

ACADEMY OF MEDICINE OF MALAYSIA



ETHICAL PROFESSIONAL PRACTICE GUIDELINES

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FOREWORD

Ethics and professionalism are integral to the practice of medicine. With advances in science and technology, health care professionals work in an environment that is increasingly complex and challenging. The profession has come under scrutiny and there is renewed attention given to doctors' ethics and professionalism. The Academy of Medicine of Malaysia is committed to upholding the highest ethical standards and professional competence of its members. This guide book on Ethical Professional Practice is intended to provide guidance to medical practitioners on matters related to ethics, professional conduct and responsibilities to patients.

I would like to congratulate the Committee on Ethical Professional Practice of the Academy chaired by Dato' Dr N K S Tharmaseelan for the dedication and enthusiasm in developing these guidelines. My hope is that this book will not only serve as a valuable resource for our members but also encourages discussion concerning ethics and professionalism in the practice of medicine.

Thank you very much.

Professor Dato' Dr P Kandasami

Master

Academy of Medicine of Malaysia

AN INTRODUCTION TO MEDICAL ETHICS

PROFESSOR DATO' DR NKS THARMASEELAN

No physician, insofar as he is a physician considers his own good in what he prescribes but the good of his patient, for the true physician is also a ruler, having the human body as his subject, and not a mere money maker. PLATO

The moral issues related to the practice of medicine was first raised by the Greeks notably as envisioned by the Hippocratic oath which later surfaced in Christian teachings. In the later medieval and early modern period, Ishaq bin Ali-Rahawi (known as Rhazes in the West) wrote the first book dedicated to Medical Ethics. India had Caraka Samhita a Sanskrit text written 2000 years urging physicians to follow moral guidelines when treating patients. In China, the Chinese text Nei Jing, the Yellow Emperor's Classic of Inner Medicine expressed similar sentiments. In the 18th and 19th century medical ethics was approached in a more systematic way. Thomas Percival in the UK wrote one of the best known works on Medical Ethics, *Medical Ethics; or, a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons*. It was at the same time that American Physician Benjamin Rush (who signed the Declaration of Independence) was actively promoting medical ethics in the Americas. In 1847, the American Medical Association (AMA) was formed and the AMA issued its own code of ethics for Physicians

DEFINITION

Medical Ethics or Bioethics is the study and application of moral values, rights and duties in the fields of medical treatment and research.

The field of medical ethics has become an International discipline. The International Association of Bioethics was founded in 1997 to facilitate the exchange of information in medical ethics issues and to encourage research and teachings in this field. In the USA alone, there are more than thirty Universities offering degrees in Medical Ethics. They are known as professional Ethicists. More medical Universities are now incorporating Medical Ethics in their curriculum. It is a developing field and medical decisions involving moral issues are made everyday in diverse situations, cultures and countries. What is ethical for one country may not be viewed as ethical in another. Even legally perfect decisions may be questioned on moral issues.

HOW ARE ETHICAL DECISIONS ARRIVED AT

The history of the practice of medical ethics has been drawn on a variety of philosophical concepts.

Main philosophical concepts

Deontology: This ethical teaching emphasises that the practice of medicine must be guided by adherence to clear principles such as respect for free will. This usually means all treatment is to be central to respect for the patient's autonomy to make decisions.

Utilitarianism: This philosophy of moral judgment championed by others is measured by the overall results. Utilitarianism is judged by the greatest good for the greatest number of people. This is how moral judgment is assessed.

Virtual Ethics: This philosophy appears very simplistic and holds that those who are taught to be good will do what is right.

Many medical ethicists find these general principles difficult to apply to complex ethical issues in medicine. Thus it was difficult

to evaluate medical cases on ethical issues. Thus over the years the American and the European counterparts devised several frameworks to judge moral values in the practice of medicine. As a result two main systems developed on how to value values in medical ethics, Principlism and Casuistry.

Principlism

This system was developed by the American Philosopher Tom Beauchamp and American Theologian James Childress. It involved four principles to which another two were added.

- **Beneficence** (*Salus aegroti suprema*): A medical practitioner should act in the best interest of the patient
- **Non-maleficence** (*Primum non nocere*) first do no harm
- **Autonomy** (*Voluntas aegri suprema lex*): The patient has the right to refuse or choose his treatment.
- **Justice** (fairness and equality): This concerns the distribution of scarce health resources and the decision as to who gets what treatment. This means distributing burdens and benefits fairly
- **Dignity**: The patient has a right to dignity and this is usually extended to the person treating the patient
- **Truthfulness and honesty**: The doctor is to be honest and be truthful to the patient. This has to be strictly adhered to in informed consent

Medical ethicists often weigh these principles against one another before arriving at a moral decision. Thus decisions are not made

based on one principle alone. An overall decision based on these six principles is arrived at and sometimes compromising one principle for the other

Casuistry

The other system developed is Casuistry which is a case based approach. When faced with a moral dilemma in handling a medical problem, Casuistry propagates a plan where virtually anyone can agree on a solution. By weighing solutions to the hypothetical case, casuists work their way to a solution to the real case at hand. The challenge for the casuist is to determine which solution most closely resembles the problem at hand and with careful consideration of the case, try to proceed from the hypothetical to a practical solution.

Each approach has its proponents and those who vehemently oppose it. Thus there were healthy debates in every school of thought. Yet each approach represents an attempt to deal with thorny conflicting issues that commonly arise in the complex and contentious arena of medicine.

Challenges for the 21st Century

Many challenges have emerged with the rapid advance of medicine. Research is testing the frontiers and limits of professionalism which has to be concordant with medical ethics. The advances in cloning new knowledge of the human brain and life, infertility research and genetics is increasing the decibels in the ethical debate. Centenarians are becoming an increasing part of the population and issues concerning equitable access to medical care will likely come to the fore. Medical ethicists will need to continuously ponder, debate and formulate acceptable ethical norms, an important and integral aspect in the field of medicine

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AN INTRODUCTION TO ETHICAL PROFESSIONAL PRACTICE

PROFESSOR DATO' DR NKS THARMASEELAN

INTRODUCTION

Professional means a member of a profession. It denotes and defines the standards of education and training that prepare members of the profession with the particular skills and knowledge to perform the role as a professional. Those who are specialists will have to perform as expected of them. As doctors and specialists we are expected not just to perform within the set norms but need to adhere to acceptable ethical standards too.

Ethics is a branch of philosophy dealing with values pertaining to human conduct which takes into consideration righteousness and wrongness of actions; the goodness and badness of the motives and ends of such action.

It is for the professional who on entering the practice to be invested with the responsibility of adhering to the standards of ethical practice and conduct set by the profession. Some of these standards are codified but moral and ethical values may not be clearly defined or delineated, as there are many grey areas that we may need to traverse and navigate whilst managing patients. Some may have or believe in their own set ethical values which may not necessarily be in line with the thinking and beliefs of the rest. Each individual has his own vision and beliefs as regards ethics and moral values in practicing medicine. Race, gender, cultural and religious values may sometimes impinge or encroach on the acceptable standards of ethical professional practice.

Professional ethics encompasses the personal, organisational and corporate standards of behavior expected of professionals

in medical practice. Professionals exercise specialist knowledge and skills but medicine is not an exact science. Thus medical professionals would exhibit various differing ways in managing a case.

Whilst the profession dictates the best mode of performing a certain procedure, ethics would seek answers as to why that is the best way and whether it is justifiable by moral and ethical standards. Thus many organizations, academies, and medical councils have chosen to formulate ethical professional practice so as to crystallize these ideas, thoughts and beliefs into setting the standards and paving the way for rational decision making for the benefit of patients and doctors. But these certainly need to evolve with changing times and changing attitudes that affect moral and ethical values.

The face of medicine is fast changing due to the rapid advances in research and treatment modalities along with the enormous technological advances being made. Occasionally market forces seem to influence how medicine is practiced. As professionals some seem to be swaying away from the basics, as we become more and more reliant on machines, gadgetry, wizardly diagnostic inventions and sophisticated non-invasive interventions to manage patients. Are they really required in a standardized manner to manage patients? Is it fair for the patient to be pounded with a series of sometimes unnecessary investigations or subjected to highly sophisticated surgery when simpler methods would suffice?

As professionals we need to keep patient interest above all else. The primary obligation will be to cause no harm. When professionals provide this specialised service to the public, it should be governed by generally acceptable moral and ethical values according to the general expectations, most importantly the patient.

INTEGRITY IN PROFESSIONAL PRACTICE

DR MICHAEL SAMY

In the healthcare setting we can define integrity as encompassing honesty, keeping to one's word and consistently adhering to principles of professionalism, even when it is not easy to do so. Accountability refers to reliability and answering to those who trust us, including our patients, colleagues and society in general. Integrity and accountability are absolutely essential to maintain the public's trust in the profession. We have a responsibility to behave in a way that is deserving of this trust by protecting patients' confidentiality, maintaining appropriate boundaries with patients and avoiding and managing conflicts of interests.

We have a responsibility to be in the know and to be alert of impaired or incompetent colleagues, and to participate in peer reviews of such colleagues. We have an important role in the prevention, detection and investigation of errors. Professional bodies should provide a framework that allow the profession to remain autonomous while ensuring transparency and accountability to the public.

The best example of a very public failure is from the Bristol Royal Infirmary fiasco. It was suggested that the results of paediatric cardiac surgery were less good than at other comparable specialist units in the United Kingdom and in particular, that mortality was substantially higher. In January 1995, a child called Joshua Loveday was scheduled for surgery against the advice of anaesthetists, some surgeons, and the Department of Health. He died and this led to further surgery being halted. An external enquiry was commissioned by experts from the Great Ormond Street Hospital for Children in London. This led to extensive local and national media coverage. Parents of some of the children complained to the General Medical Council (GMC) which, in 1997, opened an investigation into events in Bristol and

specifically examined the cases of 53 children, 29 of whom had died and four of whom suffered severe brain damage. The GMC enquiry which was concluded in 1998 found three doctors guilty of serious professional misconduct and two of them were struck off the medical register.

The doctor's integrity forms the foundation of patients' trust and fosters healthy relationships that promote patient wellbeing. Professionalism is the building and bringing the best of yourself in incredibly complex environments where suffering, strong emotions and controversies are the norm rather than the exception. The development of resilience involves knowledge, skills and attitudes that can be taught, practiced, modeled and refreshed over a lifetime in medicine. Professional lapses are common in daily practice and can be viewed as opportunities for learning rather than requiring punishment.

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RESPECT IN PROFESSIONAL PRACTICE

PROFESSOR DATO' DR RAVINDRAN JEGASOTHY

The ethical obligation of a doctor includes respect of the rights of patients, colleagues and other health professionals. This obligation will extend to safeguarding patient confidence and privacy within the constraints of the law.

Respect is a value that is often taught to us from young by our parents. Respect means honouring another person as an individual and taking into consideration the values as well as opinions in any interaction with that individual. It is an integral part of many cultures and religions. It is thus not surprising that it forms a core value of medical ethics.

Respect for human life and integrity is a core value of the medical professional. It is often tested severely in times of war and conflict and is encoded in many codes of medical ethics by professional bodies. Many regard respect for autonomy as the pre-eminent principle of contemporary bioethics. We are also taught to have respect for cultural differences. Respect is often integrated with professionalism.

It need not be said that the doctor-patient relationship is special. The patient develops confidence to reveal their innermost secrets to the doctor so that the doctor can use that information to derive a diagnosis and manage the patient in the best way possible. This confidence can only develop with respect that should be mutual. Thus respect for persons best describes how doctors should think about and act towards their patients.

Towards patients

Most complaints in the healthcare profession are often attributed to poor communication. This often stems from an attitude of

paternalism or taking superiority on the part of the doctor towards the patient.

We are often taught that we should “listen to our patients”. A doctor who does not do this often is led astray in the management of the patient and faces difficulties that sometimes end up in the courts.

The core value of respect for the patient would ensure that we will always treat the patient with dignity, listen to what is said and interact with the other caregivers associated with the patient. We must treat the patient as the most important component of the doctor-patient encounter. We can always draw an analogy with the business world which emphasises that the “The customer is always right” by substituting the patient for the customer. It serves to emphasise the fact that to the patient the interaction with the doctor is the single most important encounter whereas to the doctor it may be one of many encounters throughout the day. Doctors do not fulfil their moral responsibility unless they also engage in the internal work of appreciating the value of the people that they treat.

Towards fellow doctors

Teamwork is emphasised as value that should be inculcated in all doctors. Even as a solo practitioner in your own clinic, one would need to interact with doctors that refer patients to you as well as other specialists to whom you would refer your patients.

Colleagues should be respected as equals and given their due respect. It is unethical to make disparaging remarks about a colleague even in a social setting. Matters at work should remain at the work place and not be a source of gossip. A good rule to follow is whether you would be comfortable to name yourself as

the source of any information that is said about a colleague. If you are not, then one should have remained quiet.

One should be even more circumspect when passing remarks about a fellow professional to the patient. The patient is in a vulnerable state and is not the best judge of what is appropriate management. It is best that if one has an issue with the treatment provided by a colleague, it should be raised to the management of the healthcare institution or to a professional body.

When a specialist works in a team, it is important to realise that each member of the team brings a specific set of skills and competencies that help to manage a patient who may present with complex issues. All team members must respect this and recognise the need to continually assess their own performance and to work within the limits of their competence. A team needs to make the best use of the range of skills and expertise available.

Sometimes in a team, disagreements can arise. If the disagreement is personal in nature, it is best one member of the team withdraws from the care of the patient as that would be in the best interests of the patient. Disagreements may be due to professional reasons. If that is so, the difference can be best handled by effective communication, by sharing of information while respecting patient confidentiality, by constructive discussion about the areas of disagreement and through respect for the skills, experience and opinions of other professionals. The respect that exists between team members will ensure that such disagreements do not escalate into anything nastier.

Towards fellow healthcare workers

It is vital that we realise that doctors cannot function alone in a healthcare system. Every single member of the healthcare team

from the attendant to the subspecialist will have their specific roles to play. Doctors must never inculcate a feeling of superiority over the other categories of workers. If we do so, we will fall flat on our faces as we definitely need all others to play their specific roles in healthcare.

It is for this reason that inter-professional education is the new buzz word in medical education. Students are now encouraged to study the roles played by other allied health care professionals so that when they begin practice as doctors, they would understand the vital roles played by allied health staff. It is often said that respect has to be earned. This is even more true in the health care system where there is an inherent hierarchical system. The doctor at the top of the hierarchy must not assume that all would respect him. That respect would come from displaying good manners and role modelling that is exemplary. A physician who is dedicated to providing competent medical care, with compassion and respect for human dignity and rights would earn the respect of all.

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ACCOUNTABILITY IN PROFESSIONAL PRACTICE

PROFESSOR DATO' DR RAVINDRAN JEGASOTHY

Case Study 1

A surgeon was attending a case of ascending cholangitis with possible biliary tract malignancy. While the case was being worked up, the urine output dropped. The patient was on an antibiotic that was potentially nephrotoxic. The case was referred to the physician who stopped the antibiotic and advised to start another in place. The intensivist was upset that the antibiotic had been changed without consultation with their team.

Finally, a tumour was diagnosed in the biliary tract and prolonged surgery was performed at a referral hospital. The patient returned to the initial hospital for convalescence but developed a spiking fever. Investigations revealed a retained abdominal pack! There was a dilemma as who would break the news and what to tell the patient. It was finally decided to say nothing and refer her back to the hospital where surgery was performed.

Doctors belong to a profession and are counted upon as professionals. Professionals are groups which declare in a public way that their members promise to act in certain ways. Professionals show competence within a specialised body of knowledge and skill. The right to train, admit, discipline, dismiss its members for failure to maintain competency or observe the duties and responsibilities also lie with the profession.

The obligation and duty of a professional includes accountability. Physicians are accountable to their patients and to society on issues of public health and to their profession. Accountability is

about professionals who are responsible for a set of activities and for explaining or answering their actions. There are as many as eleven different parties who can be held accountable or hold others accountable for health care. ¹These can be the patients, other physicians, allied health staff such as nurses, hospitals, managed care organisations, professional bodies, employers, private payers, investors, lawyers, courts and the government. There may be others such as pharmaceutical companies that are also involved.

It is therefore obvious that the specialist must be clear as to who he is accountable to as otherwise he will be perceived to be acting in an unprofessional way. With such competing interests, the specialist must hold the view that the interests and safety of patients are the primary concern. Patients are the prime reason why we seek to join the medical profession. We are also aware that we cannot work alone. We are dependent on other members of the team to provide effective care. Among others we need good communication skills and all members of the healthcare team must understand the team's shared objectives. To be accountable for the care of the patient, one must respect the autonomy, skills and qualifications of colleagues. While we do so, one must remember that the ultimate accountability for the patient rests with the primary care giver.

While we are concerned with professional accountability, there may be as many as six activities for which a professional is accountable. These are professional competence, legal and ethical conduct, financial performance, adequacy of access, public health promotion and community benefit. The last three areas of accountability are often not thought of by many specialists but in the long run for the benefit of the patient, profession and nation they are of vital importance.

There are three proposed models of accountability in healthcare - the professional model in which the doctor and the patient participate in shared decision making, the economic model where accountability is mediated through consumer choice of providers and the political model where the community dictates accountability. The doctor is very familiar with the professional model but the other two have taken on an increasing focus in current times.

Case Study 2

A mother delivered at a maternity home and was managed for postpartum haemorrhage with oxytocics. The obstetrician called up the referral hospital and transferred her. The vital signs were apparently normal and she was in a stable condition prior to transfer. On arrival within 30 minutes at the hospital, she was found to be in moribund condition with profuse bleeding. Inadequate fluid therapy had been provided. There was no good venous access. Blood had not been sent for cross-matching and as a result there was further delay in starting blood transfusion. The patient soon succumbed. After an investigation, an obstetric flying squad is initiated in that district

Clinical governance is now taking on a greater role in professional practice. What we do must be dictated by evidence and clinical needs and not be dictated to by corporate managers. The accreditation movement has motivated the need for greater clinical involvement in various management committees of the hospitals and other practices. Such committees set standards and describe models of best practice. Many audit groups have set clear examples for greater accountability of the professional groups. Clear examples are the National Perioperative Mortality Reviews and the Confidential Enquiry system into Maternal

Deaths. Taking accountability for a mortality or morbidity does not mean punishment but recognition that there is often a system failure which needs to be remedied or retraining to improve competency.

Accountability often embeds a culture of safety within the organisation as a part of the commitment to clinical governance.² The extension of the concept of individual accountability for performance is reflected in the proposal for routine annual appraisal of all doctors. Appraisal is an important contribution to the safety and professional agenda, it offers a forum in which good work can be recognised, strengths acknowledged and built on, and problems identified and tackled.

Discharging this more diverse form of accountability brings with it responsibility to a new style of practice - more multidisciplinary, more patient participation and more evidence based. Finally, accountability can no longer be seen as entirely a matter for the individual practitioner. The organisation in which the professional works has that responsibility too.^{3, 4}

It has been argued that a 'no-blame' culture is neither feasible nor desirable. Some actions of doctors may be looked upon as wanton shortfalls in care. They may warrant sanctions, severe ones in some cases. A blanket amnesty on all unsafe acts would lack credibility in the eyes of the workforce. More importantly, it would be seen to oppose natural justice.⁵

What is needed is a just culture, an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information – but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour. David Marx, a US attorney and engineer, has popularised the Just Culture concept by developing a model that distinguishes between 'human error' (an inadvertent act,

such as a 'slip' or 'mistake'), 'at-risk behaviour' (taking shortcuts that the caregiver does not perceive as risky – the equivalent of rolling through a stop sign at a quiet intersection), and 'reckless behaviour'.⁶ Only the latter category, defined as 'acting in conscious disregard of substantial and unjustifiable risk', is blameworthy. Other versions of the Just Culture algorithm, including an 'incident decision tree' produced by the UK's National Patient Safety Agency (NPSA), are available.⁷

Specialists therefore must remember they are fallible and can make mistakes in the work place when they are managing patients. The patients may suffer permanent or temporary disability. The patients may or may not recover. Whatever it is, the specialist is accountable in a professional way for what happens to the patient. Although the system may be at fault, the specialist is responsible to help identify the errors within the system and help correct them so that it may never happen again.

A pneumonic that may help in being accountable is:

- A Avoid shortcuts.** Follow the standard operating procedures always, 100% of the time
- B Benchmark** your practice against good examples
- C Checklists.** We need to learn from other industries. Save Surgery Save Lives checklist is one example.
- D Document.** We document so that others may know the management plan we have for the patient.
- E Evidenced based practice.**
- F Frank explanation** must always be provided to the patient.

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CONFIDENTIALITY IN PROFESSIONAL PRACTICE

PROFESSOR DATO' DR RAVINDRAN JEGASOTHY

Confidentiality remains the cornerstone of current medical practice. The doctor-patient relationship is a trust relationship, which means patients can feel free to discuss personal and sometimes sensitive details of their lives and illnesses with the doctor, and know such information will be kept confidential. Historically, patient confidentiality was part of an ethical code that all doctors abided in, the tradition dating back to Hippocrates. It is little realized that this concept is also found in Islamic, Chinese and Indian scriptures for physicians.

Case Study 1

A 27 - year old man from a drug rehabilitation centre was brought to a hospital with complaints of abdominal pains. The medical officer was as usual deluded with work that day in the busy surgical ward and decided that he would see him later after attending to other “normal” patients. The patient was finally seen after four hours during which time the patient had considerably worsened. Even to the medical officer, it seemed that the patient had a perforated appendix. He immediately informed his specialist who then requested a HIV serological test to be performed. This was the normal practice in that hospital for all patients from drug rehabilitation centres. He did not inform the patient of the test neither did he bother to counsel or obtain his consent for the test. The patient spent a rather restless night in the ward. The next morning the test was reported as positive. The specialist was informed of the laboratory test results and he informed the results to the patient at the bedside within hearing distance of the other patients. Although the clinical findings were

still suggestive of a perforated appendix, he diagnosed him as a case of abdominal colic and referred him to the medical unit.

Discrimination can occur in a variety of ways and can impair proper care. A health professional may discriminate on the basis of age, refugee status, presenting condition, marital status, occupation (e.g. sex workers) or previous history of drug addiction to name but a few. Ethical issues which may be recognised in the above case history are:

- Stigmatisation and delay in care because of the place from which the patient was referred.
- No respect for the patient's right to information about the tests he needed to undergo.
- Neglect of responsibility in professional care (Needless referral and "passing the buck" in view of the high risk situation).
- Lack of respect for the patient's right to confidentiality

The public is entitled to expect that a registered medical practitioner will provide and maintain a good standard of medical care. This includes:

- a) Conscientious assessment of the history, symptoms and signs of a patient's condition
- b) Sufficiently thorough professional attention, examination and other necessary diagnostic intervention.
- c) Competent and considerate professional management
- d) Appropriate and prompt action after evidence suggesting the existence of a condition requiring urgent medical intervention

- e) Readiness, where circumstances warrant, to consult appropriate professional colleagues

A comparable standard of practice is to be expected from medical practitioners whose contributions to a patient's care are indirect e.g. pathology and radiological specialists.

There are no clear answers to the ethical dilemmas that have been posed. There is no doubt that there has been neglect or disregard of professional responsibilities. HIV testing is an area that has been clouded with controversies. The routine screening of blood for VDRL without consent is frequently cited as justification for the same in HIV testing. Preoperative screening without consent is sometimes carried out with the ill-conceived aim to protect surgeons. In addition, there are cases where relatives request that the test be performed without the consent of the patient. Patients may be denied adequate and prompt care or surgery if HIV positive status has been established. Marginalised groups may be discriminated against e.g. a young person who is confused may be presumed to be a drug addict; an unmarried woman may be labeled a prostitute without adequate investigation. Stigmatisation or bias may indeed be the real problem.

As specialists, we should not allow ourselves to be affected by stigmatisation and bias in our care of the patient who has a right to demand respect and confidentiality. Otherwise, we may run foul of existing ethical codes.

Case Study 2

A company doctor was asked to undertake pre-employment testing of a new recruit. The company's policy was to undertake

HIV testing of all new employees. No specific counseling was undertaken and the doctor took a blood sample as part of a battery of other tests. When the test was reported as positive, the doctor informed the company of the positive test and that the employee had failed the medical examination.

The case illustrates some of the dilemmas faced by doctors. Is the duty of the doctor to the company that employed him or to the patient that sits in front of him? It can be argued that the doctor has not established a patient-doctor relationship with the employee. Such a relationship would exist with the family doctor of the employee. Some counseling should occur with the employee about disclosure of the positive test result to the family doctor. The company doctor need only inform the company that he has failed the medical examination. No specific test result needs to be provided. After appropriate counseling, the employee himself/herself can undertake to inform the company that he/she wishes to withdraw from employment from that company.

Patients grant practitioners privileged access to their homes and confidences and some patients are liable to become emotionally dependent upon the practitioner. Good medical practice depends upon the maintenance of trust between practitioners and patients and their families, and the understanding by both that proper professional relationships will be strictly observed. In this situation, practitioners must exercise great care and discretion in order not to damage this crucial relationship. A practitioner may not improperly disclose information which he obtained in confidence from or about a patient. Any action by the practitioner which breaches this trust may raise the question of infamous conduct in a professional respect.

Case Study 3

A doctor in charge of public health matters received a letter from the registrar of the court inquiring about the HIV status of a patient. It seemed that a lady had petitioned the court for a divorce as she claimed the husband was HIV positive. The doctor on checking the records did find that the patient was notified to the health authorities as being HIV positive. Being uncertain about how to proceed further, the doctor made an inquiry to the ethical committee of the national medical association.

Case Study 4

In another case, a specialist received a request for a medical report from the human resource manager regarding a particular employee who was frequently on sick leave. The doctor wrote back providing a detailed medical report including the diagnosis that the patient suffered from a urethral stricture that resulted from an episode of gonorrhoea. The doctor thought that was the end of the matter until he received a letter from the patient's solicitor that threatened legal action over the breach of patient-doctor confidentiality that had occurred.

Doctors will need to be meticulous that all possible efforts have been made to ensure that consent has been obtained from the patient before medical reports are released to third parties. The request from the court did not constitute a subpoena and the doctor was not required to divulge confidential information that had been provided to him in his capacity as a medical officer of health. He was advised to write back to the court and inform them of his inability to provide the information required. The court subsequently issued a subpoena and he was then compelled to provide the information in court. By providing the information

requested in the letter, the doctor would have been open to a complaint of breach of confidentiality by the husband. Such confidential information can only be provided to a third party without the consent of the person concerned if there had been a court order as in this case.

Doctors are in certain cases bound by law to give or, may from time to time be called upon or requested to give particulars, notifications, reports and other documents of a kindred character, signed by them in their professional capacity, for subsequent use in a court or for administrative purposes. Doctors are expected to exercise the most scrupulous care in issuing such documents, especially in relation to any statement that a patient has been examined on a particular date. Any doctor who shall be proved to have signed or given under his name and authority any such certificate, notification report or document which is untrue, misleading or improper will be liable to action by the medical council. Doctors should particularly beware of providing backdated sick certificates. The plea of showing sympathy to a patient in overcoming a personally trying time usually does not find a receptive hearing in a disciplinary tribunal

In case 4, the doctor clearly did not distinguish between the duty of care he owed to the patient and his business relationship to the company in which he provided panel clinic services. Certainly the patient would have expected his treatment details to remain confidential. The company could have been informed that the patient required continuing care for a urethral stricture. The aetiological cause need not be stated and the report should only be furnished with the patient's consent.

The doctor-patient relationship is a trust relationship, which means patients can feel free to discuss personal and sometimes sensitive details of their lives and illnesses with the doctor, and know such information will be kept confidential. Historically,

patient confidentiality was part of an ethical code that all doctors abided in, the tradition dating back to Hippocrates.

“Whatever in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge as reckoning that all should be kept secret.”¹

Among the communities found in Malaysia, there is a strong element of confidentiality that runs through the codes of physicians.

The Oath of a Muslim Physician includes this line, among others:

“...To respect the confidence and guard the secrets of all my patients...”²

The Oath of a Doctor promulgated at the First International Conference on Islamic Medicine held in Kuwait in 1981 required the doctor to state the following:

“To keep people’s dignity, cover their privacies and lock up their secrets”.³

Among the five commandments to Chinese physicians written by Chen Shih Kung in an Orthodox Manual of Surgery was the exhortation that:

“...the secret diseases of female patients should be examined with the right attitude, and should not be revealed to anybody, not even to the physician’s own wife.”⁴

In the Oath of Initiation of an Indian Physician known as the Caraka Samhita are the words:

“The peculiar customs of a patient’s household shalt not be made public “4

The Code of Professional Conduct of the Malaysian Medical Council has these few words of advice:

“Patients grant practitioners privileged access to their homes and confidences and some patients are liable to become emotionally dependent upon the practitioner. Good medical practice depends upon the maintenance of trust between practitioners, patients and their families and the understanding by both that proper professional relationships will be strictly observed. In this situation practitioners must exercise great care and discretion in order not to damage this crucial relationship. Any action by a practitioner which breaches this trust may raise the question of infamous conduct in a professional respect. A practitioner may not improperly disclose information which he obtained in confidence from or about a patient.” 5

Healthcare professionals need to be far more circumspect in observing confidentiality. Unfortunately, carelessness seems to be less than uncommon. Loose talk, gossip, disclosure of patient identity and indiscriminate release of a patient’s medical records all represent a breach of confidentiality. In one study by Ubel, 259 one way elevator trips in 5 US hospitals were observed. 39 inappropriate comments were overheard on 36 rides⁶ (13.9% of the trips). Many of the comments clearly breached patient confidentiality.

Doctors should realise that the doctor-patient relationship is founded on trust, and without confidentiality, trust is impossible. Doctor-patient confidentiality is both a legal and ethical responsibility. Consent by the patient is the primary condition justifying the release of confidential information.

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COMMUNICATION - WITH COLLEAGUES

PROFESSOR DATO' DR NKS THARMASEELAN

Doctors will be dealing with many colleagues and staff in the course of their daily routine of seeing patients. This is a normal scenario in a multidisciplinary setting. General Practitioners too will be seeing patients seen by other GPs, specialists will be seeing patients seen by GPs and other specialists. Thus it is important that doctors maintain excellent cordial relationship with their colleagues and staff. Only then will the doctor be able to provide the best for his patients.

Communication and Dealing with Fellow Doctors

In the Malaysian set up, patients do not need a referral letter nor do they ask for one to see another doctor. This itself will lead to many potential problems as some patients will be doctor hopping without being referred. These patient will see the 'new' doctor without giving full facts of his earlier consultation. Some patients will not divulge or will be reluctant to divulge details of earlier treatment with other GPs / Specialists for a host of reasons. This leads to potential gaps in treatment history which may lead to some unexpected problems

Conversely, in some instances, where patients divulge treatment done by other doctors, the doctor inadvertently (!) passes remarks on the management by the other doctor. This also leads to problems. Statistics with medical indemnity organizations reveal that more than 50 % of litigation is initiated at the suggestion of another doctor.

Up to 50 % of litigation is initiated at the suggestion of another clinician

Doctors need to take detailed history from patients who have chronic or long standing illness, like chronic respiratory diseases

or even common illness like diabetes, hypertension etc., If the patient denies seeing any other doctor or taking any form treatment for these illnesses, it would be safe to record it down in the case notes, as this would have a bearing on the case if it proceeds to the courts. Even 'simple' fevers which of more than a week would warrant a detailed history including treatment and investigations done, so that the doctor would do the relevant investigations if not done earlier. In this type of scenario the doctor omits to investigate for dengue / malaria and lands into a potential medico-legal problem due to lack of information / inadequate treatment history from the other doctor.

On the other hand, doctors need to be careful before commenting on another's management of the patient. An inadvertent negative remark may lead to the patient believing he has grounds for suing his doctor. This leads to the patient initiating legal proceedings depending on the comments made by the doctor. The doctor will be called as witness and asked for his comments. This may be an embarrassing situation if the doctor is not able to substantiate his comments. It may be humiliating if he is proven to have made irrelevant comments. He can be sued both by the patient and his colleague. An unwarranted remark may see the doctor wasting his time in the courts as a witness for a case of his own making. This will be of no benefit to him.

Ill advised comments about treatment by a colleague can lead to

- **Litigation against your colleague**
- **Humiliation for you, should you not have the full facts**
- **Increased premiums for you and your colleagues**
- **Patient anger and even litigation**

Many a time a doctor may be asked directly or indirectly to comment on another doctor's management. It would be best to

avoid comments, if possible, though it would be tempting to do so especially so if you seem to have noticed some 'glaring' mistakes. However, doctors must be wary and resist the urge of making comments without having the full facts before them

Suggestions for responding to a patient asking you to comment on another doctor's care

“ You are entitled to an honest answer to that question but I do not think I can give you one unless I am certain that I have all the information on which to base an honest answer “

“ If you have concerns you may wish to discuss this with your doctor, I am sure he would be keen to help you again or at least discuss the matter with you.”

MPS Risk Consultancy

If a patient raises a criticism of a colleague with whom you have a working relationship

- **Confirm your commitment to take care of the patient**
- **Stress that you work as a team and each of you brings different skills**
- **You may offer to contact your colleague with the patient's permission**

If you are concerned about the standard of care from your colleague

- **Realise you may not have all the facts**
- **Contact the colleague directly to make sure you have the full story**

Referring Patients to Other Doctors

In the referral note, full details on the patient including identification details need to be given. Full treatment details including treatment given, prescription details, investigations done and planned; a working diagnosis also need to be given. These will be helpful to the doctor who the patient is referred to. Any mishap including allergies need also to be highlighted. If referred it is helpful if the reason for referral is given. It is important all these facts if hand written be legible including the referring doctor's name and contact details.

Response to referrals

It is good practice to call to the doctor referring, thanking him for the referral and if required asking any other details, instead of assuming these details, that will assist him in managing the patient. After management of the patient it will not only be a good gesture but also helpful to reply with written reports to the referring doctor regards the patient. Keeping the communication channels active with the referring doctor is important. Though it may appear cumbersome it is good practice to keep the doctor posted of further developments. As soon as the reason for referral is sorted out, the patient should be referred back to the GP for follow up.

Doctors should not feel challenged when fellow doctors request for details regarding their patients and vice versa.

Doctors should not be reluctant to release all relevant details of patient so that patient will be managed well. This is good medical practice and in addition will assist in creating a more cordial working relationship with colleagues.

COMMUNICATION AND DEALING WITH STAFF

PROFESSOR DATO' DR NKS THARMASEELAN

In a multidisciplinary hospital setting, medicine is team work. The team has to work in unison. The wheels of medicine will only function if the entire team rolls in tandem, one prodding the other. The team assisting the doctor will include fellow doctors, the paramedical staff, the nurses, the receptionist, other staff, the attendants, the cleaners and all who, in one way or another come into contact with the doctor in performance of his duties. Problems will arise when there is a discontented team member. This usually arises when the doctor take their colleagues for granted.

The team will include
• Paramedical staff • Nursing staff • Administrative staff • Attendants • Cleaners

Communication with staff

The doctor must recognize the value of his staff He must be cordial, polite and relate to his staff. There must be interaction. A staff who is treated badly and just works for the money will not be an asset to the doctor. She will be a problematic staff and increase the chances of litigation against the practice. A staff who has been treated badly will not have good things to say about the doctor to his patients. This would apply both to the private and public sector practices.

- | |
|---|
| <ul style="list-style-type: none">• Increasing recognition of the impact patient / staff interactions have on litigation |
|---|

The staff must also be trained to be polite and kind to the patients. The staff usually follow how the doctors treat the patient and how they themselves are treated by doctors. Doctors are leaders in hospitals and practices, thus they must lead by example. Doctors can set the standards for how patients are treated with respect and care.

Doctors will be dealing with paramedical and administrative staff in the course of their daily routine whilst dealing with patients. It is important that doctors maintain excellent cordial relationship with staff of all categories for smooth functioning and creation of a conducive and warm working atmosphere.

Only then will the doctor be able to provide the best for his patients.

Receptionist

She is the first point of contact for the doctor. She has to be trained to be polite and warm towards patients and their families when they approach her for making arrangements to meet the doctor, a follow up or any queries regards the management. An empathetic receptionist with good communicating skills is an asset to any doctor both in the private and public sector. A patient gets irritated and a bad impression of the practice when the receptionist is rude and has poor communicating skills. Answering a phone call may reveal what is in store for the patient. A receptionist who is cordial, polite has and well versed language skills is essential for the practice to grow. The doctor should pay more attention to this first point of contact - the receptionist. He must be able to teach or train her in communicating with patients. He also has to treat her well if she is to perform well.

She can be disruptive force to the practice. She may steer patients away from the practice if the doctor has not treated her well by passing negative comments of the doctor and practice

to the patient. Doctors do try to cut corners in these troubled economic times to employ receptionist with poor qualifications not realising the potential for damage to the practice in the long run. A well paid receptionist with good communicating skills will ultimately recoup more than the expenses

Even the telephone receptionist plays a role in this picture. A call to the practice answered by an uncaring staff would also create problems for the practice. All staff should be trained to sound polite and caring even over the phone. The entire environment in the practice should ring with happiness. This type of atmosphere is vital in any clinic, practice or hospital.

Staff must be treated with respect and care just as you would treat your patients. The staff will need to realize that respecting individual patients irrespective of their social status should come naturally.

Staff tend to treat patients
• The way they see doctors treating patients • The way themselves are treated by doctors

Confidentiality

Doctors should also not discuss matters of a confidential nature about the patient with staff. The staff should be taught early on, that confidentiality is paramount in the clinic and hospital set up. They need to be impressed upon that under no circumstance are they to reveal information regarding the patient to anyone including relatives. There will be times the relatives would want to have a peek at the medical records. They should be advised to refer these queries and other matters of a confidential nature to the doctor.

Dealing with patients

The staff should also be trained to resolve problems as they begin. They should avoid confrontations with the patient. They should also try to look into any dissatisfaction that the patient may have and resolve them. A staff with a pleasant disposition will always be an asset to the doctor. On the contrary an argumentative, rude and non caring staff will induce any patient to initiate litigation at the slightest excuse.

Staff should be trained to treat patients with
• Respect • Care • Confidentiality • Resolve problems of a personal nature

Doctors should :

Implement clear written policies in the practice regarding
• Confidentiality • Information that can be discussed by staff • Standards of respect and care • Dispute resolution with patients • Encourage staff to undertake training in how to deal with patients who are distressed / upset (Doctors too may require this training!) • Regular reviews on what patients experience when they come to your practice

All this would be implemented if the doctor arranges regular staff meetings with staff. An exchange of ideas regarding the management of patients will see the practice thriving and become litigation free. These may appear to be simple things but it will create complex situations if not adhered to in a routine natural manner.

SUMMARY

The doctor must treat his staff as he would treat his family. He should be polite and caring to them just as much with his patients. In these type of practices where you find closeness between doctor and staff, you will find them rallying together in times of crisis. Doctors who develop these practice guidelines seldom have any problems with patients resulting in litigation.

AN OBLIGATION TO TEACH BY PROFESSIONALS

PROFESSOR DR VICTOR LIM

One of the primary duties of a doctor is to teach. The word “doctor” derives from a Latin root “*docere*” which means “to teach.” Doctors have to educate patients about their medical conditions. There is in addition a professional obligation to help train other health professionals or those aspiring to the medical profession. The profession is said to be built on the premise; *videre unum, noli unum, docent*; see one, do one, teach one.

The Education Committee of the General Medical Council published a document in 1999 which was entitled “The Doctor as Teacher”¹. In this document it was explicitly stated that all doctors have a professional obligation to contribute to the education and training of other doctors, medical students and non-medical healthcare professionals on the team. Every doctor should be prepared to oversee the work of less experienced colleagues, and must make sure that students.

Under the CANMEDS Competency Framework of the Royal College of Physicians and Surgeons of Canada², scholarship or being a scholar is identified as a key competency for all physicians. Scholarship can be defined as academic study or achievement of learning at a high level. Scholarship embodies activities that result in discovery, integration, application and teaching within an environment that accepts nothing less than the highest standards of professionalism and ethics. In the CANMEDS framework physicians are expected to:

- Maintain and enhance professional activities through ongoing learning;

- Critically evaluate information and its sources, and apply this appropriately to practice decisions;
- Facilitate the learning of patients, families, students, residents, other health professionals, the public, and others, as appropriate;
- Contribute to the creation, dissemination, application, and translation of new medical knowledge and practices.

In Malaysia specialists have more recently become increasingly involved in the role of professional educators or medical teachers. In the Ministry of Health, specialists are given the roles of supervisors for the postgraduate clinical trainees as well as clinical teachers for undergraduate medical students who use their hospitals for training. This has increasingly become a core duty or job function for many physicians along with their practical duties which include patient care.

Together with teaching there is also a role in assessment and specialists are often tasked with the assessment of their trainees. All specialists have to take this task seriously as certification of trainees who have not achieved the expected level of competency or standard of professional behavior will put patients at risk. Specialists need to be honest and objective when assessing those they have supervised or trained.

Doctors should serve as effective teachers and role models for their younger colleagues and it is essential they have the following qualities:

- maintain a high standard of professional and ethical behaviour
- maintain a high standard of clinical competence

- be able to communicate effectively
- be committed to personal and professional development
- be committed to professional audit and peer review
- be a good team player in a multi-professional environment
- an enthusiasm for his/her specialty
- a personal commitment to teaching and learning
- sensitivity and responsiveness to the educational needs of students and junior doctors
- the capacity to promote development of the required professional attitudes and values
- an understanding of the principles of education as applied to medicine
- an understanding of research method
- practical teaching skills
- a willingness to develop both as a doctor and as a teacher
- a commitment to audit and peer review of his/her teaching
- the ability to use formative assessment for the benefit of the student/trainee
- the ability to carry out a formal appraisal of medical students and postgraduate trainees

Patient Education

Doctors also have an obligation to educate their patients. The best doctors also teach their patients. Doctors must have the patience and skills to explain the complexities of disease in clear and simple language, to allow the patient to have a better understanding of his condition and to be able to make informed decisions on treatment options. This is obligatory when taking informed consent. Doctors also have the obligation to

advance the health and wellbeing not only of their patients but their communities as well and should take every opportunity to educate their patients in health promotion and disease prevention activities.

Enhancing the Role as a Teacher

As teaching skills are not necessarily innate, doctors in fulfilling their obligation to teach should ensure that they develop and maintain these skills. Many doctors teach without taking formal training, as there are no mandatory requirements that a doctor must participate in teacher certification in order to provide patient education or tutoring to students. Nonetheless all doctors should be encouraged to undertake some formal training in teaching as part of their continuing professional development. Formal training in teaching during their undergraduate training will also help them better prepare for their role as teachers when they graduate as doctors. Training in assessment may also be required.

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THE DOCTOR, THE PATIENT ANDSEX !

PROFESSOR DATO' DR NKS THARMASEELAN

Doctors caring for patients over the years develop a relationship, the platonic doctor-patient relationship. As the patient sees the same doctor, the patient learns to trust the doctor. This is an essential part of treatment. But sometimes this relationship strays away from acceptable norms.

Hippocrates as far back as the 4th Century B.C recognized the potential of the relationship going astray and the Hippocratic Oath says *"Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of **sexual relationships** with both female and male persons, be they free or slaves"*

DOCTOR–PATIENT RELATIONSHIP

Fiduciary relationship

As a result of the fiduciary relationship, nearly all professional organizations have a code of ethics prohibiting sexual relationships with those they provide service to. A fiduciary relationship is defined as a relationship where a person (patient) justifiably relies upon another person (doctor) to protect their personal interests and / or act in their best interests. The Doctor/patient relationship is a clear example of a fiduciary relationship where the patient places her full trust on the doctor

Power Imbalance

Within the doctor/patient relationship is the element of power. The doctor has the training, the education and the ability to treat the patient. All these acquired knowledge places the doctor in a position of power. The patient not having the knowledge, justifiably relies upon the doctor to act in the patient's best interests.

Vulnerability

This vulnerability arises from the fact that most patients seek medical services because of a physical or mental problem or condition. The patient then is expected within this fiduciary relationship to reveal confidential and even intimate embarrassing details to the doctor thereby further increasing the patient's vulnerability as well increasing a reliance on the doctor to act in the best interest of the patient. Thus sometimes this vulnerability increases the potential for testing the boundaries of appropriateness.

Transference

Transference is a term coined by Freud which describes displacement of the patient's feelings from past events and persons onto the doctor. Transference occurs when the patient develops feelings towards a doctor unrelated to the professional care provided. The patient may idealise the doctor and in position of vulnerability may fall in love or have lustful feelings for the doctor. The doctor with his experience must be alerted to this and see that the boundaries of the doctor/patient relationship are not breached. Even if the patient initiates and consents to the relationship it is still prohibited morally and legally.

Counter-Transference

This is when the roles are reversed and the doctor develops feelings for the patient. This is a taboo area which would see the doctor veering into serious ethical problems.

POTENTIAL TRAPS IN THE RELATIONSHIP

This article will not deal with the rare predatory doctor who takes advantage of his patient but will discuss situations which will help identify boundaries, and situations verging on boundary violations of the doctor/patient relationship and subject to be interpreted as sexual misconduct. This will help doctors avoid potential pitfalls

and misinterpretation of such actions. Allegations of sexual misconduct are viewed seriously by the Medical Council, the public and even the profession. There is immense stress and misery on a doctor facing alleged sexual misconduct charges.

There are penumbra of opportunities for the patient to develop feelings for the doctor. It is incumbent for the doctor not to fall for the patient who is bent on 'seducing' him. Seduction is never a defence for the doctor. There will also be the rare predatory patient for her own reasons looking for a lawsuit or intent on having an affair or even 'fixing' the doctor.

Flirtatious Patients

There are some patients who are just flirtatious and may just want to see the reaction from the doctor. Terms of endearment are being constantly uttered by these patients. Some doctors are teased into a superficial phantasmagorical relationship.. A flirtatious patient may attempt to justify inappropriate behavior by saying *"Don't worry. It'll be our little secret."* The doctor ends up embarrassing himself. In the rare instance the doctor gets seduced into a sexual relationship. The doctor should be able to identify such patients with assistance from their staff who probably will get a better understanding of the patient even before the doctor sees them. Doctors should treat them with 'careful' respect. They also tend to appeal to the ego of doctors. Doctors should not be seduced by verbal temptations and actions.

Predatory Patients

These are rare patients who see the doctor with a hidden agenda and are intentionally inclined to fix the doctor up. They may appear to be flirtatious but actually are very scheming. There will be many tell-tale signs to identify such patients.

The predatory patient may;

- Want to be your last patient of the day or insist on seeing you after office hours

- Be very blatant and intimidating with staff
- Want to be examined without chaperones
- Disregards staff instructions and may appear naked in the treatment room
- Conversation is very seductive especially when staff are out of ear shot.
- Attempts to appeal to your ego. *'The last two doctors I saw were idiots but I've heard wonderful things about you'*

Unrealistic patients

These are patients who unconsciously idolize or see the doctor as a replacement for another important person from the patient's past or present. When trust develops between a doctor and a patient these extremely vulnerable patients may unconsciously misinterpret the role of the clinician. This is where transference takes effect and the patient visualizes the doctor as Prince Charming, Dr. Perfect, Dr Good Parent, Dr Omniscient and so on. They then 'act' their role and get disappointed when the matters do not go their way.

SPECTRUM OF ALLEGED SEXUAL MISCONDUCT

- Doctor's presence while patient is disrobing, some refer to this as voyeurism
- Subjecting patient to examination in the presence of third parties including medical students without getting permission from patient to do so
- Making inappropriate comments of patient's body, dressing, looks etc
- Inappropriate comments about patient's sexual orientation and preferences
- Making comments about patient's potential sexual performance whilst examining patient
- Requesting details of (irrelevant) sexual history, fantasies and inclinations

- Irrelevant intimate conversations
- Doctor taking off clothes for the patient without chaperones
- Performing intimate examinations without chaperones.
- Examination of sensitive areas like breasts, private areas without permission and the necessity to do so
- Taking photographs of patient especially private areas for personal use.
- Showing patient pornographic material
- Inappropriate body contact like hugging and kissing
- Constant stroking of the thighs and other sensitive areas whilst talking to patient
- Touching, stroking, massaging breasts, genitals or anus or any other sexualized part of the body when there is no necessity to do so.
- Performing a pelvic and rectal examination without wearing gloves
- Sensual or rough examination of sensitive areas
- Having 'sexual therapy' with the patient as part of 'perceived treatment '
- Sexual molestation
- Rape
- Having sex with the patient whether initiated by or with consent of the patient

The above are some of the complaints received against doctors by patients. The list is not exhaustive and there are many other areas where with common sense, the doctor needs to tread carefully. In all the studies made regarding sexual misconduct by doctors, the complainants were mainly females whose complaints were directed almost entirely towards male doctors.

RISK MANAGEMENT

How to avoid complaints of sexual misconduct

Preparing for high risk situations

Being prepared and establishing your personal policy in advance, you can avoid being caught off guard thus avoiding some awkward and potentially risky situations.

Training staff

- To be aware of risky patients and situations
Develop your own way of identifying potential risky patients without letting the patient know. Eg saying Dr Pink, so that staff are alerted and one of them is present throughout the consultation and treatment phase. Staff must be trained to inform doctors of risky patients even before they enter the consultation room;
- To recognise, respond and deal with aggressive patient
Staff should be empowered to deal and handle difficult situations including calling on security personal on duty

Some risk management tips

Consultation Room - Inform patient what you plan to do during examination

- **Greetings**
Terms of endearment, like *Darling*, *Sayang* may not be appropriate for most patients, especially on their first visit. It may put patient on a wary or suspicious mode of the doctor. Address the patient by their names or just a plain *Hello*, if need be

- **Consultation**

You need to be very careful when you ask intimate details especially regards sexual activity. Don't sound excited or react with superlatives. These must be asked in matter of fact manner.

- **Consent**

You would need consent for any examination. Do not assist in the undress and just do any examination till you have ascertained that the patient as agreeable to the proposed examination.

- **Examination**

You need to tell the patient what you plan to do e.g Chest, abdominal examination etc. You need to tell them specifically what you want removed, like *Please remove your blouse, leave your bra on, Remove you skirt but leave your undergarments on.* Some doctors would prefer their chaperones to give these instructions.

- **Intimate examination**

You should tell the patient during consultation itself that you would need to do a vaginal /anal/ pelvic examination. Any intimate details or of sexual activity should be asked before or after the examination, **not** during the examination. If you also need to examine the buttocks or breast you need to explain why you need to perform the examination before you start examination.

- **Investigations**

If you are doing an ultrasound you also need to explain to the patient what you are doing as this will involve moving the probe up and down and in all angles. especially if you need to a vaginal scan.

Other matters that count

- **Consultation Room**

- Perform all initial consultation and examinations during office hours. Doctors should avoid seeing patients after all staff have left the office.
 - The room needs to be well lit. Dim lighting provides ample avenue for misunderstanding your actions
 - The consultation room where you perform the examination should be in a room close to the front office. It should not be secluded or in a room right at the end of the practice area. It will permit easy access to chaperones and gives more confidence to the patient.
 - Privacy for the patient is important. Provide an area behind curtains for them to undress. Provide drapes and do not leave sensitive areas exposed during examination.
 - Chaperones are essential when you conduct intimate examination. Use same gender parents as chaperones during examination of children.
-
- **Signs indicating that patient is already feeling uncomfortable**
 - Patient pulls away when touched.
 - Appears terrified after your examination
 - Negative comments to staff about your bedside manners and approach
 - Insists that a nurse be present at all times during consultation/ examination
 - Informs another doctor that she is uncomfortable with your treatment.

- Does not turn up for review or follow up after an examination especially an internal.
- Turns up with her husband for subsequent examinations and insists husband remains in the consultation room.

Conclusion

Inappropriateness during consultation and examination may result in unwarranted consequences and sensational publicity resulting in 'doomed' careers for many doctors. It also becomes a black mark for the profession. One has to treat carefully in dealing with patients both male & female during their career.

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THE LACK OF COMMUNICATION - THE MAIN REASON WHY PATIENTS SUE

PROFESSOR DATO' DR NKS THARMASEELAN

Most studies around the world indicate that only a minute fraction of the adverse outcomes of medical management are pursued in the courts. Surprising, not all adverse outcomes of medical treatment, result in the doctors or hospitals being sued. This article explores as to why patients sue and why only certain doctors end up in the courts.

A Harvard Study revealed that only 3.7% of the hospital admissions resulted in adverse outcome, of this only 25% i.e. 1% of the total adverse outcomes, were due to negligence. Only 12% of the patients who suffered adverse outcomes due to negligence filed a lawsuit.

Most astonishingly. 65% of the claims made, were from patients who did not suffer any adverse outcomes. This included patients who did suffer adverse outcome not due to negligence. Thus, it is clear that not all negligence cases results in lawsuits and paradoxically some patients sue even when there is no negligence or adverse outcomes.

Harvard Study
• Only 3.7% of hospital admissions result in adverse outcomes; • Of this, only 1:4 adverse outcomes (1% of total) are due to negligence; • Only 12% of patients who suffered negligence filed a lawsuit; • 2 out of 3 claims come from patients with no adverse outcome or an adverse outcome not due to negligence.
Leape et al 1991¹

Reasons

Poor Communication

One of the commonest reasons given by patients to initiate legal actions was the doctor's refusal to communicate with them. Even when they did, most patients complained that the doctor was in a hurry, dismissive, abrupt, aggressive, patronising and sometimes down right rude.

According to **Beckman et al**² who reviewed plaintiff depositions in suits filed in courts, found that, 70% of litigation was due to poor communication, whilst, **Vincent**³ who reviewed similar material found a high figure of 80% of litigation was due to poor communication.

Statistics
• 70% litigation is due to poor communication Beckman et al 1994 • 80% of litigation is due to poor communication Vincent et al 1994

Patients usually prepare themselves for days before an appointment. They thus, feel frustrated when the doctor does not hear them out. An important awaited event for the patient turns out to be an anticlimax and becomes a source of frustration. Statistics also revealed that doctors interrupt a patient within 9 seconds of consultation. The doctor too misses the opportunity to get a detailed history which would have assisted the doctor in better management of the patient.

The above study reveals that even before a patient had completed a few sentences the doctor interrupts. Patients feel irritated and disappointed when they are not allowed to complete what they want to tell and feel the doctor ought to know. There appears

justified dissatisfaction as they feel that the doctor is making a pre-judgmental diagnosis without hearing them out. Patients usually lament that they feel devalued and deserted by doctors who always appear rushed. Sometimes, whilst the patient is seriously describing his/her problem, the doctor appears lost in thoughts which would definitely be disappointing to the patient. These days doctors appear to answer Hand-phones and talk incessantly whilst the patient is seated in front of the doctor. Some doctors fidget around with their computers during consultations,

Patients regularly complain that there is a lack of information and understanding of the diagnosis, progress and treatment. This is the major reason why many patients resort to clinic/doctor hopping to find a doctor who will listen to them. The courts are also of the view that the patient should be given sufficient information to make an informed decision on management of their illness.

It is also unfathomable how a doctor would get a decent reliable history if they do not listen to the patient. More often than not a diagnosis is made when an adequate history is taken. Many a diagnosis is staring at the doctor who fails to get the correct diagnosis when he fails to listen.

Factors Influencing the Decision to Sue

Thus, it is clear that there are many predisposing factors that induce the patient to sue and when this is compounded by precipitating factors, then litigation becomes a certainty.

Predisposing Factors

The predisposing factors are factors that would spark the thought of suing by the patient. These are usually delays of any type that arises when dealing with the patient. These delays may be due to waiting time, delays in appointments, delays in investigations, follow up and treatment. Some delays which are inevitable like

a doctor being called for an emergency during the midst of a consultation would also lead to frustrations if the situation is not explained to the patient by the doctor or his staff.

Predisposing Factors
• Delays • Inattentiveness • Miscommunication • Apathy • No Communication • Mannerisms of doctor

Another major factor is the personality of the doctor and his mannerisms whilst dealing with the patient. This plays a major role. Time and again patients who are involved in filing suits complain that the doctor was inattentive, there was lack of or no communication at all. Some doctors are accused of being apathetic.

In studies where consultations were recorded, in 90% of the cases, the researcher was able to identify a potential complaint that would arise out of the consultation. During the consultation with the patients, the doctor appeared to be dismissive, arrogant, loud mouthed and paternalistic. These doctors often do not create a bond with the patient.

The other factor is not showing that they care. This is mainly because they lack communicating skills. Patients usually do not sue someone they like⁴. **Scherger** in his paper, *What patients want* summarises eloquently that patients do not care how much you know until they know how much you care⁵.

When there are predisposing factors, the precipitating factors pushes the patient and makes sure that the patient sues. Many a time, when there were no predisposing factors the patient,

usually does not sue however serious the precipitating factor may be. Precipitating events were unlikely to lead to litigation if there were no predisposing factors⁶.

Precipitating Factors
• Adverse Outcomes • Iatrogenic Injuries • Failure to provide adequate care • Mistakes • Incorrect care • System errors

When reporting claims against doctors, both the lay and medical media tend to report mainly the precipitating factors and rarely the predisposing factors. **Lester & Smith**, found that negative communication behavior by doctors increase litigious intent even when there has been no adverse outcomes. They found that a doctor who listens and talks to patients is rarely sued⁷.

More than 50% of patients who sued claimed that they got so turned off by their doctor that they wanted to sue the doctor even before the alleged event occurred⁸.

Which Doctors Get Sued

Males more likely than females
• Males are three times more likely – Taragin et al⁹ • 60% more likely to be males NSW Health report¹⁰ • 87% of complaints related to care provided by males NSW Health report

Majority of the doctors sued were not surprisingly males. Most independent reports indicate that male doctors are more likely to be sued than female doctors. Some reports give astonishing figures of almost 90%.

Higher age group
• Doctors aged 36 – 55 with a peak incidence of 40 Taragin et al

Studies indicate that the middle aged doctors are more likely to be sued. This is contrary to the perceived view that it is the junior, inexperienced doctor who is likely to be sued. There may be many reasons for this. The junior doctor may have spent more time communicating with the patient and developed a bond with the patient. Normally most junior doctors show that they care and thus, avoid unpleasant situations which will induce the patient to sue but this trend may change as the profile of the young doctor's mannerisms and attitude appears to be following the standards set by their middle-aged peers.

Attending Risk Management Seminars
• Doctors attending risk management seminars are less likely to be sued¹¹

Studies also show that doctors who attend risk management seminars, medical professional development courses, workshops etc., are not sued as often as those who do not do so. It is more likely that these doctors believe they are human after all and may be prone to some errors of judgment. They also take steps to improve their skills, their knowledge and communicating skills. They are also well aware of their limitations and do not venture beyond their expertise.

Summary

In essence the only way to curtail or prevent patients suing is to communicate - Learning the art of talking to your patients with empathy and patience. You must be patient enough to answer queries from your patient and encourage him to ask questions. A doctor is there to serve his patients. As a service provider he has to be one who always serves with a smile. A happy and satisfied patient rarely sues a doctor with whom he develops a bond.

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ETHICAL ISSUES IN MEDICAL RESEARCH

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The protection of human participants is one of the areas addressed when assessing responsible conduct of research. Medical researchers working with human subjects are increasingly being regulated by legislation and professional ethical guidelines. This is to ensure that the rights, safety and welfare of study subjects are protected. Study subjects have the autonomy and right to decide on whether they wish to participate or not participate in a particular research. Informed consent must be obtained from study subjects. Requirements for obtaining informed consent include the subject being competent to understand and make decisions, informed on the research including the risks associated with participation as well as voluntariness.

A moral quality that medical researchers are expected to have is virtue. They are obliged to protect study participants from harm that could arise from procedures participants are subjected to. The principles of social justice must prevail and researchers have to be just and fair when requesting and using resources. They also need to prevent exploitation and protect vulnerable groups e.g. children, prisoners and students. Special ethical considerations need to be addressed when study subjects belong to these groups as they may be subject to coercion, inducement and indignity.

Ethics in medical research internationally are guided by the Belmont Report (1979) and the Declaration of Helsinki (2013). Among the principles stated in this declaration is that medical research is subject to ethical standards that promote and ensure respect for all human subjects and protect their health and rights.

It is also clearly stated that while the primary purpose of medical research is to generate new knowledge, this goal can never take precedence over the rights and interests of individual research subjects.

In Malaysia, the Medical and Research Ethics Committee (MREC) of the Ministry of Health also makes reference to the National and International Ethical Guidelines for Biomedical Research Involving Human Subjects (CIOMS). Individuals involved in designing, conducting, recording and reporting clinical trials that involve the participation of human subjects in Malaysia are required to adhere to the Malaysian Guideline for Good Clinical Practice (2011).

In conclusion, sincere consideration of ethical issues is vital in the responsible conduct of medical research.