Professional Standards and Ethical Aspirations – Should They Be One and the Same?

By A/Prof Chin Jing Jih

ONE OF the questions that I often encounter when discussing medical ethics with students and residents is: "Is there any difference between the standards for medical law and medical ethics?" I am always delighted when posed with this query as it stimulates a rich discussion and facilitates understanding of the role of ethics in our profession. This frequently asked question also suggests that even among our young students and doctors, there is an intuitive sense that while the two standards have a common intended goal of drawing certain boundaries for doctors' professional practice and conduct, they nevertheless have some important and distinctive differences.

Comparing the two concepts

In one of the classes, a medical student remarked, "Surely one cannot be on the wrong side of the law, regardless of what the profession aspires to do?" Indeed, medical law and health regulations do define a minimum standard expected of medical practitioners in their engagement with patients, and falling below this minimum standard would be considered a failure to carry out the duty of care or medical negligence.

But we should keep in mind that the medical profession did not earn its respect and admiration through these minimum standards. A significant part of society's high regard for the profession today comes from the selfless patient-first ethos of the profession, and the excellent work of virtuous doctors who came before us, as they exemplified these virtues through the way they cared for patients. Dr Edward Pellegrino, the great teacher of medical ethics and professionalism, advocated these professional values in his seminal writings and labelled them the "virtues of medicine", which included fortitude, temperance, justice, wisdom, fidelity to trust, compassion, integrity, self-effacement, and *phronesis* (Greek for "moral insight"). These are highly desirable virtues that elevate a medical practitioner to the pedestal of a virtuous physician.

The critical question, however, is where do these desirable virtues or ethical aspirations of the profession sit in relation to medical regulations that deal with minimum requirements, which are used to ensure a minimum standard of care rendered to patients? Is it appropriate to adopt these virtues as minimum requirements for the purpose of regulating the standard of care delivered by doctors? Let us put it in a different way. Is it fair and practical to make these praiseworthy conduct and ideals the basis of a set of professional standards enforced via a regulatory framework? Rules and regulations are generally designed to ensure that the standard of care and professional conduct do not fall below a certain minimum standard. But one can foresee serious conceptual and practical challenges if this minimum standard were to be pitched at the conduct and behaviour that reflect the aspirations and virtues of the profession.

An analogy that I routinely use to illustrate the point to my students relates to a problem that most Singaporeans are familiar with – littering. While we may be accustomed to, and accept without much protest, the strict laws against littering (which now carries a fine not exceeding $1,000 for the first offence), citizens would unlikely accept a law demanding that all *must* also pick up rubbish dumped by others. Such a regulation would seem harsh, impractical and counterproductive to the promotion of social responsibility. Perhaps one *should* or *ought to* pick up rubbish thrown carelessly by other citizens, as it would constitute highly commendable behaviour, but should never come across as a *must*.

The Income Tax Act prescribes punitive measures against those who evade taxation. However, charitable donations to the needy cannot and should not be similarly made compulsory by law, for charity is premised upon the social virtue of altruism and generosity. To make donations compulsory would be unjust and making it no different from taxation.

Similarly, in a soccer match, a player is prohibited from deliberately tripping his opponent in order to gain an unfair advantage. This is the rule of the game. If a player who was not responsible for the fall helps his opponent to get up quickly, his actions would be considered praiseworthy, as it reflects the sportsmanship desired in every player. Nonetheless, it should never be compulsory behaviour demanded from every

player by default, with punishment meted out to players who fail to help opponents in this way.

There are certainly similar parallels in medical practice itself that serve to illustrate the two confusing standards, and combining them into one is not helpful at all. For example, a doctor is expected to be polite to patients, but it would be ridiculous to prosecute him for professional misconduct simply because he failed to establish eye contact and use empathic cues in his clinic (despite these being strongly recommended in medical communication courses).

Another example is taking a proper and valid informed consent. Doctors are required by standards established in case law to take valid informed consent that is conditioned upon the provision of sufficient relevant information. They also have to ensure that patients have adequate mental capacity to arrive at a decision and are not under any undue coercion, inducement or circumstances of limited free will when consent was given. Beyond these elements, doctors should also ensure that patients understand all aspects of their decision, which should also be consistent with their values and beliefs. However, in actual practice, there are often elderly patients who, owing to their own illiteracy, prefer to trust their doctors and would give consent freely despite a lack of genuine comprehension. While this is not ideal, doctors cannot and should not be judged as being unprofessional just because these patients have not achieved full understanding of their conditions. Such doctors should be given some room to argue that they have made reasonable attempts to fulfill the three elements of informed consent in circumstances peculiar to their case. I would argue that using these examples as best practice or ethical guidelines are a more practical and reasonable approach than pitching them as regulatory standards.

Nurturing medical ethics

The practice of Medicine today is complex and wrought with uncertainty. Context is often critical to the interpretation of behaviour and outcome. Hence, it would be inappropriate to use language that is uncompromising and which prescribes absolute standards in documents that are advocating praiseworthy conduct.

I recall a case study, that was used in an ethics conference I attended in the US some years ago, which went something like this: an interventional cardiologist was rushing out of his clinic when he encountered a patient in the lift complaining of chest pain. The cardiologist promptly gave directions to the nearest Cardiology clinic, which was two floors away in the same building, and continued to his destination. If the patient were to collapse and die before reaching the clinic, legal liability aside, did the cardiologist behave unprofessionally by failing to act as a Good Samaritan? Certainly, one would tend to agree that this was professionally unacceptable if he were just rushing to meet his friend for lunch. However, if he were rushing to the hospital's interventional Cardiology suite to perform a potentially life-saving emergency percutaneous coronary intervention for his patient, to whom he definitely owes a duty of care, then his conduct would seem acceptable. It is important to acknowledge that systems dealing with complexities will always have variance and exceptions, and we must not prescribe only one set of acceptable behaviour based on a narrow set of presumptions.

> "THE ULTIMATE OBJECTIVES OF MEDICAL PROFESSIONALISM ARE TRUST AND RESPECT, AND THESE SHOULD BE BETTER FACILITATED BY MORALITY RATHER THAN REGULATIONS."

It can be seen from the above case study that principles to encourage commendable behaviour, such as acting as a Good Samaritan and treating sick individuals that we encounter outside of our practice spaces, are best placed in the sphere of ethical guidelines. In that way, there is sufficient latitude for interpretation and justification for cases that deviate from the expected conduct. Framing such principles as narrow mandatory standards is clearly too restrictive and can, in certain contextual circumstances, be inappropriate and even unjust.

Without going through a journey of education and training, and implementing systems changes aimed at developing a practice culture and environment conducive to professional excellence, setting high ethical standards as the minimum standards for regulating professional conduct will likely cause many medical practitioners to be guilty of ethical violations. This will have a negative impact on the integrity and self-esteem of the profession, and simultaneously lead to practical difficulties in enforcement.

Regulating at an inappropriate moral plain can also potentially result in a reactive culture of fear, leading to overcompensation among practitioners. Many will seek shelter through the practice of defensive Medicine, where the cost and risks are eventually transferred back to patients. Under such conditions, professional standards are fulfilled in a literal and superficial way, but the significant erosion of a trusting doctor-patient relationship can be anticipated.

With the rise of a culture of rights, society is increasingly advocating the control of physicians through the regulation of professional standards, in the interests of the sick and the community as a whole. While this is inevitable and justifiable in some situations, we should not overlook its intrusion into the doctor-patient relationship. The adversarial system of apportioning blame whenever there is a negative outcome, despite good medical practice, will lead to a very different terms of engagement between patients and doctors. The ultimate objectives of medical professionalism are trust and respect, and these should be better facilitated by morality rather than regulations. Increase in regulation and an impractical elevation in the standards expected will naturally inject excessive caution between doctors and patients. As one commentator opined, such developments cannot be in patients' interests if it means that "doctors and patients see each other, by default, as potential adversary". I would speculate further that it will ultimately lead to medical practice, as we know it today, becoming costly and untenable.

The medical profession deals with the two most precious assets of patients – life and health. Therefore, it would be difficult to argue against the need for self or external regulation, and reassure society that minimum expectations, in terms of standard of care and professional conduct, will be met.

But it would be unwise and inappropriate to set behaviours and practices that express the profession's ideals and aspirations as minimum regulatory standards. Moreover, many of these ethical aspirations have yet to be practised in a sustainable way by majority of doctors, and remain unsupported institutionally in their practice environment. Sustained professional excellence is best achieved via the cultivation of sound values and medical virtues through education, training, inspirational role-modelling and system changes, instead of an environment driven by fear of a strict and unrealistic medical penal code. ■

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