Summary of Questions and Answers at the Medical Ethics Seminars

Summary of Q & A

In conjunction with the publication of the 2016 ECEG and HME, the SMC organised four Medical Ethics Seminars between September and October 2016 to reach out to the medical profession. More than 530 doctors and healthcare administrators attended the seminars. The Working Committee shared the process of reviewing the ECEG and the key considerations in drafting the code with the attendees and drew attention to various sections of the 2016 ECEG to clarify ethical dilemmas raised by the participants.

To allow all doctors to benefit from the Medical Ethics Seminars, the list of issues raised and discussed at the Question and Answer sessions is summarised here.

(A1) Duty of care

Questions were raised on how general practitioners (GPs) could be equipped and kept up-to-date on all advances in medicine when there are so many different fields for them to cover. The Panel noted that family medicine is a wide field and reassured doctors that as long as GPs are practising within their ability and generally in line with how other GPs practice, they would be alright. The Panel also noted that although doctors are asked to provide a standard of care that is based on a balance of evidence and accepted good practice, they are not held to practising what is the absolute latest in literature. Not every new advance will become a new standard and even if it does it will take time. There will always be a range of acceptable management options and unless one were totally cut off from information sources, major changes in management paradigm should not be missed. This is the purpose of CME.

(A5) Working in teams

Participants queried if it was onerous for a team leader to ensure that the overall performance of the team meets the required standard of care for the patients, including, if necessary, arranging for redeployment or substitution of team members who are unable to perform to the required standard and that it might be unreasonable for the team leader to be held responsible for the mistakes made by their juniors as team leaders in the public sector often do not have the power to determine who their team members are nor have the ability to redeploy the underperforming member to another posting.

The Panel explained that medical team leaders (just like team leaders in any field) have the responsibility to train and supervise junior doctors under their supervision. It is true that in institutions, team leaders may not have a say in who is appointed onto their team. However, if team members are not functioning to the required standard, it is not right for team leaders to say they have no responsibility just because they did not choose the members. If they accepted their role as team leaders, they also accepted the responsibilities this role entails. Team leaders need to train and supervise their team members. Team leaders should identify and take steps to rectify the deficiencies of members in the team. If the issue persists, team leaders should approach their own leader or senior management for advice and help. If team members are unable to perform to the required standard, team leaders need to supervise them more closely and if they do not improve and patients are at risk, they need to take steps to remove the underperforming members from the teams. Of course every individual doctor has his or her own personal professional responsibility as well. If team members do something wrong and harm comes to patients, they will also have to answer for it themselves. This is why the ECEG asks team members to be sure that the requirements of their job do not exceed their own capabilities and to ask for help if they do. Team leaders may vicariously also have to take responsibility depending on the circumstances. If the problem was not caused by failure of the team leaders in discharging their responsibilities and they had done everything reasonable to support the team, then team leaders in such situations could be 'defended' by peers if a complaint was made.

(A6) Telemedicine

Some participants queried the difference between Telehealth and Telemedicine and the ethical considerations for doctors signing up for such web-based or remote services.

The Panel explained that Telemedicine refers to a formalised structured medical consultation service and it exclude emails, whatsapp, facetime, or other informal contact channels while Telehealth is a collection of means or methods for enhancing healthcare in a variety of different ways and encompasses a broad variety of technologies. Doctors are reminded that the quality and standard of care provided to patients over such platforms are the same as in-person care and reasonable care must be taken to ensure confidentiality of information. There ought to be sufficient patient information before the doctor gives a definitive opinion or diagnosis, otherwise the opinion must be qualified.

(A7) End-of-life care

Participants asked about the definition of 'welfare' and the ethical considerations of treating doctors for very ill, incapacitated patients who are unable to give consent. The Panel acknowledged that this topic is difficult and complicated with many emotional and ethical issues to consider and explained that upholding patients' best interests means doing what the doctors believe would be consistent with the patients' wishes and values as far as that can be deduced. Protecting patient welfare and preserving patient autonomy and patient welfare means ensuring patients have the chance, where possible, to make decisions for themselves and to ensure that patients do not suffer harm due to inappropriate treatment and to minimise suffering. However, this does not mean providing treatments to attempt prolong the patient's life, if it is inappropriate, non-beneficial or even harmful in view of the natural course of the underlying disease. But it does involve focusing on the quality of life which may matter most to the patient.

As doctors are often faced with demands from patients, patients' families and friends, doctors are encouraged to consult widely, especially the other medical professionals involved in the care of the patient and determine what the patients' best interests are. It is also important to engage in good communication to understand the patients' values and elicit their preference for treatment while helping them to understand the limits of medical care.

To a question about whether mere nutrition and hydration can constitute excessive treatment, the Panel said that in palliative care, medical professionals make a distinction between 'dramatic and heroic intervention' and 'baseline support'. The latter ought to be given unless there are clear evidence from the patients that they do not want such support.

(B3) Medical records

With regard to queries on whether case notes could be released to patients or their relatives, the Panel explained that where medical records belong to the hospitals/institutions or to the doctors' practices, such records need not be released to patients as these are doctors' notes and are not meant for laypersons' consumption. Medical information, however, could be made available to patients in a way that best suits their needs, such as in a medical summary or report. However, nothing says that the original records cannot be released to patients if the circumstances are such that patients need the notes.

In reply to queries on how retired GPs should store medical records when they ceased their medical practice, the Panel said that if patients request to be transferred to other doctors, the retiring doctors must offer to facilitate this by transferring medical records (or providing medical reports) with patient consent, to their new doctors. If the patients have not yet selected new doctors, this might be a situation in which giving the patients the original notes is appropriate, as they can hand these to their new doctors once they have chosen them. As for the storage of such medical records, they must still continue to be kept safely and securely such as to prevent unauthorised access as required under the Private Hospitals and Medical Clinics Act.

(B4) Medical certificates

A participant asked if it was the doctor's responsibility to call every worker's employer to find out if light duties are available at the worksite. Another doctor queried why SMC presently allows doctors to date the coverage of the MC before the date of the consultation.

The Panel explained that doctors have to take reasonable steps to ensure that light duties are available (it would be sufficient if the patients can provide the information). It would not be necessary for doctors to call and check with every employer. However, it is important to document all such communication. With regard to the issue on doctors having the date of coverage begin before the date of MC/consultation, the Panel explained that there could be genuine circumstances where patients were ill before they formally consulted doctors and if the clinical picture is consistent with this, subject to the doctor's clinical judgment, the doctor could issue such MCs. Again, documentation of the reasons is important.

(B8) Medical research / sponsorships for research

One participant sought SMC's views with regard to doctors receiving sponsorships for research purposes. The Panel explained that medical research requires honesty, objectivity and integrity and that the doctor should not allow commercial, financial or other extraneous considerations to influence the integrity of the patient recruitment methods, research protocols, results and findings. This would include the intention to publish regardless of the outcome.

(B9) Complementary and alternative medicine

A participant queried if it would be conflicting to practise conventional medicine (according to strict medical evidence) and yet practise or avail patients of complementary and alternative medicine (CAM). The panel explained that should doctors practise CAM, they must restrict this to only modalities which are approved by SMC. Presently, SMC supports only the needle form of acupuncture practice. Any SMC-registered medical practitioner who is presently registered with Traditional Chinese Medicine Practitioners Board, either as a TCM physician or an acupuncturist, will be allowed to practise the 'needle-form' of acupuncture only.

(C3) Personal beliefs / spiritual counselling

In relation to queries about (a) the appropriateness of spiritual counselling and whether it would flout the rule of objectivity if doctors were allowed to offer religious advice to patients and (b) whether doctors could share their own religious beliefs if the patient requests for it, the Panel first clarified that doctors must not foist their beliefs on their patients. If patients requested spiritual counselling, doctors may choose to provide it, but be mindful that once they offer spiritual or religious counselling, the doctor-patient relationship has changed and the doctor's objectivity, judgment and professionalism in medical decision making could be compromised. This means that decisions that lead to harm to patients cannot be defended on the basis that it was consistent with the spiritual relationship that had been forged.

(C6) Consent

Participants raised the following issues for clarification: (a) how doctors (supervisors) should handle the issue of informed consent (since such informed consent is usually delegated to the juniors to take) in a team setting; (b) whether there was a time limit to the validity to each signed consent; (c) the consent taking process for patients with dementia or mental capacity issues; and (d) consent process for interventional radiologists.

The Panel explained that if consent is taken by a team member/junior officer, they must go through education, training and supervision to ensure the quality of consent. It is also important to ensure adequate documentation of consent where the procedure involves more complex and invasive modalities with higher risks. For doctors who are not part of the team which took the consent earlier (this not being an ideal situation), before any procedure is to be performed, the doctor could also check that the patients understood what they have signed. As for period of validity, there is no guideline on this. Institutions may have their own policies about the validity period of their consent forms. Patients could have new circumstances or changed their minds any time after signing consent. The longer the time interval between signing of the consent and the procedure, the more doctors should take care to check with patients that nothing material has changed and their consent is still valid.

With regard to consent taking for patients with dementia or diminished mental capacity, if it is the doctor's team that took the consent from the patient, the doctor would need to ensure that the patient in fact understood the information sufficiently to give consent. If in doubt, it is better to ask for an expert assessment of the patients' ability to give consent. If the consent was not taken by the doctor's team, it would reasonable to check with the doctor who first took the consent if the patient really understood. The treating doctor could certainly ask the patients whether they knew what they had consented for, just before the procedure. If serious doubts are raised, it would be prudent to defer the procedure (unless an emergency) until the consent is unambiguously given. For such patients,

it is also beneficial to take consent in the presence of family members, not because family members can give consent on behalf of patients, but so that the families are aware of the lengths to which things were explained to the patients and that the patients demonstrated understanding and expressed consent. The relatives could then not subsequently claim that the patients did not understand yet was made to sign the consent form.

With regard to queries concerning interventional radiology and consent taking, the Panel noted that interventional radiology is a relatively new field and unlike other treating doctors, they often do not have patients directly under their care but are referred patients for interventional procedures. It would be the referring team that takes consent on behalf of the radiologist. There are several ways to ensure that the consent is well taken. The radiologist could go and see the patient, where possible, to explain the procedure personally. The radiology department could brief their colleagues in other departments how to explain their procedures to patients. The department could disseminate information sheets and brochures for other doctors to use to explain procedures to patients. The radiologist could check with the patients prior to the procedures that they indeed understood what they had signed up for. In the end, notwithstanding the structure of institutional services, interventional radiologists who do invasive procedures with significant risks have the obligation to ensure that their patients are well informed before they consent.

(C7) Medical confidentiality

In relation to queries on whether doctors could access patients' records (even if permission was granted by patients) when the patients are not under their direct care, the Panel explained that access to patients' confidential information is premised on a doctor-patient relationship. If the patient wants a doctor to be involved in his/her care, then the doctor has to become one of the patient's official doctors. The Panel stressed that the patient has no authority to grant a non-treating doctor or a doctor who was previously involved in the care of the patient (i.e. the doctor-patient relationship has ended) access to his/her medical records.

(C8) Caring for minors (persons below age 21)

Doctors shared that they had encountered patients below 16 who came for consultation and were found to be pregnant and also other instances where the patients (or their parents) requested morning-after pills (and the patients either came to see the family physicians alone or with their parents) and asked whether doctors have the legal and ethical obligations to inform their parents and the Police in the light of their duty to maintain patient confidentiality.

The Panel said that doctors have a statutory (i.e. legal) obligation to report under-aged sex or statutory rape to the Police. This will overrule ethical considerations. Assuming the patient under 21 is seeking an abortion, the doctor should decide if the patient has the capability to exercise autonomy and have sufficient maturity and understanding to make decisions for herself. If so, then he is obliged to treat the patient as any other, with the right of confidentiality, even with respect to the parents. If the doctor decides that it is in the patient's best interest to inform her parents because the parents could help prevent further harm to that young person (the patient may have diminished mental capacity etc.), the doctor is justified to breach patient confidentiality and inform the parents. However, the doctor should also inform and explain to the patient his reasons for doing so.

With regard to abortion requests by patients under 21, the Panel also explained that there are two separate considerations. Firstly, the doctor still has a professional obligation to treat the patient (including counselling the patients to tell their parents) while maintaining patient confidentiality and secondly, the doctor also has the statutory obligation to report the matter to the Police if the patient is under 16, as sexual penetration of a person under 16 (with or without consent) is an offence that must be reported under section 424 of the Criminal Procedure Code.

(C10) Visual or audio recordings of patients

In reply to a query on what doctors should do if patients constantly take videos or audio recordings of their consultations with patients, the Panel explained that in such instances if the patients or accompanying persons request to record the encounter, doctors may accede to this according to their judgment of the situation. Often the intention is to record the information given so that they can review it later, and that is legitimate. However, if doctors suspect that they are being surreptitiously recorded or there is possibly an ulterior motive, they then have the right to refuse this.

(C14) Termination of a patient-doctor relationship

A question was raised on what doctors should do if despite all efforts, there appears to be no rapport between the doctor and patient and the patient does not comply with doctors' medical advice and treatment plans. The Panel advised that in such instances, if doctors feel that they are unable to continue to provide care for the patient, the relationship could be terminated by explaining to patients and offering to refer patients to other doctors and facilitating a smooth handover of care.

(D) Relationship with colleagues

There were questions raised on what doctors should do if they found that other doctors were providing harmful treatments to patients and whether they should inform the patient (who had come to see them for a second opinion).

The Panel explained that doctors have the obligation to first consider the welfare of patients and if they have a reasonable belief that other doctors have issues with professionalism, performance or medical fitness to practise, doctors must report such instances to the relevant authorities. The options would include alerting the institution (if applicable), informing MOH or filing a complaint with SMC.

(G) Advertising

A doctor felt that there was a fine line between doctors making advertisements and having an internet presence and whether parties which put up misleading educational videos or advertisements could be taken to task. In reply, the Panel noted that advertisements are permissible as long as they comply with the PHMC (Publicity) regulations and the SMC's 2016 ECEG (i.e. the information provided is not misleading, excessively persuasive and exploiting patients' vulnerabilities and lack of knowledge etc).

(I2) Relationships with non-medical companies

A doctor raised the issue of the many credit card brochures offering discounts and other inducements for medical treatments and queried if these are allowed. The Panel explained that these practices are certainly not allowed and complaints have been received by SMC concerning such practices.

Others

In reply to queries if doctors could conduct business in non-medical context (such as music therapy or running a health spa), the Panel explained that doctors are not prohibited from conducting legal business outside of medicine. However, if the products or services are not medical in nature (and supportable by evidence), then they must not use their medical credentials to give the impression that these are medically endorsed.