

# Protecting Patients' Interests While Being Fair to Doctors – Finding a Healthy Balance

Text by Dr Tan Chi Chiu



The 2016 edition of the Singapore Medical Council's (SMC) Ethical Code and Ethical Guidelines (ECEG) and its accompanying resource document, SMC Handbook on Medical Ethics (HME), were released in September 2016. In the intervening period since the 2002 edition, medical practice has seen advancing technologies and many innovative treatments. New communication technologies allow for varied modes of patient-doctor interactions and for information on doctors' services to be easily publicised. There are also new organisational and business models as medical practice becomes more commercialised. Some areas of practice, such as end-of-life care, telemedicine, aesthetic practices and the increasing popularity of various complementary and alternative practices, have grown in significance.

Patients need to be assured that their best interests continue to be protected in these areas, as with others.

The patient-doctor relationship has changed as well. Patients are more educated, better informed and keen to be active participants in their personal healthcare. Knowing their rights, there are more patients seeking redress for a variety of perceived wrongs. Doctors may sometimes feel somewhat under siege by complaints and lawsuits. Add to this an increasingly medico-legal environment that involves lawyers and the Courts, and we have a milieu that takes a toll on mutual trust, confidence and goodwill.

In this new environment, I was tasked by SMC with the job of leading a working committee to update the

ECEG, in order to educate and guide doctors in improving their medical practice and meeting their ethical obligations. As an international medical centre of excellence, Singapore needs to have a world class medical ethics framework to match. The ECEG was revised with the following principles in mind: (a) Relevance to the complexities and variations of modern medical practice; (b) Promotion of values important to society and the medical profession; and (c) Demonstration that the profession is worthy of its society-conferred privilege of self-regulation. It is noteworthy that in several developed jurisdictions around the world, the medical profession failed to adequately self-regulate and protect society, leading to the privilege of self-regulation being rescinded and professional discipline being placed in

the hands of government-appointed lay persons. This is a fate that the medical profession in Singapore must seek to avoid.

### Drafting of the new ECEG

My experience in preparing the 2016 ECEG contrasted starkly with that of the 2002 ECEG. Back then, it was a straightforward process of the working committee writing a draft for consultation with doctors over a focus group meeting and completing the process to everyone's satisfaction within a couple of months. This time, the process took nearly six years, involving multiple rounds of consultations and feedback from the medical fraternity. A great diversity of views from medical professionals, institutions and professional bodies, many strongly held, was received and duly considered. It showed us that doctors are now less trusting that they would be fairly treated. Our challenge was to find a path that properly protects patients, but is also well accepted by a broad consensus of the profession, thus ensuring that the ECEG is fully respected by patients and doctors alike.

Medical ethics guidelines seek to ensure that when patients encounter the healthcare system, their welfare, both as an individual and as part of society, are comprehensively protected. The basic principles of medical ethics are: (a) *Beneficence* – the principle that patients must receive clear benefits and not useless treatments; (b) *Non-maleficence* – which is to minimise harm while ensuring net benefit to patients; (c) *Respect for autonomy* – where doctors have a duty to enable patients to make the choices consistent with their best interests; and (d) *Justice* – where doctors are to treat patients fairly and equitably, within resources available, with respect for the rights of the community and the laws of the land. The situational guidelines which flow from these principles emphasise to doctors the importance of providing the required standard of clinical care through good practices, building excellent relationships

with patients and colleagues, maintaining competency and fitness to practise, ensuring proper sharing of information with patients and the public, and avoiding acting out of various kinds of conflicts of interest.

In applying a codified approach to the ECEG, we followed the examples of numerous other countries that have well-developed modern ethical frameworks. These include the UK, Ireland, Canada, Australia, New Zealand, the US and Hong Kong. Helping doctors to fulfil ethical standards ought to foster public trust in the profession and lead to less misunderstandings and mismatched expectations, less inappropriate treatment, fewer complaints and lawsuits, less defensive medicine and an overall reduction in healthcare costs.

We did our utmost to ensure that the guidelines do not overly narrow the limits of ethical behaviour and are based on principles. Doing so allows a range of reasonable responses and for peer review as the means of assessing a doctor's performance or behaviour, in any situation. In fact, peer review by fair and reasonably minded doctors of suitable qualifications and experience underpins the entire disciplinary framework of SMC, as well as actions in the Courts, should doctors be challenged. Peers would have to decide whether the approach of a particular doctor lies so far outside an acceptable range of options in a particular situation that there may be an ethical breach.

We were also mindful that the guidelines must not increase the risk of malicious and unmeritorious complaints or lawsuits for doctors. While no one can be prevented from mounting an unsustainable and unjustifiable challenge, the application of the ECEG by peers will protect a doctor whose actions fall within a reasonable range. And even outside such a range, there is still the territory of "errors of judgement", where despite the bad outcome, decisions were made sincerely and diligently and therefore not unconscionable. We only intend

conduct that is clearly harmful to patients, or that destroys public trust in the integrity and honesty of the medical profession, to qualify as professional misconduct.

### Understanding its objective

This is not to say that patients are generally given to mounting frivolous or vexatious actions against their doctors. In my experience as the chairman of Complaints Committees, patients complain because they genuinely feel aggrieved in some ways. About a fifth of complaints involve miscommunication, while more than a third reflect misaligned expectations and perceptions of unsatisfactory care. Nine out of ten complaints brought to the Complaints Committees stop there. It is noteworthy that the ECEG is as much the basis for the nine cases dismissed as for the one case sent to the Disciplinary Tribunal.

The vast majority of doctors practise ethically and deserve the confidence of their patients and the public. However, some doctors may be caught out due to ignorance or confusion about their ethical obligations. A detailed ECEG will help these doctors greatly. As with the criminal law that addresses a small minority of miscreants in the population, the ECEG has a punitive impact only on those who deliberately ignore the required standards and whose actions damage the reputation of the profession. Other than this, the far greater intended role of the ECEG is to have a positive effect in improving professional practice.

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The preservation of good patient-doctor relationships hinges on a mutual understanding of each other's rights and obligations. On our part as doctors, three things are necessary. (1) We need to go back to the basics and assimilate the fundamental tenets of medical ethics in managing patients, setting aside extraneous considerations that may interfere with this. (2) We need to establish excellent patient-doctor relationships based on mutual trust and respect, and resist viewing such relationships as transactional. (3) We need to improve communications with patients to support their autonomy. The ECEG helps us to improve in all of these areas.

Patients (and persons who legally represent minors and those with diminished mental capacity) also have a part to play. Where possible, patients should take their share of responsibility for their own healthcare, regard doctors as partners and actively participate in decision-making. Where it is not an emergency, being proactive includes doing prior research as to which doctors are right for them, based on the doctors' qualifications, experience, reputation and even price of services, so as to avoid mistaken expectations. Patients should also strive to communicate

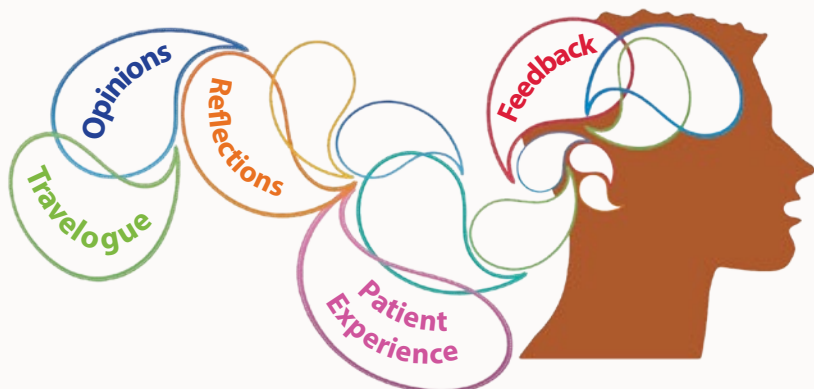
better with doctors by asking questions and voicing up concerns before deciding on any treatment, while doctors strive to encourage this during consultations. Finally, patients should understand that unreasonably high expectations would be impossible to meet in real life. The practice of medicine, like everything else, is not perfect.

### Concluding thoughts

Above all, we need to avoid an adversarial approach to medical practice. Doctors should never regard a patient as a potential complainant or litigant but as "a fellow creature in pain", as the ancient Oath of Maimonides expresses it. Patients should not approach doctors with an *a priori* attitude of mistrust that would engender defensive medical practices that do not benefit them and would escalate healthcare costs. Mutual trust and respect are required of all parties.

The tension between protecting patients and being fair to doctors has always existed, but I believe that the 2016 ECEG can achieve a healthy balance that will improve clinical practice and enhance patient-doctor relationships. ◀

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