Keynote Address:
Ethical and Medico- Legal Issues in Ophthalmology

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The Guest-of-Honour, Yang-Berhomat-Mentri-Kesihatan Malaysia, Dato Lee Kim Sai, President of the Ophthalmological Society of MMA, Dr Pall Singh, President of the Singapore Society of Ophthalmology, Dr Ang Chong Lye, distinguished guests, ladies and gentlemen.

INTRODUCTION

I am truly honoured to be speaking to you today. When Dr Pall Singh asked me to deliver this keynote address, I was not sure what I was going to speak about, and I thought that if I could not find a suitable or worthwhile topic, I would decline his invitation. The next thing i knew, I received this colourful brochure with my name on it announcing that I would be giving the keynote address. I guess that is the best way of making my mind up for me.

The topic of my address is "Ethical and Medico-legal Issues in Ophthalmology". My only qualifications for giving this talk are:

1. I have been in practice of Ophthalmology for over 20 years.
2. I have served 3 years in the Singapore Medical Council, which passes judgement on ethical cases.
3. I was President of the Singapore Medical Association, and Chairman of its Ethics Committee, which receives and reviews complaints from patients.
4. I have my own share of unhappy patients.

LANDMARK CASE

Those of you who are members of the Medical Defence Union would have received the latest issue of the Australasian Journal of the Medical Defence Union[1]. In the issue is a report of the Rogers v Whitake case, which is a landmark case in "the amount of information to be provided by a doctor to a patient before he undergoes treatment.

Dr Rogers is a well-known ophthalmologist in Australia, and had a patient who "had been blind in one eye since childhood. In 1984 she underwent elective surgery to her blind right eye to reduce intraocular pressure and to improve the appearance of her pupil. The patient asked many questions concerning the proposed procedure. The surgeon did not warn her of the 1:14,000 chances that she may develop sympathetic ophthalmia. The patient became totally blind after the operation. The High Court found that the surgeon was in breach of his duty of care in failing to warn Mrs Whitaker of the risk of sympathetic ophthalmia".

After reading the report, I am still not sure how much we should be telling our patients. The report stated that "A doctor must warn any patient of the usual risks of the procedure, such as infection or postoperative bleeding. It does not mean that a doctor has to warn the patient of the possibility of anaphylaxis". There are no specific guidelines because every patient is different- his condition, his desire for information, his temperament, and "the general surrounding circumstances". "Failure to communicate will give rise to medico-legal problems. A doctor will have to be particularly careful in giving advice in elective and cosmetic procedures. Conversely, in emergencies the duty to warn may not arise".

THE DANGERS OF STEROIDS

It is quite obvious that before we do an operation on a patient, we should explain the reason for the surgery, the prognosis, and the possible complications. When we prescribe drugs to patient, do we remember to do the same? How much should we tell a patient for whom we are prescribing steroid eye-drops? Do we tell the patient that the steroid eye-drops can cause glaucoma, cataract, and dentritic corneal ulceration?

I can remember the case of a French woman who saw her general practitioner for treatment of a red eye. The G.P. diagnosed conjunctivitis, prescribed antibiotic with steroid eye-drops. She was not better, returned to the G.P. and told him her eye was worse with pain. But the G.P. reassured her that the drops were correct and that it would take another week or so for the conjunctivitis to clear up. Her husband also told her that she must listen to the doctor. It turned out that she had a dendritic ulcer. This was eventually treated and she had residual corneal scarring with visual loss. When she returned to France, she showed the eye-drops to her ophthalmologist who told her that the wrong drops had been given to her. She returned to Singapore to sue the G.P. I understand that in France, G.P.'s are not permitted to prescribe steroid eye-drops. Fortunately, our Asian population is not so prone to dendritic corneal ulceration.

COMMUNICATION SKILLS TRAINING
Most medical schools now have communications skills training included in the medical curriculum. It is believed that better communication skills will reduce the probability of legal problems for doctors.

BESIDE MANNERS
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. "Listen to the patient- he is trying to tell you the diagnosis" was an old teaching expounded by Sir William Osler. "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." is another good reminder for us from Prof. F J. Gillingham.

A HIGH-TECH WORLD
In 1992 I delivered the Singapore Medical Association Lecture entitled "The Doctor's Role in a High-Tech World."[2] I stated that medicine is now a "technology-driven profession". This has widened the doctor's traditional role of "comfort and cure"; the modern day doctor is expected to:

1. Be wary about the cost-effectiveness of the investigation and treatment.
2. Avoid over servicing the patient.
3. Protect himself against patients who will not hesitate to complain against or sue him.
4. Display his charges so that all patients are aware of his fees.[3]
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.
8. Practise preventive medicine, and teach the patient how to lead a healthy life-style, and how to detect early signs of disease.
9. Participate in public health education.
10. Keep up-to-date with the latest developments by participating in Continuing Medical Education programmes.[4]
11. Maintain a well-equipped clinic.
12. Participate in "Quality Assurance" programmes.

HEALTH CARE COSTS
The most difficult problem in health care today is how to contain costs. At the national level, Singapore is reviewing its health care policies with a Ministerial Review Committee which will present a White Paper soon. It seems that the Singapore General Hospital costs more to run than the entire Mass Rapid Transport System. Controlling costs will mean that we have to decide that something although beneficial, are not beneficial enough. At the clinical level, the doctor is faced everyday with the problem of how much to charge each patient. It is now mandatory for doctors in Singapore to display their charges in their clinics.

THE NEWS MEDIA
Our problems are compounded by the news media which sensationalises on medical treatment and on the medical profession. It exaggerates new therapies, 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.
4) Technology can work wonders. "Some believe even death can be defeated."[5]

In reality, however,

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.

DOCTOR BASHING
The new media also sensationalises on "The Bad Boys in Medicine", who over investigate, over-treat, and over-charge patients. As a result, patients tend to think that all doctors do the same.

MORE AFFLUENT
The Singaporean population has become more affluent and more 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 then that their expectations and demands for health care are much higher than before.

SINGAPORE MEDICAL COUNCIL
The number of complaints received by the SMC have therefore increased.

COMPLAINTS RECEIVED BY THE SINGAPORE MEDICAL COUNCIL 1988-1990

Year	No. of Complaints Received	No. of Cases Considered by Preliminary Proceedings	No. of Cases Referred for Disciplinary Inquiry Committee
1988	21	21	3
1989	22	22	5
1990	36	30	13

This tread is also seen in the other professions, such as the legal profession.

WHAT CAN WE DO?
Although patient expectations will continue to rise, there are a few things we can do to curb the number of complaints and medico-legal actions:

- Promote "Quality Assurance"
- Formulate Guidelines for Procedures and for Fees.
- Practise Defensive Medicine.
- Participate in Continuing Medical Education Programmes.
- Practise the Golden Role towards our professional colleagues.

QUALITY ASSURANCE
This has also been called "Peer Review", or "Medical Audit". At a national or hospital level, one can do large studies of:

1. Quality and type of Resources available.
2. Quality of patient care: Surgical procedures, medications, waiting-time, investigations, staff rosters.
3. Outcomes, or results: Complications, perioperative deaths, poor vision, blindness.

At the clinical level, one can do Random Case Studies to show:

1. Adequacy of documentation.

2. Appropriateness of investigations.
3. Errors in prescribing.
4. Sufficiency of discharge summary.
5. Incidence of complications.
6. Delays in referral and action.
7. Record of communications with the patient and relatives, and other medical and ancillary services.
8. Quality and speed of despatch of reports and discharge letters.

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

1. 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.
2. Information regarding quality assurance activities shall be furnished to the Director as and when required by him."

GUIDELINES
Guidelines are important to standardise treatment. They are also important as a reference in cases of dispute. The Royal College of Ophthalmologists in U.K. with the Royal College of Anaesthetists this year, published a "Report of the Joint Working Party on Anaesthesia in Ophthalmic surgery", setting out guidelines for monitoring during local anaesthesia. We know how important these guidelines are; they assure a certain quality of practice, thus protecting the patient. They can also protect the practitioner, if he reads these guidelines and follows them. Guidelines for fees are also necessary; otherwise how do we know if a practitioner is "over-charging"? During my Presidency of the Singapore Medical Association, the "SMA Guideline on Fees for Doctors in Private Practice in Singapore" was instituted.

DEFENSIVE MEDICINE
As in "defensive driving", it makes sense to practise "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.

CONTINUING MEDICAL EDUCATION
As I mentioned earlier, doctors are now expected to take part in Continuing Medical Education Programmes. The Singapore Medical Council, with the Academy of Medicine, the College of General Practitioners, and SMA, have started a voluntary CME programme for doctors in Singapore. Doctors accumulate points by their participation.

As an example of the importance of continuing medical education, I would like to quote from my study on Bullous Keratopathy.[7] The results were given at a Special Lecture, during the first Anniversary Conference of the Singapore National Eye Centre in January 1992. The lecture was entitled "Lessons deom Bullous Keratopathy 1981-89". In the study, I found that:

1. Bullous Keratopathy may take years to manifest itself. In the meantime, the same procedure (which is causing the B.K.) may be carried out for the fellow eye.
2. One-eyed patient should not be subjected to the same procedure which blinded the fellow eye.
3. During eye surgery, surgical trauma must be minimal. Quality cataract surgery is important in one-eye patients and in those who have pre-disposing factors for B.K. (e.g. Fuchs' Dystrophy, Glaucoma, Previous Eye Surgery, Ischaemic Eye Disease).
4. Simultaneous bilateral cataract extraction is not recommended, especially if there is sign of corneal decompensation in one eye already.

5. Early removal of an offending intra-ocular lens implant is indicated if corneal decompensation occurs.
6. Patients with vitreo-corneal tough are prone to B.K. Be careful and inform these patients when fitting them with contact lenses, or secondary implants.
7. "One should practise self-restraint by:
   a) Not trivializing cataract surgery.
   b) Subsuming personal ambition to the patient's best interests.
   c) Resisting the pressures to present premature results with excessive enthusiasm."

THE GOLDEN RULE
To reduce medico-legal problems for ourselves, it is important to practise the Golden Rule in our professional life:

1. Do not do to your colleagues what you do not wish them to do to you/
2. Avoid cheeky remarks and criticisms.
3. Recognise that complications do occur even in the best of hands. "The only surgeons who do not have complications are the surgeons who do not do any surgery.
4. Do not say to the patient that the best person to do this kind of surgery is Dr so-and-so.

COMPLAINTS
Patients complain by writing to one or more of the following:

1. The Singapore Medical Association.
2. The Minister for Health.
3. The Hospital Administrator.
4. The Newspapers.
5. Consumers' Association.
6. Lawyers.
7. The Singapore Medical Council.

THE SINGAPORE MEDICAL COUNCIL
When a complaint is received it is first studied by the Preliminary Proceedings Committee (PPC). The complaint must be in the form of a statutory declaration (this is to discourage frivolous complaints). If indicated, the PPC then refers the case for disciplinary inquiry by the Council. If found guilty of "infamous conduct in a professional respect", the Council may do one or more of the following:

1. Remove the name of the doctor from the register.
2. Censure him.
3. Require him to give such undertaking, as the Council thinks fit, to abstain in future from the conduct complained of.
4. Suspend his registration either conditionally or absolutely for a period of not less than 3 months and not more than 12 months.

The doctor who has been struck off the register, may appeal to High Court against the removal of his name. Otherwise, after one year he may apply for restoration of his name.

INFAMOUS CONDUCT
There are many legal definitions for "infamous conduct". The following points have been made in past cases:

1. It is necessary to prove that right-thinking competent medical practitioners would regard the conduct as reprehensible, disgraceful, shameful, or dishonourable.
2. There must be departures from accepted procedures.
3. It is not enough to show that some mistakes had been made through carelessness or inadvertence. To make a charge of infamous conduct, there must (generally speaking) be some moral turpitude or fraud or dishonesty in the conduct.

MEDICAL RECORDS
It is important to keep good medical records. It has been said that if "it is not recorded, it never

took place". And never try to alter the records, Not only is this wrong, but it will almost certainly be found out.

A FINAL WORD OF WARNING

No one is safe from litigation. We must avoid hasty, routine, careless treatment of patients, we must consistently remain alert, painstaking and careful in meeting the heavy duty of care which rests on us.

REFERENCES

1. Australasian journal of the Medical Defence Union, Volume 7, No. 2, 1993, 20-21.
2. Khoo C.Y. The Doctor's Role In A High-Tech World, Singapore Med. Journal 1992, Vol 33: 347-351.
3. Singapore Medical Association. Display of Charges by Medical Practitioners, SMA Circular to all SMA members. 9 Nov.;1991
4. Singapore Medical Council and Singapore Medical Association, Voluntary Continuing Medical Education (CME) Programme for Doctors in Singapore. Circular to all Registered Medical Practitioners. 3 February 1989.
5. Lee Y.K. 1987 SMA Lecture: Consumer or Patient? Singapore Med. Journal 1988, 29: 100-2.
6. Singapore Medical Council: Annual Report 1990.
7. Khoo C.Y.: Lessons From Bullous Keratopathy 1981-89, Special Lecture, 1st SNEC Anniversary Conference Proceedings, January, 1992.