Medical Ethics and Doctor-Patient Relationship

By Dr Chew Chin Hin

Editorial Note:
This is a reproduction of a speech (based on the 1998 SMA Lecture) by Dr Chew which was delivered at a seminar on "Medical Ethics: Regulation and Practice", during the NUS Faculty of Medicine's Medical Ethics Seminar and Debate (2001 – 2002) for the Benjamin Chew Shield. This was held on 18 August 2001, at the CRC Auditorium, NUS. The full text for Dr Chew's 1998 SMA Lecture can be viewed online at http://www.sma.org.sg/smj/4001/articles/4001lec1.html

As all of you will graduate from our Singapore Medical School, I thought as an introduction, we should be reminded of the motto of the School's Alumni Association: *"Not to be ministered unto, but to minister"* as this embodies the timeless foundation of medical ethics and the true calling of our profession. A co-proposer for this was my late father Dr Benjamin Chew and comes from the Good Book. He was a graduate in 1929 in the company of our first medical President of Singapore, Dr Benjamin Sheares.

Changes in science and technology are resulting in new techniques in diagnosis, treatment and medical breakthroughs. These changes bring about tremendous excitement for development. However, while much of these can be beneficial to mankind, the medical profession is now and will increasingly be faced with a variety of complex and difficult problems. It is in this context that the motto of our Alumni serves as a rock of our profession. It provides precious reminders that ours is a calling and not a trade. To quote Sir William Osler, "The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head." Central to the doctor's calling is integrity and Dr Johnson wrote: "Integrity without knowledge is weak and useless. Knowledge without integrity is dangerous and dreadful."

To understand the dimensions of these fundamentals, we can consider more deeply the Greek root word of "Minister" - Diakonia that encompasses a wide set of philosophically related tenets linked to our calling as doctors. These actions include not merely service but rather service with humility; expression of care, compassion and charity; service with a determination to heal; awareness and attitude of kindness to the needy and certainly through example – a regard and concern for fellow doctors; and an interest to promote knowledge through teaching.

It is interesting that this same word used to describe the ministering doctor is also used for the highest political office in government leadership implying similarly, a high expectation of those who would hold such positions of responsibility. Let us not overlook the application of minister as also referring to pastoral ministry. Indeed, in keeping with past tradition, we know of several colleagues in Singapore who are holding responsibilities as doctors and the clergy, lay or ordained. In 1981, my successor as Medical Director, Tan Tock Seng Hospital, was called to be the Anglican Bishop of Singapore and later Dr Moses Tay became the Archbishop of our region till his recent retirement. More recently, another alumnus of our medical school was installed as the Methodist Bishop of Singapore, viz. Dr Robert Solomon. No doubt these are exceptional examples and society looks to and depends upon such for constancy, reliability and reference in the midst of change and uncertainty.

THE HISTORICAL EVOLUTION OF MEDICAL ETHICS

Some aspects of medical ethics are fundamental and timeless. However, as medicine does not and cannot stand still, we have to address changes while reaffirming what is fundamental, Therefore, it is helpful for us to review the historical evolution.

Since its earliest recorded history, high standards of ethics, conformity of which, has been a hallmark of a good doctor and a safeguard to the patient's welfare. Ethics is grounded on sound moral, spiritual and philosophical ideals. Thus ethics in the context of medicine concerns itself with the moral principles that underlie the doctor's obligation to the sick and to society.

Amongst the first existing documents that mentioned the priest-physician are those from the Egyptian papyri in 1600 BC and writings about classical Chinese physicians dating around 3000 BC. Such documents outlined methods of establishing diagnosis, guiding decisions on whether to treat and for choice of appropriate therapy. After this, Babylonians devised an elaborate code of laws and even set fees according to social status. The Judaeo-Christian tradition is also rich. Here medical ethics was derived from the Divine Law i.e. the Ten Commandments. It also emphasized the primacy of respect for human life regardless of estate, ethnic group or geographical origins.

The ancient Greeks as exemplified by the legendary Aesculapius, stressed the equality of service to the rich and poor. In the Hippocratic Oath, which has been the touchstone of our profession for over 2,500 years, we see how strongly the responsibility of doctor to patient is held.

As we move from the Mediterranean and Asia Minor to present-day Asia, we have much documentation on the teaching of doctors to uphold a wholehearted devotion to compassion and care. Chinese and Indian medicine, with a heritage of over thousands of years established similar precepts.

In the last millennium, Moses Maimonides, the Jewish physician-philosopher highly respected in Islamic Eqypt, where he was domiciled sometime during AD 1135-1204, integrated various major medical canons of his day. Let us not forget his prayer of a physician, "endow me with strength of heart and mind. So that both may be ready to serve – the rich and poor, the good and wicked, friend and enemy. And may I never see in the patient anything else but a fellow creature in pain."

In Britain, it was only in 1520 that the Royal College of Physicians of London drew up the code of physicians. In the United States, in 1847 following the founding of

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the American Medical Association, a similar code was established, and in 1948 after the Second World War, the World Medical Association adopted the Declaration Of Geneva that represented a revision of the Hippocratic Oath. Since 1995 in Singapore, we have the Singapore Medical Council's Physicians' Pledge.

With this rich heritage in mind, let us look at how a doctor is to apply himself to the various dimensions of relationship facing him and his patients.

THE DOCTOR-PATIENT RELATIONSHIP

Primary Goals and Principles

Central to the delivery of health care is the doctor-patient relationship and the principles that govern this. These include beneficence, honesty, confidentiality and trust. The doctor's first responsibility is and always will be to his patient. His primary goals are therefore to treat and cure where possible; to help the patient cope with illness, disability, and death; and to bring relief in suffering. In all instances, he must help maintain the dignity of his patients.

Patient Consent and Autonomy

In most medical encounters when the patient presents himself to a doctor for consultation and care, consent can be presumed. This is inextricably linked to respect for autonomy of the patient. Indeed, respect for the autonomy of the patient requires that doctors recognize the right of patients to make their own decisions about medical treatment. Effective consultation is based on continuing communication and the provision of relevant information by the doctor in such a way as to enable the patient to make an informed decision. Simply stated, information must be given in terms the patient can understand. This is an important ethical obligation. Relevant information should include the nature of the patient's medical condition, objectives of proposed treatment, treatment alternatives, and the risks involved. The thoughtful doctor communicates in a warm, comfortable and open manner that conveys competence, loyalty and respect for the patient in an attitude that engenders trust and confidence.

Patient Confidentiality and Dignity

Another fundamental tenet of medical care is confidentiality. It is a matter of respecting the privacy of patients and upholding of dignity, encouraging them to seek medical care and to discuss their problems candidly. Thus, the doctor must not release information – without the patient's consent. However, confidentiality is not unconditional. There are circumstances, under which confidentiality may have to be over-ridden, such as to protect individual persons or the public or to disclose information when required by the law e.g. in the notification of some infectious diseases. Before breaching confidentiality, the doctor should make every effort to explain the issues to the patent in a way that minimizes harm, stress or embarrassment.

Confidentiality is becoming increasingly difficult to maintain in our times of computerization and proliferation of information technology. The doctor should be aware of these increased risks of invasion of patient privacy, and apply sensitivity and wise judgement to help ensure confidentiality.

Consultation

No doctor can be expected to be competent in all aspects of medicine. A doctor should never hesitate to obtain assistance when required in the care of his patient or seek consultation when this is requested for by the patient or concerned parties, either openly or tacitly. Under certain circumstances multiple consultations may be required. Misplaced pride has no place in good medical practice and can only compromise care of the patient.

The Impaired Doctor

It has become a legal duty for any doctor who attends to a colleague who is unfit to practice by reason of his mental or physical condition to inform the Medical Council. Further, it is an ethical duty for doctors who find themselves impaired for any reason, to refrain from assuming patient responsibilities, which they cannot discharge safely or effectively. Every doctor is responsible for protecting patients from an impaired doctor, and similarly for helping an impaired colleague by ensuring he receives appropriate advice and treatment. When in doubt, it may be helpful to discuss the issue confidentially with a senior colleague.

Medical Risks to Doctors

Traditionally, the ethical imperative for doctors to provide care has always over-ridden the risks to the treating doctor, even when curing epidemics of life-threatening infectious conditions. In recent times, with better control of such risks, doctors have practised medicine with risks as a diminishing concern. However, potential exposures to new conditions such as HIV infections, multiple drug-resistant tuberculosis, and viral hepatitis require reaffirmation of our ethical duty to treat. Nevertheless, doctors must evaluate the risk of becoming infected both in their personal lives and in the work place, and put in place proper precautions.

Advance Medical Directive (AMD)

One of the pressing ethical issues which the National Medical Ethics Committee addressed, was the care and treatment of patients who are incurable and terminally ill. Today, modern medical technology is able to sustain essential physiological functions and technically prolong life in the final stages of terminal illness. Sometimes it does no more than prolong the process of dying.

A doctor has a duty to sustain life. However, he has no duty – legal, moral or ethical – to prolong the distress of a dying patient. Where there is little or no chance of survival, aggressive treatment of incurable diseases should never be automatically instituted. Invasive procedures, respirators and cardiac resuscitation are all supportive measures used to assist a patient through a critical period of illness towards recovery. Generally, to use such measures for the terminally ill, when there is little or no hope of recovery, is not good medical practice and it also prevents the patient from dying with dignity.

The Committee felt that there would be a need to allow patients to make advance medical directives or AMDs

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to instruct their doctors to withhold or withdraw life sustaining treatment when they are terminally ill with little or no hope of recovery. At this stage, difficult decisions have to be made. They may not only be medical decisions. They are also moral decisions. Without the AMD, doctors may not be prepared to make such decisions on behalf of the patients especially when they are liable to be sued. As Singaporeans become more educated and aware of medical alternatives available, civil suits will become more common and doctors become more inclined to do the safe thing from a legal point of view than to do the correct thing from the professional or moral standpoint.

The AMD provides a means for patients to continue to exercise autonomy over their medical treatment during the final stage of their terminal illness even when they are unable to express their wish. An AMD does not come into effect as long as the person is still able to decide and communicate his wishes. Legislating it would also ensure that the patient's doctors who carry out the instructions expressed in the directive, in good faith and with reasonable care, will not be exposed to legal liability.

CONCLUSION

In closing and as said earlier, some aspects of medical ethics are fundamental and timeless. However, as we have seen, the practice of medicine has changed tremendously. Many still yearn for the return to the simplicity of the past. Such is of course not possible. Nevertheless, as long as we hold true to the mission and spirit of ministering to the sick and to our fellow men, we shall be able to overcome all the challenges to our calling with confidence. ■