EDITORIAL

PROMOTING ETHICS

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GROWING PATIENT EXPECTATIONS

Although the standard of medical practice has risen to great heights with amazing cures and results, patients' expectations have grown even higher. A recent review of medico-legal trends in Singapore, carried out by the Medical Defence Union, showed that there has been a forty-fold increase in the number of claims made against Singaporean doctors over the last decade[1].

Why Is This So?

With the rise in its economic development, Singapore has grown from a developing country to a developed nation within thirty-five years. The Singaporean population has become affluent and highly educated. A recent survey showed that 97.5% of Singaporean households have television sets, and 95.3% have telephone lines. It is not surprising to find that their expectations and demands for health care are much higher than before.

The problem is compounded by a news media which sensationalise high-tech medicine, exaggerating new therapies and giving the public the impression that:

1) The new form of treatment is the best.
2) The new form of treatment has no complications.
3) Everyone has the right to benefit from the new treatment[2].
4) Technology can work wonders. "Some believe even death can be defeated"[3].

Patients who are razzmatazzed see their doctors demanding the latest treatment. The lay public do not realise that in reality:

1) The new forms of treatment are untested sufficiently.
2) The new forms of treatment are of limited value.
3) The new forms of treatment are usually more expensive.
4) Few technologies have lived up to their initial expectations.

To add fuel to the fire, the news media enjoy "doctor-bashing", sensationalising the few black sheep in the medical profession. As one Singaporean reporter told a colleague of mine "You doctors are news". A recent newspaper article was headlined "You Bad Boys in Medicine", featuring cases of doctors who over-investigate, over-treat and over-charge their patients. Such reporting gives the public the impression that the whole medical profession's ethos is degenerating. Doctors themselves are not entirely free from blame for this growing expectation of patients. Some doctors trivialise surgical procedures although they know that with any operation there is always a certain amount of risk. The risk of complications occurring may be only 0.1% but when it occurs, it is 100% to the patient who is suffering and to his loved ones. Doctors console each other by saying that the surgeon who has no complications is the surgeon who does no surgery, or that the surgeon who says he has no complications is lying. Instead of trivialising surgery, we should be educating the public that complications can occur with any form of intervention, and that they are no respector of any person and can occur in any patient. The surgeon can do a perfect operation, and he can be the best surgeon in the world, and yet a disastrous complication can occur. Another fault of doctors which has aggravated patients' expectations is that they tend to publicise and publish premature results of new techniques with excessive enthusiasm. At the time of writing, a great deal of publicity is given to "minimally invasive surgery". Unfortunately, the publicity gives the public the impression that this form of surgery is safer than conventional surgery. As doctors, we know that this new form of surgery requires more training and expertise, and that the learning curve is longer and that complications can occur, which are sometimes disastrous. This was highlighted in the latest issue of the Australian New Zealand Journal of Surgery: "Intensive care unit admissions following laparoscopic surgery: What lessons can be learned?"[4,5].

The Effect Of Medico-legal Suits On Doctors

There is nothing more traumatising to the doctor than to be the subject of a medico-legal suit. He has been taught that the medical profession is the noblest of all professions, and that his job is to act always in the best interest of the patient, to do no harm, to relieve suffering, cure the disease whenever possible, and if incurable, give comfort to the patient and his loved ones[6]. All doctors want to be good, if not excellent, doctors. All doctors are achievement-oriented. And now to be told that he has failed in his life ambition is like telling him that he is a failure in life. The effect of a medico-legal suit can therefore be disastrous to a doctor. Some doctors have committed suicide, or simply dropped dead. An American study showed that 96% of doctors who were sued by patients became psychologically traumatised; 36% required psychiatric treatment or counselling; 26% developed stress-related organic diseases like hypertension, peptic ulcers and heart disease[7].

The immediate reaction of the doctor to the news that a patient is suing him is one of anger. This is because whatever a doctor does to a patient, it is with the intention of making him better. Does anyone ever wonder why a doctor should ever want to harm a patient? If he harms the patient, he hurts his own reputation and career. In any medico-legal suit, the patient has all to gain, and the doctor has all to lose. It is a very sad situation.

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"Litigation is not peculiar to the medical profession alone but the sad part of this is that sometimes a really good physician becomes mauled by legal action which attracts undue publicity and damages his reputation."[7].

It has been said that "malpractice litigation is not that bad after all. It keeps doctors on their toes, and makes them practise better medicine." I do not know if the kind of medicine that doctors, who fear litigation, practise is better medicine. They practise what is known as "defensive medicine", ordering as many investigations as possible in order that they do not miss a diagnosis, or avoiding treating a condition when the prognosis is poor. I know of doctors who refuse to treat patients who they feel are more likely to sue them, for example, certain races or classes of patients. Instead of "defensive medicine", doctors should be encouraged to practise "defensible medicine". Patients should vent and settle their grievances out of court, with the doctors concerned, or before arbitration committees, such as hospital ethics committees, or committees of inquiry. Sometimes, all the aggrieved patients want is a way to vent their frustration; a third party who will listen to their complaint, and do something about it, such as asking the doctor to explain what had happened. Unfortunately, there is now an added reason for complaining, ie monetary compensation. Stories of huge rewards given in the United States have spurred not only patients but their lawyers to take legal action.

The Doctor's New Roles

The good old days of medical practice are gone. I am privileged to have been a part of those days when the role of the doctor was so clear-cut. We did our best for our patients, not having to worry whether they were going to sue us or not. The doctor-patient relationship was as it should be: The patient had great faith in the doctor that what he did was in his best interest, and the doctor had great faith in the patient that he will not sue him. Now all that has changed. Growing patient expectations, fanned by the availability of high-tech medicine, have added new roles for the doctor. Medicine is now a "technology-driven profession: intensive care, renal dialysis, open heart surgery, organ transplantation, computerized tomography (CT scan), magnetic resonance imaging (MRI), linear accelerator, pacemakers, serum channel autoanalysers, diagnostic radioisotope studies, percutaneous transluminal angioplasty, lithotripsy, endoscopy surgery, and now positron emission tomography (PET)".[8] The doctor is today expected not only to comfort and cure, but also to:

1) Protect himself against patients who will not hesitate to sue him (defensive medicine)[9].
2) Avoid overservicing the patient, ie overinvestigating and overtreating him[10].
3) Be wary about the cost-effectiveness of the investigations and treatment.
4) Display his schedule of charges in his clinic so that all patients are aware of his fees[11].
5) Avoid overcharging the patient.
6) Make sure that the patient is not kept waiting too long.
7) Spend more time with the patient, and explain fully all the advantages and disadvantages of the procedure[2]. High-tech medical procedures require more time, not less, to be explained to patients.
8) Practise preventive medicine: teach the patient how to lead a healthy lifestyle, and how to detect early signs of disease.
9) Participate in public health education.
10) Keep up-to-date with the latest developments in medical technology. Participate in Continuing Medical Education (CME) programmes to accumulate enough CME points every year. Attend conferences. Present papers[12].
11) Maintain a well-equipped clinic. "If a doctor does not have machines, he is not found in many quarters to be competent"[8].
12) Participate in "Quality Assurance", "Peer Review" and "Medical Audit" programmes[6].
13) After treatment, rehabilitate the patient so that he can resume normal life.
14) Co-ordinate with the other health care workers[6].

The Effects Of High Technology[9]

There is no doubt that technology has improved the quality and duration of life. The sword of technology, however, is double-edged[13]. Technology has become a major part of today's health care costs. If we do not restrain these costs, technology could consume all of our resources. The question is how much can the State really afford to spend on health care? If no citizen should be denied quality health care because of the lack of money, where do we draw the line? Should every citizen who requires renal dialysis, or intensive care be provided with it? In her book, "Technology in Hospitals", Russell stated that "controlling costs means deciding that some things although beneficial, are not beneficial enough"[8,14]. Should suffering and dying be prolonged by "life-supporting" measures? Should very premature, sickly and damaged new-born babies be saved to become mentally retarded, spastic handicapped children who will spend much of their time in hospitals demanding expert attention? It is a difficult decision to make, whether to spend limited resources on protecting the weak or caring for the healthy. It is an acid test of a nation's moral resolve. "The test of a civilization is in the way it cares for its helpless members" (Pearl S Buck).

There is another undesirable effect of high technology. We should know that machines can never replace the human touch. But I fear that with so many machines around us, we will place more emphasis on findings and tests from these machines than on clinical findings, and neglect patient-physician relationship. "Listen to the patient - he is trying to tell you the diagnosis," said Sir William Osler. With so much emphasis on technological advances, however, new slogans have emerged:

> *"As a last resort, go examine the patient."*
> *"If the X-rays and laboratory data are negative, how can the patient be sick?"*[2]

Modern medicine and high technology cannot replace the personal care that we provide for our patients. No matter how well-equipped our clinics and hospitals are with machines, patients still need that personal touch. As F John Gillingham said, "The secret lies in the end in the personal care of the doctor for his patient. It is 'as it was in the beginning, is now, and ever shall be'"[15]. Many memorable speeches have been made to this effect, including the opening address of the 20th Singapore - Malaysia Congress of Medicine by former President, Mr Wee Kim Wee, in which he stated, "The medical profession must continue to uphold its noble image of being caring, considerate and compassionate."

Communication Skills Training

Most medical schools now have communication skills training included in the medical curriculum. It is believed that better communication skills will reduce the probability of legal problems for doctors. Communication of the diagnosis, prognosis, and treatment to the patient and his relatives is all-important. There is now a call to bring back good bedside manners. For example, maintaining eye contact with the patient will tell the patient that he has your attention. Research in Australian hospitals found that the "nurses' technical skills were

excellent, but their ability to make patients feel good - often just as important in the healing process - was lagging"[16].

"The focus is on machines . . . There's a feeling that if you can push the right button, you are fantastic. Nursing education is generally so focused on the technical side of things, but being a good nurse is not just about being able to push a button. We have to refocus the profession on human beings."

"Arrogance and discourtesy reflect badly on a profession whose primary purpose is to care for patients. The importance of communication (a two-way process) is increasingly being recognised in medical schools, and role models (consultants and general practitioners) must also recognise the effect of the "hidden agenda" (their attitudes and behaviour) on medical students and postgraduates."[17]

WHAT CAN BE DONE?

This gargantuan problem requires gargantuan solutions. It has brought the American health care system down to its knees, paralysing the medical profession. It is looming over the British National Health System. "Claims are rising partly because the British public has got the idea of suing."[18] Crown immunity does not protect hospitals from legal action any more, after a series of cases of unhygienic kitchens and fire hazards. The public is encouraged by stories of huge awards in America. At the same time the legal profession is becoming "increasingly pushy". A recent change in law allows lawyers to take on personal injury cases on a "no win, no fee" basis.

The problem can be confronted at five levels - at the National, University, Hospital, Doctor and Patient levels.

At The National Level

On 18 June 1995, the Minister for Health in Singapore, BG George Yeo announced the formation of a National Ethics Committee to:[19]

1) draw up ethical codes of conduct for doctors.
2) advise the Ministry of Health on potential ethical issues based on trends in developed countries.
3) identify the prevailing ethical issues and form sub-committees to deal with specific issues.

He also recommended that all private and public hospitals set up formal ethic committees.

Codes Of Ethics

There are many codes of ethics used by the medical profession, such as:[20-22]

1) The Hippocratic Oath
2) The World Medical Association's Declaration of Helsinki.
3) The World Medical Association's Declaration of Geneva.
4) The International Code of Ethics.
5) The Ethical Code of the Singapore Medical Association.
6) The Singapore Medical Council's Ethical Code.
7) The General Medical Council of UK's Code of Professional Conduct and Discipline: Fitness to practise.

In addition to these, each hospital or medical professional body may have its own ethical code. (This is necessary because the above-mentioned codes apply to doctors only. If a hospital accuses a nurse or paramedical staff of unethical practice, he/she may ask which code of ethics the hospital is referring to). As a means of promoting ethics, copies of these codes of ethics should be circulated to members of the staff of the hospital or medical centre or professional body. The nursing profession also has its own ethical code. Ethics are a reflection of the consensus of opinion of all concerned. It will therefore be necessary to assess the consensus of opinion of all concerned in drawing up these guidelines. Ethics are also subject to change from time to time, and these guidelines will therefore need to be reviewed and updated from time to time. Codes and guidelines are important because decisions by disciplinary bodies are based on what is accepted practice. At the time of writing, issues on assisted reproduction (IVF), the living will (Advance Directive) and euthanasia are being debated, and guidelines drawn up.

At The University Level

Ethics is now included in the medical curriculum of the medical faculty in the National University of Singapore[23]. The 1995/96 final year students undertook a one-week learning module on "Ethics and Professional Conduct in Medical Practice"[24]. Although there are some who believe that one's ethos is already formed by the time one reaches undergraduate status, we should still try to imbue our medical students and young doctors good and lasting ethical values. Last year (1995), graduates in medicine at the National University of Singapore were made to take the Singapore Medical Council's Physicians' Pledge, which is based on the World Medical Association's Declaration of Geneva[24,25].

I did my undergraduate training in Queen's University of Belfast, and can remember the first lecture I attended very clearly. This is because the opening remark made by the dean, Prof J H Biggart, was that, "if your ambition is to make a lot of money then you are in the wrong faculty." This, no doubt, made a great impression on my young mind. I also remember, as a young undergraduate, reading the obituary of a British surgeon (unfortunately I did not record his name) who worked all his life in India. It said that he could have easily made millions, but he did not. I believe it is still not too late to teach ethics to university students.

At The Hospital Level

Hospitals should form their own Ethics Committees whose functions would be:

1) To promote a high standard of ethical practice through "Ethics Awareness" and "Ethics Assurance" programmes.
2) To formulate guidelines on procedures and fees, to help hospital staff deal with ethical problems.
3) To help implement guidelines drawn up by the National Medical Ethics Committee.
4) To formulate a Code of Ethics for the hospital, including administrative procedures for inquiries.
5) To resolve ethical issues in research work.
6) To facilitate feedback of unethical practices in the hospital.
7) To serve as an alternative channel for patients' complaints. (Sometimes all that a patient wants is to vent his frustration, and see that something is being done about his complaint.)

Channels For Patients' Complaints

In Singapore, patients lodge their complaints against doctors through various channels:

1) The Singapore Medical Association.
2) The Ministry of Health.
3) The Straits Time Forum page.
4) The Consumers' Association.
5) Their lawyers.
6) The Hospital Administration.
7) The Singapore Medical Council.
8) The doctor concerned directly.

Many Singaporeans do not know that the Singapore Medical Council (SMC), which is the disciplinary body, is a separate entity from the Singapore Medical Association. When a patient

complains to the Singapore Medical Association, very often he is under the impression that he is complaining to the Singapore Medical Council. Complaints to the SMA are dealt with by the SMA Ethics Committee, which will study the matter and request for an explanation from the doctor concerned. If the explanation is satisfactory, it is communicated to the patient. Often, in cases of misunderstanding or lack of communication between the doctor and patient, such a procedure settles matters amicably. The patient is quite happy that the SMA has noted his complaint, and questioned the doctor about his conduct. The SMA however has no investigatory or disciplinary powers. These functions are left to the SMC. However, should the explanation received from the doctor be unsatisfactory, the SMA will refer the matter to the SMC or advise the patient to complain to the SMC.

Complaints to SMC are dealt with initially by its Preliminary Proceedings Committee (PPC), which is made up of three members from the Council. To weed out frivolous complaints, the SMC has made it a requirement that the complainant must file an affidavit. This is quite effective in discouraging many patients from complaining.

The PPC will usually investigate the complaint and hold a pre-trial hearing. It would be ideal for doctors if all cases are settled at this level, because:

1) It does not attract damaging publicity.
2) The settlement is quick.
3) The hearing is informal.

We should invent more ways for such "out-of-court" settlements. We should devise "No-fault Compensation Systems" as practised in Sweden and New Zealand.

Medical cases should be heard by medical disciplinary bodies and not in the civil or criminal courts. A good example of why this should be so was shown in a recent trial in the criminal court in Singapore in October 1995. It involved a 75-year-old doctor who was accused by his patient of molesting her during the medical examination. He was convicted and sentenced to 10 months' jail, but appealed against the conviction. He was then acquitted by the High Court. The Chief Justice Yong Pung How said, "I venture to add that a criminal court hearing a charge alleging outrage of modesty is hardly the best forum to decide whether one method of examining a patient's breasts is more medically correct or efficacious than another."

Ethics Awareness

To promote ethics awareness, there are a number of things which the Ethics Committee can do:

1) Formulate a Code of Ethics for the Hospital. Although the medical and nursing professions have several codes of ethics to follow, there is no code of ethics for para-medical staff. If such staff is accused of being unethical, he may very well ask which ethical code the Hospital is referring to. Indeed, if the hospital itself is charged with unethical practice, by which code of ethics should it be judged, if it has no Code of Ethics? Another reason for the hospital to have its own ethical code is that the hospital may want to have a more stringent code than those available. The Singapore Medical Council, under its present code can find the doctor guilty only of "infamous conduct in a professional respect." Although there have been many judgments made as to what infamous conduct is, it is generally agreed that:

   a) Right-thinking competent medical practitioners would regard the conduct as reprehensible, disgraceful, shameful, or dishonourable.
   b) There is departure from accepted procedures.
   c) It is not enough to show that some mistakes had been made through carelessness or inadvertence. To make a charge of infamous conduct, there is, generally speaking, some moral turpitude, or fraud, or dishonesty in the conduct.

   In hospitals or medical centres where research work is carried out, there should be a Code of Ethics for clinical research. And where there is research work done on animals, guidelines on animal research should also be set.

   Copies of these Codes of Ethics should be given to the hospital staff for their information, and also for promoting ethics awareness.

2) Send circulars regularly to the staff regarding some aspect of ethics. Alternatively, a regular ethics column could be started in the hospital newsletter. However, the newsletter concerned should not be one that is circulated to the public, as this may encourage frivolous complaints, and may make an already litigious population more litigation-conscious. It may give the public the impression that there is an increasing number of unethical practices occurring in the hospital. Again, if case reports are to be quoted in the column, the newsletter should not be widely circulated.

3) Hold seminars on ethical issues. Seminars on ethics are few and far between, as compared to the innumerable medical seminars which are held all the time. These should be encouraged. Most doctors are concerned with only their own specialty conferences which do not have ethics on their programmes. Only some medical bodies such as the national medical associations, the colleges of family practitioners, and the medico-legal societies would hold lectures on ethics on a regular basis. When such lectures are held, announcements should be widely circulated to the profession so that they will be encouraged to attend. The Singapore Medical Association holds an annual lecture called "The SMA Lecture", which focuses on some ethical aspect of medicine. This lecture has not been given the publicity it should receive.

4) Formulate and propagate guidelines on the more common procedures. Guidelines on medical procedures are important because disciplinary bodies make their judgements based on what is accepted practice. However, guidelines are double-edged swords. The doctor who follows the guideline set is protected should some complications arise. However the doctor who does not stick to the guideline may be accused of improper medical practice.

Ethics Assurance

Just as we have Quality Assurance programmes, we should also have Ethics Assurance programmes. These can be listed as follows:

1) Audits
2) Surveys
3) Continuing Medical or Professional Education programmes on Ethics
4) Quality Assurance programmes on Ethics.

1) Audits

In 1991, the Singapore Government passed the Private Hospitals and Medical Clinics Act, which stated that:

   i) Every private hospital shall have a quality assurance programme to monitor and evaluate the quality and

appropriateness of patient care, pursue opportunities to improve patient care and to identify and resolve problems.

ii) Information regarding quality assurance activities shall be furnished to the Director as and when required by him.

Most hospitals would have Tissue Committees which monitor tissues removed surgically. We should also monitor other aspects of medical practice, by doing random case studies to show:

i) Adequacy of documentation
ii) Appropriateness of investigations
iii) Errors in prescribing
iv) Sufficiency of discharge summary
v) Incidence of complications
vi) Delays in referral and action
vii) Record of communications with the patient and relatives and other medical and ancillary services
viii) Quality and speed of dispatch of reports and discharge letters

DOCUMENTATION

It cannot be over-emphasised that proper and adequate documentation is quintessential to a doctor's defence. It has been said that, "if it is not recorded, it never took place." The doctor's writing must be legible. Procedures such as ultrasound studies must be reported on. The random case studies should also include the comparison of the pre-operative diagnosis and the post-operative or histological diagnosis, and whether the operation done was correct. This kind of result should, of course, not be published and circulated, even if no names are mentioned. The doctors concerned can be individually notified.

2) *Surveys*

One can do large studies of the following:

i) Quantity and type of resources available,
ii) Quality of patient care: Surgical procedures, medications, waiting-time, investigations, staff rosters.
iii) Outcomes or results: Complications, perioperative deaths, mortalities, unexpected or adverse events, infection rate, number of Caesarean sections done, and results of coronary angiograms.

The various specialities should suggest the types of surveys to do as self-imposed medical audits.

3) *Continuing Medical Education and Quality Assurance Programmes*

The Ethics Committee should work in tandem with the Continuing Medical or Professional Education and the Quality Assurance Committees. The Chairman of these Committees or their representatives should be invited to be members of the Ethics Committee.

Mortality Reviews and Pre-Complaint Inquiries

Regular reviews and inquiries on mortalities and adverse events arising from the management of patients are held in most hospitals as part of their quality assurance programmes. They have one feature in common, which is that they are held before a complaint has been received from the patient or the patient's relatives. There are some caveats to remember about this:

1) If the patient gets wind of such an inquiry being carried out, he may be made litigation-conscious. This is why such an inquiry or review should be secret.
2) If the Committee finds that there has been some mismanagement or misconduct, the patient may use the findings against the doctor or hospital. This is why all communications must be sealed, and marked "Private and Confidential".
3) On the other hand, if the Committee finds that there has been no mismanagement or misconduct, the doctor or hospital will say that he/it has been cleared by the Committee, should the patient indeed lodge a complaint later on.
4) If the committee finds that there has been nothing amiss, the patient may accuse the Committee of "covering up" matters.

For these reasons we should not convene a Committee of Inquiry unless really necessary. The fact that an inquiry is being held casts a shadow on the reputation of the doctor, the procedure, the machine, or drug and its manufacturer. It suggests to people's mind that something has gone wrong or that some doctor has done something wrong.

At the time of writing, a study called "The Quality of Australian Health Care" was published in the October 1995 issue of the Medical Journal of Australia. The study had already been extensively publicised in the local news media. The report said that there were 470,000 adverse events each year, about half of these events were avoidable, 50,000 suffer permanent disabilities from complications caused by their care in hospital or in the health system, 28,000 admitted to hospital each year suffer a temporary disability because of mishaps, and about 18,000 Australians die each year because of these mishaps. The headline for the report in the Singapore Straits Times dated 7 Nov 1995 was, "Hospital errors kill 18,000 Australians every year". On the same day, I received through the mail a large envelope with huge letterings, "Warning: Doctors are hazardous to your health. Top medical journals reveal most treatments do not work - and actually harm you. What doctors don't tell you." This is the kind of backlash we will continue to get from quality assurance programmes when publicised. It is human nature to highlight failures because failures make sensational news. I can remember the advice given to me by a senior colleague. He said that you need to do ten good cases to recover the loss to your reputation from one bad case. People will judge and remember us more by our failures than by our successes. In all the reports on medical mishaps, no mention is ever made of the many thousands of miracles which occur every day because of modern medicine. I know of doctors whose long illustrious careers have been ruined by one bad case ending up in the law courts.

Ethics Feedback

The Ethics Committee should encourage feedback from the medical profession. This encouragement can be done through the newsletter which most hospitals would have. However it should be a newsletter which is circulated in-house only, and to the doctors only. An open invitation for feedback may result in too many frivolous complaints. Letters inviting feedback can be sent to some key personnel serving as "watchdogs", such as the operating theatre manager, the ward managers, and other senior nursing staff. A senior nursing officer should be invited to sit on the Ethics Committee.

At The Doctor Level

At the doctor level, what can be done? Although patient expectations will continue to rise, there are a few things which we can do to curb the number of complaints and medico-legal actions:

1) Follow the Ethical Code
2) Promote Quality Assurance
3) Participate in Continuing Medical Education programmes.
4) Practise defensive, or at least, defensible medicine. (A pre-operative report is just as important as a post-operative report. We should prescribe an educational pamphlet at the same time we prescribe medicine)
5) Practise the Golden Rule towards our professional colleagues
6) Improve on the public image of the doctor
7) Help formulate guidelines for procedures and for fees
8) Co-operate with the Ethics Committee in its effort to promote a high level of ethical practice
9) Do not trivialise any surgical procedure or anything you do to your patient
10) Do not publicise or publish premature results of new techniques with excessive enthusiasm

Defensive Medicine

As in defensive driving, it makes sense to practise some degree of defensive medicine in the face of rising patient expectations and medico-legal actions. The following points are advisable to note:

1) Be careful and thorough; take part in quality assurance programmes
2) Spend more time talking to the patient
3) Make a pre-operative report, setting out the prognosis and the complications; it is more important than the post-operative report
4) Avoid treating a patient who is too difficult for you to manage; refer him quickly to someone else who you think can do a better job
5) Avoid surgery, if possible.

The Golden Rule

To reduce medico-legal problems for ourselves, it is important to practise the Golden Rule towards our professional colleagues:

1) Do not do to your colleagues what you do not wish them to do to you.
2) Avoid cheeky remarks and criticisms, like "why was the operation done like that?"
3) Recognise that complications do occur even in the best of hands. "The only surgeon who does not have complications is the surgeon who does no surgery."
4) Do not say to the patient that the best person to do this kind of surgery or treatment is Dr so-and-so.

The Image of The Doctor

I would like to think that the public still holds a high regard for doctors. Many young people still aspire to become doctors, not for monetary gain, but for the altruistic nature and social status of the profession. This is in spite of the "doctor - bashing" meted out by the media in recent years every time a black sheep in the medical profession is found out.

Many doctors hold key positions in social and voluntary organisations. By the nature of their training, they do not publicise their achievements and contributions to society, and are under-rated for their voluntarism. Although we should encourage doctors to do voluntary work, to improve on the "ethical tone of the profession and increase public respect", this should not be the primary aim. The primary motivation should be compassion, and one's love for helping others.

At The Patient Level

The most important step we can take to reduce the number of complaints against doctors is to educate our patients. If patients are properly informed of possible complications which may arise as a result of our intervention, then they will be less shocked and less likely to complain should the complications occur. We can promote patient education in the following manner:

1) Before consent for intervention, patients should be as fully informed as possible. I have always said that a pre-operative report is more important than the operative or post-operative report. We have always followed the tradition of writing a report of the operative findings and procedure; it has become second nature to all surgeons. It is time to develop the second nature of writing a pre-operative report. This should include the diagnosis, the need for intervention, the prognosis, the possible complications, the special circumstances of the case in question, and whether a second operation may be required, and when that is usually carried out.

   Similarly, a pre-medication report would be useful, stating the diagnosis, the need for medication, and the possible side-effects and precautions to take.

2) Educational pamphlets can be printed and made easily available to patients. They can, for example, be placed at the pharmacy, or in the clinics, so that doctors can prescribe an educational pamphlet at the same time they prescribe medication. As patients tend to forget what we have told them, such pamphlets should still be given to patients after the doctor has explained everything.

3) Public seminars should be encouraged on the management of common diseases and the complications.

4) Video-tapes of common diseases and their management and complications can be shown on the ward television system, or in waiting areas.

5) Staff education should be encouraged. Often, patients are reluctant to ask their physicians questions. They would rather talk to the nurses or technicians. It is therefore important to keep our staff well-informed. This can be done through educational programmes for our staff.

6) The news media, such as newspapers, radio and television should be made use of to publicise common diseases and their management.

References

1. Dickman J. Medico-legal trends in Singapore. The Journal of the Medical Defence Union, Australia, 1994; 8(2): 27.
2. Jeffcoate N. Medicine versus nature. A James Y Simpson Memorial Lecture, Royal College of Surgeons of Edinburgh, 26 March, 1976.
3. Lee YK. 1987 Singapore Medical Association Lecture: Consumer or Patient? Singapore Med J 1988; 29: 100-2.
4. Edis AJ, Sheiner JH. Laparoscopic surgery: An ethical dilemma. Aust N Z J Surg 1966; 66: 201.
5. Hayes C, Ambazidis S, Gani JS. Intensive care unit admissions following laparoscopic surgery: What lessons can be learned? Aust N Z J Surg 1996; 66: 206-9.
6. Cox K. Who will decide surgery's future? Editorial comment. Aust N Z J Surg 1987; 57: 215-20.
7. Chua IM. Medico-legal aspects of clinical practice. Malaysian Medical Association Newsletter 1995; 25: 1-2.

8. Organ CH Jr. Impact of technology on surgery. Archibald Watson Lecture. Aust NZ J Surg 1990; 60: 163-6.
9. Khoo CY. The Doctor's Role in a High-Tech World. The 1992 Singapore Medical Association Lecture. Singapore Med J 1992; 33: 347-51.
10. Phua KH. Privatisation and restructuring of health care services in Singapore. Institute of Policy Studies Forum, 12 December 1990.
11. Singapore Medical Association. Display of charges by medical practitioners. S M A Circular to all S M A members, 9 Nov 1991.
12. Singapore Medical Council and Singapore Medical Association. Voluntary Continuing Medical Education (CME) Programme for doctors in Singapore. Circular to all registered medical practitioners, 3 Feb 1989.
13. Spaeth GL. New technology - new pressures. Editorial and Paper presented at the Annual Meeting of the American Academy of Ophthalmology, Dallas, Texas 1987. Ophthalmic Surg 1988; 19(a) : 617-20.
14. Russell L. Technology in hospitals. Medical advances and their diffusion. Washington DC: The Brookings Institution, 1979: 156-64.
15. Gillingham FJ. The quality of life. The George Adlington Syne Oration. Aust N Z Surg J 1982; 52: 453-60.
16. Moyle W. Aussie nurses learn to cry by the book. Offbeat column, The Straits Times. 27 Oct 1995.
17. Calman K. The profession of medicine. Br J Med 1994; 309: 1140-3.
18. The Economist. Medical litigation begins to needle the British. The Straits Times, 1995 August 25.
19. BG George Yeo. Medical Ethics Committee formed. The Sunday Times, Singapore, 1994 June 19.
20. Singapore Medical Association Ethical Code. Singapore Medical Association Reprint 1992.
21. Singapore Medical Council Physician's Pledge, SMC Ethical Code. Singapore: Namic Printers Pte Ltd, May 1995.
22. General Medical Council. Code of professional conduct and discipline. Colchester, UK: Spottiswoode Ballantyre Printers Ltd, December 1993.
23. Tock E. NUS revamps medical course to stress primary health care. The Straits Times, 1992 March 3.
24. Cheah JS. Ethical pledges, declaration and oaths of medical students and doctors. Editorial. Ann Acad Med Singapore 1995; 24: 779.
25. Balachandran N. Not pride of knowledge, but humility of wisdom. 3rd Singapore General Hospital Lecture. SGH Proceedings 1995; 4(2): 63-8.