

# Medical Ethics in 2005

By Dr Tan Chi Chiu

*In 1969, Dr Tan Joo Liang wrote that “ethics in a profession like medicine is continually developing and adapting not only to changing modes of thought in the profession itself, but also changing social and legal concepts. If this is not so, our Ethical Code will one day be a dead code...”*

Developments in the practice and social organisation of medicine have indeed accelerated in the late 20<sup>th</sup> century and the 21<sup>st</sup> century. Knowledge has burgeoned to the extent that it is no longer reasonable or possible for any single doctor to be up to date with the whole body of medical knowledge and therapeutic modalities. This has led to specialisation and sub-specialisation and a myriad tests and treatments in every field. Medical research has also become more prolific, often with conflicting results, contrasting opinions and increasing difficulty in reaching consensus even amongst doctors. There are many shades of grey. More than before, patients are being asked to participate in decisions about how their medical conditions should be managed. On the other hand, with greater education, our patients demand more knowledge and the right of self-determination. Add to all of this, the global trend to make healthcare less a calling than an economically viable industry, and we have the remaking of the entire social compact between doctors and patients, now sadly also called ‘clients’. Economic imperatives have also foisted upon doctors new demands for complementary and alternative medicine, aesthetic and lifestyle services. Many doctors enter medical-related businesses, or are courted by businesses to endorse products. All of these have potential ethical pitfalls and yet have become part of our professional life.

## THE SMC ETHICAL CODE

The medical profession has traditionally been very conservative in its view of Medical Ethics. The ideal is that a doctor is a humanitarian and a pillar of society. He is well-respected and exists way above the fray of the business world. His good reputation should precede him and he should not stoop to lowly and undignified methods of advertising to tout his services. He always acts in the best interests of his patients and trust in him is absolute. The SMC Ethical Code used to be so strict that even the

dimensions of a doctor’s clinic name plate and its contents were specified. Media exposure was frowned upon and there were many other strictures such as not allowing the use of pictures and logos.

In 2001, the SMC Ethical Code (last published in 1995) was revised and updated. The need was felt to better address the ethical issues encountered in current medical practice. It was timely because of significant changes in medical practice due to rapid technological developments in medicine and in communications, such as the advent of the internet, telemedicine and remote consultations. It was recognised during the review that the Ethical Code and Guidelines is a continuous work-in-progress, since no published guidelines can be either exhaustive or final. However, in promulgating the new rules it was emphasised to doctors that they should go beyond the letter of the rules and abide by the ethical principles enunciated when facing new technologies or adapting to new circumstances.

The major areas which required considerable thought in revising the Ethical Code and Guidelines were communications, advertising, provision of non-mainstream therapies and doctors engaging in business, with much overlap between the last two. Soon after SMC revised its Ethical Code and Guidelines, the Ministry of Health also published the revised Private Hospitals and Medical Clinics (PHMC) Act (Chapter 248), Private Hospitals and Medical Clinics (Publicity) Regulations 2004. Together these two documents govern doctors’ individual professional behaviour and that of institutions and clinics. By 2005, things have already moved on and further thinking about new issues has become necessary.

## MEDICAL ADVERTISING

In the area of medical advertising, we need to recognise that we are living in an information age. Both patients and doctors require more knowledge about medicine and services, so as to make informed choices about what treatment to seek and from whom. Also in an increasingly more liberal environment, where say, lawyers are now free to advertise, doctors are asking for more leeway as well. Then, if we are aiming to make Singapore a regional or global medical hub, the expertise available in Singapore must be publicised within and outside Singapore so that patients can be attracted to our services. The dilemma is how to do all this in a professional and responsible way.



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There is a major shift in the way advertising is regulated. Whereas in the past, guidelines were extensive, exhaustive and explicit, now doctors are asked to abide by a set of principles and guidelines, with no detailed specifications to follow. This more permissive attitude allows doctors greater freedom to advertise. SMC prescribes a set of standards that information in advertising copy must abide by: factual, accurate, verifiable, no extravagant claims/exaggeration/superlatives, not misleading/deceptive, not sensational, not persuasive, not laudatory, not comparative, not disparaging/deprecating of others, not offensive or in bad taste. This list seems rather obvious and is really a reminder of what responsible and professional advertising should be like. The principle is clear: The public should not be induced to seek healthcare services through fear and exploitation of insecurities and weaknesses, and they should be invited to choose doctors on objective criteria rather than on sensational advertising, discounts or free gifts.

With respect to platforms for advertising, SMC merely requires that there be 'one degree of separation' between the information projected and the public recipient. The platform must not be so 'in-your-face' and blatant that the public is bombarded. The public must make a conscious decision to access the information offered. Hence, advertisements in most media are allowed, such as directories, listings, yellow pages, journals, newspapers, magazines and the internet. Brochures and leaflets are also allowed at healthcare facilities, but these must not be inserted into people's mailboxes.

On the other hand, by the same principle, billboards, video monitors in public, banners, posters, TV, cinema or radio commercials are not allowed.

Because the internet is a very powerful tool with interactivity and the allure of images and designs, SMC asks for this medium to be used responsibly. There should be no commercial links, and animation to illustrate medical procedures or outcomes is disallowed as this is fictitious and potentially misleading. Web-chats or email dialogues between doctors and potential patients must conform to the Ethical Guidelines for good clinical care and establishment of a proper doctor-patient relationship.

In the past, doctors could not have their photographs published anywhere, and certainly not photographs of themselves treating patients or pre- and post-treatment photographs. However, we now recognise that visual material is extremely important in information communication and education. Therefore for these purposes, photographs are acceptable if the intention is not to deliberately make a

patient seek medical care that he does not need, raise patients' expectations, or laud a particular doctor's work. Photographs should clearly be only for illustration purposes. In similar vein, patient testimonials are discouraged as these are necessarily subjective and selective.

Doctors in the media are these days, literally, big news. In this instant information age, new medical discoveries and treatments tend to be sensationally splashed in the media. Personality profiles of doctors are also becoming more mainstream, whereas in the past, doctors tended to be more modest. We need to accept such exposure as an inevitable aspect of modern communications. However, the quality of information that a doctor allows in the public domain is still governed by the same standards as for advertising, although it seems increasingly difficult to have doctors appear without sensationalism, laudatory comments or association with celebrities. For releases about medical advances, it would be preferable if such

information had already been peer-reviewed through conference presentation or publication before being announced, so that the material can be deemed factual, accurate and verifiable. Doctors who are engaged in other interesting pursuits or community service may be interviewed by the media, but they should restrain themselves from gratuitously promoting their professional services at the same time. As a principle, SMC requires doctors to take responsibility for the final output about themselves in the media as they have provided most of the material and have sufficient influence over it.

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**COMPLEMENTARY & ALTERNATIVE MEDICINE**

An emerging area of interest is that of complementary and alternative medicine (CAM). Already, the Ministry of Health regulates traditional Chinese medicine (TCM) practitioners and acupuncturists through its TCM Branch, and has set up the TCM Practitioners Board, thus providing a regulatory mechanism to ensure scientific probity and quality of care. However, there remains an enormous territory covering all sorts of interventions under different CAM systems that are increasingly being adopted by registered medical practitioners into their practices. Not only is the variety wide, the boundaries of CAM are also being blurred by the intermixing of traditional CAM with 'health promoting' services involving nutritional supplements, coffee enemas, colonic irrigation, weight loss treatments such as mesotherapy, beautician and other spa-type therapies. Should doctors be involved with all of these?

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The SMC Ethical Code and Guidelines are clear that doctors should not offer patients investigations or treatments that are not scientifically proven or generally accepted by the medical community. It follows that doctors should therefore also not advertise such services. But the truth of the matter is that such practices are already widespread within the medical community. The question is whether to clamp down and prevent doctors from engaging in non-medically proven therapies, or accept them as a fact of life and try to regulate them. The jury is still out on this. The concept of medicine as a business muddies the issue. Since there is evident public demand for such services, and there is much money to be made, why not respond by offering them? Also, if Singapore is to compete with other countries as a 'medical hub', should we not be making our offerings as attractive as possible to as wide a variety of patients as possible, competing for example with medi-spas in Thailand? Doctor-provided services would be very attractive as the doctors would provide a sheen of legitimacy and a sense of safety to these services.

But this is precisely the nature of the dilemma. Should doctors lend their professional names and reputations to non-scientifically proven practices that are also not generally accepted as good clinical practices for the purpose of financial profit? Some countries are more liberal than others. In the United Kingdom, for example, the General Medical Council countenances doctors providing CAM provided there are CAM-specific institutes or bodies that regulate training and accreditation. Registered doctors in the UK are answerable to the same ethical code whether they practise conventional medicine, integrative medicine or purely CAM. There is apparently little requirement that the CAM practices being accredited have the same high standards of evidence of clinical benefit as conventional medicine.

If Singapore is to go the same way, we will require the establishment of credible CAM institutions who can conduct and certify training and regulatory bodies equivalent to the TCM Practitioners Board. When such CAM establishments are set up and there is a clear set of guidelines on what is allowable to practise, what should be restricted to clinical trials and what is completely unacceptable, we will be in a better position to move forward on this issue. Until then, doctors who wantonly offer CAM and spa-type therapies are on ethically hazardous ground.

#### **MEDICINE AS A BUSINESS**

The doctor as a businessman is an increasingly common phenomenon. The SMC Ethical Code and Guidelines do not place any impediment against doctors doing business. However, certain principles must be upheld and these are spelled out in the Ethical Code and Guidelines. A doctor should not abuse his medical position in any way to promote

any product or service he is selling. Even if the product or service is medically sound, he must declare his pecuniary interest to any patient he sells to. If it is not medically proven or non-medical in nature, he should not endorse it as this would be tantamount to misleading the public through his medical qualifications.

There has been much ado about doctors engaging in multi-level marketing schemes involving products such as cosmetics and vitamins. These companies love to have doctors participating as they can add legitimacy to the products. The Ministry of Health has taken a stand that doctors should not engage in these schemes if their medical status exploits public ignorance or pressurises patients to buy. The SMC agrees with this on ethical grounds. Similarly, credit/charge card companies and lifestyle companies like to enhance their businesses by signing up doctors who can offer special discounts if their cards are used, or give loyalty points for redemption of various privileges or products if listed doctors are consulted. The SMC has taken a strong stand against such practices, as they offer inappropriate incentives for the public to seek healthcare services or choose doctors. Such commercialisation also demeans the good name of the profession.

#### **SELF-REGULATION**

It can be seen that the fundamental tenets of medical ethics have changed little with time, but that they have to be adapted to modern circumstances. Doctors no longer hold the same exalted position in society that they did in previous generations, and perhaps they are now regarded no more highly than other professionals, civil servants, military officers or politicians. Medical lawsuits all over the world, including Singapore, are increasing and the public threshold for lodging complaints against doctors is low. Doctors are nowadays perhaps more mainstream than ever before. It could be argued that if doctors are not special, then they should be no more constrained than other businessmen in running their practices.

On the other hand, the special depth of knowledge of the human condition possessed by doctors, the knowledge asymmetry that exists between doctors and patients and the life-changing and death-defying nature of their work remain unique amongst all professions, and so they must continue to regard their profession as humanitarian and noble, with all the responsibilities that this entails. Some balance must be struck. In being less straitjacketed, doctors have more leeway to conduct a practice as a business (not purely as a 'calling' which of course it still is), or be involved in other legitimate business ventures, and doctors have greater latitude to communicate with the rest of society. At the same time, doctors must continue to uphold higher than average standards.

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Finally, a word must be said about the medical profession's own role in the evolution of medical ethics. Ethics should not be something that comes from above. It is no doubt molded by society, but also represents the medical community's own attitudes, philosophies and tolerances at a particular historical period of our society.

We in Singapore have the privilege of professional self-regulation. Current legislation made by Parliament does not provide for policing or surveillance of the profession by an independent body. Rather, it provides for a complaints procedure and disciplinary tribunals to hear cases about breaches in professional standards and ethics. Complaints must first be received from doctors, patients, the public or government bodies, before any action can be taken. Patients and the public are often ignorant of when genuine breaches have occurred and many of their complaints turn out to be the consequence of misunderstanding. Government bodies occasionally uncover breaches that are then made known to the SMC.

It is down to the community of doctors to self-police the profession. When doctors notice unacceptable behaviour, practices or advertising, it is incumbent upon them to complain to the SMC. Unfortunately, doctors tend to be

very tolerant and adopt a live-and-let-live attitude. They also do not want to be known as the accusers, and yet anonymous complaints cannot be accepted. Only when something is overwhelmingly outrageous is a doctor or committee of doctors likely to lay a complaint.

*The result of lack of action from within the profession is that the threshold of tolerance of the medical community rises and ultimately the standard of the norm changes insidiously and unnoticed by the rest of society. There is a risk that eventually, the profession allows so much abuse to remain unchecked that society at large takes notice, becomes outraged and the government is obliged to step in, thus removing the privilege of self-regulation from the profession.*

Hopefully such a situation will not arise. But it will require doctors to be more diligent and conscientious in bringing to book errant members of their own community so that standards are maintained and trust in doctors is not diminished. ■