SMC in-touch

December 2004

Welcome Address by Prof K Satku,

Registrar of the Singapore Medical Council, at The Physician's Pledge Affirmation Ceremony on 8 May 2004 at the Auditorium, Ministry Of Health, College of Medicine Building

The Physician's Mantle

Guest-of-Honour, Mr Khaw Boon Wan, Acting Minister for Health & Senior Minister of State for Finance, Dr Lee Suan Yew, President of the Singapore Medical Council, Distinguished Guests, Colleagues, Ladies and Gentlemen, Good afternoon.

I would like to begin by saying a few words about our Medical Council and introduce the members. The Medical Council is responsible for upholding the professional and ethical standards of practice among doctors, for determining who qualifies to be registered as a medical practitioner in Singapore, and providing inputs on the training and education of doctors.

The Medical Council consists of a total of 19 members. Nine members are registered medical practitioners appointed by the Minister for Health, and another 9 members are elected by all the fully registered medical practitioners in Singapore. The 19th member is the Director of Medical Services, which is me. I serve in an ex-officio capacity as the Registrar.

Five years ago, I had the opportunity to address a class of medical students at the white coat ceremony at our medical school. As you all well know by now, medical students receive a white coat at that ceremony as a symbol of their entry into the clinical years.

Despite the tropical heat and humidity, the teaching hospitals require students to wear the white coat, so that the patients can recognise them as medical students. I assured the students that this would be temporary, and they would not need to wear them once they qualify as doctors. I also assured them that during the course of their training, they would acquire the physician's mantle, an attitude of dignity and compassion that would allow their patients to recognise them as doctors and confidently entrust their lives to them.

Your patients will know that you are their doctor the minute you walk into their room because of the way you carry and conduct yourself, white coat or no white coat. The mantle that you have acquired needs to be cared for. The practice of medicine will exact from you self-sacrifice at every turn. It will demand tenderness towards your fellowmen in the most trying of circumstances. Let your standards down and this mantle will be dimmed.

Today, you are seated here before me, brimming with youth, enthusiasm and aspirations, surrounded by friends and eager to live by the Hippocratic precepts. I remember that feeling.

But over the years, as we move up the professional ladder and get absorbed into the complexities of the healthcare system, we may, find ourselves alone and competing with our fellow physicians, for a share of the commercial pie. It becomes a struggle to balance the effects of corporate mentality on a profession of care, compassion and service. We may begin to question the purpose and values of the medical profession and its traditional commitment to the interest of the patient. These will be trying times.

The President of the College of Family Physicians Professor Cheong Pak Yean, The Acting Master of our Academy of

Medicine Professor Ho Lai Yun and The President of the Singapore Medical Association Dr Lee Pheng Soon are all with us here today. The professional organisations these people represent have a role to maintain the fidelity of our profession's social contract. This entails not only our personal commitment to the welfare of our patients but also collective efforts to improve the healthcare system for the welfare of society.

The new doctors taking The Physician's Pledge.

As members of the professional organisations, we will learn to work collaboratively to maximise patients' care, be respectful of one another, define standards for current and future members and engage in the processes of self-regulation. I sincerely hope that all of you will take up membership with these professional organisations and more importantly lend your talent to these goals.

> *"The Physician's Mantle: Your patients will know that you are their doctor the minute you walk into their room because of the way you carry and conduct yourself, white coat or no white coat."*

Summing up, the science of medicine is evolving rapidly and conditions of practice are continually changing and it will be a challenge for all of us to stay abreast and stay the course. But the art of medicine is old and yet constant.

When you take the pledge today you will be reaffirming these ancient ideals. Ideals that have placed our profession in high esteem. Ideals that still inspire. Ideals that have brought you here today. Your task will be to uphold these high standards and pass them on to the students and younger doctors that you will teach in the course of your practice.

On this note, on behalf of the Medical Council, I would like to congratulate all doctors who have recently become fully registered medical practitioners. I am certain you will bring honour to our profession.

> *"Over the years, as we move up the professional ladder and get absorbed into the complexities of the healthcare system, we may, find ourselves alone and competing with our fellow physicians, for a share of the commercial pie. It becomes a struggle to balance the effects of corporate mentality on a profession of care, compassion and service."*

Doctors And Advertising

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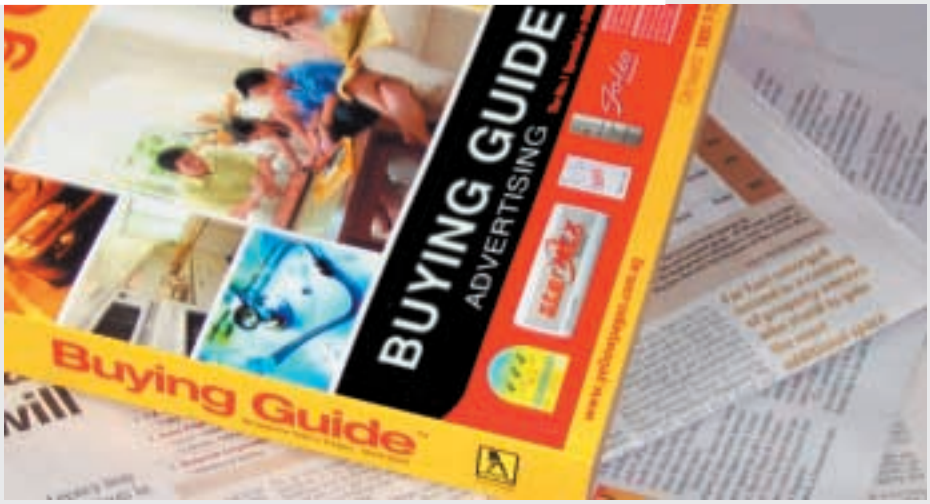
Introduction

Advertising by doctors is an issue that has assumed added importance nowadays due to several developments in our professional practice milieu. Firstly, in this information age, both patients and doctors require more knowledge about medicine and services to make informed choices about what treatment to seek and from whom. Secondly, in an increasingly more liberal environment, different professionals, not least doctors, are asking for more leeway to advertise their services directly to the public.

Finally, we are also aiming to make Singapore a regional if not global medical hub. To do this, the expertise available in Singapore must be publicised within and outside Singapore so that patients can be attracted to our services. Advertising by doctors and healthcare institutions is inevitable and indeed desirable. How this can be done in a professional and responsible way is an issue of great interest and importance.

The Singapore Medical Council's Ethical Code and Guidelines were revised in January 2002 to reflect the evolution of medical ethics, including that governing advertising by doctors. The Ministry of Health published the Private Hospitals and Medical Clinics (PHMC) Act (Chapter 248), Private Hospitals and Medical Clinics (Publicity) Regulations 2004, which has also liberalised the guidelines in a manner consistent with the SMC's Ethical Code and Guidelines. Doctors have received both these documents and it is recommended that they read them.



The SMC Ethical Code and Guidelines govern individual professional behaviour while the PHMC Act governs institutions and clinics. But it is important to note that doctors of large institutions are not absolved of individual responsibility for the institutions' publicity about themselves, and it will not be sufficient to plead ignorance of the nature or content of the organisation's media output. Equally, where doctors and clinics are materially the same, as is the case of single doctor clinics, both sets of rules apply.

> *"The principle governing what platforms are allowable is that there should be "one degree of separation" between the information projected and the public recipient."*

Because the two documents referred to above are not exhaustive, there may be areas in which they are not totally explicit. While the opinions in this article are offered in good faith, it should be noted that MOH and SMC are not bound by the content of this article in the course of handling any issues that may arise.

What is "Publicity"?

In general, this is any form of advertisement, whether printed or transmitted. It covers any mass media and any communication that is usually retrievable by the public by any means.

The principle governing what platforms are allowable is that there should 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 cannot avoid being bombarded by the information. The public must be able to make a conscious decision that they wish to have the information offered.

Approved platforms for publicity include:

- Directories
- Professional and healthcare institution listings
- Yellow Pages and equivalent publications
- Business directories e.g. International Enterprise Singapore
- Medical journals
- Newspapers
- Commercial magazines
- Information brochures, leaflets, pamphlets
- Name cards
- The Internet

Conversely, the following platforms are not allowed:

- Billboards
- Light boxes or video monitors
- Banners
- Posters
- TV or cinema commercials
- Radio commercials

Note that information brochures, leaflets and pamphlets can be placed in clinics and hospital lobbies, but not actively distributed in public places or placed into letterboxes. Similarly name cards can be handed out by the doctor but not distributed unsolicited to the public. Clinic stationery with letterheads should only be used for professional communications and not for other purposes unrelated to the doctor's medical practice.

The Internet is a powerful tool with interactivity and allure of images and designs. Because of its power, using the Internet has added responsibilities.

The standard of information must be very high, websites cannot have 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 SMC's guidelines for good clinical care and establishment of a proper doctor-patient relationship. E-consultation is not appropriate and any "advice" given over the Internet should come with a disclaimer stating that it is not possible to offer individualised advice to a patient without a proper consultation and the patient should seek a proper medical opinion if desired.

Standards for Publicity & Advertising

Members of the profession and the public require information about doctors and medical services. However unlike commercial advertising, medical advertising should not persuade the public to seek healthcare services they do not need, nor cause patients to make a choice based on factors other than objective information about the service.

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Patients seeking information are entitled to protection from exploitation of "knowledge asymmetry" or lack of medical knowledge, misleading or incomplete information, persuasive influence, exploitation of vulnerabilities or ill-founded fear of future health.

Doctors can provide information about:

- Qualifications - only those approved by SMC
- Appointments/titles/ designations - only those approved by SMC, as not all honorary or overseas appointments may be cited.
- Areas of practice - as determined by the Specialist Accreditation Board. Subspecialties are not currently accredited and may not be quoted. However, specific training received by a doctor can be indicated. Non-specialists must not offer services they are not properly trained to provide.
- Practice arrangements
- Contact details

In general, information put out by doctors must conform to these standards:

- Factual
- Accurate
- Verifiable
- No extravagant claims/ exaggeration/superlatives
- Not misleading/deceptive
- Not sensational
- Not persuasive
- Not laudatory (e.g. prominence/ uniqueness)
- Not comparative vs other healthcare providers
- Not disparaging/deprecating of others
- Not offensive/in bad taste such as to bring disrepute to the profession

Patient expectations

There must be no implication that a doctor or a health care institution can obtain results from treatment not achievable by others. In other words, there should be no

laudatory, comparative or disparaging advertising. For example, a statement such as: "You can now have world class treatment in Singapore" is problematic because it implies that until now and with this medical facility, no world class treatment has hitherto been available.

Another example is: "Our technology often eliminates the need for repetitive tests, painful surgical procedures or medical treatments and can diagnose a disease before it shows up on other tests. In one exam, our scanner can help physicians answer questions like: Does the patient have cancer? What is the optimum therapy?" The first problem is that the advertising copy is not factually complete nor accurate. There is no one test that can answer all questions about all types of cancer. Secondly, it is somewhat disparaging in that it suggests that other doctors may be conducting repetitive and painful surgical procedures unnecessarily.

I place under "patient expectations" advertising techniques such as emotive appeal and exploitation of people's weaknesses, insecurities and fears to make them seek medical services. Consider a statement such as: "Regain your confidence and improve your youthfulness! We offer Botox injections, cosmetic surgery, intense pulsed light treatments and endermologie." The appeal to a potential patient's lack of self-confidence and poor body image is unacceptable in medical advertising even though it is a legitimate ploy in commercial advertising. This copy also mixes legitimate medical practice and non-medical therapies, which is not allowed (see below).

Photographs

There has been much discussion about the use of photographs in advertisements including websites, as well as those used in the media such as in newspaper or magazine articles. In the past, "before" and "after" photographs were not allowed because they were deemed sensational, laudatory and would unfairly raise patient's expectations. However, it is recognised that in this information age, visual material is extremely important in communications.

Therefore, for the purpose of information and education, the use of photographs is acceptable if the intention is not evidently to deliberately make a patient seek medical care that he does not need, raise patients' expectations excessively, or laud a particular doctor's work. If visual material is used, there should be an accompanying statement that this is merely for illustration purposes and does not claim to represent the work of any particular doctor, nor does this indicate an outcome that a patient should expect.

Another kind of photograph is that of medical facilities or doctors. This is not usually a problem, unless the photographs are laudatory. A typical example would be a photograph of a doctor taken with a celebrity or VIP. This is clearly laudatory, sensational and unacceptable, as much as putting into the advertising copy names of famous patients in order to put a subjective gloss on a doctor's practice.

Testimonies

Testimonials are subjective, unverifiable and persuasive. It is part of an emotional appeal to prospective patients to say how happy previous patients are with a particular doctor or service. As they are not objective, no testimonies from patients or doctors are allowed in advertising copy or on websites, even via hyperlinks. A typical example would be a statement by a "genuine patient" such as: "I have never experienced a more caring atmosphere than at [named facility]. You have truly created something wonderful." Such statements should not be used in advertising.

Discounts

Many third party healthcare providers such as insurance companies offer their clients, members or subscribers medical services from a list of doctors on contract with them, at lower prices. Such triumvirate arrangements are acceptable within the context of "managed care". However, discounts per se are not allowed to be advertised for the purpose of enticing the public to seek health care services that they would otherwise not seek.

An example of a problematic advertising copy is: "Introducing the [named] bank's special card. You get special privileges. Enjoy a 10% discount at [named medical service]. From health screenings,

dental care, GP consultations and aesthetic services, your special needs will be well cared for." This copy persuades cardholders to seek medical care through the inducement of a discount. This is similar to restaurants offering discounts to cardholders with the expectation that business will increase. This is not acceptable.

Rates for medical care may be stated as fact, but not phrases such as "discount", "0% instalments", "preferential rates", "free to lucky draw participants", "early bird specials", "save $50 to enrol now" etc, all of which entice the public to seek medical care for perceived financial advantage rather than genuine medical need.

Alternative practices

The SMC Ethical Code and Guidelines is 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 advertisements by doctors should also not offer such services.

For example, an advertising copy might read: "A total health care package: Blood screening, including full blood count, liver and kidney tests, cancer markers, anti-oxidant profile. Also enjoy the benefits of full body seaweed wraps and coffee enemas, all under the supervision of medical professionals."

This copy is problematic in several areas. Firstly, it offers "anti-oxidant profile" amidst conventional blood screening tests. (Cancer markers are controversial in themselves, but that is another discussion.) Anti-oxidant profile is not generally accepted as a health-screening test but patients are misled into believing that it is mainstream. Secondly, seaweed wraps and coffee enemas are not acceptable medical therapy and should not be offered by a registered doctor or a registered clinic or hospital. Worse, the emphasis that such treatments are under medical supervision misleads patients into believing that there is proven medical benefit of these treatments.

Public talks, articles in the media and filming

When a doctor speaks, writes or is reported in association with professional bodies, public institutions or professional journals, it is not usually a problem. However, unsolicited information that doctors put or allow to be put into the public domain comes with added responsibilities. A doctor should restrict his public talk, contributed article or interview to the medical topic at hand and not use these as platforms to encourage the public to seek him or his organisation out for treatment.

A doctor's name, specialty, place of practice and special expertise are all factual information and can be included. However, there should be no allusion to the doctor's superior skills or knowledge, nor any association between him and celebrities or VIPs.

Although newspapers and magazines often do not allow interviewees the right to approve the final copy, editors are generally very aware of the special standards doctors are held to. Doctors should specifically remind journalists not to be sensationalistic or laudatory and they should not provide information that they know ought not to go into the copy. Ultimately doctors are held responsible for the final output as they have sufficient influence over it.

> *"A doctor should restrict his public talk, contributed article or interview to the medical topic at hand and not use these as platforms to encourage the public to seek him or his organisation out for treatment."*

Similarly, there may be opportunities for a doctor's premises or a healthcare institution to be filmed either for documentaries or drama. There should be no undue prominence of the doctor's or practice's name in the film and there should be no appearance of solicitation for patients. Acknowledgement is allowed, but in modest fashion.

Sponsorships

Doctors or a practice may sponsor, endow scholarships, donate, participate in or render services for charitable projects. A doctor can have his name and practice appear in the list of benefactors as acknowledgement, but such listing should not appear to encourage the public to seek his or his practice's services.

Advertising overseas

Advertisements overseas should comply with the relevant requirements of the overseas country. MOH or SMC will not enforce Singapore standards on overseas advertising. However, a foreign complainant may submit a complaint to SMC on breaches of local rules and guidelines, thus opening the way for action to be taken against a doctor for unprofessional behaviour.

In general, if advertisements overseas are also reasonably expected to be received or accessible in the normal course of events, the advertisements are deemed to be conducted in Singapore. Examples include foreign published magazines that are circulated in Singapore, foreign TV stations that are routinely received in Singapore or any website which can be located by a search engine.

On the other hand, if receipt of publicity is "incidental", it will not be regarded as being conducted in Singapore. This includes foreign publications that are not routinely available in Singapore. An example is a travel magazine proposed by a trade promotion organisation that is distributed to departing air passengers in India that contains advertorials on medical services and doctors in Singapore. Since it is not distributed in Singapore, and its distribution in Singapore is only incidentally through arriving passengers, the content is not regulated by MOH or SMC. However, if a local newspaper or other media pick it up and secondarily report its contents, then the material would be covered.

Professional self-regulation

The SMC administers a system of professional self-regulation. It does not police nor conduct surveillance, but administers a complaints procedure and holds disciplinary tribunals in cases that are deemed to have potentially breached professional standards. Complaints are received from the public, patients, other doctors, healthcare institutions and the government.

> *"The SMC Ethical Code and Guidelines is clear that doctors should not offer patients investigations or treatments that are not scientifically proven or generally accepted by the medical community."*

In general, activities that do not appear excessive to the community will not attract attention. On the other hand, apathy in the face of falling standards and improper practices will lead to a lowering of professional standards in our society. Self-regulation is an important means of upholding the good name of the medical profession, but it requires the community, not least doctors to be diligent and responsible in alerting the authorities when they see breaches of standards, including those in medical advertising.

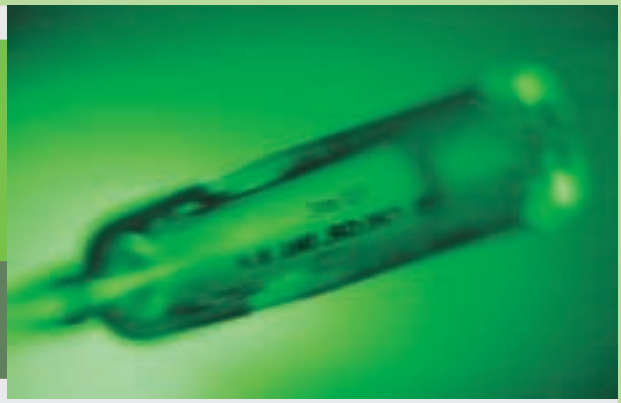
Conclusion

Guidelines promulgated by MOH and SMC are there to protect patients and the vulnerable public and to preserve the good name of the profession. These guidelines are not there to constrain information provision. The principles inherent in the guidelines are more important than the details. These principles can and should be extended to other areas not explicitly covered and to new developments that take place from time to time.

Medical advertising cannot be conducted in the same way as commercial advertising, but nevertheless can be successfully done in a professional and tasteful manner. Standards and acceptable practices will no doubt evolve with time as society changes its expectations and its norms. The guidelines as they now stand will no doubt also evolve and change with time, as it is a dynamic process. As the medical profession proves itself able to maintain professional standards, more leeway will no doubt be given in the future.

Medical Errors And Patient Safety

By Prof Feng Pao Hsii, Emeritus Consultant, Dept of Rheumatology, Allergy & Immunology, Tan Tock Seng Hospital



"As to disease make a habit of two things - to help, or at least, to do no harm."

Hippocrates
Greek Physician (460 BC-377 BC)

Patient safety can be considered as one of the most important aspects of healthcare. Very few patients who see a doctor or enter a hospital would imagine that they may come out worse than when they went in. Unfortunately some of them do. Surgical mishaps like amputating the wrong foot or a deadly chemotherapy overdose make headlines. However the public and patients may never hear of the more subtle errors like a delay in diagnosis and timely treatment because the blood samples were lost or a laboratory result or X-ray report was misfiled. These can also be costly to the patient.

In a report released by the Institute of Medicine (IOM) in November 1999,[1] medical errors in the United States cause from 40,000 to 98,000 deaths per year - more than that caused by AIDS. These figures indeed are alarming but we need to put them into some proper perspective. First of all, "medical" errors involve not only doctors but also involve nurses, pharmacists, health technicians, nursing aides - in short anyone who is working in the complex system of healthcare delivery. Hence medical errors are not about "bad doctors" alone. In fact the IOM reported that errors almost always resulted from poorly defined work systems and not from careless providers. As doctors we all know that it is often very difficult to pinpoint a specific cause for a patient's death. The demise of a patient is often multifactorial. Many research workers and academics have also taken issue with the estimates contained in the IOM report. Critics of the report have noted that the estimates were extrapolated from data collected years ago from just a few hospitals (only 6 in fact). They have also pointed out flaws in the methodology and interpretation of the data. Nevertheless, in a prospective study analysing 18,820 admissions to hospitals in Merseyside, UK, Pirmohamed and colleagues[2] found that 1,225 admissions (6.5%) were related to adverse drug reactions. Hence the medical profession has to recognise that a medical error is indeed an important cause of morbidity and mortality for patients and the problem by and large is fixable. These would include the following:

1. Improve skills and knowledge of the healthcare practitioner

While many reports and studies ascribe medical errors primarily to systems factors, this does not and should not free healthcare practitioners from individual responsibility. The failure of a junior doctor to recognise impending shock in a patient with a falling blood pressure and a rising pulse rate, the failure of a junior nurse to properly suck out a tracheostomy tube and the misplaced attempt of a pharmacist to decipher a doctor's scribble are too mundane to mention - but such errors occur over and over again in hospitals. In such obvious instances the person involved and indeed his or her supervisor should be held responsible.

Besides such obvious examples, healthcare workers are also woefully deficient in mediation and communication skills. Numerous studies have shown that it is not the quality of medical care, chart documentation or poor treatment per se that leads to patient's or their family's displeasure and ire and subsequent litigation. Rather it is ineffective communication and the perception that the doctor or the healthcare person was not completely honest, the inability of family members to get any information and the sense that no one appears to listen form the basis of their complaints. Research also shows that often there is a mismatch between what patients and their families want and what physician and hospitals provide following an adverse event or medical error.

Patients and their relatives want basic information about the event, assurances that they would not suffer financially because of it, an apology and prevention of similar events or errors in the future. Physicians and hospitals often "guided" by their lawyers respond by choosing their words carefully, mentioning the event but not that an error has occurred, and failing to reveal what caused the error, how it might have been prevented and how they may have acted differently in the future. Therein lies

the great divide and often the root of the problem.

In an attempt to provide more transparency and disclosure, the States of Pennsylvania, Nevada and Florida, US, have imposed on hospitals a statutory duty to notify patients or their families either verbally or in writing of a serious event resulting in injury or death of a patient within 7 days[3]. It is hoped that with such an undertaking, medical errors will be reduced. Many other countries are considering similar legislation.

2. A String of Mistakes - Cascade Analysis

While some errors are easy to recognise (e.g. adverse drug events, surgical mishaps) most error incidents are not single acts but a chain of events[4]. Prescribing the wrong dose of a drug may be counted as a single error or event but this error may have occurred because the medical record contained an incorrect body weight or because a laboratory report was missing or because the doctor was just plain tired after a long night duty. In a recent study looking at the working hours of nurses, the risks of making an error were significantly increased when work shifts were longer than 12 hours, when nurses worked overtime or when they worked more than 40 hours per week[5].

In a 6-country analysis of errors in primary care, a chain of errors were identified in 77% of incidents[4]. 80% of errors that initiated the cascade involved informational or personal miscommunication between doctors, patients and their colleagues, wrong information in the medical records, mishandling of patient's requests and messages, inaccessible medical records and inadequate reminder systems. About 50% of these resulted in some form of "harm" to patients. The importance of such cascade analysis is to identify faulty systems so that they can be fixed.

3. Reducing medical errors with technology

It is obvious that information is a key element to reduce medical errors and improve patient safety[6]. Technology resources can be used to document patient clinical data, drug prescription and interaction and retrieve patient information at the point of care. However, mere provision of such hardware is insufficient to influence patient safety. Students and faculty members must also possess the necessary competence to use these tools and resources. Consequently introducing health and nursing informatics in the students' curriculum is necessary to enhance competencies of the next generation of providers.

However in our present obsession with designing new computer programmes and establishing safety committees we must also not forget the central element in all this - the patient. In fact one element that doctors and the system have not utilised adequately is sitting in the waiting room - the patient himself or herself. For a safety system to work, patients must know what is wrong with them, what options are available for treatment, what drugs are being prescribed and what are the side-effects. The reticent or silent doctor has no place in the present healthcare scene. He or she is better off in the laboratory dealing with rats. Many patients now turn to the Internet for information. The Internet is a double-edged weapon and is unregulated. Doctors and healthcare workers have to guide patients to differentiate the genuine from the obviously fraudulent sites. An informed patient is a safer patient and will have a better outcome. However, an informed patient is not created overnight or at the point of a single clinical encounter. It is through better public and doctor education and health promotion.

Conclusion

It is obviously unrealistic to expect zero error or death due to medical mistakes - yet one mishap or one death is one too many. There needs to be a change in the mindset of the healthcare industry and its practitioner. Besides individual responsibilities that are obvious, there must be new designs of equipment and better use of technology like in the transport and aviation industry. Just as engineers design cars so that they cannot start in reverse and airlines limit pilots' flying time, similar models should be followed in healthcare.

An important step has been made with the 1999 Institute of Medicine report. We need now to take the journey further to realise its goals. To Err Is Human - But Not Too Much!

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Patient Empowerment - A Dream, Necessity or Reality?

By Clinical Assoc Prof C Rajasoorya, Senior Consultant Endocrinologist, Department of Medicine, Alexandra Hospital

Introduction

Traditional focus of medicine has often been likened to a one way process - the physician heals and therefore has the most important and perhaps the only say in the management of the patient. Information is a fundamental piece in the puzzle of good healthcare. The right to know is often argued as a basic human right. Patients seek information about their illness and the alternatives for treating it. Practitioners seek information on the patient's symptomatology and signs, amalgamate with their knowledge and training before suggesting a diagnosis with treatment. Healthcare may, not infrequently, involve a surgical procedure, a prescription drug, or prosthesis. However, an immeasurable time of a healthcare professional is spent in the decision process that couples information acquisition and interpretation.

> *"The concept of Empowerment embraces the idea that patients have the right to make their own choices about their healthcare."*

Patients and their relatives have increasing access to information on clinical care, healthcare experience and performance characteristics of healthcare institutions. Information technology has enabled and facilitated this; sometimes to the extent where the untrained can come to the same, if not a better, decision process than a trained individual - through a systematic algorithm of analysis with the aid of programmable software. Academically medical schools have emphasised in their curriculum the need to respect and honour the rights of a patient. On the public health front, the new centre of gravity has shifted from illness care to preventive healthcare. Economically and politically a market-driven economy that encourages the user to pay for his/her healthcare needs has imposed greater expectations on the healthcare delivery process. All these changes have culminated in the gestation of the concept of Patient Empowerment in healthcare.

What is empowerment?

Empowerment as defined by Rappaport as an enabling process through which individuals and communities take control over their lives and their environment.[1] The concept of Empowerment embraces the idea that patients have the right to make their own choices about their healthcare. The model is based on the assumption that truly healthy people must bring about changes not only in their personal behaviours but also in their social situations and in the environments that influence their lives. Empowerment has evolved out of the realisation that patients cannot be forced to follow a lifestyle dictated by others. The principle underlying empowerment seeks to obtain information, act on it in relevance to the individual patient with an informed decision on his health and treatment strategies. It assumes that the rights of the individual are respected and also that responsibility for decisions come clearly after knowing all potential alternatives and consequences, that are not biased by a doctor's training or bias. The decision and mode of treatment is shifted back to the patient as the primary decision-maker. Patients seek information, healthcare workers facilitate but do not dictate the information, contents or accessibility.

Fawcett et al[2] elucidated 4 important strategies for facilitating the empowerment process and related outcomes: "(a) enhancing

experience and competence, (b) enhancing group structure and capacity, (c) removing social and environmental barriers, and (d) enhancing environmental support and resources".

The Utility of Empowerment

Despite the concept of empowerment being relatively new in clinical phraseology, many of us may not realise that a lot of our daily practice at the bedside and the clinic involves the utilisation of patient empowerment as our tool towards holistic patient management. By allowing for self home blood glucose monitoring - we allow the diabetic patient to decide and sometime dictate what he/she consumes and to adjust the medication as appropriate - the decision, responsibility and accountability is shared between the patient and the doctor to varying degrees. The same applies when we allow automated screening of weight and height to determine the associated indices like body mass index and osteoporosis risk profile. We provide our patients the tools for them to decide the nature and course of action they prefer.

Empowering patients with knowledge and education can also allow them to alert their physicians to remind and reinforce what the physicians may have missed or been unaware of. It represents a patient-activated alert system. Modern clinical practice has facilitated patients to request for tests, e.g. a patient who is at higher risk for developing breast cancer may alert her physician to request for a mammography study which would otherwise have been ignored. Health screenings with automated report systems and risk profile analysis together with advice provides an avenue for patients to be educated, alerted and to be the focal point of decision on the need to seek attention or treatment.

But empowerment, as highlighted earlier, goes beyond the patient, it moves into his/her milieu of illness and health. Chronic pain management can serve as an illustrative model to demonstrate this principle. Pain is a complex blend of emotions, culture, experience, spirit, and sensation. Pain specialists still struggle to find a single pill, potion, or therapy that provides a complete cure for chronic pain. Yet with empowerment comes an effectively palliative pain management system that transmits the decision process

to the individual patient with the help of knowledge, resources and medication. Many things can be done by healthcare professionals to facilitate this empowerment. Some key elements[3] for pain patient empowerment include (a) multidisciplinary pain management, (b) education and information, (c) active patient participation in treatment decisions, (d) being respectful of patient's hope and will to live, (e) understanding the need for human connections, and (f) compassion. It may go beyond in this same patient communicating his knowledge and experience and social responsibility to other similarly afflicted members in society.

Benefit and risks in empowerment

Empowerment has gained increasing momentum in health education theory and health promotion programs. It stems from the belief that empowerment, both as a process and an outcome, has the potential to reduce disparities and maintain consistency of delivery in health status among subgroups of the population. Through its emphasis on increasing the role of individuals, groups, and communities in the work of social and structural change, empowerment practice and theory can contribute to problem-solving capacity, critical awareness, and control and influence among individuals, organisations, and communities.

Empowerment however can be a dual-edged sword. Empowerment through knowledge or otherwise may be perceived as providing opportunities for "de-medicalisation". There appears to be moral and financial benefits from having a condition defined as a disease for patients[4]. Pharmaceutical companies and equipment manufacturers and some doctors have a clear interest in "medicalising" life's problems[5]. Similarly the media and the press, particularly when highlighting miracle cures would prefer to "medicalise" a problem. Government and insurance companies on the other hand would benefit from empowerment to patients. Accreditation organisations argue that empowerment offers greater "medicalisation" with associated improved healthcare outcomes. Handing back power to patients can encourage self-care and autonomy, allow for better distribution of resources and resist the categorisation of life's problem as medical.

An inherent fear may exist amongst healthcare professionals that they are inadvertently disseminating tools that identify and expose their inefficiencies and deficiencies. Communication of this tool requires added time to a consultation in a clinic or hospital, in a system where

there is increasing pressure to see more patients. Patient empowerment can also lead to increased demands for knowledge and utility of advanced medical technology, wasteful resource utilisation as well inappropriate use of technology. Lobby and pressure groups may thrive in the pretext of empowerment. There is a strong notion that information to save lives is widely available and it is up to the individual patient to seek, understand and utilise such information. However, this may have a negative influence on the consumerisation of healthcare. Consumers are highly variable and individualistic; their "shopping practices" and tastes vary widely. While trying to make themselves informed on life-enhancing products, they do run the danger of obtaining or utilising the wrong information. The wide availability and utility of as yet unproven purported growth hormone products is a classic example of this.

Questions do arise as to what empowerment can do to patients who decide that they do not want to be treated. The examples of obesity and its attendant coronary risk factors empower a patient to decide not wanting intervention or treatment is a classic dilemma. The financing system, be it state or third party has to burden itself with the consequences of an individual's "empowered decision". Human right issues confound the problem. How society comes to terms with the issue of self-endangerment despite empowerment will long remain a highly contentious issue that politicians and healthcare leaders have to deal with. While punitive solutions have been suggested, this in itself does not negate the need for empowerment.

Conclusion

Despite this increased interest, there is a lack of clarity regarding definitions and scope of empowerment. In addition, much remains to be learned about the pathways and mechanisms through which empowerment can affect health. Doctors and other healthcare workers face enormous pressures to sustain their present services as well as the explosion in knowledge, within their resources. Moynihan and Smith[5] have made an interesting observation in relation to modern healthcare: "Death, pain, and sickness are part of being human. All cultures have developed means to help people cope with all three…Modern medicine has unfortunately destroyed these cultural and individual capacities, launching instead an inhuman attempt to defeat death, pain, and sickness. It has sapped the will of the people to suffer reality. People are conditioned to get things rather than to do them...They want to be taught, moved, treated, or guided rather than to learn, to heal, and to find their own way." Despite this "modern medicine malady" understanding the transformations that are changing the practice tomorrow cannot be ignored. Newer hospital accreditation standards like Joint Accreditation International (JCI) demand that patients and their relevant family members are involved in their care decision and processes in a way that matches cultural and current expectations.

Medical schools are trying to pull healthcare away from the initial focus on diseases to stressing the important role of the doctor as a partner, teacher, advisor and a coach - all primary roles that the "empowering" process entails. Freire[6] recommends that the structural power inequalities be looked upon in 3 dimensions - the traditional power-over (Oppression) has evolved into power-with (collaborative). Empowerment leads to Power-within (the patient). Will empowerment shift the centre of gravity from a traditional doctor-patient to a new patient-doctor relationship? Where the latter scenario dominates, the mind-boggling potential where the patient will dictate his care in time to come will remain a mystery as healthcare evolves. At this point in time we are probably at the stage of a collaborative relationship. Meanwhile we can take comfort, that what empowerment most clearly demonstrates is its acknowledgement and deep respect for people's capacity to create knowledge about, and solutions to, their own experiences.

The healing process thrives about knowing the patients' needs, values and objectives in their cultural setting. Empowerment is just one tool. Like all tools, utility requires proper indications and continual evaluations. The inappropriate tool or wrongly used tool can only make matters worse. We can refine the tool as we continue to work in the best interest of the patient. Total empowerment may remain a dream, but in the modern era of medicine, empowerment is here to stay as a necessity - it is the job of us as doctors to make it a reality.

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The Reunion of A Student With His Teachers 26 Years Later

By Clinical Associate Professor Siow Jin Keat, MBBS, FRCSEd, FAMS, Chairman, Division of Surgery & Senior Consultant, Otorhinolaryngology, Tan Tock Seng Hospital.

A/Prof Siow Jin Keat (centre) with his former teachers Dr Lee Suan Yew (left) and Prof K Satku (right).

At the SMC Physician's Pledge Ceremony held on 8 May 2004, I had some fond recollections to share with my former teachers, Dr Lee Suan Yew, President of the Singapore Medical Council and Prof K Satku, Director of Medical Services and Registrar of the Singapore Medical Council.

I had spent my Family Medicine posting with Dr Lee, 26 years ago as a 3rd Year Medical Student. Dr Lee was then running two clinics, one in Whampoa in the mornings and one in Shenton Way in the afternoons. Besides the treats of duck rice in Whampoa and Mayflower restaurant that Dr Lee gave, I recalled Dr Lee's excellent bedside manners with his patients and his art of making someone better. I then thought if I could be just 10 percent of Dr Lee, I would be a good doctor. When Prof Satku joined in the conversation, I recalled how Prof Satku, 25 years ago, showed me, then a 4th Year Medical Student, that even at a very late hour of a very busy orthopedic outpatient clinic, when faced with another new case of a national serviceman with backache, a young orthopedic surgeon carried on with the flair and professional competence of a dedicated doctor. Twenty-six years on, both teachers were given feedback on their teaching, and it is timely for the seniors to remember that how we behave in front of impressionable young medical students and doctors, leaves lasting memories and shapes the apprentices' future.

SMC Elected & Appointed Members

The Singapore Medical Council (SMC) held an election over 10 days from 25 October to 3 November 2004 to fill 2 vacant positions in the Council.

Dr Ho Nai Kiong and A/Prof Gilbert Chiang Shih Chuin were duly elected into the Council as they received the highest and second highest number of votes respectively. They will serve for a term of office from 6 November 2004 to 20 November 2006.

Dr Yap Lip Kee has been re-appointed member of the SMC by the Minister for Health. The Minister has also appointed Dr Walter Tan Tiang Lee as a member of the Council in place of Dr Tan Hooi Hwa whose term of office ended on 5 November 2004. Both members will serve a term of 3 years with effect from 6 November 2004.

Compulsory CME - Reminder

All fully and conditionally registered doctors renewing their practising certificates (PCs) with effect from 1 Jan 2005 must fulfil the compulsory CME requirements for their CME qualifying period before their PCs can be renewed:

PCs expiring in	Validity of PC	CME Qualifying Period
2005	2 years	1 Jan 2003 - 31 Dec 2004
2005	1 year	1 Jan 2004 - 31 Dec 2004
2006	2 years	1 Jan 2004 - 31 Dec 2005
2006	1 year	1 Jan 2005 - 31 Dec 2005

Doctors with PCs expiring in 2005 are reminded to fulfil their CME requirements before 31 Dec 2004.

To check you CME points, please login to the SMC Online System (http:www.smc.gov.sg) using your MCR number and password. Please call the CME Secretariat at 6372 3060 for any queries.

National Day Awards

The Singapore Medical Council (SMC) congratulates **Prof Tan Chorh Chuan**, our former Registrar, and **Prof Low Cheng Hock**, Council member, for receiving National Day Awards this year - the Public Administration Medal (Gold) and Public Service Medal respectively.

Our heartiest congratulations also to **Prof Lee Eng Hin**, Council member, for winning the President's Social Service Award for his outstanding voluntary contributions to the disadvantaged. Prof Lee has devoted more than 20 years to improving the lives of disabled children here. Prof Lee is the president of the Rainbow Centre, which coordinates the activities of both the Margaret Drive and Balestier Special Schools. Both schools cater to children with intellectual disabilities, multiple disabilities and autism.

Thank You Prof Tan Chorh Chuan, Prof Lee Hin Peng, Prof Tan Ser Kiat, Dr Tan Kok Soo and Dr Tan Hooi Hwa

SMC would like to thank the following 5 senior members of the SMC, Prof Tan Chorh Chuan, Prof Lee Hin Peng, Prof Tan Ser Kiat, Dr Tan Kok Soo and Dr Tan Hooi Hwa, who stepped down when their terms of office ended in March 2004, June 2004, November 2003 and November 2004 (Dr K S Tan and Dr H H Tan) respectively.

Prof Tan Chorh Chuan was appointed Director of Medical Services (DMS), Ministry of Health, on 1 June 2000. As DMS, he was also the Registrar of SMC. During his term, he had spearheaded several new initiatives to improve the operation of the Council. The Medical Registration Act was amended in January 2003, followed by amendments to the Schedule of Registrable Basic Medical Qualifications in March of the same year. Prof Tan was also at the forefront in the fight against SARS. For his leadership role, he was given the Public Service Star Medal in 2003.

Prof Lee Hin Peng from the Community, Occupational and Family Medicine Department, National University of Singapore, was first appointed as member of the SMC in July 1989. The SMC deeply appreciates his long and dedicated service as member of the Council. We thank him for his invaluable contributions as Chairman of several Disciplinary Committees and Complaints Committees, the Finance Committee and Health Committee and as a member of the Credentials Committee.

Prof Tan Ser Kiat was elected as a member of the Council in November 2000. In spite of his busy schedule, he had actively participated in the work of the SMC and chaired a few Complaints Committees and Disciplinary Committees.

Dr Tan Kok Soo was first elected as SMC member on 6 November 1998. Dr Tan served as an elected member for 2 terms of 3 years each. Dr Tan was a member of the SMC's Credentials Committee and Ethics Committee. He also chaired many Complaints Committees and Disciplinary Committees.

Dr Tan Hooi Hwa was first appointed as SMC member on 6 November 2001. Despite having to run a busy medical practice, he had actively participated in the work of the SMC and chaired many Complaints Committees and Disciplinary Committees. Prior to stepping down, he was Chairman of the SMC's Health Committee and Finance Committee.

The SMC has benefited tremendously from their wisdom, judgement and experience and we wish them all the best in their future endeavours.

SMC In-Touch is published by Singapore Medical Council, 16 College Road, #01-01 College of Medicine Building, Singapore 169854.
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