to ‘save’ our social floundering was to assume control of the conversation and direct it to the reason I had asked for this meeting. I quickly stated that these papers [the ones I had dropped off] were not necessary and that I had another copy of my proposal handy. [Dr. Hum] sat down again taking the proposal from my hand. I proceeded to describe who I was and what I was doing in Singapore. She listened carefully with very little body language or verbal feedback. I began to show her my folder of articles and booklets I had collected on health care in Singapore and asked if she could help direct me to better, more updated, sources of information. She responded affirmatively but was not clear to me in what way she would be helpful.

I began describing my research methodology and what I have learned so far from the academic and diabetic community. I began to feel more comfortable. This was one of the key reasons I was there, to share my research experiences with a potential colleague.

I found when I mentioned the DSGS I had hit a nerve of some sort. [Dr. Hum] burst into a fairly passionate account of how [a member of the DSGS] had approached her complaining that the government was not doing enough for “Type I” diabetics. [Dr. Hum] claimed that these people from DSGS were a minority and that they were an educated, well-taken-care-of group and would not be receiving any special treatment from the Ministry. (Fieldnotes, First government meeting 1994, p. 5)

I had initially found it difficult to ascertain what Dr. Hum was thinking until this expression of her negative opinion of the DSGS. I recognized that I was in a difficult position. I wished for some epidemiological survey results and perhaps an introduction to the some future physician participants. I did not intend to offend anyone or fight a battle with the government which was
not mine to address. I certainly did not wish to risk my freedom to conduct my inquiry in this
host country. I shared with her that I knew that NIDDM was the more common type of diabetes:

I decided that I had been overly formal during our meeting and that I had
nothing to lose by expressing the enthusiasm I had for my research plans. I
decided to not try so hard and to just be myself. I [described] how the
incidence of “Type II” diabetes was increasing at an alarming rate in Singapore
and that it was a disease that was medically managed 90 percent of the time by
the patient and 10 percent of the time by the doctor. Clearly patient education
and doctor-patient relationship issues were critical to the treatment of diabetes
and furthermore, to my knowledge, there had been no systematic study
addressing this area. “Why”, I continued, “I read that over 50 percent of
diabetics in Singapore don’t even know they have diabetes.”…I felt the
coolness in the room abate. Dr. Hum smiled and said that we best go down the
hall to her office as she had some papers that she wanted her secretary to
photocopy for me before everyone left for the day. When we passed the
reception desk she told me I could buy [certain government documents]. As I
trailed behind her down the long hall I felt like somehow I had passed a test.
(Fieldnotes, First government meeting, 1994, p. 6)

I left with some epidemiological reports and an appointment to return to hear a formal talk on the
“health trends in Singapore” that she presents to groups of physicians.

The formal talk was rescheduled from November 1994 to January 1995 by Dr. Hum’s
secretary. I arrived for it with a bulleted agenda of questions based on the literature given me by
the official. I intended to ask for some feedback on the feasibility of my research plans and the
possibility of her assisting in my meeting future participants:

Of course the fact that I had met Dr. Hum previously served to reduce my
anxieties somewhat although I found this to be counterbalanced with some
uncertainties regarding her reception of my two page, single-spaced, agenda.
…I have come to realize that a critical part of this type of research rests upon
the interrogator skills in assessing each situation and adapting their approach
accordingly.

I am beginning to acquire a faith in my abilities to perceive how
Singaporeans react to me. In this way, my skills at “reading” how well the
interaction is progressing coupled with my abilities at adjusting or abandoning
differing communication strategies have helped prepare me to be a more valid
and reliable interviewer. It has become evident to me that the very process of
organizing my research plans has been instrumental in preparing me as an
interviewer. (Fieldnotes, Second government meeting, 1995, p. 8)
In early 1995, I recognized that it was important to not be seen as the stereotypical “aggressive American.” I was in the challenging position of having to ask busy people to stop their activities and participate in my inquiry without appearing aggressive. I knew that in order to be successful in my request I would have to be more sensitive to the subtle social feedback provided by Singaporeans. My second meeting with the government official was recorded as follows:

Dr. Hum told me that she was extremely busy and asked me if I minded if a [government departmental doctor, named Dr. Sim] gave me the [previously-prepared epidemiological] presentation with the three of us having a discussion in her office afterwards. I agreed that this would be completely acceptable. I stated that I was most appreciative of any time they could offer me and that meeting one of her colleagues would be a pleasure. Dr. Hum seemed pleased with my reaction. (Fieldnotes, Second government meeting, January 10, 1995, p. 10)

Dr. Hum introduced me to the Dr. Sim before she hurried away. It was evident that I would be the only person at this presentation as we made our way to the conference room where a slide projector was set up. I wondered about the motive regarding the extraordinary amount of positive attention I was receiving. The Canadian government would certainly have not treated me with such distinction!

Dr. Sim, a male Chinese physician, was pleasant yet reserved. I introduced myself and gave him a brief summary of my research activities thus far as well as my plans for the future. He quietly listened, then stated that I could ask any questions I wanted throughout this slide presentation. The atmosphere was very informal and we chatted about the demographic information. I copied down the slides that I felt might be relevant background to my study. I also asked him some questions regarding his experiences working with diabetics in the government polyclinics. I took notes throughout our discussion. We talked on tangential topics regarding life in Singapore. (Fieldnotes, Second government meeting, 1995, pp. 10-11)

Had I not interrupted with questions, this presentation would have probably been approximately one half hour in duration. I took this opportunity to informally interview this physician regarding his clinical experiences working at a PC during his prior medical training years in Singapore. I took fieldnotes in his presence and mentioned that, in my research, “everything” was considered data. When we returned to Dr. Hum’s office she
tease[d] me regarding how long I had kept Dr. Sim. I [said] that it was my
inquisitive nature and that as long as I had an audience I would keep on asking
questions. I, again, thanked her for her generosity in helping me with my work.
(Fieldnotes, Second government meeting, 1995, p. 11)

The three of us chatted about my research for a little while. I learned from the government
official that a department within the MOH offered a “Diabetic Training Program for Primary
Health Physicians” and that its attendance was poor. I asked if this was something I could attend
or whether I could have access to the course materials. I did not receive a direct answer to this
request. I knew that the position of the National Diabetes Commission was that educating
physicians about diabetic management was an important component of addressing this serious
national health problem and that a copy of their recommendations in the Singapore Medical
Journal (1993) had been distributed to primary care physicians. I had many questions about the
nature of this MOH-sponsored course but sensed that it was time for me to leave.

I was hungry and tired but did not want to seem unappreciative of the interest in my
work by dropping hints that I had had enough. I unsuccessfully waited for a social cue from them
to begin terminating our meeting. I eventually thanked them again and said that I would
summarize all that I had learned and would send them each a copy for verification. I reflected on
the way home that social ‘endings’ in Singapore were different from those I was accustomed to
in the West. I later learned that in Singapore it was rude for a host to insinuate that a guest should
leave. This courtesy extended to service personnel in restaurants where I observed it to be
unacceptable for a patron to be presented with the meal’s bill without its request.¹⁶ I believe this
is related to the cultural phenomenon of Singaporeans considering it impolite to overtly say “no”
to a request. Both parties would experience a loss of face. Later on, during this fifth period, I had
further insight into this matter when discussing my inviting people with diabetes or doctors to
participate in my inquiry:
Liz: But to translate it over into “please do me a favour” I’m having difficulty with that kind of idea, what’s Eastern and what’s Western. I don’t want to step on anybody’s toes.

Dr. Chiew: Well, what happens is that they won’t say “no”, but you can tell—They would say they are usually very busy and... “I’m afraid I can’t help you” or something like that. They won’t tell you and then you don’t visit the practice again.

(Dr. Chiew, Transcript, September 13, 1995, p. 15)

At my January 1995 meeting at the government office, I did not recognize that I had most likely outstayed my welcome as I was expecting social cues that were not forthcoming. Finally, I was responsible for initiating the farewells.

I mailed a bulleted summary of my second meeting at the government office to Dr. Hum and from Dr. Sim. This document contained what I had learned during the presentation and informal interview with the government departmental doctor. I received a stiff-sounding phone call Dr. Sim, requesting a follow-up meeting to my letter. When I arrived, the secretary escorted me to Dr. Sim’s workspace Monday morning February 13, 1995:

I wondered if there was a slight frost in the air. I decided to stop talking and let Dr. Sim steer our agenda. He apologized for having such a small workspace. I decided to pull a chair around to the front of his desk in order to facilitate the two of us reading the notes that he had jotted in the margins of my...[mailed] summary. I saw that both Dr. Hum’s and Dr. Sim’s copy of the meeting notes had a fair number of comments pencilled throughout.

I began to wonder if he appeared stiff towards me because he had some unpleasant news to deliver. I decided that it was important that I not appear flustered, to be business-like and to speak in a quiet tone with carefully chosen words.

I soon discovered that he had many minute clarifications and bits of detail to add here and there. I still noted a certain degree of tension, as if he were unsure of my reaction to this feedback. I hoped that I looked grateful for his interest and for his time in helping me acquire [epidemiological] information as well as a generalized overview of the health care delivery system in Singapore. I diligently noted all of the changes Dr. Sim suggested. I also felt comfortable enough to ask questions in one area where I was unsure of his point. When he rephrased his feedback my original error in interpretation became clearer to me.

I...poked fun at my slowness in understanding his logic. Dr. Sim seemed to relax a little. A minute or so later when we were reviewing the third page of the document I learned what I believe to be the source of his tension.

(Fieldnotes, Third government meeting, 1995, pp. 2-3)
The feedback regarding the notes I had taken on epidemiological information was not the source of tension. Rather, it was the summary notes I had made from our informal interview. There were some observations that were not flattering to people with diabetes or to primary care physicians: "In both of the physicians' copies this section was crossed out. Dr. Sim had written in the margin: 'Not to include.' ... I believe that he was nervous of my reaction" (Fieldnotes, third meeting, 1995, pp. 3-4). This field experience was pivotal to my realizing the care that ethnographers must take when interviewing in the field. I learned that the printed word was very powerful and that if I chose to share my fieldnotes I was risking participants asking for potentially critical comments to be considered "off the record." I decided that, in the future, I would tape-record such interviews where possible and that I could not share these transcripts with anyone but my OISE supervisor. I would also be more diligent in my emphasis of confidentiality. I had erroneously sent both of these governmental officials the same report.

My promise of these comments being 'off the record' was a sincere pledge and I have not included these flagged personal opinions regarding people with diabetes or the health care system in Singapore anywhere in my thesis. The references here are with respect to the field experiences that I had regarding participant access issues and my learning how to more effectively communicate within Singaporean culture. I was successful, during the course of my inquiry, in finding similar information from other, quotable, sources. This experience precipitated a heightened awareness of the multiple dimensions of ensuring confidentiality that I incorporated in my more formal data collection in Phase 6. It is apparent to me now that I was learning to protect the privileged by adhering to this nature of confidentiality.

The two government officials and I proceeded to further discuss the methodological implications regarding the 'off the record' areas. My consciousness was raised to some of the difficulties I might face with my research. I was aware that there was no talk about our meeting
again in the future. I reiterated that I was interested in learning more about the Diabetic Training Program for Primary Health Physicians and that perhaps I would meet the government official responsible for the course. I found their responses to be vague, as if they did not hear or understand my request. I understood these subtle cues and did not push this matter. I said my goodbyes in Mandarin, which seemed to surprise as well as please them. “It was a pleasant ending,” I wrote that evening in my journal (Fieldnotes, third government meeting, 1995, p. 7). We never met again.

4. Increasing importance of critical autoethnography

My ongoing journaling was an important aspect of my becoming aware of my effectiveness as an ethnographer. These diary pages were also a therapeutic outlet for me to reflect on the experiences I was having with my own chronic health condition. I had intended to be silent about the varied personal experiences of trying to do my research in Singapore. Subsequently, I decided to include some of these personal disclosures in this thesis to illustrate the positive ways that I related to people with diabetes and their health struggles. My own health challenges were useful in my gaining certain understandings as to what it must be like to live with diabetes.

It was not until the Spring of 1998 after having read critical arguments of Smith (1987b; 1990), Harding (1987) and de Montigny (1995) that I seriously began to question a grounded theory approach. During Phase 5, I conceptualized my observations and interviews as the preparatory work for my survey construction. In the Spring of 1998 I recognized that, with a reorganization and reinterpretation of my qualitative data, I had completed an institutional ethnography. I came to understand that the personal beliefs, experiences, sex and social backgrounds, to name a few, of the investigator should be made as available to the people reading the research document as the research findings themselves.
I valued the autoethnographic dimension of my research reflections as these self-observations and self-analyses assisted in my developing more meaningful relationships with people with diabetes. They also contributed to my ability to make sense of my field experiences. I spent a significant portion of my time and resources behaving as a critical theorist during these fifth and sixth phases of my work.

There was a practical side to my journaling and fieldnote efforts. I initially found that by reconstructing my experiences in writing I was better able to note my research progress as well as my ‘mistakes.’ In a postpositivistic fashion, I devised strategies to avoid similar ‘errors’ in the future and made any necessary amends. I later made use of these personal anecdotal data to explicate the social relations evident between myself, that is the inquirer, and the inquired. I adapted my research methods to better avoid the reoccurrence of any methodological difficulties or misunderstandings. Ultimately I wrote about some of these experiences and presented papers about them at four qualitative research conferences (Crowe-Joong, 1995; 1997; 1998; 1999) where I received feedback from scholarly colleagues facing similar challenges in the West. Throughout my accessing the field experiences and two pilot activities, I was behaving in many ways as an institutional ethnographer. These early reflexive documents were born out of a pragmatic need to adapt the OISE-taught Western-based methodologies to a distant, non-Western culture. I was reproducing the ruling relations of traditional intelligentsia. I experienced a disjuncture with regard to the “best” methods to obtain social knowledge.

5. **Questionnaire development**

I began drafting survey items during the Spring of 1995 (within Phase 5). This survey ended up being the first pilot version of my questionnaire. I started with the version for participants with diabetes because I anticipated that this instrument, as opposed to the doctors’ version, would be the most challenging to construct. I worked on the first of six drafts of this
questionnaire. My mentor and I discussed the phrasing of the devised items that were of both ‘open’ and ‘closed-ended’ types. In these discussions, I learned more about the use of Singlish. I categorized items according to their reflecting certain theoretical dimensions of the relations between people with diabetes and doctors as I conceptualized them at that time.

I formally solicited feedback from six DSGS members, half of whom were health professionals, regarding my questionnaire for people with diabetes and outlined options regarding its distribution to various primary care clinics. I considered these taped interviews (in addition to my interviews with two specialists and a GP) to be my first pilot of the survey. I tape-recorded these interviews. These individuals were regarded as key informant sources of information whose input affected decisions associated with better adapting my survey to the diabetic population in Singapore. I asked DSGS members about their thoughts on the role of the support group in their lives and its function within the health care community. These nine people, in addition to Dr. Chin and my OISE supervisor, were helpful in my revising this survey to become more sensitive to the local health care structure and of higher relevance to experiences between doctors and people with diabetes. I considered these DSGS members to be knowledgeable about diabetes, and the local health care structure, thus I included them in the capacity of key informants.

I had originally intended to pilot the patient version only once but, based upon the insights that were derived from this feedback, decided upon significant revisions. I subsequently chose to pilot this revised questionnaire for people with diabetes with that of the physician’s version.

The pilot of the two versions of the questionnaire was intended to help fill the theoretical gaps in the literature regarding the social and structural dimensions of this professional relationship. My idea was to use quantitative data as qualitative data as suggested by Glaser and Strauss (1967). Boon (1996) stated that in her study, “survey data analysis was
instrumental in identifying the conceptual categories upon which (the qualitative data) analysis was based” (p. 227). This evolving theoretical, or explanatory, model was also to have guided my theoretically driven sampling decisions whereby I would invite certain questionnaire respondents to engage in in-depth, follow-up interviews. As Glaser and Strauss point out: “theoretical sampling is done in order to discover categories and their properties, and to suggest the interrelationships into a theory” (1967, p. 62). This theoretical model would have been continually adapted to reflect the knowledge gained through ongoing qualitative analyses of these interviews. In a grounded theory fashion, this theory would not have been considered finished until the data-determined theoretical categories had been saturated, that is, were no longer providing noteworthy information with further sampling.

6. Meeting potential inquiry participants

I met with my mentor 12 times throughout the yearlong Phase 5. I was increasingly aware that he was held in very high esteem within this primary care community. Dr. Lip, a specialist, mentioned the importance of my mentor’s help many times: “I sound as though I’m saying Dr. Chin’s name all the time. …Because if you are on attachment to his department, then I think your case will be easier” (Dr. Lip, Transcript, September 14, 1995, p. 21). I felt increasingly confident that my mentor would be helpful in my accessing the field when the time came to ask doctors to participate in my inquiry. During my four years in Singapore I saw him on the local television station a couple of times and, on occasion, read about his activities in The Straits Times.

I had originally hoped to generate a random sample of physicians whom I would invite to participate in my study. I planned to mail each my two letters of endorsement with a covering letter. My discussions with physician key informants, as well as with many DSGS members, centred around my needing formal introductions from someone of equal or higher status than the
invited physician. I was told that without following this social practice, I would have difficulty securing the interest of this professional group. My experiences thus far had convinced me that I personally did not possess enough status to warrant their accepting an invitation to participate. My own physicians had communicated to me that they were too busy. It appeared unlikely that a written solicitation from me alone to participate in my inquiry would be successful. A DSGS member explained to me that the doctor might lose face if I was not properly introduced, as I was a stranger. It was also seen as likely that, even with the permission of potential participants with diabetes to participate and to contact their doctor, physicians would not be interested in my inquiry. I noted the implicit assumption: patients did not inherently possess sufficient status to affect decisions regarding clinical activities. My status-by-association reflected my ‘lowly position’ in the extra-local reproduction of biomedical clinical practice.

I wondered how I would deal with the regular occurrence of patient “doctor shopping” (or “hopping”) that my key informants frequently mentioned to me. The methodological logistics seemed formidable. How could doctors introduce me to patients that they have never met themselves? Nancy, a DSGS member, suggested that the working class were more likely not to be loyal to one particular doctor: “a lot of the common men, they see more than one GP” (Transcript, September 5, 1995, p. 15). This observation about patients meeting with various GP consultants for their diabetic health needs appeared to be structurally reinforced within the polyclinics. Sue stated that at a PC “the chance of seeing a new doctor is very high” (Transcript, September 5, 1995, p. 13). Others shared this view. Sasman, a DSGS health professional, also stated that this was not usually the case in the private sector:

Sasman: [A]t the polyclinics...you see different doctors, different occasions.

Liz: Right.

Sasman: That’s the problem with polyclinics. GPs [in the private sector] no problem. They will be seeing the same doctor again and again.
Liz: In the office?

Sasman: In the [private sector there is] the office, usually [one] general practitioner. That is a one-person practice. If you have a few persons...you may get to see sometimes different doctors unless [patients] make requests that they want to stick to the same doctors.

Liz: Do they make requests?

Sasman: Yes, yes.
(Transcript, September 8, 1995, p. 7)

The perception was that in the public sector there was no choice regarding which physician could be consulted. This was not the case in the private sector. I considered phrasing the survey items for those people with diabetes who would be meeting their doctor for the first time in such a way as to ascertain their general experiences with doctors. I was unsure if I would have different sections within the survey or construct similar but separate surveys from the original version for people with diabetes who were reflecting upon their relationship with a physician that they have seen more than once. All versions of the surveys and associated letters and consent forms are in Appendices E-R. I learned that people with diabetes disproportionately attended the polyclinics, as their health care was more highly subsidized there than in the private clinics:

Dr. Chiew: This is because diabetic treatment is heavily subsidized and if you are not on any kind of medical insurance from the company, then you would find that less people will be going to private clinics. They will be actually going to the government centers. (Transcript, September 13, 1995, p. 4)

A specialist pointed out that the PCs are “filled with diabetics” (Dr. Kong, Transcript, September 14, 1995, p. 9) and that these diabetics are largely elderly. I learned, by way of contrast, that private practices attracted “mainly professional people, people who are working and [are] covered by some form of insurance or by their company” (Dr. Chiew, Transcript, September 13, 1995, p. 5). It was becoming apparent that a postpositivistic study which focused on people with diabetes, if it were to be representative of this health population, would also have to seek mostly-Chinese speaking participants from the polyclinics.
Dr. Chiew (Transcript, September 13, 1995) pointed out that physicians might be reluctant to participate in my inquiry “because it might be too threatening” (p. 7). I asked Dr. Kong if physicians would take my questionnaire to which he responded that they might as long as it did not interfere with their meeting patients: “Maybe not a lot. If you don’t have patients, maybe at the end of the day” (Dr. Kong, Transcript, September 14, 1995, p. 13). This specialist also admitted that he did not like open-ended questions when completing a survey as this “puts [him] off” (p. 17). Sue, a DSGS health professional, suggested that I needed to point out a pragmatic use of the results of my inquiry to secure physicians’ interest. We discussed my potentially offering participant GPs summaries of the quantitative study data.

DSGS key informants unanimously informed me that Singaporeans would not complete my open-ended questions: “Sometimes, they may just leave it blank. Don’t be surprised” (Sasman, Transcript, September 8, 1995, p. 11). It was mentioned by a couple of key informants that Singaporeans would not be entirely truthful if they perceived themselves in a position in which they might lose face. I asked if it was a notable risk that participants might lie in the survey. One response was:

[T]hey don’t want to lose face--or they don’t want to disclose too much about their living conditions, or their economic status. So you are getting some information which are false or falsified. And then [you] may not get a fool proof, statistical reading if they lie. (Jane, Transcript, June 21, 1995, p. 7)

Another point made was that Singaporeans were often rushed and would not want to take the time to complete an open-ended type of question. Sue told me that Singaporeans were accustomed to simple governmental forms. With these forms the person simply had to “tick, tick, tick” their responses (Transcript, September 5, 1995, p. 4). Sue explained that most people would be “more comfortable” if I made use of this familiar closed-ended item type.

Sue asked if people in North America were in a rush, as this was seen as a common situation in Singapore. I had personally experienced people in Singapore to be either slow, as in
the service and retail industry, or very rushed, as in their driving habits and the hurried climate in the business district. Key informants insisted that my questionnaire must be presented as something that could be completed quickly. I decided to revise the open-ended questions to the closed-ended type and to save the exploring of individual experiences and opinions for the in-depth follow-up interviews. I became concerned that participants would be reticent to participate in an interview, although I had originally viewed the questionnaire phase as part of a relationship-building aspect of my inquiry after which people with diabetes and physicians might feel more comfortable speaking candidly with me during follow-up.

7. **Adapting the phrasing of survey items to best fit Singapore culture**

A large portion of my time during piloting was spent revising the wording of various items so that they might be better understood. An illustration of the variability of interpretation of my items that I became aware of occurred in a conversation around question #22 in the version of the survey for people with diabetes. The statement read: *In the past year I have tried to see the same G.P. for my general health needs.* This question was accompanied by a Likert scale with the alternatives: all of the time; most of the time; some of the time; rarely; never.

Kate: [reading question #22 to herself] ... What do you mean by “in the past year?”
Liz: I’m just trying to get a basic time frame--I have heard that many diabetics will switch over to the public health care system because it’s so expensive--so I’m trying to get an idea of what have they generally done this past year.
Kate: Or past one year, or every one year as in the past?
Liz: Nope. Just this past year. You would say one year? Because where I’m from, it’s implied.
Kate: Whereas you would say in the past one year.

(Kate, Transcript, September 28, 1995, p. 21)

In this illustration, Kate did not understand that the phrase “in the past year” meant the same thing as “in the past one year.”
Other examples of items containing implicit assumptions were pointed out to me.

Another illustration of my adapting the phrasing of items occurred around whether a person "lived with" or "stayed with" you.

Jane: Who live with you or who you live with? Who you stay with, maybe. Something like that.
Liz: But stay with you?
Jane: Ya. Who stays with you or you stay with.
(Jane, Transcript, June 21, 1995, p. 7)

This (to me) was an insignificant difference. However, my version of "living with" someone was not as easily understood as the "stay with" version. I adapted many pilot questionnaire items based upon these types of feedback from my first pilot participants. I was frequently unaware of the origins of these differences of English language usage. I believed some to be incorrect grammar and other times postulated that some were perhaps British in their origins. Singapore, as Canada, was a British colony and contained vestiges of this colonial heritage. I noted many British terms in my daily activities in Singapore. There were "tyres" on cars, "lifts" in office buildings and "carparks" to store vehicles. I adapted these non-Canadian English terms and phrases to the survey for people with diabetes.

Another area of concern brought to my attention was that, especially with the older population, there would be difficulties in reading and writing English:

Dr. Lip: Say if you are below 40, and you are educated, or I guess, literate, you would write and read either English or Chinese. Say if you are above 40--
Liz: It's the "NIDDMs" who are--
Dr. Lip: You're trying to catch them. But, say if they are Malay, they can't read,...not even Malay. They probably speak fluent Malay. But not really read the Malay. And the Chinese will be able to read Chinese or they can't read anything at all.
Liz: So you are saying if the Malay [people] can read, they'll probably be fine in English?
Dr. Lip: Ya.
Liz: What about the Indian [population]?
Dr. Lip: Same. I think so.

(Dr. Lip, Transcript, September 14, 1995, p. 2)

I was informed that many individuals would most likely not admit to this English literacy challenge, as this would cause a loss of face. Rather, my key informants anticipated that my surveys would either be ignored or that my collected data would not be valid. The option of mailing the questionnaires was considered and rejected. I made a note to consider the possibility of my translating the questionnaire for people with diabetes into Chinese and finding a Chinese speaking assistant. I decided that it was too formidable a task to consider translating the questionnaire into Malay and Tamil given the minority status of these groups and the reasonable potential for their understanding and speaking English.

The statistics that I had read regarding Singaporean literacy rates were not solely with regard to English literacy. The general literacy rate in 1995 was reported as 91.8% and literacy in two or more languages as 45% (Singapore Ministry of Information and the Arts, 1996, p. i). In a Westerncentric fashion, I had thought that English would be more widely understood and spoken within the diabetic community than I had experienced. I was informed by Dr. Chiew, among others, that the elderly are likely to be illiterate and that Singaporean with diabetes tend to belong to this segment of the population (Transcript, September 13, 1995, p. 12). I was increasingly anxious about the logistics of the implementation of a Chinese version of my research and worried about how I would manage the follow-up interviews.

Another, related issue was brought up by the founder of the DSGS when I questioned her about the ramifications of low literacy levels on my questionnaire. She commented:

But you see, filling in questionnaires, even in the, you know, even in our simple support group, you prepare a questionnaire, we try, we have to get our own people to sit by them because they will ask questions. “What is this for?” --They might be able to read. But they still want to know. I feel this kind of
survey is better done with somebody sitting down with you. In order to get it done then. (Lin Yee, Transcript, 1995, p. 4)

It was evident that it would be best to personally assist people with diabetes in completing the survey. I also thought that it would be best for me to read aloud the questionnaire to the participants and to complete the items for them in order to maximize their comprehension. But I was concerned about the lack of consistency of the instrument delivery: I would be violating the prescribed rigor of survey methodology.

8. Need for multiple versions of patient and physician questionnaires

a. Introduction

I recognized that I would have to re-pilot the patient survey to evaluate how effective a 'read-aloud' version would be. I intended to learn from the second pilot which items needed re-wording and planned on devising a list of standardized alternate explanations to assist in the overcoming the language challenge. In the study, I intended to be as consistent as possible in the delivery of the questionnaire and to save any discussions for the follow-up interview phase of my research. I did not problematize the amount of control of participant responses that would be required to achieve this result.

I wondered about my securing permission to tape-record these questionnaire sessions. My DSGS informants thought it might be difficult to convince people with diabetes to allow these interviews to be taped but that it would be worth the effort to explain that this would be for my own information. It was clear that they believed many people with diabetes to be private about their condition and thus reluctant to be candid with me about their experiences living with this chronic condition.
b. **Patient questionnaire versions: translations into Chinese**

Many key informants mentioned the importance of my speaking to people with diabetes who were older if my “sample” was to “representative.” Dr. Chin pointed out that the expense of translating my survey into three languages was prohibitive and that the majority of those non-English speaking people with diabetes would be Chinese as they were the largest ethnic group in Singapore. I finally decided to translate the pilot questionnaire people with diabetes into Chinese. The second pilot included these versions during Period 6.

I recognized the necessity for the translated questionnaire to be “back translated” to ensure validity. As one of my informants emphasized:

> Now, the interpreter will have to have a very correct interpretation of your questions and he will have to try it on someone to see if the answers come out right. And if they don’t, the questionnaire, or the interpreter’s version, will have to be modified to suit the examination [referring to my thesis defense]. Otherwise, what would happen is that they will say that you’ve asked one set of questions. But the recipients have had a total misconception of your ideas. So, therefore, you have to have what we call “back translation.” (Dr. Chiew, Transcript, September 13, 1995, p. 2)

I began asking my key informants and ex-patriate colleagues for advice on how to begin the process of translating the survey for people with diabetes. I also sought an affordable Chinese speaking assistant to do the questionnaire reading as well as to engage in some follow-up interviews.

9. **Planned methodological approach for second pilot study**

At the beginning of the pilot study, I anticipated a physician-centred hierarchy within the primary care clinics. As advocated by Dr. Chin and others, it seemed best to use the “top down” method of being introduced. I was unsure of how, or if, my mentor would personally introduce me to the sample physicians for my study. I was concerned about the amount of time
required of Dr. Chin to engage in formally introducing me by telephone but decided that details such as these would be determined after the second round of piloting experiences.

Dr. Chiew and I discussed how the clinics, especially the polyclinics, were extremely busy. We thought that it would not be likely that the nurses could find the time to help participants. I considered paying a small sum of money to those who assisted me with my research but decided against it as it was likely that this might offend some. The idea of a gift was well received. The G.P. Dr. Chiew suggested that I “give the nurses...a little box of confectionery or a box of chocolates or something like that. Just to be nice to them” (Transcript, September 13, 1995, p. 14). I thought anything containing sugar was inappropriate and wondered about his sensitivities to diabetic dietary regimes. I decided upon a keychain that retailed for approximately S$8 with my name and “University of Toronto” written on one side and the phrase “Research is the key” on the flipside. My partner had received a similar type through his business connections and I thought it expensive enough to be useful but not worth enough money to be considered a payment. I was fortunate to be able to order it through my husband’s office and received a 40 percent discounted price.

I was, as yet, unsure of my intended study sample size. This was a question to be discussed at my February 1996 committee meeting in Toronto. I intended to have a questionnaire for people with diabetes and another version for the physicians. As for data analysis, I intended to use frequency counts and significance tests of cross-tabulations of responses for items both between and within questionnaire types. The outcomes of these analyses were to have provided me with a basic understanding of the various influences, and reflections of, relations between doctors and people with diabetes in Singapore. I planned on contextualizing my follow-up in-depth interviews with the knowledge gained from these quantitative analyses and the literatures I was reading.
I explained to Dr. Chin that I considered the qualitative data to be more significant to my theory building than the survey results. I do not know if he ever agreed, although he did confide that he found our conversations stimulating. He was an important academic link for me to help combat my feelings of isolation from OISE. Many times I had to explain to my mentor that my inquiry was not a randomized control trial. I found my conversations with him to be helpful in my keeping committed to a grounded theory vision of research.

10. **Accessing the polyclinics**

I knew that I would need authorization from a MOH official when the time came for me to interview within the polyclinics. It was brought to my attention that the power structure in the PCs was hierarchical with the MOH at the apex. Sasman mentioned:

> Because here, the polyclinics here are very sticky, you know, red tapes. They are always very worried...[I]f you can get [your mentor], you know, to give the “okay” from the doctors, and it will [be] much, much easier for the nurses. (Sasman, Transcript, 1995, p. 25)

I spoke with a physician regarding how I should secure permission to interview in the polyclinics during the end of Phase 5. Dr. Chiew pointed out the important gatekeeper role of my mentor, advising me to “get Dr. Chin to introduce you to the MOH physician looking after the PCs--Dr. Yong--as well so that he (Dr. Yong) will take you seriously” (Dr. Chiew, Transcript, September 13, 1995, p. 4). Dr. Chiew said that these introductions were very Asian. It is roundabout. ...I think just get Dr. Chin to approach [Dr. Yong] and [have Dr. Chin] say, “well, this is a friend of mine, and she is going to approach you for this matter.” (Dr. Chiew, Transcript, September 13, 1995, p. 21)

He mentioned that I must be clear about my research intentions. I should have my questionnaires ready to submit for approval to the MOH’s internal ethics committee and expect that some sort
of conditions would be placed on my research at the PCs. For example, Dr. Chiew thought I
needed to add some survey items that were of interest to the MOH:

Because right now, they are quite strict about doing research on patients.
...[T]he easiest thing for Dr. Yong to do is to say “no.” So what you can do is
to say that “would you mind if I just spend half an hour with you explaining to
you my intentions?”—“I wouldn’t mind sharing data with you and I would be
prepared to subject my questionnaires and my study to an ethics committee
from your Ministry of Health.” That will put him at ease—what you do is don’t
commit yourself and say I am not intending to publish anything. All I’m doing
is doing my Ph.D. and that the only kind of thing I’m interested at the moment
is getting...the thesis out.... (Dr. Chiew, Transcript, September 13, 1995, p. 17)

I explained that I did intend to publish after my dissertation was accepted in Toronto. We
concluded that I should be prepared for the above scenario and should be clear in communicating
that I would acquire some information that I would be willing to share with the MOH:

Well, I think Dr. Yong is likely to be interested in your information because
there’s a lot of information that he hasn’t been able to get out of GPs and he is
likely to be interested in looking at that. So I guess you could sell your study
that way and say that you are prepared to just go out and have a look at what
people [are doing]. (Dr. Chiew, Transcript, September 13, 1995, p. 20)

I learned that sometimes there are letters of complaints sent to the press about the polyclinics. Dr.
Chiew mentioned that this MOH physician looking after the PCs might think: “Well, I don’t
want any bad publicity, just stop her from doing it especially since there’s no obvious benefits to
us” (Dr. Chiew, Transcript, September 13, 1995, p. 21). I agreed that it was important to
convince Dr. Yong that I would not upset people at these primary health clinics.

11. Ongoing participant observer role at the DSGS

My first pilot interviews with DSGS informants were not completely centered on the
task of improving my survey. We also talked about what they considered relevant to living with
diabetes. That is, I heard stories about their experiences living with diabetes. Health professional
members of the DSGS also shared their opinions of the experiences of people with diabetes in Singapore. These interviews were a time of relationship-building with core group members.

During one interview with Nancy which took place immediately after another interview, I pointed out that I had brought along something to eat in order to help avoid triggering my own health condition (September 5, 1995). Nancy was aware that my condition also required attention to my diet. We spent some time chatting during this snack break about the social challenges we both faced in meeting our similar dietary schedules. I did not portray myself as an expert scholar from the West investigating their support group experiences. Rather, I was soliciting her help in the better design of a culturally sensitive instrument. I believe our meetings were collegial in nature as we both brought our respective knowledge and experiences to the discussion.

I solicited help, such as for the translation described above, from my ongoing contact with various members of the DSGS during Phase 5 of my inquiry. I also envisaged their facilitating my introduction to potential participants when it came time to complete the study. At this point of my inquiry, I was seeking people with diabetes who I felt were more representative of the diabetic population. I did not consider those individuals who had joined the DSGS to be typical of the Singaporeans who had diabetes. Thus the DSGS, as yet, was not considered a major focus of my inquiry. At the time, I included the data from my participant observations at support group activities as a contextualizing feature for what was to be the central study. The DSGS participants were aware of my continued participant observer role and were regularly reminded as such that I would maintain their anonymity. I was teased and referred to as 'Big Brother' once since I was "always watching." I maintained my fieldnote and journal writing. I kept all handouts and newspaper accounts of the group’s activities and filed my varied fieldnotes and journal entries. I was still thinking as a grounded theorist and focused on the survey construction part of my triangulation of methods. I now see the behavioural seeds of what was to become my epistemological evolution. My continued participatory efforts at the DSGS, coupled
with my ongoing fieldnotes and other written reflections, were the beginnings of my epistemological shift towards institutional ethnography.

12. **Conclusion**

In this section, my detailed accounting of my first pilot activities identifies the relevant experiences that drove the adaptation of my thesis ideas to best fit the diabetic community in Singapore. As Bochner and Ellis (1996) point out vis-à-vis their ‘conversation’ style of ethnography:

Art: The positivist idea that applying rigorous scientific method could give us a place to stand apart, remove us from the intrusions of our own experience and subjectivity—that’s nonsense! We can’t extricate ourselves from language.

Carolyn: When ethnographers like me make texts, try as we may to report and represent accurately, we necessarily invent and construct the cultures we write about. We cannot help but read something into what is there, because we are there with it.

Art: Your utterances in language cannot express anything completely independent of what you’re doing there. When we give up the notion of an unmediated reality, we forgo the scientist’s strong claim that he is discovering something completely outside himself. (p. 20)

The information-rich “patchwork” of experiences described in this section was not divided into neat scientific-like compartments. I was a white embodied Westerner who was not only revising my thesis proposal to best suit my new home, but experiencing daily life as an expatriate minority in South East Asia. During this time I considered most social experiences, both personal and those related to my inquiry, to be data. In an anthropological fashion, I consciously laboured at improving my sensitivity to Singaporean culture. My critical autoethnography best communicates the rationale behind my decisions regarding the focusing, and implementation, of my inquiry. It also illustrates my bifurcation of consciousness as a Western researcher in Singapore.

1. **Introduction**

   Figure 8 is a flowchart of my second pilot study activities. This account of the second pilot study activities reveals the extreme disjuncture I was experiencing between my Western-based expectations regarding my revised survey and the realities of the field. When compared to my convoluted path described in Phase 5, Phase 6 is less methodologically detailed.

2. **Adaptations to 'PWD' questionnaire**

   The revisions of the first pilot survey were made so that the items better reflected Singaporean culture, health care structure and more typical local English usages. Appendices C through R include copies of the letters of introduction, consent forms and questionnaires (including all versions) used for my second pilot study.

   Participants with diabetes were to be asked to complete, with my assistance, one of two similar questionnaire types. One was prepared for those visiting a private G.P. practice or those visiting a polyclinic doctor respectively (Appendices I-J, and M-N including Chinese versions). I defined the items within these two versions to be similar and intended to pool the quantitative data from both of these questionnaire types in my analyses. The phrasing of the items was adapted to best reflect the health care context of the clinic. The wording of the items was specific to that clinic type in order to avoid any confusion for people with diabetes. I simplified the questionnaires by instructing participants to skip certain non-applicable sections or multiple phrasing choices within items.18

   In a similar fashion, the phrasing of the 'PWD' questionnaire items was adapted for a third version which were designed for those patients attending private clinics who did not have
A. Questionnaires:

**Version**

- PWD
  1. Visit to Private GP practice
  2. 1st visit to Private GP practice
  3. Visit to Polyclinic doctor

- Physician
  4. Private GP practice
  5. Polyclinic

**Methodology:**

1. Letter of introduction
2. Consent form completed
3. Questionnaire items read aloud
4. Questionnaire/interview responses:
   - Survey completed by interviewer
   - Discussion of content, process or phrasing encouraged — often participant initiated
   - Tape recorded and transcribed

**Participants:**

- DSGS members
- Participants

**Physicians:**

- Introduced by mentor
- PWD patients

**DSGS participant observations**

**ongoing journaling/fieldnotes**

**associated challenges fueling shift towards critical theory**

**Singapore society observations**
an ongoing relationship with the particular doctor they were visiting on that occasion. I included this questionnaire type, “Private G.P. Practice—First Visit” (Appendices K-L), for the unlikely option of my being introduced to a person with diabetes who was meeting a participant physician for the first time. I deemed this scenario as a possibility. I felt it was worth the effort of being prepared since I had learned that there were frequently “walk-in,” that is, patients arriving at a clinic without an appointment or record of previous attendance. I anticipated that most people with diabetes would prefer to participate in my inquiry before meeting with their physicians. I anticipated that they would, most probably, be used to a certain amount of “waiting-room time” and, therefore, would not find my questionnaire too disruptive to their schedule.19

The ‘PWD’ questionnaires were comprised of four general sections. The Background Information section asked for general demographic information such as their age, sex, living arrangements, ethnic group and languages spoken at home. The Medical History section collected information on the type, duration and the health care access pattern (that is, the proportion of visits at either private or public primary care clinics). This section focused upon whether or not people with diabetes frequented specialists for the care of their diabetes. The last two sections of the survey, entitled “Living with Diabetes and Relationship with my G.P.” used a Likert scale format. In “Living with Diabetes,” the items were statements that addressed people with diabetes’ degree of acceptance of this condition in their daily lives. Items probed people with diabetes’ perceived control of their condition, how often and to whom they confided that they had diabetes and the degree of effort it took to adhere to a regime. I had linked, in an a priori fashion, the theoretical constructs that I was ‘measuring’ with the corresponding survey item numbers.
3. *PWD* questionnaire translation

I decided that, in order to access the Chinese-speaking community, I would require translations of the three versions of the *PWD* questionnaire (Appendices J, L, N). I was surprised to learn that many educated Singaporean ethnic Chinese (although they regularly spoke Mandarin and local dialects fluently) did not read and write Chinese characters. Interestingly, the first couple of ethnic Chinese doctors with whom I spoke about this translation requirement appeared somewhat embarrassed about their inability to read and write their maternal language. I did not want to cause any loss of face for the doctors and decided to seek a translator from other, non-physician, contacts.

My attempts to find a local person, including members of the DSGS, who felt capable of translating these three questionnaire versions, were unsuccessful. My opportunities to meet key informants in the spring of 1994 stemmed from my acquaintances within the ex-patriate community as did my chances of meeting someone to help me meet my questionnaire translating requirements in the Winter of 1995. I had become friends with an American woman who was completing a Ph.D. at the National University of Singapore (NUS) in the Management Department. She offered to share her office with me at NUS during periods 6 and 7 and was an enthusiastic colleague with whom I could share my scholarly experiences and expertise. It was also through this friend that I met a foreign student from Beijing who was interested in earning some money translating my survey.

I met with this NUS foreign student and provided some general background information regarding my inquiry and the purpose of the questionnaires. His translated versions were sent to another NUS student from China who 're-translated' these surveys into English. I had indirectly learned of this person through an introduction from another ex-patriate. I approached a recommended local office consultant used by a Western colleague for her import
business. This office consultant agreed to help me with my upcoming tape transcriptions. She also recommended a "re-translator" for my questionnaire.

This second translator did not know who was responsible for the first translation and was given little information regarding the nature of the study. I wished to ensure that the Chinese characters were as representative of the English version as was possible given my limited resources and language skills. I compared the re-translated English version with my original to ascertain the level of item "matching." I noted any significant discrepancies and discussed my queries during a follow up meeting with these two translators at NUS. Both of these Chinese students knew each other and were unaware of their efforts in my study. The outcome of our 45-minute discussion was that my first translator agreed to complete the final negotiated revisions. I found this experience insightful. In particular I concluded that my abilities at speaking slowly with persons who knew English as a second language and increased sensitivity in avoiding their loss of face had notably improved since moving to Singapore.

I piloted the polyclinic questions (Chinese version) with a bilingual member of the DSGS who was more comfortable reading, writing and speaking in Chinese than she was in English. Her recommendations were critical, as she noted that certain key terms, such as "polyclinic," were not the characters used in Singapore but a rather literal translation that would not have been easily understood by local people. She spoke directly to my first translator over the phone in Chinese regarding how to best revise these particular items.

4. **Physician questionnaires**

The physician survey was written in two similar formats entitled, "Questionnaire for General Practitioners: Private Practice" and "Questionnaire for Polyclinic Doctors" (Appendices Q-R). Survey items on each questionnaire addressed patients' and physicians' responses.
Physician questionnaires were divided into three sections. The first contained items addressing a doctor’s general background such as personal demographics, preferred and functional languages, history and location of medical education and number and type of patients regularly seen. I also included specific items that probed their interactions with patients of differing diabetic type (IDDM vs. NIDDM) and the nature of their relationships with specialists.

In the second section, “Relationship with your Patients with Diabetes,” I used a Likert scale format that addressed the degree of agreement with various statements regarding their experiences with their patients with diabetes. I phrased these items to depict a typical, or generic, impression of their patient relationships. I felt it would be seen as too time costly for physicians to complete this section for each of the two or three of their patients who were participating in my inquiry. I was, in this section, investigating the doctor’s view of diabetes as a treatable condition. I also sought reflections on their “typical” communication style. I included items that addressed the physician’s view regarding whose responsibility it was to decide a particular diabetic regime. In other words, did physicians see this decision-making as theirs’ or their patients’ role? Other items looked at how physicians regarded their own levels of expertise and their typical relations with specialists. Some statements inquired about physician perception of time and how this resource was managed when consulting with patients with diabetes. Two sections of this questionnaire were also to have been read aloud by me with our discussion tape-recorded, i.e. a structured interview. I planned on scheduling these interviews at convenient times, most likely after clinic hours.

The third section, or “last page” of the questionnaire was to be completed immediately after seeing a participating people with diabetes. This mini-survey had just seven items and used a Likert scale format. These statements probed views of a particular participating patient. The items addressed the doctor’s assessment of that patient’s ability to maintain a regimen: his or her
view of the patient-doctor relationship; and his or her knowledge of this patient’s experiences of living with this chronic condition.

5. Plans for accessing potential people with diabetes and physician participants

I planned to contact physicians suggested by Dr. Chin (or other members in the health care community) by writing an introductory letter outlining my proposed inquiry (Appendix O). I intended to include a copy of my revised research proposal (Appendix B) and a thank-you note reminding them of our meeting date. I planned to include my letters of introduction from my thesis supervisor (Appendix C) and local mentor (Appendix D). I hoped that these recommendations from members of the academic community would secure sufficient interest in my inquiry.

I planned to subsequently place a follow-up phone call approximately four to five days after their receiving this mailed information. I intended, when visiting the clinic, to give one of my university-crest business cards to the receptionist as well as to all the participants. I had been told, and had frequently observed, that accepted procedure was to present the card using two hands and by holding the edges of its long side and to position it so the text was facing the recipient. I noted that when a card is given in this way its presenter makes a small bow of courtesy.

For my second pilot phase, Dr. Chin agreed to personally introduce me to three physicians. I planned a mailout to these health care participants after this telephone introduction. For the purposes of the second pilot study, I asked to be introduced to two physicians in the private sector, one ORT and one HDB type. In addition, I asked Dr. Chin to introduce me to Dr. Yong at the MOH who would, hopefully, grant my access to a polyclinic.

This was an example of “theoretical sampling,” as outlined by Glaser and Strauss (1967), and a part of the grounded theory approach to my qualitative inquiry. I had given up the
idea of securing a random sample of physicians in my study that was intended to follow this
second pilot. The 'actual' study never took place. My original plan was to theoretically sample
within both the quantitative and qualitative phases of my inquiry after the second pilot. I
intended on sampling according to (1) structural features (for instance “clinic type” as I had
organized in the second pilot); (2) categories that reflected personal features (for instance
number of years in practice); or (3) social features (for instance whether the doctors reported
“scolding” their patients with diabetes). These criteria would be based upon my ongoing analysis
of the literature, in addition to insights derived from previously collected quantitative and
qualitative data.

According to grounded theory methodology, my emergent theory explaining this
relationship between doctors and people with diabetes would be considered complete when I
decided that the categories I generated from the data were “theoretically saturated.” I would
consider my theory “saturated” once I felt an adequate understanding, and consequent
predictability,\(^2\) about the relationships among data-determined categories.

I planned for potential patient participants to be theoretically sampled as well. My
intention was to request participating physicians to invite two to three patients to participate in
my inquiry. These choices would be made according to how the physician evaluated particular
patients as possessing certain theoretically determined attributes. I wanted to remain flexible
enough to ensure adequate participation rates. I intended to ask for the physicians to invite three
people who had diabetes (leaving the specific organizing details regarding these introductions up
to each doctor).

The second pilot study provided an opportunity to test my methodological plans in
clinical settings. I planned on explaining to the doctors that I would be reading the questionnaires
aloud and would attempt to secure permission to tape record questionnaire, or structured
interview, sessions. In addition, I would also be reading aloud the physician version of the
questionnaire in order to be consistent. I believed that this would best ensure high completion rates of the physician surveys.

My promise was to minimize any disruptions to the clinic and to adapt to physician and patient natural schedules and activities as best as I could. I hoped to be offered as private a location as was feasible in order to promote a comfortable environment and encourage participants to be reflexive and truthful. I was aware of the significance of this methodological challenge, as space was very limited and privacy a difficult commodity to secure. I was concerned that there would be a reluctance of people with diabetes to confide their private concerns and experiences with me. It was important to communicate to the physician my need of having access to as quiet a corner as possible. A noisy clinic might have offered a certain degree of privacy but would have increased the difficulties in transcribing the taped discussion. I decided to respond to each scenario as I felt was best at the particular time and to “make do” with whatever environment and participant-types were offered.

In addition to my seeking an appropriate place for participants to share with me personal aspects of their lives, I planned to read to them my “Letter of Introduction to the Patient With Diabetes” (Appendix E). This letter described my background, the importance of my inquiry and the non-evaluative nature of my research. My intentions were to assure these individuals that their views and experiences were valued and that their input would be an important scholarly contribution and perhaps assist towards the improvement of the doctor-patient relationship. In addition, I would review the “Patient Informed Consent Form” (Appendix G) and state my pledge to maintain confidentiality. I also intended to remind them of their right to withdraw from my study at any time.

My mentor telephoned three doctors, one from each of the primary clinic types. I was ‘introduced’ over the telephone, that is, handed the receiver by my mentor after he had placed the call and outlined my request. The two private clinic physicians, an ORT and HDB type, agreed
to meet with me to discuss my research intentions. The polyclinic doctor sounded interested but would not meet with me until I had sought approval for my inquiry by Dr. Yong. I sent each of these physicians a copy of my thesis proposal, letters of introduction and a hand-written thank you note. I similarly ‘met’ Dr. Yong over the phone and later saw him in person. I secured permission for my second pilot without any additional governmental requirements. I was hopeful for the same allowance for the future ‘actual’ survey. I was granted permission to take fieldnotes throughout this discussion.

My second pilot study plans with the three physicians introduced to me by Dr. Chin were executed in differing ways. At both the ORT and PC clinics, I accepted offers to include more than one participating physician in my second pilot. My second pilot became a series of lengthy interviews with a greater number of participants that is typically necessary for pilot work. These interviews ultimately provided rich qualitative data from an institutional ethnographer’s perspective.

Throughout Period 6, I increased the time devoted to participant observation activities within the DSGS. These data were originally intended to be peripheral to the more central inquiry about relationships between doctors and people with diabetes. To this end, my DSGS fieldnotes were accounts of my experiences, observations and open discussions with members of the DSGS. I was informal with my data collection at the DSGS during this phase and did not impose any conditions or research agendas. I listened and learned what it was like to be a DSGS member and a person with diabetes in Singapore according to these participants. I experienced the camaraderie of the group. In retrospect, I see that my bifurcation of consciousness was becoming increasingly pronounced.

My three-year relationship with the DSGS included dozens of participant observer activities. I attended many support group meetings that were a part of 10 weekly sessions that averaged two to three hours in length on a Saturday afternoon. I informally spoke with many members and organizers regarding their day-to-day experiences of living with diabetes and their views of doctor-patient relations in Singapore. In the final year of my participant observation, I facilitated the education segment of two sessions on the assigned topic of “improving doctor-patient relationships.” In addition, I participated in “end-of-session” parties.

I attended three annual family retreats in Malaysia with members of my own family. These lasted three to four days. I was included in the planning and some of the efforts towards the DSGS’s annual public “diabetic information days” at a downtown hotel. One time, I was included at a plenary meeting regarding the strategies associated with ‘training’ certain volunteers to become group facilitators. With my two children, I volunteered at one annual fundraising event of the umbrella charitable organization.

During the first two years of my being part of the DSGS, meetings took place at a member’s home on Saturdays between four and six p.m. Usually, there were written programs outlining the various topics and many times there were invited “experts” to speak. Typically these were health professionals with the “expert” doctor being the salaried DSGS member.

My first support group meeting was the seventh of a nine week set. The central education topic was on foot care. It was entitled “Looking after your feet” and had a podiatrist as the guest speaker. Among other health care professionals who volunteered their time as guest speakers, this podiatrist later became a regular member of the group. Other ‘core’ health professionals who regularly attended meetings and events as participants included a diabetic nurse educator, a nurse, and a dietician. These health care professionals did not always perform as experts during many DSGS activities and included their families at certain events.
The structure at the beginning of meetings was usually informal. As is often the case in Singapore, people arrived sporadically. Occasionally it was mentioned that so-and-so was working and would make the meeting if he or she could. Meetings were relaxed and often included spouses and, in later groups, children. The social tone was usually ‘up-beat’ by the ‘regulars’ (or core members). This often contrasted with newcomers who tended to be, at least initially, quite reserved. Notably, some newcomers did not return after one or two meetings.

Activities during the first hour of meetings typically began with arrivals putting on nametags and visiting amongst themselves. People tended to circulate in a cocktail party-style around the snacks that were laid out in the dining room. The designated facilitator would command the attention of the group. People sat around on the floor or on chairs near this person. The facilitator varied by session. At times it was the doctor or nurse educator (or, in the last year of my participant observation, a social worker) all employed by the umbrella charity organization. Facilitators frequently included Lin Yee, the volunteer founder of the group. Lin Yee later became salaried at the DSGS umbrella charity organization and worked exclusively with people with diabetes.

As the membership of the DSGS grew in number, differing session types were attempted with varying results. These included sessions for parents of children with IDDM variety of diabetes, Mandarin groups for adults, and teen groups. These groups were the result of increasingly involved core members who had participated in varying sessions and other DSGS activities including plenary meetings. A facilitator training option became available to these individuals who, in turn, became facilitators of their own DSGS 10-week sessions.

After the facilitator called the meeting to order, there would be an ‘icebreaker.’ The following is an illustration of one organized by the salaried nurse educator:

Janet asked us to stand up and to form three to four groups. The icebreaker was to join hands and to tie ourselves into knots[, and then to untie ourselves
without breaking our hand link. The laughter and giggling was incredibly loud considering how quiet these people were [before].

Of course, I was much taller than my group [including one member who was probably five feet tall]. I [made] Janet and my group [laugh] when I worked my height to our advantage as I could step over arms. I did not have to squeeze underneath.

I noticed Anna [my daughter who was helping babysit the accompanying children during this parent support group] and her friend watching.... These icebreaker activities always seem to do the trick as the group felt much more comfortable [afterwards]. I know I did.

...[My daughter and her American friend]...told me in the car going home that they had never seen adults giggle so much in their lives. They thought it was “weird” to hear this giggling. (DSGS meeting, Fieldnotes, October 7, 1995, pp. 2-3)

After the icebreaker, there would usually be a mini lecture offering a biomedical explanation of the IDDM and NIDDM forms of diabetes, their ‘treatment,’ and information regarding various challenges associated with the need for a healthy lifestyle. During my first meeting, for example, the podiatrist gave an informal lecture on the importance of people with diabetes being stringent on cleaning and examining feet in order to avoid serious complications. This was explained as being due to the possibility of individuals being unable to sense a small cut or infections.

Often, before the informal lecture began, I would be introduced as a visiting academic and friend. I was usually the only one taking any notes.

Questions were encouraged during the expert presentations, although for the first 10 or 15 minutes, it would be fairly quiet and then some restlessness or questioning would usually begin. Small group activities involved three to five individuals with the goal of applying-through-discussion some aspect of the topic covered during the more didactic part of the session. When small group activities began, the social atmosphere of the room often became more socially charged. The ‘assignment’ would be completed but usually with informal chatting and sharing of experiences. I noted that the small group activities were often cut short due to a shortage of time, with large group sharing of answers between groups often going overtime.
During the final year of my participant observation, the structure of the support group itself began to increase. The number of participants was also increasing. By this time the core group of friends had not only experienced a number of support group meetings but were increasing their involvement and beginning to volunteer at more organizational activities that pertained to the planning of DSGS sessions and events. Various sub-groups had evolved to address the special needs of dropouts with the IDDM type of diabetes. Such individuals would show interest in the support group but not return before this special programming was instituted. The original adult English-speaking core remained. A Mandarin-speaking subgroup was formed but had difficulty in securing a facilitator. The format of a subgroup that included the parents of children with the IDDM variety of diabetes was especially challenging, as the children themselves needed attention during the meeting and were at times distracting. Coupled with DSGS members or spouses who were not parents of a child with diabetes, my two daughters would periodically help as babysitters. In addition, there were camps for children with IDDM in which certain staff members participated.

I attended the meetings of the adult group as well as those of the sub-group for parents of children with the IDDM variety of diabetes. The structure of the sessions taking place after 1996 changed and began with the icebreaker, proceeding to the large group lecture followed by a small group activity. The tea break was less of a feast and took place just prior to the small group activity. This accommodated the food and social needs of the group while making better use of time. The small group activities, although seemingly didactic in nature, were more often private opportunities for individual members to meet and talk with other members who might not otherwise have spoken. These were also opportunities for newcomers to learn that they were not alone in their challenges, network and to share information and resources.

The core group had grown to approximately 20 to 25 people through the three years of my observations and there was an increase in the number of copyrighted informative handouts.
Manila folders were distributed for participants to keep track of their papers. They were instructed to leave these documents behind until they had completed a full 10-week session. The objective of the salaried and official volunteer facilitators was to encourage the completion of sessions. An incentive was a reduced rate at the annual retreat. No one commented, in my presence, regarding the increased structure over time. During the last few months of my participant observations, the venue had also changed from personal homes to a satellite branch of the umbrella charity organization, which had the effect of formalizing or institutionalizing the group.

The small group activity was always held in the last quarter of the meeting. By then, the icebreaker activity and large group session, which may have included a mini-lecture and tea-break would have passed. The noise level and silly 'kidding' activities—including poking fun at my being Western—continually surprised me. I could not believe Singaporeans could be so loud and playful. This was not the behaviour I was accustomed to witnessing of Singaporeans in public places. The intimacy and friendships outside of DSGS activities between the increasing numbers of core members were evident.

By the end of the summer of 1997 there had been four family retreats—with the fourth and largest one planned for March. At this point, I had witnessed approximately 20 support group sessions and had documented increasing diversity and numbers of health care professional speakers. There had also been three public information days at various downtown hotels and an official-looking newsletter appeared. Wai Mun, a DSGS health professional, stated that there were approximately 15 core volunteer and 15 regular volunteers, with the database listing 295 members. He explained that the numbers of participants had been doubling every year but felt that the 295 number was probably high (Wai Mun, Transcript, June 12, 1997). At this time, plans had begun for a DSGS pharmaceutical supplies shop that would reduce personal health care costs by making use of group purchases. Subsidized pharmaceutical supplies and psychological
counselling services for people with diabetes were also becoming increasingly available through the "umbrella" organization.

The approach to the family retreats and public information days paralleled the tone of the session meetings. There were games and "fun" activities as well as serious lectures. The annual information days included free blood glucose testing, as well as many informative activities for all ages. These were well attended with the "free blood test" line up being the longest. I learned that some people had high enough glucose readings to warrant the suggestion that they see a physician as soon as possible. The venues were always ballrooms at prestigious downtown hotels with backing from various companies that manufactured drugs and associated technologies. Throughout these years, there was increasing media attention.

7. Survey challenges

a. Introduction

I discovered there to be three interrelated kinds of obstacles that impeded my collecting 'valid' and 'reliable' quantitative survey data. All three of these obstacles relate to the inappropriateness of a Westerner using a quantitative (extra-local) instrument that had its epistemological rationale derived from a Western perspective. My field experiences in Singapore raised my consciousness to question the relevance of my survey. I was specifically experiencing the acquisition of more knowledge regarding the social experiences relating to interactions between doctors and people with diabetes through my 'peripheral' activities. These included my unconventional administration of the questionnaire and my participant observation activities at the DSGS.

I also came to realize during this period that, in addition to my methodological premises, most of the scholarly literature I had read was from a Western perspective. The
literature was not critical in nature and did not provide me with an awareness of other epistemological possibilities.

The first challenge I experienced was in understanding, and being understood, by those who communicated with the English dialect known as Singlish. In addition, there was a more complex set of language challenges obtaining survey data from unilingual Chinese people with diabetes. The second type of challenge was how to deal with “misunderstandings” due to differing perspectives between interviewer and interviewee that I, as a Westerner, did not anticipate. For example, although it might seem obvious, my social and historical background was not Singaporean so my history and that of my participants differed. The third type of challenge was that many participants with diabetes did not seem to understand the concept of, and their role as respondents in a survey. The ‘business’ of choosing a point along a Likert scale was often forgotten and/or poorly understood. My assistant and I were frequently in the position of repeatedly coaxing certain participants to select for themselves the scaled option that best reflected their answer after our listening to varying descriptions of living with diabetes. I was acutely aware of how I could not argue the ‘validity’ and ‘reliability’ of a quantitative analysis where certain data had not been obtained according to the rules of postpositivism. I was also aware of the rich qualitative data I was collecting as participants shared their personal stories with my Chinese-speaking assistant and me.

b. **Challenge #1: Language differences**

An example of a misunderstanding based upon Singlish-English differential usage occurred when Mr. Salleh did not interpret the phrase “if only there were more time” (Appendix I, item #55) in the manner that I had intended:

Liz [reading Likert item]: “I would tell my GP more about my personal life if only there were more time during our appointments.”
Mr. Salleh: [pause] I normally have the time, so I will say I strongly agree.
(Mr. Salleh, Transcript, February 8, 1996, p. 9)

I chose not, in this case, to politely point out his misunderstanding of the question. I believe that had I corrected him, this gentleman would have lost face and would most probably have remained monosyllabic for the rest of the interview.

I was more forthright in confirming the comprehension of various terms by the more talkative and less formal Mr. Kausalya:

Liz [reading Likert item]: “Diabetes is a major source of stress in my life.”
(Appendix M, item #45)
Mr. Kausalya: Sorry I don’t understand.
Liz: Okay. A major source of stress. [pause] Do you understand the word stress?
Mr. Kausalya: Stress.
Liz: Like things that make you nervous. So diabetes a big cause, one of the biggest causes of stress in your life? [pause] You don’t understand, okay, so this is not clear.
Mr. Kausalya: Yeah.
Liz: I’m writing this down because I am still re-writing this question.
Mr. Kausalya: I see. I see (Mr. Kausalya, Transcript, April 15, 1996, p.15)

I found, as the above examples illustrates, that the task of understanding, and being understood by local people was a language skill that frequently required a certain degree of interchange and effort from both parties. Questionnaire items often needed explaining, or the provision of some illustrative examples, before participants were able to respond with confidence. This occurred regularly with those who spoke Singlish and, unfortunately, with little systematic pattern of survey items. During my second pilot I felt sufficiently skilled at assessing when certain questionnaire items were unclear to people with diabetes. I became increasingly able to rephrase or explaining the item’s meaning with little loss of face to either my interview partner or myself. I learned to recognize that when my question or statement was repeated back, it became an indirect cue that I was not being understood.
I noted, after interviewing Mr. Kausalya who was one of the three English (or more specifically, Singlish) speaking people with diabetes at the polyclinic, in my fieldnotes:

Eventually I got to know when Mr. Kausalya did not understand and I would say a definition of the difficult word or phrase. It is hard to say if I was leading him or not. . . . I noted that he did not answer when he did not understand [he did not say "I do not understand" at the beginning]. He seemed comfortable saying he did not understand when I asked. His cue was silence and I began to offer alternative words/phrases when he became silent. (Fieldnotes, April 3, 1996, p. 18)

I became experienced at noting the difference between a silence that was a result of people considering their answer versus one that was due to their incomprehension. I found that the pilot status of the survey provided me with a legitimate rationale to shift the focus away from the perspective that certain Singaporeans were linguistically incapable in some way. Many times at the beginning of our interaction, I felt participants stiffen in silence when they apparently did not comprehend an item. In a Freirian manner, my aim was to cast them as experts of their culture and to reframe these communication challenges as an opportunity for individuals to share with me their perspectives and stories of living with diabetes.

The questionnaire often became a jumping off point for story-telling by participants. I noticed that these narratives increased in frequency during the latter half of an interview session as rapport developed. At times, especially when these shared stories became animated and impassioned, I did not understand the meaning or relevance of what was being told to me. I inwardly worried that the quantitative data would be useless or that the questionnaire would not be finished before the participant had to leave. Many times I simply fared the best I could in soliciting questionnaire responses by interjecting questions in the least intrusive or insulting fashion.

I frequently discovered the participant's line of reasoning by verbally or non-verbally encouraging the continuation of their story telling. These 'in the dark' interviewing segments
were personally stressful but necessary to ensure rapport. At other times, the ‘sense’ of a person’s story became evident to me later when I listened to the audiotaped version a couple of times or discussed my comprehension difficulties with my native Singaporean transcriber. I did not presume control of the direction of their stories of living with diabetes and their relations within the health care structure:

In the interview transcripts [I sometimes] notice that the conversation doesn’t make “sense”!—By the end [of the interview] I will, hopefully, have a coherent “story.” Of course there will be inconsistencies but…I try to address these at various points in the interview so as to avoid offending my interviewee. To do this I must be relaxed and feel the fun, or insanity, of the situation. I view my skills at making myself understood, followed by actually understanding what they said (and even what they meant!), as a kind of detective work. It won’t all make sense at the beginning but don’t lose the faith.

In the interview with Mr. Aw it took a little while for me to understand his personal accent. Nearer the end of the interview I understood his words better. I also found that I better understood the first half-hour of our discussion when I heard it for the “second” time on the tape. What I am unsure of is whether or not this was because it took a little while before my Singlish skills kicked in. Or, did I need a better understanding of the context of what he was telling me? That is, once I began to fit some of the disjointed pieces of his story together, the individual words began to make more “sense” and were more easily understood. I believe that this rationale is another reason why it is so important for the interviews to be taped. I can’t take clear notes when I don’t understand what is being talked about. (Fieldnotes, February 14, 1996, p.5)

The following is a portion of the lengthy discussion I had with a DSGS member who frequented the Mandarin-speaking support group. It is an illustration of how my asking Mr. Aw questionnaire items (stated within quotations in this citation) addressing his diabetic regimen was interrupted by his bursting forth with his emotional, and at times confusing, story:

Liz: (Looking at item #16, Appendix M) Now we are on the medical history. “When was your diabetes first diagnosed?” Can you remember about the month or the year? The year that you were—

MR. Aw: Erhh, I think it is around 1975.

Liz: 1975. “How is your diabetes treated now?” You can tick as many as apply to you, “regular exercise?”
MR. Aw: Erh, at present, no. Because of my leg, [as it is painful with a diabetic complication] I don’t go for exercise. Normally I go for swimming.

Liz: Okay.

MR. Aw: And I do some light exercise sometimes.

Liz: Okay. So normally, it’s regular exercise.

MR. Aw: Yes

Liz: “A special diet?”

MR. Aw: Erh, yes. I’m on high nutritious food.

Liz: “Are you taking pills or are you injecting insulin?”

MR. Aw: No—oh ya, injecting insulin, twice a day.

Liz: Twice a day. Erhm, anything else you would like to add on how you treat your diabetes?

MR. Aw: Ah, okay. I think I treat my diabetes because of the doctors that you have seen, erh, for so many already, and beginning to start with the general practitioner, and a company doctor, I don’t, I think they did not pay much attention to our needs.

Liz: Hm, hm.

MR. Aw: So from there, erh, we regularly went to see them. Everytime, they would prescribe the same medicine, drugs for you. That’s Daniel. And gradually, we go and told them, that, “Doctor, after prescribing these pills to us, we don’t feel good.” So what he told us is, “Doesn’t matter. Diabetics is just like that.” No choice. So gradually for too long we are not under any guidance, so…and I’m a sales rep, I personally, we need to work very hard.

Liz: Hm, hm.

MR. Aw: So, I followed up with the entertainment. So, from there, I think, due to all these entertainment, that cause the diabetic to be more deteriorated.

Liz: When you say entertainment, you mean all the food,—and all—

MR. Aw: Yes, yes. And work also, the pressure, also very stressful. So I see many doctors. Yes, but, the doctor did not do anything much at all. So that’s what I’m facing. Even up to date, today, the doctor just tell you, “It’s like that. No hope.” You have to stay—
Liz: Even today?

MR. Aw: Yes, they say you’ve to stay with it. That’s all. So I never accept such a word. I keep on looking for other alternatives.

Liz: Right.

MR. Aw: Those nutritious foods.

Liz: Who do you go see to get nutritional advice?

MR. Aw: Erh, it’s from friends. I have been involved in nutrition for the past eight years already. So it’s does help me.

Liz: Uh huh.

MR. Aw: It does help me.

Liz: What kind of nutritional---?

MR. Aw: Pollen.

Liz: Pollen, the--oh, okay. Do you find luck with that?

MR. Aw: Again? [Singlish for “pardon me”]

Liz: Do you have luck with the pollen? Do you find that it helps with your blood sugars more regular?

MR. Aw: Yes, yes, yes.

Liz: Wow, I’ll have to make note of that.

MR. Aw: Yes, so because of the—I just these two days, I tried of a fifth formula according to my [?]... So after taking the three formulas, there is a reaction why I get running nose, because of the reaction. It’s not I fall sick.

Liz: Oh, okay... okay.

MR. Aw: So I did not have to go and see a doctor.

Liz: That’s an allergic reaction to the pollen?

MR. Aw: No, not allergic. That’s the reaction where the doctor say, mine blood arteries clot.

Liz: Ya.
MR. Aw: But it doesn’t go through. So after taking all these foods, they help me to go through the blood clot.

Liz: The blood clot.

MR. Aw: Ya, to soften the blood arteries. So it does help. So I believe a lot of good nutrition helps. Normally, I don’t take much drugs.

(Mr. Aw, Transcript, February 14, 1996, pp. 9-11)

During this portion of the interview I did not understand the term “pollen” right away.

Afterwards I questioned his allergy-like symptoms and deduced them as probably due to the side effects of the pollen. I think that Mr. Aw did not understand my assuming his runny nose was a pollen side effect. He seemed to think about the situation from the perspective of pollen being responsible for certain intended therapeutic effects such as clot thinning. I chose not to debate the possibility of the multiple effects pollen might have on Mr. Aw’s body as this might have been perceived as my being critical to his worldview. These challenges associated with my understanding Singlish often precipitated relationship-building and interesting discussions.

My Chinese-speaking assistant was an office consultant who conducted the questionnaire/interview in one of a couple of Chinese dialects or Mandarin as appropriate. I was introduced to each unilingual person with diabetes and presented each with my card in the traditional manner. I spoke a few Mandarin phrases and spent most of my time observing and taking fieldnotes. My assistant did not transcribe these taped interviews but rather wrote a bulleted report. We subsequently had follow-up discussions about these Chinese interviews that I taped and transcribed.

The language challenges were complex. My Chinese-speaking assistant explained to me that certain words were too difficult for certain participants to understand (i.e. repeatedly needed defining as I had experienced with certain English people with diabetes). I regularly observed my Chinese-speaking assistant placing the often elderly people with diabetes at ease by explaining various questionnaire items in a relaxed and informal manner. Typically she would
read the item aloud and wait for a response. It was rare for these elderly individuals to simply select a particular item option as there lengthy discussions between herself and the participant as the question was explained or a story shared. I noted the body language of these individuals and found that his or her relationship with my Chinese speaking assistant became increasingly comfortable as in interview proceeded. For example,

Mrs. Goh was very animated and took a fair bit of time to go through the items....[My Chinese-speaking assistant] was basically reading the items and Mrs. Goh [would] chat for quite a while with very little prompting....[Their discussion was] very friendly, comfortable. This lady also looked like an old friend of [my Chinese-speaking assistant]. (Fieldnotes, May 15, 1996, pp.7-8)

It was not uncommon for physical ailments to be described in detail. I found my Chinese-speaking assistant to be highly attentive and sympathetic. She showed great interest in looking at Mr. Lau's sore on his foot.

When [Mr. Lau] was answering item #17 he took his slipper off to show a yellow-y dry patch on the bottom of his foot. [My Chinese-speaking assistant] looked at it sympathetically. She was great. (Fieldnotes, April 3, 1996, p.22)

My subsequent discussions with my Chinese-speaking assistant confirmed that many items had required clarification. I was told that most questions were eventually understood as long as participants were not rushed and were allowed to tell their story in their own way.

c. Challenge #2: Differing cultural perspectives

The second type of challenge due to differing cultural locations could not be remedied with alternate wordings or a Chinese-speaking interviewer. The assumptions inherent to my survey questions were Western in origin. I did not recognize the influence of my “natural attitude” on communication (Mannheim, 1936). Some refer to this as the influence of “common sense” assumptions. Ng explains that the term “commonsense” refers to people behaving in ways which they consider ordinary and have little or no consciousness of the implications or consequences of these acts (1995).
Airhihenbuwa (1995) points out that:

The use of language in any culture is designed to mirror the worldview of the culture. It is often suggested that African languages have limitations in their usage, but this is a myopic conclusion that uses Western standards to evaluate the lexical functions of all languages and their cultural relevancies (p. 15).

Regarding the research process, Cicourel (1964) writes that sociologists’

lack of methodological sophistication means that the decision procedures for categorizing social phenomena are buried in implicit common-sense assumptions about the actor, concrete persons, and the observer’s own views about everyday life. (p.21)

I did not want to assume a “Western-centric” position unproblematically and engage people with diabetes in discussion when it was evident that their interpretation of my questions differed from my intended meaning. I became increasingly sensitised to my own commonsense assumptions that were not held by my participants.

A typical example of this phenomenon occurred when the term “should” was used. The statements “My G.P. should know about the nature of my work (school)” or “It should be up to my diabetic specialist to decide what is best in treating my diabetes” were especially challenging to the unilingual Chinese people with diabetes. The notion of questioning the physician did not seem to be part of their world. I had expected that those individuals who did not question their physician’s authority would disagree with these statements. I had not anticipated that these items reflected an idea that was so foreign to certain people with diabetes that it, in fact, made no logical sense. That is, I did not consider that these individuals would house the oppressor.

Another illustration of my being unaware of my non-Singaporean worldview was evidenced by my not anticipating that the subtle difference between the statements “I feel in good health today” and “Generally speaking, I feel in good health” would be missed by many people with diabetes. My Chinese-speaking assistant reported that, especially the elderly,
unilingual Chinese participants repeatedly told her that these statements were repetitive. I did not question the erroneous commonsense assumption I had made. "Clearly, speaking a similar language does not guarantee communication" (Anderson, Blue, & Lau, 1991, p. 110). I thought that it would be "commonsense" that individuals could reflect upon their typical feelings of health and provide a generic index as opposed to feeling tired or having a flu on a particular day. From my perspective, this item is in contrast to a self-assessment of how they rate their health at that particular moment.

I did not appreciate the source of the problem until I became aware that Eastern cultures traditionally do not view health in the reductionistic, scientific fashion of the West. My relaxed interview format allowed for such discrepancies in health conceptualization to become apparent to me. I would have "collected" data reduced into categories that did not reflect their original meaning had I maintained a detached approach to my questionnaire. Instead, I became increasingly aware of potential commonsense, Western assumptions embedded within my inquiry.

d. **Challenge #3: Questionnaire rules**

The third type of methodological challenge was with regard to those people with diabetes who were not aware, or could not remember, the rules associated with completing a closed-ended type of questionnaire. I had intended the second piloting of my questionnaire to be essentially structured interviews as I assisted people with diabetes with the survey. However, participants would not stay focused upon the selection of provided options. Instead, most people with diabetes (and many physicians) became animated and eager to tell their stories from their perspectives. The questionnaire, or structured interview task, often became secondary, something to "get back to" once their train of thought was finished. I did not discourage this story telling. These often hour-long, survey narratives were taped and transcribed.
I had anticipated that this familiar postpositivistic research instrument would assist in my being perceived as conducting valid and reliable research within the medical community. I had not expected it to be a way of saving participants' face when they may have inadvertently shared more of their personal experiences than they anticipated.

For example, a DSGS member who participated in both pilots was clearly distressed with her relationship with her doctor. She seemed to have 'slipped' and became emotional in her sharing her story with me. The 'job' of providing feedback regarding the improvement of my survey became a method of her saving face. This professional clearly knew the rules of completing, or critiquing, a questionnaire item, yet 'burst forth' with her own frustrations. The requirement of piloting the survey provided a safe venue for her to recover her composure.

Many items became springboards for discussion. Instead of my conducting a structured interview in a systematic fashion, I adapted to the field and allowed the survey questions to become a tool to stimulate discussion. Within a traditional scholarly framework, the 'job' of piloting the questionnaire allowed me the methodological leeway to encourage these taped narratives. There was something seriously wrong with my idea of administering a questionnaire in Singapore (rather than some deficiency in my research skills). It was with this sense of un-ease that, in the Fall of 1996, I began the task of organizing my quantitative data from the second pilot to make plans for the future.

V. Layer/Phase 7a: Period of Postpositivistic Organization of the "Data" (Fall 1996-Fall 1997)

1. Analyzing the second pilot study data

Figure 9 is a summary of how I spent a year organizing and analyzing the quantitative data collected during the questionnaire/interview part of period 6. This was also the time that the
Figure 9
Layer/Phase 7a: Quantitative organization of the "data"
Fall 1996 - Fall 1997

questionnaire type / (# of participants)

Private (9 English
4 Chinese)  
Polyclinic (4 English
6 Chinese)

Private (6 English)  
Polyclinic (3 English)

People with Diabetes

quantitative data

entered onto SPSS-PC

indexed to theoretical categories in "Nudist"

unstructured interviews + focus groups(2)

transcripts

multiple informal discussions

fieldnotes

qualitative data
qualitative data that I obtained while piloting my questionnaires was analyzed. I was simultaneously increasing my participant observation activities within the DSGS. In the process, my second survey pilot had become a small survey in itself. I had questionnaire/semi-structured interviews with six private GPs and three PC doctors. In addition, I had unstructured interviews that were taped and transcribed with some of the above physicians and other doctors who did not complete the questionnaire. I had numerous informal discussions with many physicians where fieldnotes were recorded. Nine English-speaking private GP patients, four Chinese-speaking private GP patients, four English-speaking PC patients and six Chinese-speaking PC patients participated in the questionnaire/interview. These more formal activities were between 25 and 90 minutes.

The patients, especially the unilingual Chinese and elderly patients, were the most generous with their time. Physicians did not appear rushed, although questionnaire/interviews tended to be regularly interrupted. All of these questionnaire/interview sessions were taped. The English ones were transcribed and the Chinese ones were summarized in English after my assistant listened to the tape. The quantitative data was originally intended to form the foundation of my inquiry. This was to have been part of my triangulation of methods within a grounded theory approach. The follow-up in-depth interviews were to have provided the detailed data upon which I would construct a theory that best ‘explained’ the relationship between doctors and people with diabetes.

My quantitative analyses involved learning (and sometimes re-learning) various software such as Excel’s spreadsheet management and SPSS-PC for the statistical analyses. I also became familiar with a qualitative data software called Nudist by attending a workshop in Melbourne, Australia sponsored by its developers at La Trobe University. The purpose of Nudist is to hierarchically organize various meaningful portions of data, reflective memos and any other resources that would facilitate the generation of theory. I indexed the sections of my transcripts
and fieldnotes that I considered representative of the theoretical categories that I was systematically noting from the multiple sources of data. I hired a Canadian librarian friend who was living in Singapore to assist with my data entry in January 1997.

In addition to handling the vast quantities of qualitative data, I also used Nudist to compare the quantitative with the qualitative findings by indexing the closed-ended survey choices. I indexed the quantitative data, that is, created separate nodes for each item number and indexed participants' responses to these nodes, within the Nudist program. In addition, my survey data was entered onto an Excel spreadsheet and subsequently imported into SPSS-PC. I intended to utilize the quantitative data later on in a qualitative manner. I stayed close to the original data.\textsuperscript{23} The contextual details of the participants' stories, both observed and reported, were important in explaining relationships. To this end, I used Nudist as a sophisticated filing instrument (that I am unsure was worth the expense and effort).

I had intended to revise the survey/interview for the upcoming study and to begin my theoretical sampling along the dimensions that I had constructed from my two pilot experiences. Throughout the process of entering data for a basic quantitative analysis, I was keenly aware of many shortfalls (from a positivistic point of view) of the execution of my second pilot questionnaire. I put the term 'questionnaire' in inverted commas, because I see that in retrospect I had facilitated unstandardized questionnaire activities in the field during my pilot phase. I wrestled with my worries of how I would quickly finish what I had originally intended to be a short second pilot activity and move on to the 'real' study. It took many months of effort before I recognized that it was a misnomer to call what I had done in administering the survey methodological "errors." I had responded in ways that resonated with institutional ethnography. I had only to see this for myself. As I worked at making the best sense of the data I realized that I was reluctant to separate the theoretically substantive subtexts of participants' lives from the contexts of their patient-doctor stories. My gestalt-like flipping between the experiences
associated with not being able to ‘design’ a better questionnaire and the experience of knowing
that I had completed the ‘data collection’ part of my inquiry finally reached a critical juncture.

2. **Awareness of breaking the ‘rules’**

In an ongoing fashion I had been considering how to best revise the questionnaire and
associated methods given the ‘feedback’ of the two pilot studies. The challenge of constructing a
defensible argument regarding my methodological adaptations was formidable. I had, in the two
pilots, broken too many scientifically-based rules to present my work as positivistic—such as the
holding of survey administration constant and asking my questions in a standardized (or
preferably participant-read) fashion. Further, I had solicited feedback regarding the adaptation of
my research methodology within the more flexible piloting phases of the questionnaires so that
eventually I found myself in the paradoxical position of having to choose between university-
sanctioned rules of good survey research and the narratives that had been shared with me over
the past three years. I did not initially pay heed to my bifurcated consciousness as I did not feel
empowered to question the ruling relations of academe. As a result of this, I was unsure as to the
best way to proceed. Eventually, my field experiences facilitated my epistemological shift away
from my original postpositivistic orientation.

I knew that the inquiry would not be as meaningful if I continued with my planned
survey. I agreed with Cicourel’s (1964) critique of such surveys:

> If the “rules” governing the use of language to describe objects and events in
everyday life and in sociological discourse are unclear, then the assignment of
numerals or numbers to the properties of objects and events according to some
relatively congruent set of rules will also reflect a lack of clarity. (p. 15)

Cicourel (1964) further states:

> The difficulties of taking language and cultural meanings for granted are
obscured but not eliminated when a measurement system is arbitrarily imposed
on the “data” into which are built language usages, implicit and explicit
grammatical rules and cultural meaning, whose correspondence with the measurement properties is unknown (p. 24).

Cicourel (1964) argues that cultural meanings are often taken as “self-evident” (p. 108) and that “different types of responses...[reflect the] inner attitudinal states of the actor” (p. 108). The difficulties in quantitative measurement that I experienced would also have been present in a Western environment, but were exacerbated in a cross-cultural setting.

Most problematic from a positivistic point of view, my research ‘subjects’ could not be considered representative. These individuals were colleagues or connected to my mentor in some fashion. The people with diabetes were selected by these participating physicians. For this reason, I suspect that they might characterize some of the ‘best case scenarios’ of relations between doctors and people with diabetes in Singapore.

I had, as did my Chinese speaking assistant, genuinely attempted to provide as consistent a reading of the questionnaire with our prompts regarding the rules of survey-taking being as neutral as possible. Many participants, especially unilingual Chinese and working class individuals, seemed to regard the survey as a prop of some kind to stimulate their sharing personal experiences with their chronic condition and encounters within the health care environment. Westernized people with diabetes and physicians, although clear regarding the nature of surveys, also seemed comfortable sharing personal opinions and experiences.

Collection of the quantitative data was easily completed while also recording participants’ narratives. Although the qualitative data was from varied and multiple sources and rich in detail, I knew my survey data was unacceptable from a positivistic point of view. Although I was increasingly cognizant of the value of my interviews, I spent an inordinate amount of time labouring the quantitative aspect of my analyses.
3. **Epistemological shift**

By early spring of 1997, I began to assimilate some of the suggestions from my supervisor and committee members that the quantitative instrument was letting me down in the field and not the reverse. It was with a profound epistemological conviction that I became strong enough to reject this postpositivistic aspect of my inquiry and 'let go' of the quantitative aspect of my research. I chose to continue with my participant observations and redoubled my efforts at speaking with DSGS members during the last six months of our stay in Singapore.24

After the time and effort required to enter all of the quantitative data from the pilot study onto the computer, it was difficult for me to stop focussing upon this aspect of my research. It had been costly in terms of time, effort and money. It was a learning experience, however, that I do not regret and that will not be wasted.

At the same time, it was a liberating feeling to embrace this epistemological shift from postpositivism to one that was more focused upon the qualitative data. I was no longer searching for a universal theory. In a grounded theory fashion, I intended to make more detailed use of the qualitative data from which I could explain relationships between doctors and people with diabetes. I planned to rectify any theoretical sampling gaps by arranging follow-up interviews and organizing two focus groups at the DSGS. My analyses thus far were socially critical in nature, though I had not, as yet, read any of Dorothy Smith’s work.

VI. Layer/Phase 7b: Participant Observations of the DSGS from a Critical Perspective (Fall 1996/Fall 1997)

Figure 10 is a summary of how I began to contextualize my participant observations of the DSGS. During the fall of 1996, I was still unsure where my participant observation fieldnotes would fit within my inquiry but reconciled the research method with my survey by asserting that I was gaining insights regarding life with diabetes. I was indeed learning more about diabetic
Figure 10
Layer/Phase 7b: Participant observations of the DSGS increasingly from a socially critical perspective (Fall 1996 - Fall 1997)

- Librarian friend
- Support group meetings
- Fund raising
- Hospital visits
- Librarian friend & family
- Informal discussions
- Parties
- Open-ended interviews
- 3-day family retreats
- 2 focus groups
- Participant observations at DSGS

- Fueling epistemological shift to institutional ethnography
- Explicating social relations among DSGS members
- Explicating DSGS as a social group within Singapore
- Noting the relations of ruling
- Fieldnotes
- Interview transcripts

(Noting the relations of ruling)
regimens and keeping up my contacts in the field. I could also justify these activities by the possibility that my membership within the support group might help facilitate future participant recruiting for my study. I held on to my volunteer and 'researcher' role. I was increasingly aware that I was learning things of greater value. I was engaging in two parallel paths of inquiry, each with their own epistemologies and corresponding methodological approaches.

My experiences during my final year as a participant observer of the DSGS continued to include formal open-ended interviews and informal discussions with my impressions recorded in field notes later that evening. I increased my attendance at support group meetings, and parties that took place in members' homes, including my own, as well as at a meeting room belonging to the parent umbrella social service group.

I participated, with my children, during one DSGS fund-raiser asking for donations at a downtown location. I visited a couple of members who were in hospital due to diabetic complications and was visited by some when I was hospitalized for my own health condition. My librarian assistant also joined the DSGS during my last eight months in Singapore and was warmly welcomed. She facilitated my fieldnote writing and was a valued resource in my discerning the various and complex social relations between DSGS members as well as the physician-patient with diabetes groups.

My family and I attended our third retreat in a nearby Malaysian resort. My librarian assistant and her family accompanied us. I held two focus groups in the home of a friend on two consecutive nights in October 1997 after my family and I had moved to Hong Kong. These activities included core group members. I purposefully did not include any DSGS staff to help ensure members' candidness. These core members were increasingly active within various subspecialty of support groups that had evolved by 1997. Some of these individuals at the focus groups were regular volunteers who were trained support group facilitators; others were members who had been active for over a year. The two focus groups in total had 11 participants
and included two non-physician support group members. I was unsuccessful at organizing a focus group of DSGS members who had not been to a meeting or an event for over a year.

I began to consciously recognize my skills at adapting to the field. I was acquiring data that permitted my problematizing the everyday experiences that were recounted to me. It was not until my exposure to Smith’s (1987a) proposal for institutional ethnography that I realized that the organization of my qualitative data best fit socially critical research objectives. This took place in the Spring of 1998.

My thesis became two studies. The first, as described throughout this appendix, is an institutional ethnography demonstrating how a postpostivistically-designed survey did not work in Singapore. The result of my research disjunction is a reorganization of the epistemological conceptualization of the inquiry. My institutional ethnography drew on all the varied sources of information I had gathered in Singapore.

The ‘second’ study, which is the body of the thesis, focuses on the information and insights gained from a critical perspective. I explicate, as an embodied investigator, the phenomenon of the DSGS as it relates to the larger diabetic health community. In the words of Dorothy Smith (1987b):

The work of the sociologist is to develop a sociology of explicating for members of the society the social organization of their experienced world.... Rather than explaining behavior we begin from where people are in the world, explaining the social relations of the society of which we are a part, explaining an organization that is not fully present in any one individual’s everyday experience. ...The everyday world is that world we experience directly. It is the world in which we are located physically and socially. (p. 89)

My inquiry shifted away from the construction of an inductive explanatory theory of people with diabetes and their relations with physicians in Singapore. Rather, my purpose became an explication of the social relations between physicians and their patients with diabetes. These are contextualized within Singaporean society as described in Chapter Four. In addition, within this
conceptual framework, the DSGS is explicated in a similar fashion. My analysis is centred on how relations of ruling are reproduced within these local relationships in Singapore.

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1 Original author’s emphasis.
2 Anna frequently came home from school upset about not ‘fitting in.’ It was common for her, upon returning from her British school, to slam the door and complain about various schoolyard misunderstandings such as: “I am never going back there — they laughed when I said I bought new “pants” yesterday. They thought I meant underwear!” This was a stressful period for my grade 5 girl.
3 My neurological condition worsened in Singapore. I was regularly experiencing balance difficulties. At this time I was seeing a number of physicians, and following up on suggested biomedical testing. I was told by an endocrinologist to maintain a strict diet as I was hypoglycaemic and that low blood glucose levels might be triggering my neurological condition.
4 Original author’s emphasis.
5 Original author’s emphasis.
6 Original author’s emphasis.
7 Again, in order to preserve anonymity I do not provide individual code names beside any information that I believe might assist in those reading this thesis realizing their identity.
8 I tried to adapt to a kind of ‘Singapore time’ and to not take it personally, or find it rude, when people were late for appointments, meetings, movies, etc. After all, the government even had an advertising campaign outlining why Singaporeans should be courteous and be on time for weddings!
9 Original author’s emphasis.
10 Others referred to my local mentor by the familiar ‘Prof’ title. I called him ‘Doctor’ as it took a couple of years for me to notice the reason for this social difference.
11 I discovered Singaporeans used the phrase “doctor hopping” as well as the more familiar “doctor shopping” expression.
12 As previously noted, due to my own and the chronic conditions of my children, and maintenance of a health regimen and numerous doctors’ appointments, I had personally accessed the Singaporean primary health care system frequently.
13 I should say ‘official relationship,’ as I still maintain contact with some DSGS members.
14 I have already noted that this term, “compliance” in the biomedical literature is doctor-centric.
15 In the year and a half of my living in Singapore I had quickly learned that I would be assumed to be American and that it was in my best interest to point out that I was from Canada. Some local people had told me that I was loud “like an American” but that I was not as “aggressive.” I had heard a similar type of feedback when my family and I lived in Brussels, Belgium in the late 1980’s.
16 Of course, as Westerners we often found ourselves waiting for the cheque after a restaurant meal! Once we were aware of this practice we knew to ask for it. As an American Club member I frequently noted frustrated members searching for the personnel who served them so that they might pay and leave. The coffee shop billing changed their procedure to bridge these differing social expectations. The bill was brought with the meal and left for the member to sign at his or her leisure.
17 This local English phraseology is not to be confused with the working class dialect of Singlish.
18 For example, item #25 in the Private G.P. Practice version (Appendix H) reads: In the past one year, when you go to a private G.P. clinic is it the same one? __all of the time; __most of the time etc; whereas item #25 in the Visit to Polyclinic Doctor version reads: In the past one year, when you go to the polyclinic is it the same one? __all of the time; __most of the time? et cetera. In addition, this dual type of phrasing reflected the reality that people with diabetes at polyclinics do not often see the same doctor.
19 To this end, I did not consider my being introduced to many people with diabetes visiting a particular private clinic for the first time. Physicians would most likely not become aware of these potential participants’ diabetic status until the actual consultation, that is, after the patients’ waiting room time had passed. I included this third ‘PWD’ version as an option in the event that I was fortunate enough to meet people who agreed to stay after their consultation and allow me to read aloud the survey in a structured interview fashion.
20 Question number 15 is an example of the slight differences between questionnaire type: Approximately how many patients do you see in a typical day at your private clinic? __less than 10; __between 10 and 19 etc. (Appendix P) compared with Approximately how many patients do you see at the polyclinic during a typical day? (Appendix Q) __less than 10; between 10 and 19 etc. Again, the purpose of my producing two questionnaire types was to simplify the complexity of choices within the items.
21. This quality of "predictability" is an important feature of positivism and postpositivistic epistemology. It is not one inherent to critical theory.


23. This included regularly listening and 're-listening' to the tapes of the interviews when walking my dog. In this way I was not able to take notes or restrict my perceptions of their stories until I was home. I kept the contexts of my experiences of their stories as 'whole' as I could in a critical theory fashion. During this same time period, I generated the theoretical dimensions that might best explain the dynamics of the relationship between doctors and people with diabetes.

24. After the death of a dear friend and work colleague, my husband, was transferred during the Fall of 1996 to Hong Kong as a result of a corporate reorganization. The family and I joined him that August with my 'commuting' to Singapore for two focus groups (Fall 1997).
Objective

To provide a detailed description of the relationship between General Practitioners in the private sector and the Primary Health Care Doctor in the polyclinics and their patients with the chronic disorder of diabetes. The purpose of this research, based on both qualitative and quantitative data, is to provide a model of the nature of the doctor-patient relationship in Singapore, specifically focusing on the extent to which patient autonomy is encouraged in diabetic care. The research will explore the various communication, education and psychosocial aspects of these relationships for diabetic patients. A model of doctor-patient interactions will be constructed based upon the themes emerging from the data itself. This Ph.D. dissertation is not an evaluative study. Rather, its objective is to systematically isolate and describe the parameters which make-up this particular doctor-patient relationship.

Methodology

The proposed study utilises a combination of both quantitative and qualitative approaches. A three tiered approach is suggested.

Level 1. Review of the relevant literature:

The literature review will address the following three general areas of research: The first will provide a general overview of the clinical aspects of diabetes. The second type of literature will pertain to the epidemiological patterns of diabetes in Singapore and how these patterns relate to world statistics. The Ministry of Health's preliminary reports from the 1992 National Health Survey is one such document which will be examined. The third general literature base which will be examined will be a review of any research on the doctor-patient relationship with particular attention to studies which examine the patient with diabetes in particular. (Preliminary medline searches from 1990 onwards have indicated that there has been no such study completed in Singapore and only two worldwide.) The purpose of the literature review is to provide information on the context within which the research is done as well as a pragmatic rationale for questions to be directed to physicians and patients.

Level 2. Questionnaires:

Two questionnaires were constructed for the purpose of quantitatively describing the characteristics, as well as the opinions and experiences, of 1) the patients with diabetes and 2) their primary care physicians. A minimum of 50 questionnaires will be distributed. Preliminary key informant interview data has indicated that the patient questionnaires should be read aloud by the researcher to the participant in
APPENDIX B

an interview-like fashion. It has also been decided to translate the questionnaire into Chinese as it was learned that many of the elderly patients with diabetes would not be functional in English. The patient questionnaire has been adapted into three similarly-worded formats with one type chosen for the diabetic patients on a return visit to their GP in a private clinic; the second type is for a visit to a particular GP for the first time in a private clinic and the final type is for the polyclinic patient. Similarly the physician's questionnaire has been prepared in two versions: one for the GP practising in the private sector and the second for the primary health care doctor practising in a polyclinic.

Level 3. Selected Interviews:
From the 50 previous questionnaire participants, a minimum of 10 will be selected to engage in a half to one hour interview. The physicians and their patients with diabetes will be "theoretically sampled" according to the trends or regularities observed within Level 2 of this study. Interview data analysis will be ongoing with the emerging theory explaining this doctor-patient relationship being the basis for subsequent sampling choices.

Data Analysis:
The quantitative and qualitative approaches within this research each merit a different approach to data analysis. The relevant academic literature and Singaporean health surveys will be summarised. These references will provide a rationale and context for this research design.

The results from the questionnaire, or Level 2, will be organised using such descriptive statistics such as frequency counts. Qualitative data housed in both Level 2 and 3 of this research will be approached from a perspective based upon "Grounded Theory" by Glaser and Strauss (1967). In this way, theorisation will not be the result of the investigator's preconceived hypotheses but rather are "discovered" through induction as they are "grounded" in the data (Polit & Hungler, 1989). The participants which will be selected as interview candidates in Level 3 will be an example of the "theoretical sampling" approach advocated by Glaser and Strauss (1967).

References


APPENDIX C

Faculty of Pharmacy
University of Toronto

September 19, 1994

Dear Physician:

I am writing to you in my capacity as graduate advisor for Elizabeth Crowe Joong, M.A., to introduce her to you. Elizabeth, who is currently residing in Singapore, is a Ph.D. candidate under my supervision; Ruth Hayhoe, Ph.D., Chair of the Higher Education Department at the Ontario Institute for Studies in Education is also on her committee. Elizabeth's doctoral dissertation, entitled "Relations Between Family Physicians and their Chronically-Ill Patients", aims to provide a comprehensive description of the relationship between primary care physicians practising in Singapore and their patients with the chronic disorder of diabetes. Elizabeth has successfully defended this thesis proposal to her committee, passed her comprehensive examinations and has completed the required coursework for her doctorate. She is now beginning work on her thesis. I believe her thesis research to be both important and timely, with the results having a pragmatic application in Singapore, as well as being relevant to a multicultural nation such as Canada.

Elizabeth has had many years of experience in health care research and a number of notable academic achievements. Her masters' thesis was supported by a $7500 scholarship by the Province of Quebec's Fonds pour la Formation de Chercheurs et l'Aide à la Recherche. After completing her master's degree, she worked full-time with the government-sponsored project, "Educating Future Physicians for Ontario" (EFPO) and was the sole author of their 1992 working paper #6 entitled, "Chronically-Ill and Disabled People: Some Views on their Expectations of Physicians". Elizabeth's writing skills and expertise in medical education issues are illustrated in her recently-published article, "Evidence of the Effectiveness of a Problem-Based Learning Approach in the Medical Curriculum", Higher Education Group Annual, Toronto, Canada: Ontario Institute for Studies in Education Press, 1993: 22-33.

As she works on her thesis research, I am sure that Elizabeth will impress you with her research skills, particularly her abilities as a sensitive communicator. I respectfully request that you extend to her your time and interest in this important diabetic research.

Sincerely,

[Signature]

Linda J. Muzzin, Ph.D.
Associate Professor
Faculty of Pharmacy
& Dept. of Behavioural Science,
Faculty of Medicine
University of Toronto

19 Russell Street Toronto Ontario Canada M5S 2S2 Telephone (416) 978-2869/2873 Fax (416) 978-8511
Ref: Department of Community, Occupational and Family Medicine

20th February 1996

To:

Whom it may concern,

Dear Dr,

RE: INTRODUCTION LETTER FOR MRS JOONG ELIZABETH CROWE

This is to introduce Mrs Joong Elizabeth Crowe who is a Ph.D. candidate from the University of Toronto and she is doing a dissertation on Doctor-Patient Relationship in Diabetes Mellitus. She has been staying in Singapore for the last 2 and half years.

Her dissertation consists of a descriptive research on the doctor-patient relationship in the context of Singapore. She has discussed her study design with me and I think her study would give us some good ideas about the relationship that exist between doctors and their patients in this important medical condition.

I will be grateful if you could assist her in arranging for cases for her to interview as well participating in the interview on the doctor’s ideas in the doctor-patient relationship. I will leave her to elaborate her study to you.

Thank you for your support of her study.

With best regards,

Yours sincerely,

My Mentor
Doctor-Patient Relationship Study
Letter of Introduction to the Patient with Diabetes

Research has shown that the quality of the doctor-patient relationship is an important feature to the management of diabetes. The treatment of this chronic disorder is one which requires the good understanding and cooperation of the patient. The expectations and needs of the patient with diabetes is also important in the best management of diabetes.

You have been asked as a patient with diabetes to participate in my Ph.D. research thesis. I am a University of Toronto doctoral student pursuing a Medical Education topic in the Faculty of Higher Education who has been living in Singapore for over two years. I am being supervised by Dr. Linda Muzzin, a Medical Sociologist, in Toronto. Locally, my mentor [My Mentor] who is an Associate Professor at the National University Of Singapore’s Community, Occupational and Family Medicine.

My study has never been done in Singapore. I have therefore chosen to look at Singaporeans who have diabetes and their relationship with their GPs (or Polyclinic doctors). I have learned that patient education is a critical feature in treating this increasingly common disorder. My objective is to “paint” a picture of the different types of this kind of doctor-patient relationship. By sharing your experiences with me I am better able to describe this relationship accurately.

I must stress that this research is not a study which evaluates the quality of a doctor-patient relationship. It is a descriptive study. In other words the purpose of this research is to describe, and not to judge, this important doctor-patient relationship.

I sincerely look forward to having you participate and help with this study. The results of this research will definitely go on to help doctors and patients to achieve the best possible care.

Thanks for participating!

Sincerely,

Elizabeth Crowe Joong
Ph.D. Candidate
University of Toronto, Canada.
APPENDIX F

Elizabeth Crowe Joong, Ph.D Candidate
University of Toronto

医生-病人关系研究
致糖尿病患者的简介信

研究显示医生-病人关系的质量是糖尿病管理的重要因素。此种慢性病的
治疗需要病人很好的理解与合作。糖尿病患者的期望与需要糖尿病的最佳管理
也是十分重要的。

您作为糖尿病患者被邀请参与我的博士论文研究。我是多伦多大学高等
教育学院的博士研究生，医疗教育是我的研究方向，我在新加坡已住了两年，
我的导师是 Linda Muzzin 博士，他是多伦多的医疗社会学家，我在新加坡的导师
是[My Mentor] 博士，他是新加坡国立大学社区，职业与家庭医疗方面的副
教授。

我的研究以前在新加坡从未有人作过。因此，我选择考察新加坡糖尿病
患者及他们与私人医生(或综合医院医生)的关系。我知道病人的教育对治疗这
种越来越普遍的疾病是一个关键因素。我的目标是描述这种医生-病人关系的
不同类型。通过分享您的经验，我更精确地描述这种关系。

必须强调，此研究不是评估医生-病人关系的质量，这是一个描述性研
究，换句话说，此研究的目的是描述而不是判断这一重要的医生-病人关系。

我真诚地希望您能参与并为此研究提供帮助。此研究的结果无疑会帮助
医生及病人达到最好的治疗效果。

多谢您的参与。

您的真诚的，

Elizabeth Crowe Joong
博士研究生
加拿大多伦多大学
It is a requirement in research that we have your written consent. It is, therefore, important that you are clear about your role as a participant in this research study. (please refer to my letter of introduction) All of the information provided by you in this study will be regarded as strictly confidential.

Please read and sign the following:

- I agree to being interviewed while I am waiting for my appointment with my doctor. I understand that this means that the researcher will read a questionnaire to me and record my answers in writing.
- I understand that anything I say will be considered confidential and that my name, as well as the name of my doctor, will never be used in any report. I also understand that my doctor will not have access to my interview responses.
- I understand that I am being asked to participate and may withdraw from this study at any time. I have been assured that my medical care will not suffer as a result of my declining to participate in this study.

(please sign here)                                           (date)

please print name, address and contact number:

Principal Investigator:
Elizabeth Crowe Joong
Ph.D. Candidate
University of Toronto
2B Ardmore Park 07-01
Singapore 259949
Tel: 735-1165
Fax: 735-1167
医生-病人关系研究

受访病人同意书

研究工作需要征得您书面的同意。因此，您清楚知道您在此研究中作为参与者所扮演的角色是非常重要的（请参阅简介信）。

您在此研究中提供的所有情况将被视为绝对机密。

请阅读下文并签字：

• 我同意在等待我的医生看病时接受访问。我明白这意味着研究者向我阅读问题并记录我的回答。

• 我明白我说的任何东西均被视为机密。我及我医生的名字不会用于报告中。我也明白我的医生不会看到我的访问回答。

• 我明白虽然我被邀请参加，但是我也可以随时退出此研究。我已得到肯定，我的医疗照顾不会因为加入此研究而受到损害。

（签字）

（日期）

请留下姓名地址及联络电话：

主要调查者：

Elizabeth Crowe Joong
博士研究生
多伦多大学
2B Ardmore Park 07-01
Singapore 259949
电话：735-1165
传真：735-1167
Pilot Questionnaire for Persons with Diabetes:
Private G.P. Practice

I. Background Information

1. Sex: □ male □ female

2. Age: □ 10-19 years □ 20-29 years
   □ 30-39 years □ 40-49 years
   □ 50-59 years □ 60-69 years
   □ 70 years and older

3. Nationality: □ Singaporean
   □ other (please specify ____________)

4. Ethnic Group: □ Chinese □ Malay □ Indian
   □ Caucasian □ other (please specify ____________)

5. Languages spoken at home (tick off as many as apply to you):
   □ Mandarin □ Chinese Dialect □ Tamil
   □ Malay □ English □ Indian
   □ other (please specify ____________)

6. Marital status: □ single □ married
   □ separated /divorced □ widow(er)

7. Do you live alone? □ yes □ no

8. How many family members, including relatives, live with you? ___

9. How many friends, if any, live with you? ___

10. Do you have a live-in maid? □ yes □ no

11. What is your occupation? ____________

12. Do you live in a HDB flat? □ yes □ no

   If yes, number of rooms: ____ (please specify)

13. If no, do you live in a:
   □ condominium? □ bungalow?
   □ semi-detached? □ terrace home?
   □ other? (please specify ____________)

14. The place you are staying in is:
   □ rented □ owned by ____________
APPENDIX I

15. What is your highest level of education?
   □ tertiary (distance learning or university or polytechnic)
   □ some tertiary education
   □ secondary school
   □ primary school
   □ other (please specify: ____________________)

II. Medical History

16. When was your diabetes first diagnosed? ____________
   (please specify the month and year or the best you can remember)

17. How is your diabetes treated now? (tick off as many as apply to you):
   □ regular exercise
   □ a special diet
   □ taking pills
   □ injecting insulin
   □ other (please specify ____________________)

18. Just before you were diagnosed with diabetes did you feel: (chose one)
   □ quite ill
   □ not quite well
   □ well

19. Who first diagnosed your diabetes? (chose one):
   □ a polyclinic doctor
   □ my G.P.
   □ a specialist referred to by my G.P.
   □ a specialist I referred myself to
   □ a hospital physician/specialist
   □ a nurse
   □ a traditional Chinese doctor
   □ other (please specify ____________________)

20. About how long were you unwell before your diagnosis?
   ____ days ____ months ____ years

21. In the past one year, about how many times have you seen a G.P. (or regular doctor) in the:
   ____ polyclinic?
   ____ private G.P. clinic?

22. Of these G.P. (or regular doctor) visits about what percentage were for diabetic care?
   ____ % in the polyclinic
   ____ % in the private G.P. clinic

23. Since your diabetes was diagnosed have you switched from using private G.P. clinics to polyclinics?
   □ yes □ no □ sometimes
APPENDIX I

If "yes" (or "sometimes"), did you switch because the polyclinics (tick as many as apply to you):
☐ were less expensive?
☐ provided better care?
☐ other (please specify: ____________________________)

24. Since you were diagnosed with diabetes have you switched from using polyclinics to private G.P. clinics?
☐ yes ☐ no ☐ sometimes

If "yes" (or "sometimes"), did you switch because the private G.P. clinics (tick as many as apply to you):
☐ provided better care?
☐ had shorter waiting hours than the polyclinics?
☐ other (please specify: ____________________________)

25. In the past one year, when you go to a private G.P. clinic is it the same one?
☐ all of the time
☐ most of the time
☐ some of the time
☐ rarely
☐ never

26. In the past year, when you go to a private G.P. clinic do you try to see the same G.P.?
☐ all of the time
☐ most of the time
☐ some of the time
☐ rarely
☐ never

27. In the past one year, about how many different private G.P.s have you seen? ________ (please specify how many)

28. Do other members of your family go to your present G.P.?
☐ yes ☐ no

If yes, who?  ☐ spouse (how many: ___)
☐ children (how many: ___)
☐ other relatives (how many: ___)

29. Why are you visiting your G.P. today? (tick off as many as apply to you):
☐ regular diabetic check-up
☐ to pick up diabetic medications
☐ feeling unwell
☐ need "well" medical attention, for example a Hepatitis injection
☐ other (please specify: ____________________________)
APPENDIX I

30. Do you usually go to a private G.P. clinic instead of a private diabetic specialist clinic because the visits are cheaper?
   □ yes □ sometimes □ no □ don’t know

31. About how often in the past one year have you attended a diabetic specialist clinic? _______ times
   If you did attend a diabetic specialist clinic was this clinic:
   □ a private clinic or □ a public clinic?
   Where? ________________________________

32. Are you a member of the Diabetic Society of Singapore?
   □ yes □ no □ used to be (but not now)

For the following statements circle the number which best describes how you feel:

1 - if you strongly agree
2 - if you simply agree
3 - if you have no opinion
4 - if you simply disagree
5 - if you strongly disagree
NA - (not applicable) if the question does not apply to you

Living With Diabetes

33. Many of my colleagues at work (or school) know that I have diabetes.
   1 2 3 4 5 NA

34. I do not mind that my work (or school) colleagues know that I have diabetes.
   1 2 3 4 5 NA

35. Diabetes is a nuisance at work (or school).
   1 2 3 4 5 NA

36. My immediate family members know that I have diabetes.
   1 2 3 4 5 NA

37. Many of my relatives know that I have diabetes.
   1 2 3 4 5 NA

38. Diabetes is an incurable illness.
   1 2 3 4 5 NA

39. Diabetes is an accepted part of my life.
   1 2 3 4 5 NA

40. It is up to me to learn about diabetes.
   1 2 3 4 5 NA

41. It is up to me to learn about what I can do to control, or lower, my blood sugars.
   1 2 3 4 5 NA

42. I do not usually tell my friends that I have diabetes.
   1 2 3 4 5 NA

43. I feel in good health today.
   1 2 3 4 5 NA

44. Generally speaking, I feel in good health.
   1 2 3 4 5 NA
APPENDIX I

45. I usually do not mind the discipline required to keep to my diabetic diet.
   1 2 3 4 5 NA

46. I believe that if I look after my diabetes today I will improve my chances for good health in the future.
   1 2 3 4 5 NA

47. Diabetes is a major source of stress in my life.
   1 2 3 4 5 NA

48. I often talk about my diabetes with my family.
   1 2 3 4 5 NA

49. I often talk about my diabetes with my friends.
   1 2 3 4 5 NA

Relationship With My G.P.

50. It should be up to my G.P. to decide what is best in treating my diabetes.
    1 2 3 4 5 NA

51. It should be up to my diabetic specialist to decide what is best in treating my diabetes.
    1 2 3 4 5 NA

52. My G.P. knows how difficult (or easy) it is for me to live with diabetes.
    1 2 3 4 5 NA

53. My G.P. should know about the nature of my work (school)
    1 2 3 4 5 NA

54. My G.P. knows about the nature of my work (school).
    1 2 3 4 5 NA

55. I would tell my G.P. more about my personal life if only there were more time during our appointments.
    1 2 3 4 5 NA

56. It is important that my G.P. knows about my personal life.
    1 2 3 4 5 NA

57. I think my G.P.'s only job is to prescribe medicine.
    1 2 3 4 5 NA

58. I think my G.P.'s job should include giving me advice on my eating habits.
    1 2 3 4 5 NA

59. I think my G.P.'s job should include giving me advice on my exercise habits.
    1 2 3 4 5 NA

60. I think my G.P.'s job should include giving me advice on my personal life.
    1 2 3 4 5 NA

61. My G.P. will scold me when it is obvious that I have not been eating correctly.
    1 2 3 4 5 NA

62. My G.P. will scold me when it is obvious that I have not been exercising regularly.
    1 2 3 4 5 NA

63. My G.P.'s job is to look after my general health needs only, for example a sore throat, and not my diabetes.
    1 2 3 4 5 NA
APPENDIX I

64. I often feel rushed for time in my G.P.'s consulting room.
   1 2 3 4 5  NA

65. It took too long for my diabetes to be diagnosed.
   1 2 3 4 5  NA

66. My G.P. asks me questions in a way where I am comfortable to express my thoughts.
   1 2 3 4 5

67. I do not care to learn more about diabetes.
   1 2 3 4 5  NA

Please complete items number 68-74 if it is your G.P. who manages your diabetes (that is you do not usually see a specialist or go to any diabetic clinics):

68. I am comfortable talking with my G.P. about any aspect of my diabetes.
   1 2 3 4 5  NA

69. I am generally honest with my G.P. about how I manage my diabetes.
   1 2 3 4 5  NA

70. My G.P. allows me to make suggestions about future plans to manage my diabetes.
   1 2 3 4 5  NA

71. My G.P. encourages me to make suggestions about future plans to manage my diabetes.
   1 2 3 4 5  NA

72. I think G.P.'s should scold their patients when they find out that their patients are not keeping to instructions (for example following their diet, exercising or taking medicines).
   1 2 3 4 5  NA

73. My G.P. helps motivate me to try harder when my diabetes is not well-controlled.
   1 2 3 4 5  NA

74. My G.P. is my best source of information about diabetes.
   1 2 3 4 5  NA
糖尿病患者试验性调查表: 私人医生业务

1. 背景资料

1. 性别:  □男    □女
2. 年龄:  □10-19岁   □20-29岁
        □30-39岁   □40-49岁
        □50-59岁   □60-69岁
        □70岁以上
3. 国籍:  □新加坡
        □其他 (请注明____________)
4. 种族:  □华人    □马来人    □印度人
        □高加索人(白种人) □其他 (请注明____________)
5. 家庭使用语言: (请勾出所有适用者)
        □华语    □华语方言  □波米尔语
        □马来语    □英语    □印度语
        □其他 (请注明____________)
6. 婚姻状况:  □单身    □已婚
        □分居/离婚    □丧偶
7. 您是否独自生活?  □是    □否
8. 多少家庭成员(包括亲戚)与您生活在一起? ________
9. 多少朋友(有朋友的话)与您生活在一起? ________
10. 您有住在家里的人吗?  □是    □否
11. 您的职业是什么? _________________________________
12. 您是否住在政府组屋?  □是    □否
    如果是, 房间数: _________(请注明)
13. 如不是, 您住在:
        □共管式公寓    □独立式洋房
        □半独立式洋房    □排屋
        □其他 (请注明____________)
14. 您住的地方是
        □租用的    □属于____________所有
APPENDIX J

15. 您的最高学历是
   □ 高等教育(函授或大学或理工学院)
   □ 教育
   □ 中学
   □ 小学
   □ 其它(请注明______________)

16. 您的糖尿病何时第一次诊断出？__________________________ (请注明年或尽
    您的记忆)

17. 您的糖尿病现在如何治疗 (请勾出所有适用者)？
   □ 定期运动
   □ 特别的饮食
   □ 吃药
   □ 注射胰岛素
   □ 其它(请注明______________)

18. 在糖尿病诊断出之前您感到:(选一个)
   □ 病情严重
   □ 不太好
   □ 好

19. 谁第一次诊断出您的糖尿病？(选一个)
   □ 政府综合诊疗所医生
   □ 我的私人医生
   □ 我的私人医生介绍的专科医生
   □ 我自己找的专科医生
   □ 医院的普通医生/专科医生
   □ 护士
   □ 中医
   □ 其它(请注明______________)

20. 诊断出之前您有多长时间感到不适？
     __天 __月 __年

21. 在过去的一年，您找您的私人医生(或普通医生)看病大概多少次？
     ____(在政府综合诊疗所)
     ____ (在私人诊所)
22. 以上看病次数中，大约多大的比例是为糖尿病？
   ___ %（在政府综合诊疗所）
   ___ %（在私人诊所）
23. 自从糖尿病诊断出来后，您是否从私人诊所转移到政府综合诊疗所？
   □是  □否  □有时
   如果“是”（或“有时”），是否因为政府综合诊疗所（请勾出所有适用者）
   □比较便宜？
   □照看的比较好？
   □其它（请注明__________）
24. 自从糖尿病诊断出来后，您是否从政府综合诊疗所转到私人诊所？
   □是  □否  □有时
   如果“是”（或“有时”），是否因为私人诊所（请勾出所有适用者）
   □照看的比较好？
   □比政府综合诊疗所排队时间短？
   □其它（请注明__________）
25. 在过去的一年里，如果去私人诊所，您是否去同一间？
   □总是
   □多数
   □有时
   □很少
   □从不
26. 在过去的一年里，如果去私人诊所，您是否尽量找同一医生？
   □总是
   □多数
   □有时
   □很少
   □从不
27. 在过去的一年里，您大约找了多少不同的私人医生看病？______
28. 您家里的其它成员是否找同一私人医生看病？
   □是  □否
   如“是”，谁？  □配偶
   □孩子（多少：______）
   □其它亲戚（多少：______）
APPENDIX J

29. 您今天为何找您的私人医生？
   □常规糖尿病检查
   □取糖尿病药
   □感觉不适
   □需要“好”的医疗，比如肝炎注射
   □其它（请注明____________________）

30. 您是否因为价格便宜去私人诊所而不是私人糖尿病专科诊所？
   □是   □有时   □否   □不知道

31. 在过去的一年里，您去糖尿病专科诊所多少次？
   如果您的确去过糖尿病专科诊所，那么此诊所是
   □私人诊所   □公立医院/诊所？
   地点？______________________________

32. 您是否新加坡糖尿病协会的成员？
   □是   □否   □过去是（现在不是）

对以下陈述，请圈出最能描述您感受的数字：

1 - 非常同意
2 - 同意
3 - 没有意见
4 - 不同意
5 - 非常不同意
NA - 问题不适用于您

糖尿病患者的生活

33. 许多同事（或同学）知道我患有糖尿病．
    1 2 3 4 5 NA
34. 我不介意同事（或同学）知道我患有糖尿病．
    1 2 3 4 5 NA
35. 糖尿病在工作（或学习）中是一件令人讨厌的事．
    1 2 3 4 5 NA
36. 我的近亲家庭成员知道我患有糖尿病．
    1 2 3 4 5 NA
APPENDIX J

37.许多亲戚知道我患有糖尿病。
   1 2 3 4 5 NA

38.糖尿病是不治之症。
   1 2 3 4 5 NA

39.糖尿病是我生活中可以接受的一部分。
   1 2 3 4 5 NA

40.学习有关糖尿病的知识是我自己的责任。
   1 2 3 4 5 NA

41.学习如何控制或降低血糖是我自己的责任。
   1 2 3 4 5 NA

42.通常我不告诉朋友我患有糖尿病。
   1 2 3 4 5 NA

43.今天我感觉很健康。
   1 2 3 4 5 NA

44.通常来讲，我感觉很健康。
   1 2 3 4 5 NA

45.我通常不介意遵守对糖尿病患者的饮食要求。
   1 2 3 4 5 NA

46.我相信如果我今天照顾好我的糖尿病，就会增加将来健康的机会。
   1 2 3 4 5 NA

47.糖尿病是生活压力的主要来源。
   1 2 3 4 5 NA

48.我经常同我的家人谈论我的糖尿病。
   1 2 3 4 5 NA

49.我经常同我的朋友谈论我的糖尿病。
   1 2 3 4 5 NA

与我的私人医生的关系

50.应由我的私人医生决定什么是治疗我的糖尿病的最好方法。
   1 2 3 4 5 NA
APPENDIX J

51. 应由糖尿病专家决定什么是治疗我的糖尿病的最好办法。
   1 2 3 4 5 NA

52. 我的私人医生知道患有糖尿病的我生活有多难(或容易)。
   1 2 3 4 5 NA

53. 我的私人医生应该知道我的工作(或学习)性质。
   1 2 3 4 5 NA

54. 我的私人医生知道我的工作(或学习)性质。
   1 2 3 4 5 NA

55. 就诊时只要时间允许我就告诉我的私人医生更多我的个人生活。
   1 2 3 4 5 NA

56. 我的私人医生知道我的个人生活这一点是重要的。
   1 2 3 4 5 NA

57. 我认为我的私人医生的唯一工作就是开药单。
   1 2 3 4 5 NA

58. 我认为我的私人医生的工作应包括给予饮食方面的指导。
   1 2 3 4 5 NA

59. 我认为我的私人医生的工作应包括给予运动方面的指导。
   1 2 3 4 5 NA

60. 我认为我的私人医生的工作应包括给予个人生活方面的指导。
    1 2 3 4 5 NA

61. 如果我的饮食明显不正确，我的私人医生会责怪我。
    1 2 3 4 5 NA

62. 如果我的运动明显不规律，我的私人医生会责怪我。
    1 2 3 4 5 NA

63. 我的私人医生的工作只是满足一般求诊需要(例如喉咙痛)，而不是糖尿。
    1 2 3 4 5 NA

64. 在我的私人医生就诊室，我通常觉得医生在赶时间(即希望尽早结束)。
    1 2 3 4 5 NA

65. 我患糖尿病很久，但医生没发现，结果拖了相当长的时间才被诊断出来。
    1 2 3 4 5 NA

66. 我的私人医生问我问题时，其方式使我能轻松的表达我的想法。
    1 2 3 4 5 NA
67. 我不想对糖尿病了解更多。
   1 2 3 4 5 NA

假如是您的私人医生在负责治疗您的糖尿病(即您通常不找专家或去糖尿病诊所)，请完成第68-74项：

68. 在与我的私人医生谈论我的糖尿病的任何方面时，我都感到很自在。
   1 2 3 4 5 NA
69. 关于我如何处理我的糖尿病，我通常对我的私人医生是诚实的。
   1 2 3 4 5 NA
70. 我的私人医生允许我对处理我的糖尿病的将来计划提出建议。
   1 2 3 4 5 NA
71. 我的私人医生鼓励我对处理我的糖尿病的将来计划提出建议。
   1 2 3 4 5 NA
72. 我认为私人医生在他们发现病人没有遵照医嘱时，应该责骂他们(例如，遵照饮食计划、运动或吃药)。
   1 2 3 4 5 NA
73. 当我的糖尿病不能很好的控制时，我的私人医生帮助我更努力地尝试。
   1 2 3 4 5 NA
74. 我的私人医生是我有关糖尿病的最佳信息来源。
   1 2 3 4 5 NA
APPENDIX K

Pilot Questionnaire for Persons with Diabetes:
Private G.P. Practice - 1st Visit

I. Background Information

1. Sex: ☐ male ☐ female
2. Age: ☐ 10-19 years ☐ 20-29 years
   ☐ 30-39 years ☐ 40-49 years
   ☐ 50-59 years ☐ 60-69 years
   ☐ 70 years and older
3. Nationality: ☐ Singaporean
   ☐ other (please specify ____________)
4. Ethnic Group: ☐ Chinese ☐ Malay ☐ Indian
   ☐ Caucasian ☐ other (please specify ____________)
5. Languages spoken at home (tick off as many as apply to you):
   ☐ Mandarin ☐ Chinese Dialect ☐ Tamil
   ☐ Malay ☐ English ☐ Indian
   ☐ other (please specify ____________)
6. Marital status: ☐ single ☐ married
   ☐ separated /divorced ☐ widow(er)
7. Do you live alone? ☐ yes ☐ no
8. How many family members, including relatives, live with you? __
9. How many friends, if any, live with you? __
10. Do you have a live-in maid? ☐ yes ☐ no
11. What is your occupation? ____________________________
12. Do you live in a HDB flat? ☐ yes ☐ no
   If yes, number of rooms: ____ (please specify)
13. If no, do you live in a:
   ☐ condominium? ☐ bungalow?
   ☐ semi-detached? ☐ terrace home?
   ☐ other? (please specify ____________)
14. The place you are staying in is:
   ☐ rented ☐ owned by ____________
APPENDIX K

15. What is your highest level of education?
   - tertiary (distance learning or university or polytechnic)
   - some tertiary education
   - secondary school
   - primary school
   - other (please specify: ________________________)

II. Medical History

16. When was your diabetes first diagnosed? __________ (please specify the month and year or the best you can remember)

17. How is your diabetes treated now? (tick off as many as apply to you):
   - regular exercise
   - a special diet
   - taking pills
   - injecting insulin
   - other (please specify: ________________________)

18. Just before you were diagnosed with diabetes did you feel: (choose one)
   - quite ill
   - not quite well
   - well

19. Who first diagnosed your diabetes? (choose one):
   - a polyclinic doctor
   - my G.P.
   - a specialist referred to by my G.P.
   - a specialist I referred myself to
   - a hospital physician/specialist
   - a nurse
   - a traditional Chinese doctor
   - other (please specify: ________________________)

20. About how long were you unwell before your diagnosis?
   __ days __ months __ years

21. In the past one year, about how many times have you seen a G.P. (or regular doctor) in the:
   __ polyclinic?
   __ private G.P. clinic?

22. Of these G.P. (or regular doctor) visits about what percentage were for diabetic care?
   __% in the polyclinic
   __% in the private G.P. clinic

23. Since your diabetes was diagnosed have you switched from using private G.P. clinics to polyclinics?
   - yes
   - no
   - sometimes
APPENDIX K

If "yes" (or "sometimes"), did you switch because the polyclinics (tick as many as apply to you):
☐ were less expensive?
☐ provided better care?
☐ other (please specify: __________________________)

24. Since you were diagnosed with diabetes have you switched from using polyclinics to private G.P. clinics?
☐ yes  ☐ no  ☐ sometimes

If "yes" (or "sometimes"), did you switch because the private G.P. clinics (tick as many as apply to you):
☐ provided better care?
☐ had shorter waiting hours than the polyclinics?
☐ other (please specify: __________________________)

25. In the past one year, when you go to a private G.P. clinic is it the same one?
☐ all of the time
☐ most of the time
☐ some of the time
☐ rarely
☐ never

26. In the past year, when you go to a private G.P. clinic do you try to see the same G.P.?
☐ all of the time
☐ most of the time
☐ some of the time
☐ rarely
☐ never

27. In the past one year, about how many different private G.P.s have you seen? _______ (please specify how many)

28. Do other members of your family go to the G.P. that you are seeing today?
☐ yes  ☐ no

If yes, who?
☐ spouse
☐ children (how many: ___)
☐ other relatives (how many: ___)

29. Why are you visiting your G.P. today? (tick off as many as apply to you):
☐ regular diabetic check-up
☐ to pick up diabetic medications
☐ feeling unwell
☐ need "well" medical attention, for example a Hepatitis injection
☐ other (please specify: __________________________)
APPENDIX K

30. Do you usually go to a private G.P. clinic instead of a private diabetic specialist clinic because the visits are cheaper?
   □ yes □ sometimes □ no □ don't know

31. About how often in the past one year have you attended a diabetic specialist clinic? ______ times
   If you did attend a diabetic specialist clinic was this clinic:
   □ a private clinic or □ a public clinic?
   Where? _______________________

32. Are you a member of the Diabetic Society of Singapore?
   □ yes □ no □ used to be (but not now)

For the following statements circle the number which best describes how you feel:

1 - if you strongly agree
2 - if you simply agree
3 - if you have no opinion
4 - if you simply disagree
5 - if you strongly disagree
NA - (not applicable) if the question does not apply to you

Living With Diabetes

33. Many of my colleagues at work (or school) know that I have diabetes.
   1 2 3 4 5 NA
34. I do not mind that my work (or school) colleagues know that I have diabetes.
   1 2 3 4 5 NA
35. Diabetes is a nuisance at work (or school).
   1 2 3 4 5 NA
36. My immediate family members know that I have diabetes.
   1 2 3 4 5 NA
37. Many of my relatives know that I have diabetes.
   1 2 3 4 5 NA
38. Diabetes is an incurable illness.
   1 2 3 4 5 NA
39. Diabetes is an accepted part of my life.
   1 2 3 4 5 NA
40. It is up to me to learn about diabetes.
   1 2 3 4 5 NA
41. It is up to me to learn about what I can do to control, or lower, my blood sugars.
   1 2 3 4 5 NA
42. I do not usually tell my friends that I have diabetes.
   1 2 3 4 5 NA
43. I feel in good health today.
   1 2 3 4 5 NA
APPENDIX K

44. Generally speaking, I feel in good health.
   1 2 3 4 5 NA
45. I usually do not mind the discipline required to keep to my diabetic diet.
   1 2 3 4 5 NA
46. I believe that if I look after my diabetes today I will improve my chances for good health in the future.
   1 2 3 4 5 NA
47. Diabetes is a major source of stress in my life.
   1 2 3 4 5 NA
48. I often talk about my diabetes with my family.
   1 2 3 4 5 NA
49. I often talk about my diabetes with my friends.
   1 2 3 4 5 NA

Relationship With My Previous G.P.s

50. It should be up to my G.P. to decide what is best in treating my diabetes.
    1 2 3 4 5 NA
51. It should be up to my diabetic specialist to decide what is best in treating my diabetes.
    1 2 3 4 5 NA
52. My previous G.P.(s) knew how difficult (or easy) it was for me to live with diabetes.
    1 2 3 4 5 NA
53. My G.P. should know about the nature of my work (school).
    1 2 3 4 5 NA
54. My previous G.P.(s) knew about the nature of my work (school).
    1 2 3 4 5 NA
55. I would have told my previous G.P.(s) more about my personal life if only there had been more time during our appointments.
    1 2 3 4 5 NA
56. It is important that my G.P. knows about my personal life.
    1 2 3 4 5 NA
57. I think my G.P.'s only job is to prescribe medicine.
    1 2 3 4 5 NA
58. I think my G.P.'s job should include giving me advice on my eating habits.
    1 2 3 4 5 NA
59. I think my G.P.'s job should include giving me advice on my exercise habits.
    1 2 3 4 5 NA
60. I think my G.P.'s job should include giving me advice on my personal life.
    1 2 3 4 5 NA
61. My previous G.P.(s) would scold me when it was obvious that I had not been eating correctly.
    1 2 3 4 5 NA
APPENDIX K

62. My previous G.P.(s) would scold me when it was obvious that I had not been exercising regularly.
   1 2 3 4 5 NA

63. My G.P.'s job is to look after my general health needs only, for example a sore throat, and not my diabetes.
   1 2 3 4 5 NA

64. I would often feel rushed for time in my previous G.P.'s (or G.P.s') consulting room.
   1 2 3 4 5 NA

65. It took too long for my diabetes to be diagnosed.
   1 2 3 4 5 NA

66. My previous G.P.(s) would ask me questions in a way where I was comfortable to express my thoughts.
   1 2 3 4 5

67. I do not care to learn more about diabetes.
   1 2 3 4 5 NA

Please complete items number 68-74 if it is your G.P. who manages your diabetes (that is you do not usually see a specialist or go to any diabetic clinics):

68. I was comfortable talking with my previous G.P.(s) about any aspect of my diabetes.
   1 2 3 4 5 NA

69. I am generally honest with my G.P. about how I manage my diabetes.
   1 2 3 4 5 NA

70. My previous G.P.(s) allowed me to make suggestions about future plans to manage my diabetes.
   1 2 3 4 5 NA

71. My previous G.P.(s) encouraged me to make suggestions about future plans to manage my diabetes.
   1 2 3 4 5 NA

72. I think G.P.s should scold their patients when they find out that their patients are not keeping to instructions (for example following their diet, exercising or taking medicines).
   1 2 3 4 5

73. My previous G.P.(s) helped motivate me to try harder when my diabetes was not well-controlled.
   1 2 3 4 5 NA

74. My previous G.P.(s) was my best source of information about diabetes.
   1 2 3 4 5 NA
糖尿病患者试验性调查表:
私人医生业务 — 第一次看病

1. 背景资料

1. 性别:  □男  □女
2. 年龄:  □10-19岁  □20-29岁
    □30-39岁  □40-49岁
    □50-59岁  □60-69岁
    □70岁或以上
3. 国籍:  □新加坡
    □其它 (请注明____________________)
4. 种族:  □华人  □马来人  □印度人
    □高加索人(白种人)  □其它(请注明____________________)
5. 家庭使用语言: (请勾出所有适用者)
    □华语  □方言方言  □法米尔语
    □马来语  □英语  □印度语
    □其它 (请注明____________________)
6. 婚姻状况:  □单身  □已婚
    □分居/离婚  □丧偶
7. 您是否独自生活?  □是  □否
8. 多少家庭成员(包括亲戚)与您生活在一起?______
9. 多少朋友(如有的话)与您生活在一起?______
10. 您有住在家里的佣人吗?  □是  □否
11. 您的职业是什么?_________________________________________
12. 您是否住在政府组屋?  □是  □否
    如果是, 室号数:________________________ (请注明)
13. 如不是, 您住在:
    □共管式公寓  □独立式洋房
    □半独立式洋房  □排屋
    □其它(请注明____________________)
14. 您住的地方是
    □租用的  □属于____________________所有
APPENDIX L

15. 您的最高学历是
   ☐ 高等教育 (包括及大学或理工学院)
   ☐ 一些高等教育
   ☐ 中学
   ☐ 小学
   ☐ 其它 (请注明__________)

16. 您的糖尿病何时第一次诊断出？__________（请注明年或尽
   您的记忆）

17. 您的糖尿病现在如何治疗 (请勾出所有适用者)？
   ☐ 定期运动
   ☐ 特别的饮食
   ☐ 吃药
   ☐ 注射胰岛素
   ☐ 其它 (请注明__________)

18. 在糖尿病诊断出之前您感到:(选一个)
   ☐ 病情严重
   ☐ 不太好
   ☐ 好

19. 谁第一次诊断出您的糖尿病？ (选一个)
   ☐ 政府综合诊疗所医生
   ☐ 我的私人医生
   ☐ 我的私人医生介绍的专科医生
   ☐ 我自己找的专科医生
   ☐ 医院的普通医生/专科医生
   ☐ 护士
   ☐ 中医
   ☐ 其它 (请注明__________)

20. 诊断出之前您有多长时间感到不适？
   _____天 _____月 _____年

21. 在过去的一年, 您找您的私人医生 (或普通医生)看病大概多少次？
   _____ (在政府综合诊疗所)
   _____ (在私人诊所)
APPENDIX L

22. 以上看病次数中，大约多大的比例是为糖尿病？
   ____ % (在政府综合诊疗所)
   ____ % (在私人诊所)

23. 自从糖尿病诊断出来后，您是否从私人诊所转移到政府综合诊疗所？
   □是  □否  □有时
   如果“是” (或“有时”)，是否因为政府综合诊疗所 (请勾出所有适用者)
   □比较便宜?
   □照顾的比较好?
   □其它 (请注明 ____________ )

24. 自从糖尿病诊断出来后，您是否从政府综合诊疗所转移到私人诊所？
   □是  □否  □有时
   如果“是” (或“有时”)，是否因为私人诊所 (请勾出所有适用者)
   □照顾的比较好?
   □比政府综合诊疗所排队时间短?
   □其它 (请注明 ____________ )

25. 在过去的一年里，如果去私人诊所，您是否去同一间？
   □总是
   □多数
   □有时
   □很少
   □从不

26. 在过去的一年里，如果去私人诊所，您是否尽量找同一医生？
   □总是
   □多数
   □有时
   □很少
   □从不

27. 在过去的一年里，您大约找了多少不同的私人医生看病？____

28. 您家里的其它成员是否找您今天所找的同一私人医生看病？
   □是  □否
   如“是”，谁？ □配偶
   □孩子 (多少：_____)
   □其它亲戚 (多少：_____)

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APPENDIX L

29. 您今天为何找您的私人医生？

①常规糖尿病检查
②取糖尿病药
③感觉不适
④需要"好"的医疗，比如肝炎注射
⑤其它（请注明__________________）

30. 您是否因为价格便宜去私人诊所而不是私人糖尿病专科诊所？

①是  ②有时  ③否  ④不知道

31. 在过去的一年里，您去糖尿病专科诊所多少看病 次？

   如果您的确去过糖尿病专科诊所，那么此诊所是
   ①私人诊所  ②公立医院/诊所？

   地点？____________________________________

32. 您是否参加糖尿病协会的成员？

①是  ②否  ③过去是（现在不是）

对以下陈述，请圈出最能描述您感受的数字：

1 - 非常同意
2 - 同意
3 - 没有意见
4 - 不同意
5 - 非常不同意
NA - 问题不适用于您

糖尿病患者的生活

33. 许多同事（或同学）知道我患有糖尿病。

   1 2 3 4 5 NA

34. 我不介意同事（或同学）知道我患有糖尿病。

   1 2 3 4 5 NA

35. 糖尿病在工作（或学习）中是一件令人讨厌的事。

   1 2 3 4 5 NA

36. 我的近亲家庭成员知道我患有糖尿病。

   1 2 3 4 5 NA
37. 许多亲戚知道我患有糖尿病。
   1 2 3 4 5 NA
38. 糖尿病是不治之症。
   1 2 3 4 5 NA
39. 糖尿病是我生活中可以接受的一部分。
   1 2 3 4 5 NA
40. 学习有关糖尿病的知识是我自己的责任。
   1 2 3 4 5 NA
41. 学习如何控制或降低血糖是我自己的责任。
   1 2 3 4 5 NA
42. 通常我不告诉朋友我患有糖尿病。
   1 2 3 4 5 NA
43. 今天我感觉很健康。
   1 2 3 4 5 NA
44. 通常来说，我感觉很健康。
   1 2 3 4 5 NA
45. 通常不节食能遵守糖尿病患者的饮食要求。
   1 2 3 4 5 NA
46. 我相信如果我今天照顾好我的糖尿病，就会增加将来健康的机会。
   1 2 3 4 5 NA
47. 糖尿病是我生活压力的主要来源。
   1 2 3 4 5 NA
48. 我经常同我的家人谈论我的糖尿病。
   1 2 3 4 5 NA
49. 我经常同我的朋友谈论我的糖尿病。
   1 2 3 4 5 NA

与我以前的医生的关系

50. 应由我的私人医生决定什么是治疗我的糖尿病的最好办法。
   1 2 3 4 5 NA
APPENDIX L

51. 应由糖尿病专家决定什么是治疗我的糖尿病的最好办法。
   1 2 3 4 5 NA

52. 我以前所有的私人医生都知道我有糖尿病的我生活有多难(或容易)。
   1 2 3 4 5 NA

53. 我的私人医生应该知道我的工作(或学习)性质。
   1 2 3 4 5 NA

54. 我以前的私人医生知道我的工作(或学习)性质。
   1 2 3 4 5 NA

55. 就诊时只要时间允许我就告诉我以前的私人医生更多我的个人生活。
   1 2 3 4 5 NA

56. 我的私人医生知道我的个人生活这一点是很重要的。
   1 2 3 4 5 NA

57. 我认为我的私人医生的唯一工作就是开药单。
   1 2 3 4 5 NA

58. 我认为我的私人医生的工作应包括给予饮食方面的指导。
   1 2 3 4 5 NA

59. 我认为我的私人医生的工作应包括给予运动方面的指导。
   1 2 3 4 5 NA

60. 我认为我的私人医生的工作应包括给予个人生活方面的指导。
   1 2 3 4 5 NA

61. 如果我的饮食明显不正确，我以前的私人医生会责怪我。
   1 2 3 4 5 NA

62. 如果我的运动明显不规律，我以前的私人医生会责怪我。
   1 2 3 4 5 NA

63. 我的私人医生的工作只是满足一般求诊需要(例如喉咙痛)，而不是糖尿病。
   1 2 3 4 5 NA

64. 在我以前的私人医生就诊室，我通常觉得医生在赶时间(即希望尽早结束)。
   1 2 3 4 5 NA

65. 我患糖尿病很久，但医生没发现，结果拖了相当长的时间才被诊断出来。
   1 2 3 4 5 NA

66. 我以前的私人医生问问题时，其方式使我能轻松的表达我的想法。
   1 2 3 4 5 NA
APPENDIX L

67. 我不想对糖尿病了解更多。
   1 2 3 4 5 NA

假如是您的私人医生在负责治疗您的糖尿病(即使他通常不找专家或去糖尿
病诊所), 请完成第68-74项:

68. 在与我以前的私人医生谈论我的糖尿病的任何方面时, 我都感到很自在。
   1 2 3 4 5 NA
69. 关于我如何处理我的糖尿病, 我通常对我的私人医生是诚实的。
   1 2 3 4 5 NA
70. 我以前的私人医生允许我对处理我的糖尿病的将来计划提出建议。
   1 2 3 4 5 NA
71. 我以前的私人医生鼓励我对处理我的糖尿病的将来计划提出建议。
   1 2 3 4 5 NA
72. 我认为私人医生在他们发现病人没有遵照医嘱时, 应该责骂他们 (例如, 遵照
   饮食计划、运动或吃药)。
   1 2 3 4 5 NA
73. 当我的糖尿病不能很好的控制时, 我以前的私人医生帮助我更努力地尝试。
   1 2 3 4 5 NA
74. 我以前的私人医生是我有关糖尿病的最佳信息来源。
   1 2 3 4 5 NA
Pilot Questionnaire for Persons with Diabetes: Visit to Polyclinic Doctor

I. Background Information

1. Sex: □ male □ female
2. Age: □ 10-19 years □ 20-29 years
   □ 30-39 years □ 40-49 years
   □ 50-59 years □ 60-69 years
   □ 70 years and older
3. Nationality: □ Singaporean □ other (please specify _________)
4. Ethnic Group: □ Chinese □ Malay □ Indian
   □ Caucasian □ other (please specify _________)
5. Languages spoken at home (tick off as many as apply to you):
   □ Mandarin □ Chinese Dialect □ Tamil
   □ Malay □ English □ Indian
   □ other (please specify _________)
6. Marital status: □ single □ married
   □ separated /divorced □ widow(er)
7. Do you live alone? □ yes □ no
8. How many family members, including relatives, live with you? ___
9. How many friends, if any, live with you? ___
10. Do you have a live-in maid? □ yes □ no
11. What is your occupation? ____________________________
12. Do you live in a HDB flat? □ yes □ no
    If yes, number of rooms: ____ (please specify)
13. If no, do you live in a:
    □ condominium? □ bungalow?
    □ semi-detached? □ terrace home?
    □ other? (please specify ____________)
14. The place you are staying in is:
    □ rented □ owned by ____________
APPENDIX M

15. What is your highest level of education?
   [ ] tertiary (distance learning or university or polytechnic)
   [ ] some tertiary education
   [ ] secondary school
   [ ] primary school
   [ ] other (please specify: ______________________)

II. Medical History

16. When was your diabetes first diagnosed? __________ (please specify the month and year or the best you can remember)

17. How is your diabetes treated now? (tick off as many as apply to you):
   [ ] regular exercise
   [ ] a special diet
   [ ] taking pills
   [ ] injecting insulin
   [ ] other (please specify ______________________)

18. Just before you were diagnosed with diabetes did you feel: (chose one)
   [ ] quite ill
   [ ] not quite well
   [ ] well

19. Who first diagnosed your diabetes? (chose one):
   [ ] a polyclinic doctor
   [ ] my G.P.
   [ ] a specialist referred to by my family doctor
   [ ] a specialist I referred myself to
   [ ] a hospital physician/specialist
   [ ] a nurse
   [ ] a traditional Chinese doctor
   [ ] other (please specify ______________________)

20. About how long were you unwell before your diagnosis?
    ___ days ___ months ___ years

21. In the past one year, about how many times have you seen a G.P. (or regular doctor) in the:
    ___ polyclinic?
    ___ private G.P. clinic?

22. Of these G.P. (or regular doctor) visits about what percentage were for diabetic care?
    ___ % in the polyclinic
    ___ % in the private G.P. clinic

23. Since you were diagnosed with diabetes have you switched from using private G.P. clinics to polyclinics?
   [ ] yes  [ ] no  [ ] sometimes
If "yes" (or "sometimes"), did you switch because the polyclinics (tick as many as apply to you):
☐ were less expensive?
☐ provided better care?
☐ other (please specify: ______________________________)

24. Since you were diagnosed with diabetes have you switched from using polyclinics to private G.P. clinics?
☐ yes  ☐ no  ☐ sometimes

If "yes" (or "sometimes"), did you switch because the private G.P. clinics (tick as many as apply to you):
☐ provided better care?
☐ had shorter waiting hours than the polyclinics?
☐ other (please specify: ______________________________)

25. In the past one year, when you go to a polyclinic is it the same one?
☐ all of the time
☐ most of the time
☐ some of the time
☐ rarely
☐ never

26. In the past year, when you go to your polyclinic do you ever ask to see the same doctor?
☐ all of the time
☐ most of the time
☐ some of the time
☐ rarely
☐ never

27. In the past one year, about how many different doctors have you seen at the polyclinic? ________ (please specify how many)

28. Why are you visiting the polyclinic today? (tick off as many as apply to you):
☐ regular diabetic check-up
☐ to pick up diabetic medications
☐ feeling unwell
☐ need "well" medical attention, for example a Hepatitis injection
☐ other (please specify: ______________________________)

29. About how often in the past one year have attended a diabetic specialist clinic? ______ times.

If you did attend a diabetic specialist clinic was this clinic:
☐ a private clinic  or ☐ a public clinic?
Where? ________________________________

30. Are you a member of the Diabetic Society of Singapore?
☐ yes  ☐ no  ☐ used to be (but not now)
APPENDIX M

For the following statements circle the number which best describes how you feel:

1 - if you strongly agree
2 - if you simply agree
3 - if you have no opinion
4 - if you simply disagree
5 - if you strongly disagree
NA - (not applicable) if the question does not apply to you

Living With Diabetes

31. Many of my colleagues at work (or school) know that I have diabetes.
   1 2 3 4 5 NA

32. I do not mind that my work (or school) colleagues know that I have diabetes.
   1 2 3 4 5 NA

33. Diabetes is a nuisance at work (or school).
   1 2 3 4 5 NA

34. My immediate family members know that I have diabetes.
   1 2 3 4 5 NA

35. Many of my relatives know that I have diabetes.
   1 2 3 4 5 NA

36. Diabetes is an incurable illness.
   1 2 3 4 5 NA

37. Diabetes is an accepted part of my life.
   1 2 3 4 5 NA

38. It is up to me to learn about diabetes.
   1 2 3 4 5 NA

39. It is up to me to learn about what I can do to control, or lower, my blood sugars.
   1 2 3 4 5 NA

40. I do not usually tell my friends that I have diabetes.
   1 2 3 4 5 NA

41. I feel in good health today.
   1 2 3 4 5 NA

42. Generally speaking, I feel in good health.
   1 2 3 4 5 NA

43. I usually do not mind the discipline required to keep to my diabetic diet.
   1 2 3 4 5 NA

44. I believe that if I look after my diabetes today I will improve my chances for good health in the future.
   1 2 3 4 5 NA

45. Diabetes is a major source of stress in my life.
   1 2 3 4 5 NA

46. I often talk about my diabetes with my family.
   1 2 3 4 5 NA

47. I often talk about my diabetes with my friends.
   1 2 3 4 5 NA
APPENDIX M

Relationship With My Doctor

48. It should be up to the polyclinic doctors to decide what is best in treating my diabetes.
   1 2 3 4 5 NA

49. It should be up to my diabetic specialist to decide what is best in treating my diabetes.
   1 2 3 4 5 NA

50. The polyclinic doctors know how difficult (or easy) it is for me to live with diabetes.
   1 2 3 4 5 NA

51. The polyclinic doctors should know about the nature of my work (school).
   1 2 3 4 5 NA

52. The polyclinic doctors know about the nature of my work (school).
   1 2 3 4 5 NA

53. I would tell the polyclinic doctors more about my personal life if only there were more time during our appointments.
   1 2 3 4 5 NA

54. It is important that the polyclinic doctors know about my personal life.
   1 2 3 4 5 NA

55. I think that the polyclinic doctors’ only job is to prescribe medicine.
   1 2 3 4 5 NA

56. I think that the polyclinic doctors’ job should include giving me advice on my eating habits.
   1 2 3 4 5 NA

57. I think that the polyclinic doctors’ job should include giving me advice on my exercise habits.
   1 2 3 4 5 NA

58. I think that the polyclinic doctors’ job should include giving me advice on my personal life.
   1 2 3 4 5 NA

59. The polyclinic doctors will usually scold me when it is obvious that I have not been eating correctly.
   1 2 3 4 5 NA

60. The polyclinic doctors will usually scold me when it is obvious that I have not been exercising regularly.
   1 2 3 4 5 NA

61. The polyclinic doctors need only look after my general health needs, such as treating a sore throat, and not my diabetes.
   1 2 3 4 5 NA

62. I often feel rushed for time once I am in a polyclinic doctor’s consulting room.
   1 2 3 4 5 NA

63. It took too long for my diabetes to be diagnosed.
   1 2 3 4 5 NA

64. The polyclinic doctors usually ask me questions in a way where I am comfortable to express my thoughts.
   1 2 3 4 5
APPENDIX M

65. I do not care to learn more about diabetes.
   1 2 3 4 5 NA

Please complete items number 66-74 if it is the doctors at the polyclinics who manages your diabetes (that is you do not usually see a specialist or go to any diabetic clinics):

66. I am usually comfortable talking with the polyclinic doctors about any aspect of my diabetes.
   1 2 3 4 5 NA

67. I am generally honest with the polyclinic doctors about how I manage my diabetes.
   1 2 3 4 5 NA

68. The polyclinic doctors usually allow me to make suggestions about future plans to manage my diabetes.
   1 2 3 4 5 NA

69. The polyclinic doctors usually encourage me to make suggestions about future plans to manage my diabetes.
   1 2 3 4 5 NA

70. I think doctors should scold their patients when they find out that their patients are not keeping to instructions (for example following their diet, exercising or taking medicines).
   1 2 3 4 5 NA

71. The polyclinic doctors usually help motivate me to try harder when my diabetes is not well-controlled.
   1 2 3 4 5 NA

72. I find the polyclinic doctors to be my best source of information about diabetes.
   1 2 3 4 5 NA
糖尿病患者试验性调查表：
政府综合诊疗所医生业务

1. 背景资料

1. 性别：
   - 男 □
   - 女 □

2. 年龄：
   - 10-19岁 □
   - 20-29岁 □
   - 30-39岁 □
   - 40-49岁 □
   - 50-59岁 □
   - 60-69岁 □
   - 70岁或以上 □

3. 国籍：
   - 新加坡 □
   - 其他（请注明） □

4. 种族：
   - 华人 □
   - 马来人 □
   - 印度人 □
   - 高加索人（白种人） □
   - 其他（请注明） □

5. 家庭使用语言：（请勾出所有适用者）
   - 华语 □
   - 马来语 □
   - 英语 □
   - 印地语 □
   - 其他（请注明） □

6. 婚姻状况：
   - 单身 □
   - 已婚 □
   - 分居/离婚 □
   - 寡居 □

7. 您是否独自生活？
   - 是 □
   - 否 □

8. 多少家庭成员（包括亲戚）与您生活在一起？

9. 多少朋友（如有的话）与您生活在一起？

10. 您有住在家里的佣人吗？
    - 是 □
    - 否 □

11. 您的职业是什么？
    □

12. 您是否住在政府组屋？
    - 是 □
    - 否 □
    - 如果是，房间数：□（请注明）

13. 如不是，您住在：
    - 共管式公寓 □
    - 独立式洋房 □
    - 半独立式洋房 □
    - 排屋 □
    - 其他（请注明） □

14. 您住的地方是：
    - 租用的 □
    - 属于 □
    - 所有 □
APPENDIX N

15. 您的最高学历是
   □ 高等教育（包括大学或理工学院）
   □ 一些高等教育
   □ 中学
   □ 小学
   □ 其它（请注明__________________）

16. 您的糖尿病何时第一次诊断出？__________________(请注明年或月)

17. 您的糖尿病现在如何治疗（请勾出所有适用者）？
   □ 定期运动
   □ 特别的饮食
   □ 吃药
   □ 注射胰岛素
   □ 其它（请注明__________________）

18. 在糖尿病诊断出之前您感到：（选一个）
   □ 病情严重
   □ 不太好
   □ 好

19. 第一次诊断出您的糖尿病（选一个）
   □ 政府综合诊疗所医生
   □ 我的私人医生
   □ 我的私人医生介绍的专科医生
   □ 我自己找的专科医生
   □ 医院的普通医生/专科医生
   □ 护士
   □ 中医
   □ 其它（请注明__________________）

20. 诊断出之前您有多长时间感到不适？
    ______天 ______月 ______年

21. 在过去的一年，您找您的私人医生（或普通医生）看病大概多少次？
    ______(在政府综合诊疗所)
    ______(在私人诊所)
APPENDIX N

22. 以上看診次數中，大約多大的比例是為糖尿病?

_____% (在政府綜合診療所)
_____% (在私人診所)

23. 自從糖尿病診斷出來後，您是否從私人診所轉移到政府綜合診療所?
   □是   □否   □有時
   如果“是”(或“有時”)，是否因為政府綜合診療所(請勾出所有適用者)
   □比較便宜?
   □服務的比較好?
   □其它(請注明____________________)

24. 自從糖尿病診斷出來後，您是否從政府綜合診療所轉移到私人診所?
   □是   □否   □有時
   如果“是”(或“有時”)，是否因為私人診所(請勾出所有適用者)
   □服務的比較好?
   □比政府綜合診療所排隊時間短?
   □其它(請注明____________________)

25. 在過去的一年裡，如果去政府綜合診療所，您是否去同一間?
   □總是
   □多數
   □有時
   □很少
   □從不

26. 在過去的一年裡，如果去政府綜合診療所，您曾否盡量找同一醫生?
   □總是
   □多數
   □有時
   □很少
   □從不

27. 在過去的一年裡，您大約找了多少不同的政府綜合診療所醫生看病?____

28. 您今天為何找到政府綜合診療所?
   □常規糖尿病檢查
   □取糖尿病藥
   □感覺不適
   □需要“好”的醫療，比如肝炎注射
   □其它(請注明____________________)
29. 在过去的一年里，您去糖尿病专科诊所多少看诊____次？
如果您的确去过糖尿病专科诊所，那么此诊所是
□私人诊所  □公立医院/诊所？
地点？________________________

30. 您是否参加或糖尿病协会的成员？
□是  □否  □过去是（现在不是）

对以下陈述，请圈出最能描述您感受的数字：

1 - 非常同意
2 - 同意
3 - 没有意见
4 - 不同意
5 - 非常不同意
NA - 问题不适用于您

糖尿病患者的生活

31. 许多同事（或同学）知道我患有糖尿病。
   1  2  3  4  5  NA

32. 我不介意同事（或同学）知道我患有糖尿病。
   1  2  3  4  5  NA

33. 糖尿病在工作（或学习）中是一件令人讨厌的事。
   1  2  3  4  5  NA

34. 我的近亲家庭成员知道我患有糖尿病。
   1  2  3  4  5  NA

35. 许多亲戚知道我患有糖尿病。
   1  2  3  4  5  NA

36. 糖尿病是不治之症。
   1  2  3  4  5  NA

37. 糖尿病是我生活中可以接受的一部分。
   1  2  3  4  5  NA
APPENDIX N

38. 学习有关糖尿病的知识是我自己的责任。
   1 2 3 4 5 NA

39. 学习如何控制及降低血糖是我自己的责任。
   1 2 3 4 5 NA

40. 通常我不告诉朋友我患有糖尿病。
   1 2 3 4 5 NA

41. 今天我感觉很健康。
   1 2 3 4 5 NA

42. 通常来说，我感觉很健康。
   1 2 3 4 5 NA

43. 我通常不介意遵守对糖尿病患者的饮食要求。
   1 2 3 4 5 NA

44. 我相信如果我今天照顾好我的糖尿病，就会增加将来健康的机会。
   1 2 3 4 5 NA

45. 糖尿病是我生活压力的主要来源。
   1 2 3 4 5 NA

46. 我经常同我的家人谈论我的糖尿病。
   1 2 3 4 5 NA

47. 我经常同我的朋友谈论我的糖尿病。
   1 2 3 4 5 NA

与我的政府综合诊疗所医生的关系

48. 应由政府综合诊疗所医生决定什么是治疗我的糖尿病的最好办法。
   1 2 3 4 5 NA

49. 应由我的糖尿病专家决定什么是治疗我的糖尿病的最好办法。
   1 2 3 4 5 NA

50. 我的政府综合诊疗所医生知道患有糖尿病的我生活有多难(或容易)。
   1 2 3 4 5 NA

51. 我的政府综合诊疗所医生应该知道我的工作(或学习)性质。
   1 2 3 4 5 NA
APPENDIX N

52. 我的政府综合诊疗所医生知道我的工作(或学习)性质。
   1 2 3 4 5 NA

53. 就诊时只要充足允许我就告诉我政府综合诊疗所医生更多我的个人生活。
   1 2 3 4 5 NA

54. 我的政府综合诊疗所医生知道我的个人生活这一点是很重要的。
   1 2 3 4 5 NA

55. 我认为我的政府综合诊疗所医生的唯一工作就是开药单。
   1 2 3 4 5 NA

56. 我认为我的政府综合诊疗所医生的工作应包括给予饮食方面的指导。
   1 2 3 4 5 NA

57. 我认为我的政府综合诊疗所医生的工作应包括给予运动方面的指导。
   1 2 3 4 5 NA

58. 我认为我的政府综合诊疗所医生的工作应包括给予个人生活方面的指导。
   1 2 3 4 5 NA

59. 如果我的饮食明显不正确，我的政府综合诊疗所医生会责怪我。
   1 2 3 4 5 NA

60. 如果我的运动明显不规律，我的政府综合诊疗所医生会责怪我。
   1 2 3 4 5 NA

61. 我的政府综合诊疗所医生的工作只是满足一般求诊需要(例如喉咙痛)，
   而不是糖尿病。
   1 2 3 4 5 NA

62. 在我的政府综合诊疗所医生就诊室，我通常觉得医生在赶时间(即 希望尽早结束)。
   1 2 3 4 5 NA

63. 我患糖尿病很久，但医生没发现，结果拖了相当长的时间才被诊断出来。
   1 2 3 4 5 NA

64. 我的政府综合诊疗所医生问我问题时，其方式通常使我能轻松的表达我的想法。
   1 2 3 4 5 NA

65. 我不想对糖尿病了解更多。
   1 2 3 4 5 NA
假如政府综合诊疗所医生在负责治疗您的糖尿病(即您通常不找专家或去糖尿病诊所)，请完成第66-72项:

66. 在与我的政府综合诊疗所医生谈论我的糖尿病的任何方面时，我通常都感到很自在。
   1 2 3 4 5 NA

67. 关于我如何处理我的糖尿病，我通常对政府综合诊疗所医生是诚实的。
   1 2 3 4 5 NA

68. 我的政府综合诊疗所医生通常允许我对处理我的糖尿病的将来计划提出建议。
   1 2 3 4 5 NA

69. 我的政府综合诊疗所医生鼓励我对处理我的糖尿病的将来计划提出建议。
   1 2 3 4 5 NA

70. 我认为政府综合诊疗所医生在他们发现病人没有遵照医嘱时，应该责骂他们(例如，没有服用过药物)。
   1 2 3 4 5 NA

71. 当我的糖尿病不能很好的控制时，政府综合诊疗所医生帮助我更努力地尝试。
   1 2 3 4 5 NA

72. 政府综合诊疗所医生是我有关糖尿病的最佳信息来源。
   1 2 3 4 5 NA
APPENDIX O

Elizabeth Crowe Joong, Ph.D Candidate
University of Toronto

Doctor-Patient Relationship Study
Letter of Introduction to the GP (or Polyclinic Doctor)

As I am sure you are well aware, the incidence of diabetes — and its associated complications — is considered a global epidemic and is rising at a dramatic rate in Singapore. The role of the general practitioner in the private sector, and the primary health care doctor in the polyclinics, is critical to the early detection and management of this chronic disorder. Once the diagnosis of diabetes has been made the physician then has the challenge of educating their patients to the necessity of self-care.

The quality of the doctor-patient relationship is an important feature to the management of diabetes. The treatment of this chronic disorder is one which requires the understanding and co-operation of the patient. The expectations and needs of the patient with diabetes also influence this professional relationship.

I am a University of Toronto doctoral student pursuing a medical Education topic in the Faculty of Higher Education who has been living in Singapore for over two years. I am being supervised by Dr. Linda Muzzin, a Medical Sociologist, in Toronto. Locally, my mentor is [[My Mentor]] who is an Associate Professor at the National University of Singapore’s Community, Occupational and Family Medicine.

The aim of my Ph.D. study is to examine the doctor-patient relationship from both the doctor’s and the patient’s perspectives. It is not a study which evaluates the quality of this relationship; rather this is a descriptive study. In other words, the purpose of this research is to describe, and not judge, this important professional relationship.

I chose to look at patients with diabetes and their relationship with their GPs (or Polyclinic doctors) because I have learned that patient education is a critical feature in treating this increasingly common disorder. My objective is to “paint” a picture of the different types of this kind of doctor-patient relationship. By sharing your experiences with me I am better able to describe this relationship accurately.

I invite you to participate in this important and timely research. I appreciate that you are busy and have designed my study to accommodate this. I am planning to summarise the questionnaire results in a 2-3 page article which I will submit to the Singapore’s Family Physician. In recognition of your participation I will provide an advance copy of this article which I hope you will find insightful in your relationship with your patients with diabetes.

Sincerely,

Elizabeth Crowe Joong
Ph.D. Candidate
University of Toronto, Canada.

28 Ardmore Park, Ardmore View #07-01, Singapore 259949. Telephone (65) 735-1185 Fax (65) 735-1167 Email: antistar1@singnet.com.sg
Doctor-Patient Relationship Study  
Physician Informed Consent Form

It is policy at the University of Toronto that I have the written consent of all research participants.

All of the information provided by you and your patients will be regarded as strictly confidential.

Please read and sign the following:

- I understand that I (or one of my clinic’s employees) will select potential research participants from my patients with diabetes and invite them to join this study.
- I agree to permit the investigator to read a questionnaire to these invited patients in a private area that I will provide or in the waiting area of my clinic.
- I agree to being interviewed by the investigator which will involve the investigator reading a “general” questionnaire to me and recording my answers in writing. I also agree to complete a brief seven item written questionnaire which focuses on my relationship with each participating patient.
- I understand that anything I say will be considered confidential and that my name, as well as the name of my clinic and patients, will never be used in any report. I also understand that my patients will not have access to my interview responses.
- I understand that I am being asked to participate and may withdraw from this study at any time.

(please sign here)  
(date)

Please print your name and clinic’s name below:

Principal Investigator
Elizabeth Crowe Joong
Ph.D. Candidate
University of Toronto
2B Ardmore Park 07-01
Singapore 259949
Tel: 735-1165
Fax: 735-1167
APPENDIX Q

Questionnaire for General Practitioners
Private Practice

I. Background Information

1. Sex: □ male □ female

2. Nationality: □ Singaporean □ other (please specify ____________________________)

3. Ethnic group: □ Chinese □ Malay □ Indian □ Caucasian □ other (please specify ____________________________)

4. Which year did you graduate from medical school? __________

5. Language(s) that you are functional in: (tick off as many as apply to you): □ Mandarin □ Chinese dialect □ English □ Malay □ Indian □ Tamil □ other (please specify ____________________________)

6. Language(s) that you usually converse with your patients in your private practice: (tick off as many as apply): □ Mandarin □ Chinese dialect □ English □ Malay □ Indian □ Tamil □ other (please specify ____________________________)

7. Language(s) that you occasionally converse with your patients in your private practice: (tick off as many as apply): □ Mandarin □ Chinese dialect □ English □ Malay □ Indian □ Tamil □ other (please specify ____________________________)

8. How long have you been a G.P.? __________

9. Did you attend medical school in Singapore? □ yes □ no
   If no, where did you attend medical school? (please specify ____________________________)

10. Did you complete any of your post-graduate training abroad? □ yes □ no
    If yes, where did you complete your post-graduate training? (please specify ____________________________)

11. Have you heard of the "Diabetes Training Programme" offered by the Ministry of Health for GPs and primary health doctors: □ yes □ no

12. Have you completed the above training program? □ yes □ no
APPENDIX Q

2

If yes, did you find this course of practical value in learning how to better meet the health care needs of your patients with diabetes?

☐ absolutely
☐ found many practical applications
☐ somewhat
☐ not at all

13. Do you generally find post-graduate courses offered by the Ministry of Health helpful?

☐ all of the time
☐ most of the time
☐ some of the time
☐ rarely
☐ never
☐ never taken one

14. Do you generally find post-graduate courses offered by the College of Family Physicians helpful?

☐ all of the time
☐ most of the time
☐ some of the time
☐ rarely
☐ never
☐ never taken one

15. Approximately how many patients do you see in a typical day at your private clinic?

☐ less than 10
☐ between 10 and 19
☐ between 20 and 29
☐ between 30 and 39
☐ between 40 and 49
☐ 50 and over

16. Approximately what percentage of your patients have diabetes?

☐ less than 5%
☐ between 5 and 9%
☐ between 10 and 14%
☐ between 15 and 19%
☐ between 20 and 25%
☐ 25% and over

17. Approximately what percentage of your patients with diabetes are insulin dependent (IDDM)?

☐ less than 1%
☐ between 1 and (including) 4%
☐ between 5 and (including) 9%
☐ between 10 and (including) 14%
☐ 15% and over
18. Approximately what percentage of your patients with **IDDM**, in addition to their regular health care needs, see you specifically for their well diabetic care?

- [ ] less than 10%
- [ ] between 10 and 19%
- [ ] between 20 and 29%
- [ ] between 30 and 39%
- [ ] between 40 and 49%
- [ ] between 50 and 59%
- [ ] 60% and over

19. Approximately what percentage of your patients with **NIDDM**, in addition to their regular health care needs, see you specifically for their well diabetic care?

- [ ] less than 5%
- [ ] between 5 and 9%
- [ ] between 10 and 19%
- [ ] between 20 and 29%
- [ ] between 30 and 39%
- [ ] between 40 and 49%
- [ ] between 50 and 59%
- [ ] 60% and over

20. Approximately what percentage of your patients with diabetes did you personally diagnose?

- [ ] less than 10%
- [ ] between 10 and 19%
- [ ] between 20 and 29%
- [ ] between 30 and 39%
- [ ] between 40 and 49%
- [ ] between 50 and 59%
- [ ] 60% and over

21. Approximately what percentage of these patients that you diagnosed with diabetes presented with clinical symptoms?

- [ ] less than 10%
- [ ] between 10 and 19%
- [ ] between 20 and 29%
- [ ] between 30 and 39%
- [ ] between 40 and 49%
- [ ] between 50 and 59%
- [ ] 60% and over

22. Do you refer your patients with **IDDM** to Specialist clinics for their well diabetic care:

- [ ] all of the time
- [ ] most of the time
- [ ] some of the time
- [ ] rarely
- [ ] never

- [ ] never had a patient with **IDDM**
APPENDIX Q

23. Do you refer your patients with NIDDM to Specialist clinics for their well diabetic care:
   □ all of the time  
   □ most of the time  
   □ some of the time  
   □ rarely  
   □ never  
   □ never had a patient with NIDDM

24. When you refer your patients with diabetes to a Specialist clinic do you usually use the same one or two?
   □ all of the time  
   □ most of the time  
   □ some of the time  
   □ rarely  
   □ never  
   □ do not usually refer to Specialist clinics

25. When you refer your patients with diabetes to a Specialist clinic do you regularly discuss the details of these patients with the specialist(s):
   □ frequently  
   □ regularly  
   □ occasionally  
   □ rarely  
   □ never  
   □ do not usually refer to Specialist clinics

26. How many GPs work at the private practice where you work? (please specify __________)

27. How many days a week do you work at this private clinic? (please specify __________)

28. Approximately what percentage of your patients with diabetes return regularly to the private practice where you work?
   □ less than 10%  
   □ between 10 and 19%  
   □ between 20 and 29%  
   □ between 30 and 39%  
   □ between 40 and 49%  
   □ between 50 and 59%  
   □ between 60 and 69%  
   □ between 70 and 79%  
   □ 80% and over

29. Approximately what percentage of your patients with diabetes specifically ask for you when they book return appointments at the private practice where you work?
   □ less than 10%  
   □ between 10 and 19%  
   □ between 20 and 29%
APPENDIX Q

II. Relationship With Your Patients With Diabetes

For the following statements circle the number which best describes how you feel:
1 - if you strongly agree
2 - if you simply agree
3 - if you have no opinion
4 - if you simply disagree
5 - if you strongly disagree
NA - (not applicable) if the question does not apply to you

30. Diabetes is an incurable illness.
   1 2 3 4 5 NA

31. It is up to me to prescribe a diabetic regime which my patients are expected to follow.
   1 2 3 4 5 NA

32. I believe that good glucose control significantly reduces complications.
   1 2 3 4 5 NA

33. I believe the team approach is the best way to help people with diabetes achieve their best glucose control.
   1 2 3 4 5 NA

34. My patients with diabetes usually need more time for their appointments than patients without diabetes.
   1 2 3 4 5 NA

35. I usually manage to provide more time for my patient with diabetes than patients without diabetes.
   1 2 3 4 5 NA

36. Educating my patients with diabetes to the various aspects of self-care takes up a large proportion of my consulting time.
   1 2 3 4 5 NA

37. I feel relatively up-to-date on the latest research findings regarding diabetic management.
   1 2 3 4 5 NA

38. I believe it is important that physicians be generally aware of the social circumstances of their patients with diabetes.
   1 2 3 4 5 NA

39. I usually ask my patients open-ended questions about their health.
   1 2 3 4 5 NA

40. I believe that my patients will feel better when they achieve good glucose control.
   1 2 3 4 5 NA
### APPENDIX Q

<table>
<thead>
<tr>
<th>Question</th>
<th>Score Options</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. I often try to personalise a diabetic regimen which best suits each patient’s lifestyle.</td>
<td>1 2 3 4 5 NA</td>
<td></td>
</tr>
<tr>
<td>42. I often try to consider my patients’ financial circumstances when I prescribe medicines.</td>
<td>1 2 3 4 5 NA</td>
<td></td>
</tr>
<tr>
<td>43. Sometimes I find it a waste of time to counsel my patients with diabetes on lifestyle changes because my advice is often ignored.</td>
<td>1 2 3 4 5 NA</td>
<td></td>
</tr>
<tr>
<td>44. I am usually available to answer questions for my regular patients over the telephone.</td>
<td>1 2 3 4 5 NA</td>
<td></td>
</tr>
<tr>
<td>45. I usually explain to my patients the importance of keeping their regular “well” check-up appointments with me.</td>
<td>1 2 3 4 5 NA</td>
<td></td>
</tr>
<tr>
<td>46. I feel my role as a patient educator when treating my patients with diabetes is important.</td>
<td>1 2 3 4 5 NA</td>
<td></td>
</tr>
<tr>
<td>47. I think my job as a GP should included giving advice on eating habits to my patients with diabetes.</td>
<td>1 2 3 4 5 NA</td>
<td></td>
</tr>
<tr>
<td>48. I think my job as a GP should included giving advice exercise habits to my patients with diabetes.</td>
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III. Relationship With This Particular Patient with Diabetes

Patient Code: __________

Please complete the following “minute questionnaire” immediately after the above patient leaves your consultation room.

For the following statements circle the number which best describes how you feel:
1 - if you strongly agree
2 - if you simply agree
3 - if you have no opinion
4 - if you simply disagree
5 - if you strongly disagree
NA - (not applicable) if the question does not apply to you

1. I have met with this patient a number of times.
   1 2 3 4 5 NA
2. I feel I understand this patient’s day to day experiences of living with diabetes very well.
   1 2 3 4 5 NA
3. I believe that this patient wants a GP to take charge and make the decisions which relate to their health care regimen.
   1 2 3 4 5 NA
4. I believe that this patient wants a GP who acts as a health care consultant whose role is to help patients make informed choices in their diabetic regimen.
   1 2 3 4 5 NA
5. I feel that this patient and I are well matched with regard to our expectations of each other.
   1 2 3 4 5 NA
6. The time I take in diabetic education activities with this patient is usually time well spent.
   1 2 3 4 5 NA
7. This patient is motivated to keep to their diabetic regimen.
   1 2 3 4 5 NA
APPENDIX R

Questionnaire for Polyclinic Doctors

1. Background Information

1. Sex: □ male □ female

2. Nationality: □ Singaporean □ other (please specify ____________________________)

3. Ethnic group: □ Chinese □ Malay □ Indian
   □ Caucasian □ other (please specify ____________________________)

4. Which year did you graduate from medical school? _________

5. Language(s) that you are functional in: (tick off as many as apply to you): □ Mandarin □ Chinese dialect
   □ English □ Malay □ Indian □ Tamil
   □ other (please specify ____________________________)

6. Language(s) that you usually converse with your patients at the polyclinic: (tick off as many as apply):
   □ Mandarin □ Chinese dialect □ English □ Malay
   □ Indian □ Tamil
   □ other (please specify ____________________________)

7. Language(s) that you occasionally converse with your patients at the polyclinic: (tick off as many as apply):
   □ Mandarin □ Chinese dialect □ English □ Malay
   □ Indian □ Tamil
   □ other (please specify ____________________________)

8. How long have you been working at a polyclinic? _________

9. Did you attend medical school in Singapore? □ yes □ no
   If no, where did you attend medical school? (please specify ____________________________)

10. Did you complete any of your post-graduate training abroad? □ yes □ no
    If yes, where did you complete your post-graduate training? (please specify ____________________________)

11. Have you heard of the "Diabetes Training Programme" offered by the Ministry of Health for GPs and primary health doctors: □ yes □ no

12. Have you completed the above training program? □ yes □ no
APPENDIX R

2

If yes, did you find this course of practical value in learning how to better meet the health care needs of your patients with diabetes?

☐ absolutely
☐ found many practical applications
☐ somewhat
☐ not at all

13. Do you generally find post-graduate courses offered by the Ministry of Health helpful?

☐ all of the time
☐ most of the time
☐ some of the time
☐ rarely
☐ never
☐ never taken one

14. Do you generally find post-graduate courses offered by the College of Family Physicians helpful?

☐ all of the time
☐ most of the time
☐ some of the time
☐ rarely
☐ never
☐ never taken one

15. Approximately how many patients do you see at the polyclinic during a typical day?

☐ less than 10
☐ between 10 and 19
☐ between 20 and 29
☐ between 30 and 39
☐ between 40 and 49
☐ 50 and over

16. Approximately what percentage of your patients have diabetes?

☐ less than 5%
☐ between 5 and 9%
☐ between 10 and 14%
☐ between 15 and 19%
☐ between 20 and 25%
☐ 25% and over

17. Approximately what percentage of your patients with diabetes are insulin dependent (IDDM)?

☐ less than 1%
☐ between 1 and (including) 4%
☐ between 5 and (including) 9%
☐ between 10 and (including) 14%
☐ 15% and over
18. Approximately what percentage of your patients with **IDDM**, in addition to their regular health care needs, see you specifically for their well diabetic care?

- less than 10%
- between 10 and 19%
- between 20 and 29%
- between 30 and 39%
- between 40 and 49%
- between 50 and 59%
- 60% and over

19. Approximately what percentage of your patients with **NIDDM**, in addition to their regular health care needs, see you specifically for their well diabetic care?

- less than 5%
- between 5 and 9%
- between 10 and 19%
- between 20 and 29%
- between 30 and 39%
- between 40 and 49%
- between 50 and 59%
- 60% and over

20. Approximately what percentage of your patients with diabetes did you personally diagnose?

- less than 10%
- between 10 and 19%
- between 20 and 29%
- between 30 and 39%
- between 40 and 49%
- between 50 and 59%
- 60% and over

21. Approximately what percentage of these patients that you diagnosed with diabetes presented with clinical symptoms?

- less than 10%
- between 10 and 19%
- between 20 and 29%
- between 30 and 39%
- between 40 and 49%
- between 50 and 59%
- 60% and over

22. Do you refer your patients with **IDDM** to Specialist clinics for their well diabetic care:

- all of the time
- most of the time
- some of the time
- rarely
- never
- never had a patient with **IDDM**
APPENDIX R

23. Do you refer your patients with NIDDM to Specialist clinics for their well diabetic care:
   □ all of the time
   □ most of the time
   □ some of the time
   □ rarely
   □ never
   □ never had a patient with NIDDM

24. When you refer your patients with diabetes to a Specialist clinic do you usually use the same one or two?
   □ all of the time
   □ most of the time
   □ some of the time
   □ rarely
   □ never
   □ do not usually refer to Specialist clinics

25. When you refer your patients with diabetes to a Specialist clinic do you regularly discuss the details of these patients with the specialist(s):
   □ frequently
   □ regularly
   □ occasionally
   □ rarely
   □ never
   □ do not usually refer to Specialist clinics

26. How many doctors do you work with at the polyclinic? (please specify __________)

27. How many days a week do you work at the polyclinic? (please specify __________)

28. Approximately what percentage of your patients with diabetes return regularly to the polyclinic where you work?
   □ less than 10%
   □ between 10 and 19%
   □ between 20 and 29%
   □ between 30 and 39%
   □ between 40 and 49%
   □ between 50 and 59%
   □ between 60 and 69%
   □ between 70 and 79%
   □ 80% and over

29. Approximately what percentage of your patients with diabetes specifically ask for you when they book return appointments at the polyclinic where you work?
   □ less than 10%
   □ between 10 and 19%
   □ between 20 and 29%
II. Relationship With Your Patients With Diabetes

For the following statements circle the number which best describes how you feel:
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30. Diabetes is an incurable illness.
   1 2 3 4 5 NA

31. It is up to me to prescribe a diabetic regime which my patients are expected to follow.
   1 2 3 4 5 NA

32. I believe that good glucose control significantly reduces complications.
   1 2 3 4 5 NA

33. I believe the team approach is the best way to help people with diabetes achieve their best glucose control.
   1 2 3 4 5 NA

34. My patients with diabetes usually need more time for their appointments than patients without diabetes.
   1 2 3 4 5 NA

35. I usually manage to provide more time for my patient with diabetes than patients without diabetes.
   1 2 3 4 5 NA

36. Educating my patients with diabetes to the various aspects of self-care takes up a large proportion of my consulting time.
   1 2 3 4 5 NA

37. I feel relatively up-to-date on the latest research findings regarding diabetic management.
   1 2 3 4 5 NA

38. I believe it is important that physicians be generally aware of the social circumstances of their patients with diabetes.
   1 2 3 4 5 NA

39. I usually ask my patients open-ended questions about their health.
   1 2 3 4 5 NA

40. I believe that my patients will feel better when they achieve good glucose control.
   1 2 3 4 5 NA
APPENDIX R

41. I often try to personalise a diabetic regimen which best suits each patient's lifestyle.
   1 2 3 4 5 NA

42. I often try to consider my patients' financial circumstances when I prescribe medicines.
   1 2 3 4 5 NA

43. Sometimes I find it a waste of time to counsel my patients with diabetes on lifestyle changes because my advice is often ignored.
   1 2 3 4 5 NA

44. I am usually available to answer questions for my regular patients over the telephone.
   1 2 3 4 5 NA

45. I usually explain to my patients the importance of keeping their regular "well" check-up appointments with me.
   1 2 3 4 5 NA

46. I feel my role as a patient educator when treating my patients with diabetes is important.
   1 2 3 4 5 NA

47. I think my job as a doctor should included giving advice on eating habits to my patients with diabetes.
   1 2 3 4 5 NA

48. I think my job as a doctor should included giving advice exercise habits to my patients with diabetes.
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