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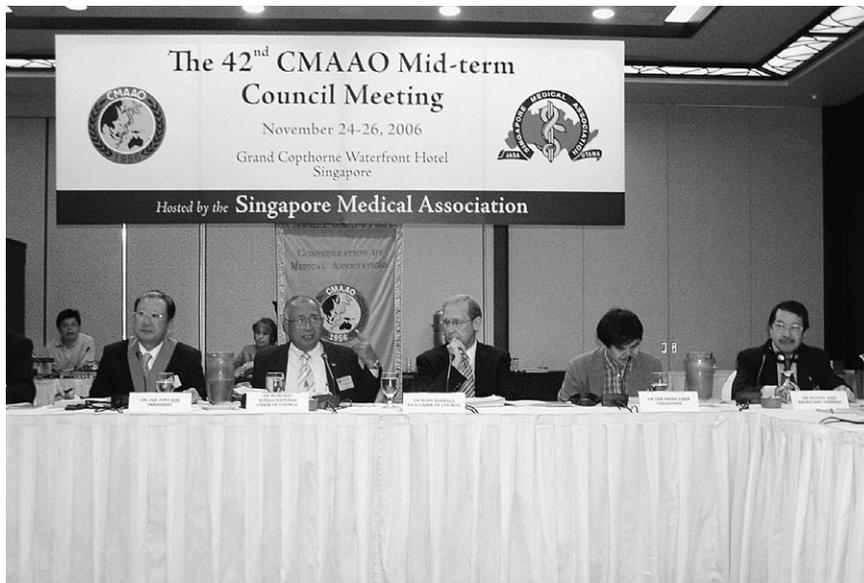
42nd CMAAO Mid-Term Council Meeting: SYMPOSIUM —Continuing Development in Ethics and Professionalism—



Grand Copthorne Waterfront Hotel, Singapore
November 24–26, 2006

The 42nd CMAAO (Confederation of Medical Associations in Asia and Oceania) Mid-Term Council Meeting was held from Fri. November 24 to Sun. 26, 2006 in Singapore and attended by a total of some 50 representatives of 13 medical associations (12 existing medical associations and Sri Lanka, whose membership has been newly approved).

The following is a summary of the symposium that was held on November 26, on the theme of “Continuing Development in Ethics and Professionalism.”



CMAAO Meeting in Singapore

[Hong Kong]

The Hong Kong Medical Association— Symposium paper for year 2005–2006



CHAN Yee-shing Alvin*¹

42nd CMAAO Council Meeting

24-26 November 2006

SINGAPORE

The Hong Kong Medical Association *Symposium Paper for Year 2005-2006*

Presented by

Dr. CHAN Yee Shing, Alvin

Council Member, The Medical Council of Hong Kong
Chairman, International Affairs Committee
Chairman, Committee on Rehabilitation
Co-Chairman, Health Education Committee
Co-Chairman, Task Force on "Exercise for Health" Project
Central Coordinator, The HKMA Community Network
Council Member, The Hong Kong Medical Association

Topic:

*Continuing Education in Ethics &
Professionalism*

- No. of CME lectures organized and provided by HKMA last year – 75
- all for maintaining and upgrading the ethical and professional standard of our members

What is the standard?
Who sets the standard?

*1 Council Member, Hong Kong Medical Association, Hong Kong (yvonne@hkma.org).

Professionalism and Ethics have to be self-regulated

In Hong Kong, the self-regulatory statutory body governing the standard and ethics of medical practice is:

The Medical Council of Hong Kong (MCHK)

- consists of 28 members of which 14 were government-appointed, including 4 lay members

Motto:

1. Ensuring Justice
2. Maintaining Professionalism
3. Protecting the Public

HKMA representation in MCHK

7 **elected representatives** within the Council of 28 members

plus

Representatives in:

1. Education & Accreditation Committee
2. Ethics Committee
3. Health Committee
4. Licentiate Committee
5. Credentials Sub-Committee of the Licentiate Committee
6. Exemption Sub-Committee of the Licentiate Committee
7. Review Sub-Committee of the Licentiate Committee
8. Preliminary Investigation Committee

Controversies of the year 2006

- ❖ How much could doctors advertise?
- ❖ How much professional autonomy do we have?
- ❖ How should MCHK be formed?
- ❖ Should HMOs/medical groups be regulated?

How much could doctors advertise?

- ❖ Last year, a private hospital advertised in a weekly journal
- ❖ The doctors involved in such an exercise received warning letters because of an allegation of practice promotion
- ❖ Some doctors considered the Code of Practice out-dated and in breach of the Basic Law and the International Covenant on Civil and Political Rights
- ❖ Requested MCHK to revise the Code

Should doctors be allowed to advertise?

The Medical Council had conducted a survey amongst members in 2006.

“The majority of the respondents were against the proposal.”

- ❖ In fact, MCHK is all along relaxing the Code on regulating advertisement by medical doctors, but could not drastically alter in this aspect due to the profession’s response

❖ 72 Doctors joined hands in seeking judicial review from the High Court:

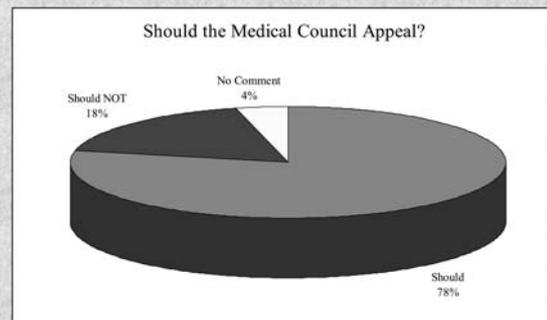
1. The Code of Practice (Section 5) provides that a doctor may communicate certain basic information about his qualifications, his consultation hours, the languages spoken by him and the services and procedures which he offers on websites, on Service Information Notices within his office or immediately outside of it, and in Doctors’ Directories. However, it prohibits the communication of precisely the same information in newspapers, magazines or other print media. There is (Dr. Kwong argues) no good rationale for the prohibition
2. The Code limits the number of services which a doctor can list on a Service Information Notice to 5 items, but Dr. Kwong queried the need for a maximum. If a doctor offers (say) 6 or more medical services, why should he be prohibited from so informing the public?

3. The Code permits a doctor to give public lectures, participate in TV or radio programmes and publish books to inform the public about medical or health developments. But a doctor “should ensure that reference is not made to the doctor’s experience, skills and reputation, or practice in a manner which can be construed as promotional”, “[i]nformation should never be presented in such a way that it furthers the professional interests of the doctors concerned, or appears to attract patients to their care”. Dr. Kwong says that it is impractical for a doctor to speak on medical topics without reference to his experience and skills in the area under discussion. Thus, a doctor who lectures or writes in the public interest on questions of health will almost certainly breach the Code against self-promotion. There is (Dr. Kwong contends) no justification for the constraint, which only leads to the public being deprived of important information on health issues and medical developments.

4. The Code imposes strict liability on a doctor for advertising or promotion by an organisation (such as a hospital) with which he has a financial or professional association. Concerning a doctor’s conduct in relation to advertising by an associated organisation, the Code provides that: “it will not be sufficient for an explanation to be based on a lack of awareness ..., or lack of ability to exert any influence...”, punishing even the doctor who uses “due diligence” to see that an organisation complies with the Code on practice promotion. A doctor will be subject to disciplinary proceedings if for some reason, beyond his control, a related organisation’s advertising breaches the Code. That (Dr. Kwong argues) is unfair and disproportionate. It goes too far and cannot be justified in the public interest.

- ❖ In August, the Court of First Instance ruled in favour of their judicial review
- ❖ MCHK intended to appeal
- ❖ HKMA’s Ethics Committee conducted a survey seeking members’ opinion on the appeal

Survey Result



How much professional autonomy do we have?

- ❖ MCHK found it had no ability to appeal because it had no financial independence
- ❖ All the income came from membership fee and examination fees which were in fact heavily subsidized by the government. As a statutory body, it cannot raise funds and cannot receive donation.
- ❖ Even the Secretariat is run by the staff of the Department of Health.

How much professional autonomy do we have?

- ❖ MCHK had to depend on the legal representation of the Department of Justice.
- ❖ In the past, in all the judicial review against MCHK, legal officers provided by the Department of Justice stand for the MCHK.
- ❖ But in this particular case of judicial review in 2006, the Department of Justice refused to represent the MCHK in appealing. The MCHK had to depend completely on the Department of Justice because the MCHK had no fund to employ lawyers in the appellation and the court proceedings. MCHK has no extra money to do something else.

How much professional autonomy do we have?

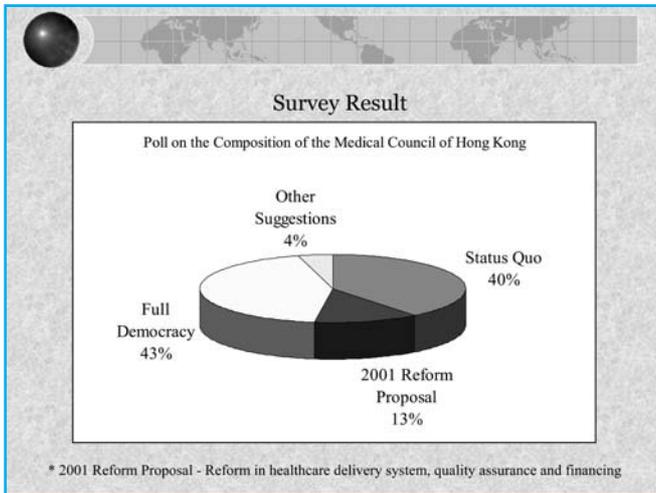
- ❖ So HKMA formed a Task Force on the Revision of the Medical Registration Ordinance, together with the Legislative Councillor representing the Medical Profession, it looked for the composition details of statutory bodies of other professions like law, accounting, engineering, etc. to seek reform of the MCHK in the composition and the financial and legal independence of MCHK.

Where has the professional autonomy gone?

- ❖ The HKMA actively pursued in fighting MCHK to persuade the Department of Justice and the Department of Health to send legal representation to MCHK to appeal. Eventually, the Department of Justice agreed to help MCHK, but at the end of the day, we still have to ask “where has the professional autonomy gone?”

How should MCHK be formed?

HKMA's Task Force on Review of Medical Registration Ordinance conducted a survey seeking members' views on the composition of the MCHK



Should HMOs/medical groups be regulated?

- ❖ HMOs/medical groups constitute a significant portion of medical workforce in Hong Kong, creating unfair competition – no level playing field because of the strong financial background of HMOs

- ❖ At present, no law is enacted to regulate HMOs. Some HMOs are listed companies, so medical organizations in Hong Kong can be run by a governing board without a medical practitioner
- ❖ The MCHK only regulates medical practitioners, but cannot control the misdeeds committed by HMOs. Doctors employed by HMOs could be punished by MCHK for unethical practice but the administration of HMOs would not suffer a bit

- ❖ The HKMA formed a Task Force on HMOs, together with legislators and Patients' Group as well as Consumer Council, we work to strive for enactment of laws to govern the practice of HMOs

Risk Management

One important aspect of professionalism is the ability in risk management

- ❖ In late May 2005, a private practitioner was found to have mis-prescribed Diamicon as Simethicone for many patients with stomach problems
- ❖ → widespread concern among the public and in particular the medical and pharmacological professions
- ❖ The latter stirred up a fuss and kept lobbying for separation of consultation and dispensing in 2005 and 2006

In response, the HKMA:

1. formed a working group to review the dispensing process
2. encouraged a voluntary medication incident reporting mechanism in all clinics to collect information on episodes of dispensing errors for analysis purpose.

3. published the "Good Dispensing Practice Manual" endorsed by the Medical Council of Hong Kong to all of the Association members

The Manual makes recommendations on safety in the premises, dispensary design and equipment, stores procurement, stock management, dispensing of medicine, education, training and development etc.

❖ Drug Dispensing Courses

5 courses launched together with the SCOPE of City University of Hong Kong were successfully completed in August 2006. They were:

1. Basic knowledge of medicine for nurses and clinic assistants
2. Clinic computer application and management skills
3. Knowledge on common diseases
4. Dispensing skills for nurses and clinic assistants
5. Clinical care and infection control skills

Medico-legal CME Lectures

- ❖ Co-organized with Medical Protection Society (MPS)
 1. April 2006 - Safe Prescribing and Dispensing
 2. November 2006 - Dangerous Drugs, Dispensing and Doctors
- ❖ Co-organized with Kennedys
 1. October 2006 - The Legal Standard of Care
 2. November 2006 - The Requirement of Consent
 3. December 2006 - The Standard of Expert Reporting

The Smoking (Public Health) (Amendment) Bill 2005

HKMA fully supported the Bill, which aimed at calling for a universal ban of smoking in indoor workplaces and public places.

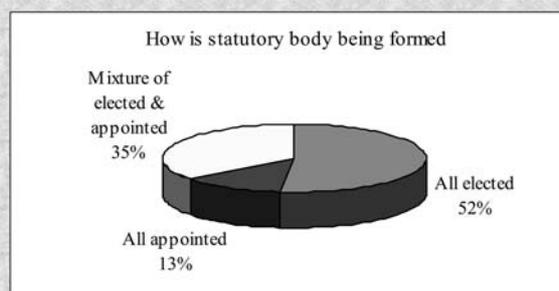
HKMA's stance:

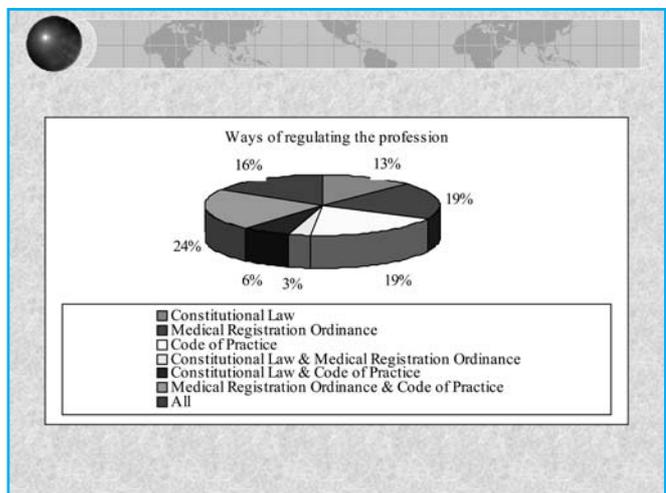
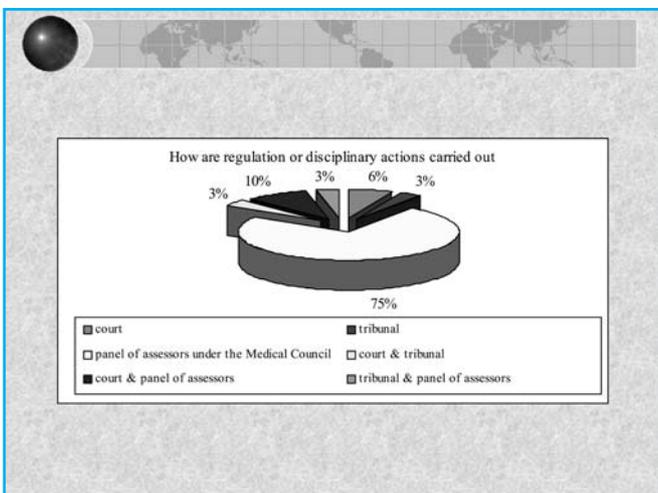
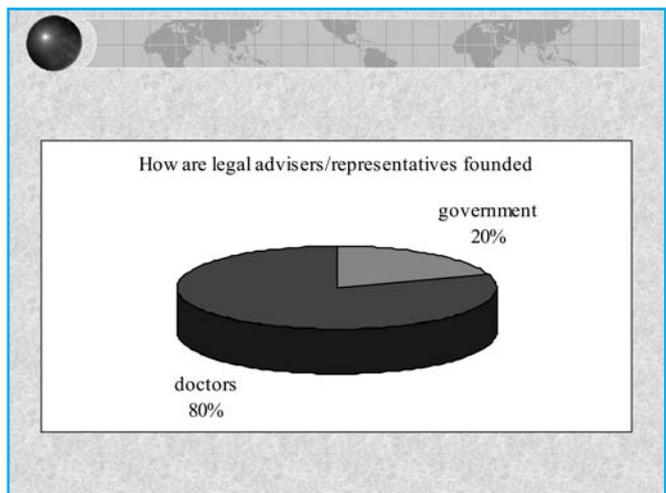
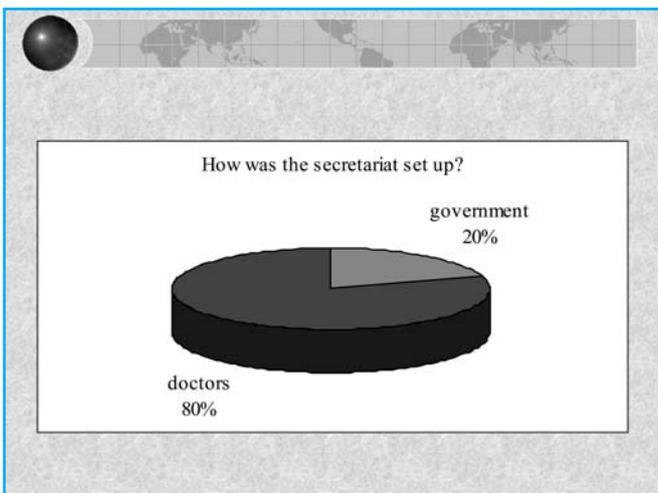
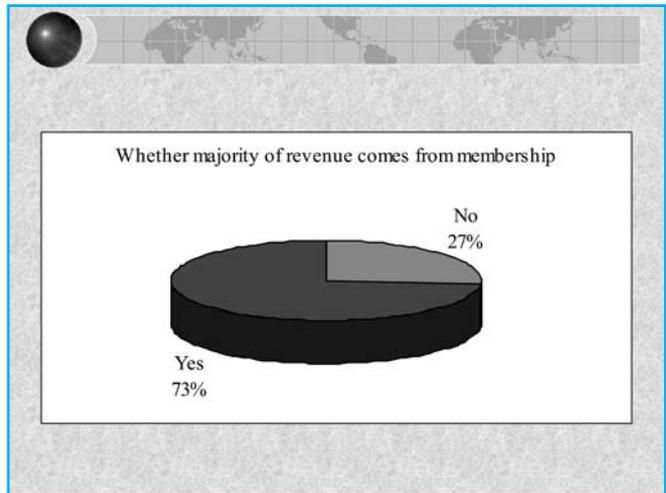
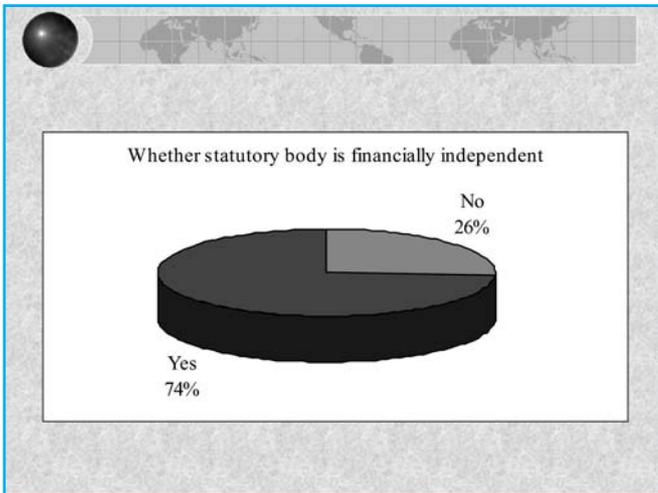
- ❖ A comprehensive ban of smoking in all restaurants, bars, karaokes, schools, indoor workplaces, and other indoor public premises such as private clubs, nightclubs, bathhouses, and mahjong places.
- ❖ Tightening the control on tobacco advertisement and promotion
- ❖ Introducing pictorial and graphic contents to the health warnings on tobacco products.

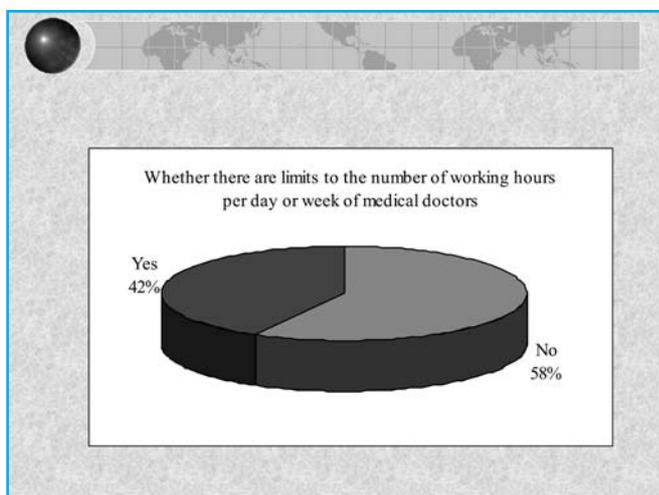
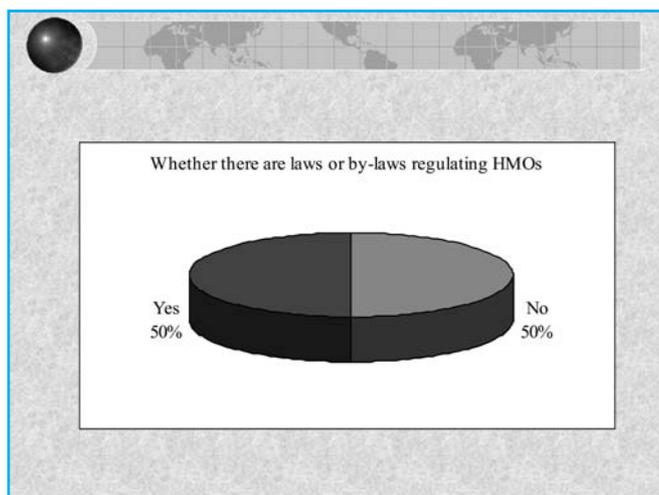
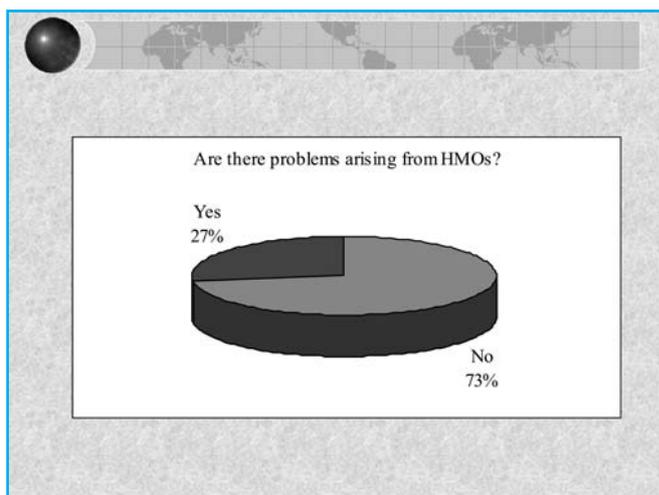
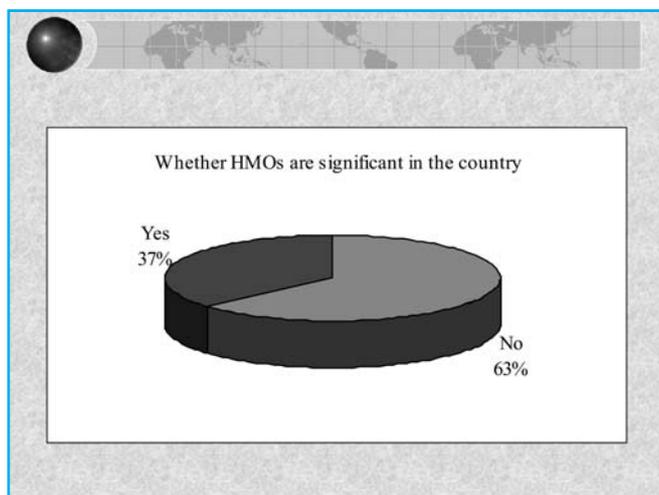
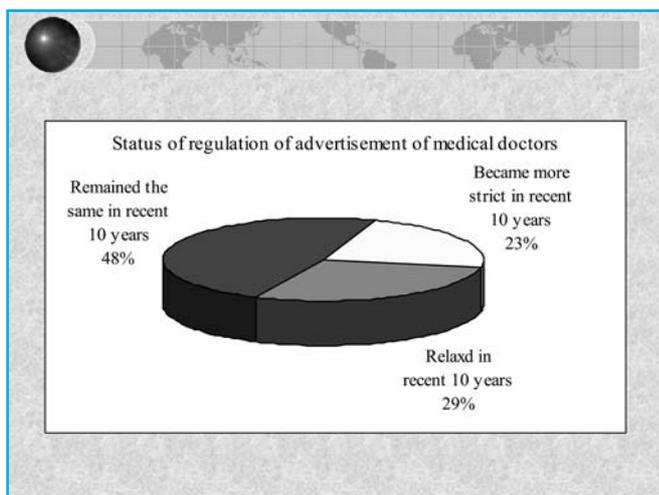
→ passing of the Bill on 18/10/2006

Survey at World Medical Assembly (WMA)

A total of 34 responses were collected.







- The results for the limit of number of working hours per day/week for medical doctors were as follows:
- ⊛ govt - 8 per day; private - none
 - ⊛ 6 per day
 - ⊛ 8 per day / 40 per week
 - ⊛ 40 per week
 - ⊛ 42 per week
 - ⊛ 42.5 per week
 - ⊛ 48 per week (4)
 - ⊛ 56 per week
 - ⊛ 80 per week



The data of this survey will be shared with WMA.

According to Dr. Otman Kloiber, Secretary General of WMA, there seems to be some concerted forces to disintegrate the professional autonomy of medical profession in different places of the world.

What do you think?
What should we do?



END

~ Thank you! ~

[Indonesia]

Ethico-Legal System as Framing Tools to Enhance Professionalism in Indonesia



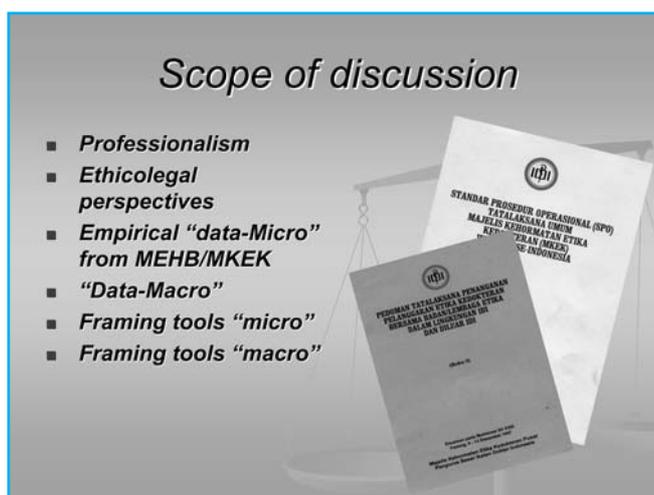
Agus PURWADIANTO*1

Professionalism is a big issue towards Indonesian doctors nowadays. We have had “malpractice fever” as a result of cumulative miscommunication gap between doctors/hospitals – patients. The Indonesian people become more litigious. As a result, mostly Indonesian doctors become a little bit defensive in doing their practice, giving the “out of pocket” health care system more expensive.

The competition between doctors become fiercer. There are a huge number of new Indonesian doctors – approximately about 2,000 first professional degree doctors – come to the medical and health sector, as a product from 53 medical faculty through out Indonesia. But only a few – about less than 30% out of them – that do not have opportunity to entry residency as post-graduate students. The Indonesian College of Medical Specialist still has difficulties to develop “mass production” of specialist to fulfill the society’s existing demand.

At the suprastructure level, there are two important regulation for medical practitioners’ professionalism, i.e. Medical Practice Act 2004 and National Social Security Act 2004. Indonesia is now in a transition period to meet the mostly international standard of health care system, by focusing professionalism as an important paradigm of the medical profession. The Medical Council with it’s subordinate the Medical Disciplinary Board as well as the Ministry of Health with National Health Insurance and Indonesian Medical Association with it’s “subordinate” Medical Ethics Honorary Board will play a significant role to make “law as a social/medical practitioners engineering” to regulate and prescribe the good competency, quality and professional conduct of Indonesian doctors.

But professionalism can not stand alone. It should be packaged as a system. We call it: the ethicolegal system.



*1 Secretary of Medical Ethics Honorary Board, Indonesian Medical Association, Jakarta, Indonesia (pbidi@idola.net.id).

PROFESSIONALISM

- True professionalism means the pursuit of excellence, not just competence
- Professionalism is predominantly an attitude, not a set of competencies
- A real professional is a technician who cares
- Professional is not a label you give yourself. It's a description you hope others will apply to you

Maister DH: True Professionalism, The Free Press, 1997

Charter on Medical Professionalism

Fundamental Principles:

- Principle of primary of patient welfare
- Principle of patient autonomy
- Principle of social justice

Annals of Internal Medicine, Vol 136 Issue 3, 5 Feb 2002
<http://www.annals.org/cgi/content/full/136/3/243>

ABIM's elements of professionalism

- altruism,
- accountability,
- excellence,
- duty,
- honor and integrity, and
- respect for others

Professional Responsibilities

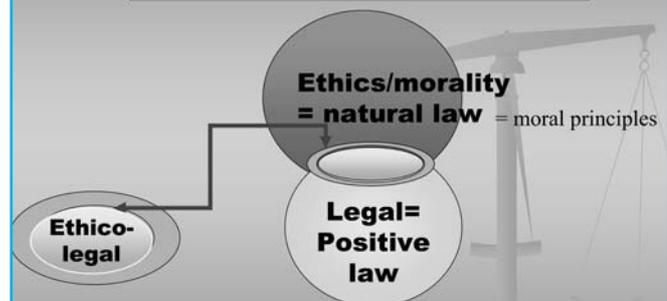
- Commitment to professional competence
- Commitment to honesty with patient
- Commitment to patient confidentiality
- Commitment to maintaining appropriate relations with patients
- Commitment to improving quality of care

Professional Responsibilities

- Commitment to improving access to care
- Commitment to a just distribution of finite resources
- Commitment to scientific knowledge
- Commitment to maintaining trust by managing conflict of interest
- Commitment to professional responsibilities

Please visit : www.professionalism.org

Ethicolegal Perspectives



Data "micro" from MEHB/MKEK

- Sources of Problems
- Problem Specialist
- Type of Problems



2 Years Report to Med.Ethics Hon.Board(MEHB)-IMA (2004 – 2005)

Mo's Yrs	Jan	Feb	Mar	Apr	Ma y	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2004		3	6	1	1	3	2	11	5	6	2	4
2005	3	10	11	10	5	2	4	12	10	1	1	9

Total Cases : 122 Cases
 2004 : 44 Cases
 2005 : 77 Cases

The Sources of Problems

No	Sender	Total
1	Private	32
2	IMA Chapter	17
3	Law Firm	16
4	IMA – CEO	14
5	Med spec.org.	10
6	NGO/institution	11
7	Hospital	9
8	University	4
9	M.O.H	4
10	Police Inst.	3

The "Problem Specialist"

No	Area of Training	Total
1	Ob-gy	7
2	GP	7
3	Surgery	7
4	Pediatrician	4
5	Internal Med	4
6	Anesthesiology	2
7	Hospital's CEO	2
8	Nutrition specialist	1
9	Psychatrist	1
10	Ophtalmology	1

Type of Problems

No	Type of Problem/complaints	Total
1	Suspected Malpractice/Med Error	22
2	DR-DR, DR-Hosp/Clinic Disputes	10
3	Info Clarification's letter	10
4	Hospital services	8
5	Need the speakers/consultation	8
6	Provincial's Med Ethic H.B. report	10
7	Asking Medical Record	6
8	DR/Clinic's advertising	6
9	Workshop invitation	6

Type of Problems (2)

No	Type of Problem/complaints	Total
1	Inter-professional & membership disputes	6
2	Violence against DR	3
3	Insurance's disputes	3
4	Fake DR	2
5	Medical Acts' amendments	2
6	Medical Acts' responsiveness	2
7	Asking Expert witness	2
8	Euthanasia	2
9	Household conflicts	5

Other type of problems

No	Type	Total
1	Med.Eth.HB's statements	1
2	Data info for educational research	1
3	IMA – Logo's "wrong" application	1
4	Abortion	1
5	Med.Report's disputes	1
6	Adv. of sending Patients abroad	1
7	Anti-Malpractice's petition	1
8	Post rural-service-duty status	1
9	Court verdict	1

Data "macro" of Ethicolegal Issues

- Qualitative data
- Public Mistrust
- Supra-structural condition
- DR's risk possibility – supra-structural instability



6 months after- Ministerial Decree No. 1419/2005 - Qualitative data

Problems	Magnitude	Anticipation/solution
Cross-membership of IMA's at district	++	SOP about membership/> details IMA bylaws
"Issuance-jam" of Registration Certificate	+++	"Provincial" Med. Council (branches)
Slow performance of Med.Council	++	Web-based info / transparencies
Competence-Proficiency check at district level	++	Unifying & coordinating of professional org. at district level
Med.Hon.Disciplinary B. action	+++	Empowering ex member of MEHB + "good medical lawyer"

6 months after-Ministerial Decree No. 1419/2005 - Qualitative data

Problems	Magnitude	Anticipation/solution
Clinic's Sweeping (> 3 location)	+	MOU IMA-Police (Prov Level) DR's Advocating Body (IMA)
Private Hosp become Satellite Hosp	++	MOU Med.School – Private Hosp based on & Criterion
DR/s migration from District/s small hosp	+	DR's Mapping & the issuance of temporary license
No guidelines of temporary license	++	Specific criterion for specialist distribution
Re-filing malpractice's suit to Med. Hon.Disc.Board	+++	Criteria of admissibility & time expiration

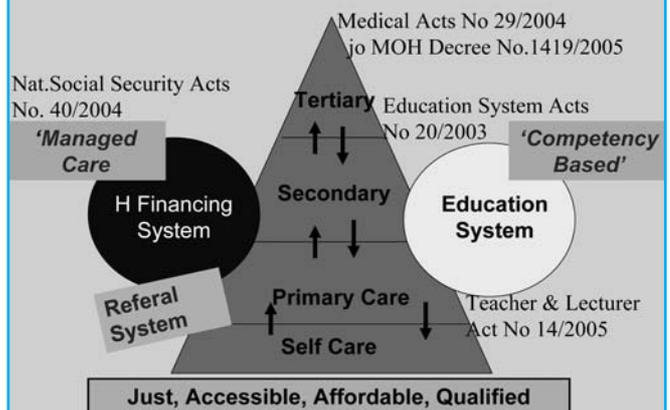
MOH Decree No. 1419/2005 is a direct implementation regulation of Medical Practice from Medical Acts

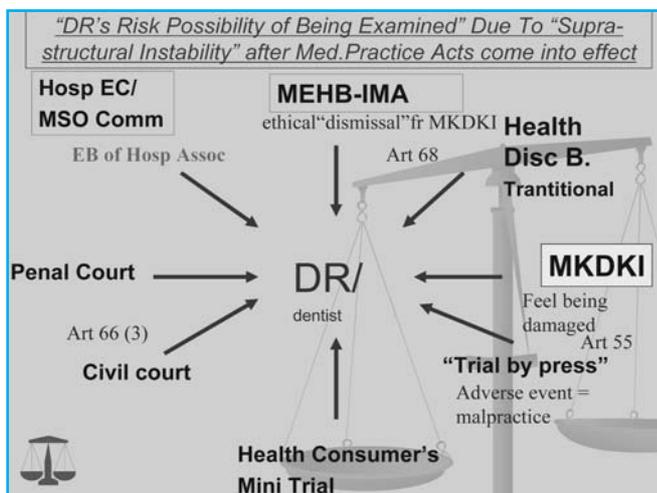
PUBLIC MISTRUST

- public perception that medicine failed to self-regulate in a way that can guarantee competence, and that it put its own interest above that of patients and the public
- medicine has protected incompetent or unethical colleagues in the name of collegiality

•Cruess SR et al: MJA 2002 177 (4): 208-211

'Integrated Health Care system'-suprastructures





Framing tools "micro" MEHB-IMA

- **Strategies**
- **Opportunity**
- **Constraints**
- **Role on Ethical Conflicts**
- **Being Punished DR**
- **Future Role**

Med.Ethics H.B. strategies Nat.workshop 2005 :

- Proactive & responsiveness from ethical issues : problems, dilemma, misconduct etc → integrated peer assessments : MEHB – IMA – other IMA's unit member (active & former but senior)
- > independent power (not depend on executive board)
- Deployment of Indonesian Med Ethics' Code
- Renewal Issuance of MEHB Guidelines & Bylaws

Med.Ethics H.B. strategies IMA Nat Congress 2003 :

- > transparencies & accountability
- Anticipating the supra-structural regulation on "litigious society"/anomic situation : ballancing 3 : patient's safety - medical goals – professional dignity by preventing & solving DR's/health personnel's conflicts via ethicolegal system
- Improving ethics as 1 major topic/session at every Nat. congress → improving guiding principles on every subject + Code of Ethics + "lege artis culture" → networking with other local and foreign professionals' Ethics Board

Opportunity

- Ongoing training towards all members of MEHB at any level formally/informally with ethicolegal casuistry-based method
- Intensive dialog & networking on ethicolegal issues with EB of the Businessmen's Assoc of Pharmacy, Med.Disciplinary Board (& Med. Council), Indon.Network on Bioethics & Humanities of Health Consumer's Conflict Resolution's Instituion, EB of lawyers and journalist assoc., police investigators, etc
- Internal consolidation with EB of every specialist's assoc.- Hospital assoc., groups of med.staff org., etc,

Constraints

- SOP should be evaluated periodically due to instability of supra-structural regulation/condition
- MEHB is not as attractive "unit" as IMA executive board, weakline of coordination between MEHB at national – provincial & district level
- Developing concept of ethicolegal : i.e. "substandard-ism" – will violates ethics-disciplinary-legal (civil & penal as well) → need objective criterion and rule of evidences respectively.
- Discoverability of the petition/decision being misused by "bad lawyers" and the rehabilitation of "punished's" DR
- Limited budget allocation & poor management → in compare with big role preventing un/deprofessionalism – early detection of Problem /malfunction DR's

MEHB-IMA's role in Ethical Conflict

- “authorized referee” to decide the “clinical privileges disputes due to different training modality between med specialist
- Improving the best and more morally justified ethical guidelines as complementary to Code of Med. Ethics or standard of care
- Giving medical opinion of ethical dilemma in clinical practice, med research and filtering the new med technologies.
- Enlightening the epistemological aspect of multicultural diversity of ethical issues during the legislation process and improving med. ethics education.

“Being Punished-DRs”

- a. Being advised by his peers
- b. Reprimands
- c. Should be supervised by special program (unstructured)
- d. *Reschooling (structured)*
- e. Revoking IMA's membership (desertification)

Future Role of MEHB-IMA

1. Developing bigger organizational function & structure and “more executing”
2. Improving the secretariat personnel/staff to give rapid responses of any ethical issues/problems/dilemmas in health care and medical encounters setting → developing specific guidelines & “casuistry-based jurisprudence” to improve ethicolegal problem
3. Supporting any disciplinary proceeding referred from Med.Hon.Disc.Board (MKDKI) – articles 68 Medical Practice Act No. 29/2004 or cooperation in provinces w/ no MKDKI

Future Role of MEHB-IMA

5. Sustaining capacity building upon its provincial members to prevent any de-professionalism leading to malpractice crisis/defensive medicine/DR's brain-drain /bad practice (malfunction DR's) locally/regionally
6. Improving the dual tiers of ethical proceeding
7. Networking with any local and foreign medical ethics/bioethics institution in research & education.

Framing tools “macro” MEHB-IMA

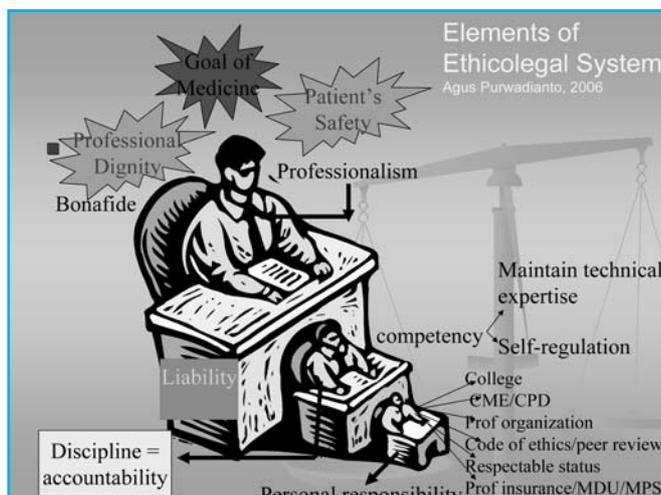
- **Amendments of Medical Practice Acts**
- **Elements of ethicolegal system**



Ethicolegal Issues for amendments of Med Pract Act

Topic	Protecting People	Empowering Institution	Guiding Doctors
“Malpractice cap” compensation	+++	+++	+
Decriminalization of administr violation	++	++	++
Administrative prior to penal law's punishments	+	+++	++
Protecting good& professional DR	+++	+++	+++
Upholding best remuneration of DR	+++	+++	+++

Ethicolegal Issues for amendments of Med Pract Act (2)			
Topic	Protecting People	Empowering Institution	Guiding Doctors
Accountability & good governance of medical leader	+++	+++	+
Non discoverability MKDKI's petition	++	++	++
Alignment with decentralization	+	+++	++
Empowering the eradication of bogus DR	+++	+++	+++
Supporting Public health emergency	+++	+++	+++



Conclusion

1. Indonesian context of professionalism mostly influenced by the macro-ethics condition, especially by the instability of the supra-structural condition, blurred by "ethicolegal complications" due to existing litigious society.
2. Medical Ethics Honorary Board (MEHB) of IMA give the pivotal role in "mini ethics" condition to guard the professional dignity, patient safety and medical goals
3. Enhancing the role of MEHB-IMA in wider contexts could be a key component in the developing ethicolegal system as a framing tools to achieve future professionalism in Indonesia.



[Japan]

Challenges of Physicians and Medical Associations in Japan

—Japan Medical Association playing a leadership role in child support activities—



Sadaomi IMAMURA*¹

Current State of Japan's Declining Birthrate

In Japan the total fertility rate is declining at a rapid pace; in fact Japan currently has one of the fastest falling birthrates in the world. As the trend for women to continue working and marry later has continued to grow, the birthrate has fallen, with the total fertility rate dropping to a record 1.25 in 2005. The government has been putting forward various measures to counter this declining birthrate, but unfortunately we cannot say that these have had sufficient effects. How to curb the declining birthrate is an extremely important issue facing Japan today.

The enhancement and strengthening of support activities for child-raising has been promoted as one countermeasure to the falling birthrate; however, in recent years the child-raising environment has changed tremendously with the rise of the nuclear family and changes in local communities, leading to a notable increase in child-raising anxiety and difficulties. An increase in the incidence of child abuse is also becoming a serious social problem. Numerous reports of child abuse have appeared in the news, making this a problem for the whole of society. The number of child abuse cases reported to child counseling centers has increased, with a record 34,472 cases reported in 2005 — a 30-fold increase over the 1,101 cases reported in 1990, the first year records were kept. Over 80% of child abuse is perpetrated by the child's parents — the mother in 61% of cases and the father in 32% — demonstrating a need for support of parental education. In schools there are problems such as bullying, and thus the improvement of the environment of children at

school as well as at home is an extremely urgent issue.

Because child abuse has such a tremendous affect on the psychological well-being of children during their formative years, its early identification and early intervention are particularly important; the role of physicians is thus extremely significant.

To enable parents to successfully balance work and child-raising, child-raising support in the local community is vital. Considering the anxiety about child-raising felt by many women and the incidence of child abuse by mothers, there is a need for physicians — particularly pediatricians — to not only supervise children's health and medical treatment, but also act as children's advocates.

JMA's Child Support Activities

The Japan Medical Association (JMA) believes that we have come to a time when we must take some form of action from a medical perspective to protect the medical and social environment of children, who are the leaders of the next generation.

The JMA has been proactively promoting measures to support children through such activities as the implementation of "Prenatal Visit Model Activities," the compilation and distribution of pamphlets such as "Child Health Support — Temporary Childcare Services Q&A" and "Prenatal Visiting Services Q&A," compilation and distribution of "The Doctors' Manual for the Early Discovery and Prevention of Child Abuse," implementation of Child Immunization Week, and supervision and production of an anti-smoking DVD.

*1 Executive Board Member, Japan Medical Association, Tokyo, Japan (jmaintl@po.med.or.jp).

As a further measure to curb the declining birthrate and protect the medical care environment for the children who are to become the leaders of the next generation, based on the recommendations of the JMA Child Health Committee, the JMA in May 2005 issued a declaration. This is the “Japan Medical Association Declaration to Support Children” with regard to pregnancy, birth, and the child-raising years in order to promote the improvement of the medical care, health insurance, and welfare environment for mothers and children so that the children who are to become the leaders of the next generation may grow healthy both physically and psychologically. The Declaration has eight items with details of a total of 36 specific measures.

The JMA has compiled a leaflet on the above declaration which is being distributed to its members and local medical associations to spread and educate people about its principles.

JMA declaration to support children

The content of the Declaration to Support Children is as follows.

1. We will endeavor to support those who desire to become pregnant.
2. We will endeavor to enhance the health care environment to enable greater safety in pregnancy and birth.
3. We will endeavor to improve the social environment to enable mothers find satisfaction in pregnancy and birth.
4. We will endeavor to enhance the health care environment to make child-raising easier.
5. We will endeavor to improve the social environment with regard to child-raising.
6. We will endeavor to enhance school health.
7. We will endeavor to provide support for children with special needs.
8. We will endeavor to lobby the government and other organizations responsible for the formulation of policies concerning the support of children and child-raising.

Next I would like to talk about specific measures for each item.

For the first item, “Support for those who desire to become pregnant,” there are two measures:

- (1) Enhancement of sterility and infertility treatment; and
- (2) Improvement of counseling organizations.

With regard to the “Enhancement of sterility and infertility treatment,” the Ministry of Health, Labour and Welfare of Japan implemented Special Assistance for Fertility Treatment in 2004, but because the nationwide performance and results of this system are unclear, the government is to establish the “Study Group on the Effective and Efficient Management of Special Assistance for Fertility Treatment” this year and deliberations began recently. The Group intends to clarify the nationwide performance and results of the program as well as consider prerequisites for such treatment, such as facilities and staff at medical institutions in the program, and methods for validating the results and outcomes of fertility treatment. I will be participating in these deliberations as a member of this Study Group.

The upper limit for Special Assistance for Fertility Treatment is US\$830 per year, but from this year the benefit period will be extended from 2 to 5 years.

For the Second item, “Enhancement of the health care environment to enable greater safety in pregnancy and birth,” there are five measures:

- (1) Establishment of a perinatal stage network to reduce maternal mortality and perinatal mortality,
- (2) Establishment of a Community Health Care System to identify and manage high risk pregnancies,
- (3) Enhancement of perinatal care staff at birthing facilities,
- (4) Enhancement of measures to prevent mother/child infection, and
- (5) Establishment of a system of no-fault compensation.

With regard to a system of no-fault compensation, the Japan Medical Association has established a Project Committee to consider the systemization of an “accident compensation system for cerebral paralysis related to childbirth” with the aims of providing an environment in which women can give birth with a sense of security; removing the temporal and psychological burden of childbirth accident lawsuits from obstetricians who are neither negligent nor responsible for the accident; and assure women of a healthy perinatal medical care environment based on a relationship of trust between doctors and patients. The draft proposal for this system was drawn up in August this year, and the JMA is working to see that systemization is realized by presenting this proposal to the

Minister for Health, Labour and Welfare for inclusion in the 2007 budget as an urgent issue with which the JMA is highly concerned.

For the third item, “Improve the social environment to enable mothers find satisfaction in pregnancy and birth,” there are two measures:

- (1) Increase in the Lump Sum Birth Allowance, and
- (2) Support of younger and working pregnant women.

From October of this year, the Lump Sum Birth Allowance has been raised from US\$2,500 to US\$2,900 and the application procedures have also been improved. Previously the pregnant woman (the insured person) paid the childbirth costs to the hospital, before receiving the Lump Sum Birth Allowance; in order to lighten the burden of payment on the insured person, a mechanism has been introduced whereby the Lump Sum Birth Allowance is paid directly to the medical institution rather than the insured person.

For the fourth item, “Enhancement of the health care environment to make child-raising easier,” there are seven measures:

- (1) Expansion of the Infant Medical Expense Aid System,
- (2) Realization of a medical fee payment obligation of 10% for children aged 15 years and younger,
- (3) Improvement of the Emergency Pediatric Care System,
- (4) Enhancement of perinatal visitation (perinatal child health guidance), medical examinations for infants, and child-raising counseling,
- (5) Enhancement of vaccination and increase in the immunization rate,
- (6) Enhancement of health care for intractable diseases and cutting-edge medical care for children, and
- (7) Promotion of organ transplants for children.

The JMA has held “Child Immunization Week” since 2003 in an effort to raise the immunization rate with the cooperation of local medical institutions.

The JMA aimed in particular to raise the immunization rate for rubella. The immunization rate was 70.4% in 2000, but had risen to 85.4% by 2005. Thus the “Child Immunization Week” initiative has received much praise for its effectiveness.

For the fifth item, “Improvement of the social environment with regard to child-raising,” there

are eight measures:

- (1) Improvement of care for children who are ill,
- (2) Cooperation with childcare centers and kindergartens,
- (3) Support of coordination between social child-raising groups and child-raising salons,
- (4) Improvement of the work environment for working parents raising children,
- (5) Support of parents concentrating on child-raising,
- (6) Support for the development of environments in which children of the same age can play together,
- (7) Prevention of child abuse and early intervention, and
- (8) Improvement of the environment based on conventions concerning the rights of children.

In order to lighten the burden of balancing work and child-raising, in 1994 the Ministry of Health, Labour and Welfare implemented “Child Health Support – Temporary Childcare” for children recovering from illness to be temporarily cared for at hospitals, clinics, and childcare centers.

In order to spread and teach people about this system, the JMA has produced a leaflet entitled “Child Health Support – Temporary Childcare Services Q&A” and is working to ensure that many more medical associations throughout Japan become involved in these activities.

For the sixth item, “Enhancement of school health,” there are five measures:

- (1) Efforts to nurture respect for life in children’s mind,
- (2) Enhancement of sex education and preventative measures against sexually transmitted disease,
- (3) Promotion of anti-smoking education,
- (4) Preventative measures against lifestyle diseases, and
- (5) Efforts to deal with psychological problems.

In recent years, the incidence of sexually transmitted diseases has been growing due to such factors as the diversification of sexual conduct, a lack of sexual knowledge, and people beginning their sexual experience at younger ages. To help as many people as possible to correctly understand sexually transmitted disease, the JMA recently held a public forum on the theme “The Current State of Sexually Transmitted Disease and Countermeasures.” The forum was broadcast nationwide on November 18. Furthermore,

because of the importance of sex education, the JMA intends to distribute a DVD of the forum to high schools throughout the nation to be used as material for sex education.

With regard to the promotion of anti-smoking education, in March 2003 the JMA issued an "Anti-smoking Day Declaration" and had been carrying out various activities to encourage people to quit or refrain from smoking. Because a major problem is the increasingly young at which people begin smoking, the JMA is promoting anti-smoking measures aimed at young people, including the production and distribution of an educational video.

For the seventh item, "Support for children with special needs," there are three measures:

- (1) Enhancement of medical care,
- (2) Promotion of the securing of beds for children with special needs who require long-term hospitalization, and
- (3) Contribution to special support education.

And finally, **for the eighth item, "Lobbying of the government and other bodies responsible for the formulation of policies concerning the support of children and child-raising,"** there are four measures:

- (1) Promotion of measures to resolve the shortage and uneven distribution of obstetricians, pediatricians, and midwives,
- (2) Promotion of measures to train doctors who provide psychological care for children,
- (3) Formulation of a Child Health Law, and
- (4) Tax benefits for pregnancy, birth, and child-raising.

As a measure to secure and improve the infrastructure for reducing the uneven distribution of doctors and providing quality care, this year the JMA is setting up a "Female Doctor Bank" spon-

sored by the Ministry of Health, Labour and Welfare in the belief that this may help alleviate the shortages of pediatricians and obstetricians which are becoming a serious problem in many areas. In the future, we intend to expand the bank to include all doctors to help alleviate the shortages of doctors in remote areas.

With regard to doctors who care psychological aspects of children, the number of children with psychological problems stemming from developmental disorders or abuse continues to increase and measures to deal with this should be improved. Because there are only limited doctors and medical institutions that can provide the specialized care required in this field, there is an urgent need to train and secure specialists in child psychology. For this reason, the JMA is lobbying the government for funding for workshops to train and secure child psychologists.

Based on the "JMA Declaration to Support Children" and "Specific Measures," in future the JMA intends to cooperate with all relevant organizations in proactively undertake activities related to the support of children. Currently we are developing a plan for broadly publicizing the endeavors of the JMA as part of the "Love Family" project by Asahi Newspaper Company.

In order to enhance support for children, there is a need for various measures to be integrated and promoted comprehensively. To have most effective results from each measure, the JMA intends to spearhead support of children and with the support of members and related organizations, proactively engage in activities to support children.

We believe that fulfillment of the "JMA Declaration to Support Children" is an important social mission for physicians and medical associations.

[Korea]

The Development of Medical Ethics in Korea



Dong Chun SHIN,*¹ Ilhak LEE*²

According to Hippocrates, the three elements that embody the field of medicine are sickness, patients and doctors. Medical ethics is formed and developed through the relationships between these three elements of medicine. In particular, through the doctor's relationship with the patient and the ethics that may arise from that relationship, the study of disorders and their treatments, and the various responsibilities that arise through a doctor's relationship to the field of medicine and his colleagues. Of course, in today's world there have been a diverse range of other parties that have become involved in these relationships, such as with government, third party payer or future generations, making the relationships more complicated, but the relationships between the three basic elements remain to be essence and core of medical ethics.

The source of medical ethics is primarily internal, namely through the beliefs that are acknowledged by the doctor and his associates. In particular, the doctor's oath comprises the basis of his ethics. However, as duties to society, particularly to the patient, became recognized, those beliefs and oaths gradually became promises to the general public that the doctor is "this kind of person" and the approval and granting of authority from society followed and the substance of medical ethics was formed. If that is indeed the case, then a look into the ethics that doctors adhere to can reveal how the doctor's consciousness of ethics was formed. In particular, if the course of transitions in the declaration of medical ethics is examined, the transitions in consciousness can be tracked as well.

Through the transitions in the declaration of medical ethics, this paper will examine the changes that have taken place in the advice that doctors give. Together with a number of cases

that influenced changes in the declaration of medical ethics, this paper will show the changes that society demanded and how doctors were able to cope with these demands. The examination of this process will also reveal the type of ethics-related mindset that a doctor requires.

The Function of the Declaration of Ethics

As a profession, there are various characteristics that a doctor has or requires that sets it apart from other occupations, such as the training required, specialized technical skills, professional self-control, adherence to societal values and ethical rules, particular motives for choosing this line of work, devotion to duties, a sense of collaboration with colleagues, and so on. Doctors accept these features publicly as their own, so that society can expect the manner doctors will show during the medical service. The Latin origin of the word 'professional' means "to publicly acknowledge, to make a declaration, to make a promise." This sort of public promise became widely known through the Hippocratic Oath, which was written between the 4th and 1st Century B.C., as well as through more recent documents such as the World Medical Association's "Declaration of Geneva." After 1964, there have been numerous medical ethics-related public declarations adopted and amended in Korea as well.

These ethics declarations commonly make pledges regarding the devotion to the relationships that a doctor makes with his patients and colleagues. Placing the patients' interests before their own, comradeship with fellow doctors, and the promise to provide care are the basis of those pledges. Medical ethics declarations, particularly

*1 Executive Board Member, Korean Medical Association, Seoul, Korea. Professor, Department of Preventive Medicine, Yonsei University, Seoul, Korea (intl@kma.org).

*2 Department of Medical Law and Bioethics, College of Medicine, Yonsei University, Seoul, Korea.

to those just starting out in the medical profession, are accepted voluntarily and take on a dual role as a promise to fellow medical professionals and to society. This concept of a dual role can be explained further by saying that the primary value of having a grasp of society's expectations and knowing to what extent they should be accommodated, along with the medical community's ability to rely on each other to conduct themselves in a medically ethical manner are emphasized and reinforced. Furthermore, if these ethics declarations are looked at from a historical perspective, they have influenced the traditionally accepted roles of doctors, as well as the demands that present-day society places on doctors.

How do these ethics declarations come to have any binding force with doctors? Ethics declarations are made with a backdrop of the considerations of the individuals and the communities that will be affected by them, and this creates an ethical climate. Rather than seeing a doctor's response to an individual's ethical dilemma as an isolated event, if it is seen from a perspective that encompasses societal and cultural views, the individual's own experiences, and ethical norms, then ethics declarations can have the ability to embody these norms.

The Stages of Development in Korea's Declaration of Ethics

Literature referring to medical ethics can be found in any culture. In case of Korea, one of the oldest documents that refers to the proper conduct of doctors was written in the medical encyclopedia called *Ui-Bang-Yu-Chui* (醫方類聚; A Collection of Medical Procedures) published in 1445. The following is the list of doctor's duties compiled in it:

- 1) A doctor has the duty to study sicknesses and treatments.
- 2) A doctor exists to treat the patients' illnesses. Doctors should consider the best interest for patients only, regardless of their social status.
- 3) All lives including those of plants and animals should be respected and not be harmed senselessly in the process of medicine preparation.
- 4) A doctor must do everything he can to treat patients.
- 5) A doctor should not put his or her personal interests over care for patients. He or she must try to keep his or her dignity.

- 6) A doctor should be satisfied with what patients give him or her as an expression of their gratitude and should not be interested in compensation.¹

The medical ethics presented in this medical encyclopedia stresses that high priority should be placed on the interests of patients. It goes even beyond humans and urges that attention be paid to animals and plants as well. This document emphasizes that a doctor, as a specialist in treating patients, should continually study medicine and goes so far as to say that a doctor is a professional who recognizes that he should ignore his own personal gains and interests. However, this type of thinking from the Chosun era lost significance, as modern Western medical systems began to be introduced. Other medical literature from the Chosun era also refer to some essence of medicine, a doctor's behaviour, payments, basic mental attitudes, medical taboos, and so on.

Although the traditional writings may not have direct impact thereafter, it can be said that public expectations about doctors and doctors' own perceptions have not changed so significantly. You can assume that the patient-focused ethics then — alleviating suffering and not considering of their societal conditions — might have been carried on continuously combined by the works of Western medical missionaries to introduce Western medicine in Korea and the government's poverty relief efforts.

However, sustainable development of medical ethics in Korea was interrupted for a while by the Japanese occupation. During the colonization era, doctors were used by the imperial government as "medical police" to maintain surveillance of the Koreans, as well as for any other means the imperial government deemed necessary.²

Korea's new declaration of medical ethics was established in 1961, a number of years after regaining independence. Although this new declaration was not totally unrelated to the period of enlightenment, it did not reflect Korea's particular situation remaining simply as a translation of the Geneva Declaration enacted by the World Medical Association in 1948. This declaration was composed of the general duties of doctors, duties to patients, and doctors' duties to each other and so forth. Although this declaration failed to reflect the circumstances completely, it was accepted broadly and stands still valuable in that the classification of doctors' duties presented in it

became a standard for discussions on medical ethics thereafter. The examination and amendments to it began in 1970. At that time, the health insurance system was just introduced in Korea and access to medical services was still hard to get among public. Especially when excessively high health insurance claim fees became a societal problem in 1978, the Korean Medical Association began to review the ethical position of doctors and a new declaration of medical ethics was enacted in the following year as a result of the review. The changes are meaningful in that they reflect contemporary realities and principles in order to truly deal with medical ethics issues and thus promoted a large number of medical communities to join in the process of producing genuine agreement.

From 1980 to 1990, medicine in Korea expanded both quantitatively and qualitatively. It can be attributed to the advances in society and in medical technologies around the globe, increase in efforts of doctors and expand of medical expenditure through health insurance system. During this time of change, patients and doctors became increasingly aware of human rights issues and this further influenced the development of medical ethics. The declaration of medical ethics was amended in February 1997 to reflect these changes. The new declaration held on to the existing ideas of medical training and providing the best treatment to patients (including the ethical duty to do everything possible), but it expanded the scope of guidelines on cooperation among professionals into nurses and other medical staff. However, the most significant amendment was that this declaration shaped the code of medical ethics (1997, 2006) and medical ethics guidelines separately, thus having a more substantial and practical influence. This was truly a turning point in that the medical association recognized the society's demand for a high level of ethics and made a real effort to meet them. From the code of ethics by the Korean Medical Association, the following can be found:

- 1) A devotion to human dignity.
- 2) Self-control in medical treatment and proper conduct.
- 3) The pursuit of awareness and public health.
- 4) The protection of the patient's right to decide for oneself.
- 5) The protection of the patient's privacy, rights and interests.

- 6) Rejecting unnecessary medical actions.
- 7) Care and medical intervention for dying patients.
- 8) The protection of safety and autonomy for medical research subjects.³

These statements are a positive reflection of the demands of the past 20 years to guarantee patients' rights and research test subjects' rights. It can be said that to guarantee patient's personal rights does not have to be mentioned specifically as it is the very basic in medical conduct, but it shows doctors' strong resolution towards them by stating it clearly and specifically.

So far, we have examined that Korea's declaration of medical ethics have been revised to adjust to public demands and changes in doctors' perception shift towards their mission in community. What needs to be done from now on should be that the declarations be shared and accepted through diversified communication channels to the public, so that they don't merely remain as one-way declaration of doctors' own.

Events That Changed the Landscape of Korea's Medical Ethics

If medical ethics should be developed through communication with society, a chaos brought forth by a medical scandal would be the time, when those communications take place the most. There have been a number of eye-opening scandals in the Korean medical field. Among those, two issues stand out: One is the "Boramae Hospital Case" occurred in 1997, in which the courts called doctors to account regarding their duty on the a patient's discharge, who lost consciousness. The other is "The Separation of Functions between Prescription and Dispensary," against which doctors went on a general strike as an expression of strong protest. The strike brought forth a lot of controversies over its righteousness.

The Boramae Hospital case

On December 4 in 1997, a 58-year-old-man fell on the floor at his house in a drunken state resulting in an epidural hemorrhage in his head. He was taken to the Boramae Hospital in an emergency situation and received a 6-hour-long operation to remove the hematoma caused by the epidural hemorrhage successfully. Although he was attached to a respirator because of difficulties in breathing resulted from cerebral edema from the brain sur-

gery, he was recuperating little by little and chances were for further recuperation. The patient's wife learned from medical staff that the hematoma was removed through surgery and that her husband's condition would improve. However, she requested her husband to be discharged due to financial burdens. The wife was told that he would die if he were to be discharged without medical staff or a respirator. On December 5, she ignored the advice of the medical staff and requested her husband to be discharged. In less than 5 minutes after leaving the hospital, the patient began to have trouble breathing and died. The wife and the hospital staff in charge of the patient were charged with homicide and were prosecuted as joint offenders in this case.

On June 24, 2004, the Supreme Court sentenced the doctor to 1 year and 6 month in prison and 2 years probation. As grounds, the Court asserted that the doctor still followed the demands of the guardian and permitted the patient to be discharged although he knew that he would die without a respirator. This judgment imposed the responsibility on the doctor. This judgement came as a shock to most Korean doctors, as decisions of patient's family were generally accepted as an important ground for doctors in making difficult decisions regarding treatment interruption. With this judgement, doctors remind of their duties to treat a patient as an autonomous individual and their best interest should be considered under any circumstances. There is a provision referring to this in the medical ethics guidelines, but no explicit written provisions in laws, causing confusions. Although there formed an implicit ethical consent on the necessity of those provisions, measures for legislation. This shows an aspect of lack of communication between medical professional and the frame of the society.⁴

The separation of dispensing function from prescribing

Conflicts among doctors, pharmacists and the government regarding the separation of dispensing function from prescribing provoked doctor's general strike of 2000 nationwide and became a national issue that roused much conflict and

interest. Beginning with a one-day strike, it went on for five rounds, in addition to the nearly 4-months-long specialists' strike.

Doctors focused on banning alternative filling of prescriptions by pharmacists. However, under the circumstances in the medical field back then, it was hardly possible and they determined to block the implementation of the system itself.

Despite doctors' strong opposition, the Government the system announced its stance to implement the system in September of 1998, with an exception of hospital in-patients and passed the bill in the following year. This brought forth strike among primary care physicians first and expanded into general strikes by doctors thereafter.

This event stemmed from the different views between the professionals' interests and the government's role over implementation of new policy. The fact that physicians, who stand conservative towards social issues, initiated a strong action like general strike came to many people as a shock.

It still remains to be seen whether this event will be seen by the society as a fair protest for the justifiable rights of doctors or as an improper exercise of power. This provided a good opportunity to debate society's values regarding medicine and the medical workers' role. However, doctors could not receive sympathy from the public and failed to adhere to Article 8 of in the Declaration of Medical Ethics, thus bringing down the level of trust invested in them by the society.

Conclusion

We have examined how doctors are recognized and perceived by the society and how changes in the general principles of medical ethics have affected doctors' own perception. We have also examined the events that increased awareness of the medical field and how that has affected society's expectations in physicians. Physicians, who doctors, who have the highest professionalism which society grants, must positively accept their role in society and developments in ethics must continually be made so that they can present justifiable views and knowledge.

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The Development of Medical Ethics in Korea

SHIN, Dong Chun, MD,PhD
Executive Board Member, KMA
Professor, Department of Preventive Medicine, Yonsei University

LEE, Ilhak, MD
Department of Medical Law and Bioethics, Yonsei University

Introduction

- ☒ Medicine's three elements
 - ☒ Sickness, Patients, and Doctors
- ☒ Ethics may arise from this relationship



essence and core of medical ethics

Introduction

- ☒ The source of medical ethics: the beliefs of doctors and his associates → the doctor's oath
- ☒ Doctor's Promise and the approval from society
- ☒ Medical ethics is both..
 - ☒ from society and
 - ☒ from doctors.



Introduction

- ☒ This presentation will examine...
 - ☒ the changes that have taken place in the ethics that doctors profess to reveal
 - ☒ the type of ethics-related mindset that a doctor requires.

The Function of the Declaration of Ethics

- ☒ Doctors are professionals...
- ☒ Various characteristics:
 - ☒ the training required
 - ☒ specialized technical skills
 - ☒ professional self-control
 - ☒ adherence to societal values and ethical rules, particular motives for choosing this line of work,
 - ☒ devotion to duties, a sense of collaboration with colleagues, and so on

5

The Function of the Declaration of Ethics

- ☒ Doctor's Profession
 - ☒ Professional: "to publicly acknowledge, to make a declaration, to make a promise. (*Latin*)"
 - ☒ accept these features publicly as their own
 - ☒ society can expect the manner doctors will show during the medical service.
- ☒ History of "public promise"
 - ☒ Hippocratic Oath (BC 4~1c)
 - ☒ Declaration of Geneva (1948) by the WMA
 - ☒ Korean doctors also adopted and amended several declarations

6

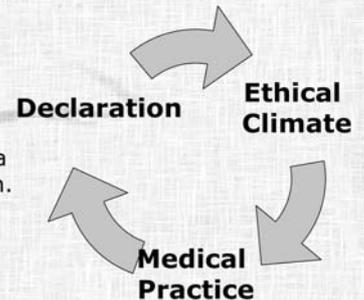
The Function of the Declaration of Ethics

- ☒ The Declaration of Ethics
 - ☒ The devotion to the relationships that a doctor makes
 - ☒ Placing the patients' interests before their own
 - ☒ Comradeship with fellow doctors, and
 - ☒ The promise to provide care are the basis of those pledges.
 - ☒ accepted voluntarily and
 - ☒ a dual role as a promise to fellow medical professionals and to society.
 - ☒ have influenced the traditionally accepted roles of doctors, as well as the demands that present-day society places on doctors.

7

The Function of the Declaration of Ethics

- ☒ Declaration as an ethical climate
 - ☒ Affects doctor's moral decision making in every day medical life, but especially in a dilemma situation.



8

Development Ethics Declaration in Korea

☒ Duties of doctors in *Ui-Bang-Yu-Chui* (醫方類聚, 1445)

1. The doctor has a duty to study sicknesses and treatments
2. The doctor exists to treat the patient's sickness.
Further, the patient's social status should not be a consideration, only medical considerations should be taken into account.
3. All lives should be respected and all lives, including

The medical ethics stresses...

1. high priority placed on the interests of the patient
2. it goes beyond just humans... attention be paid to animals and plants as well.
3. the doctor, as a specialist in treating patients, should continually study medicine
4. he should ignore his own personal gains and interests.

9

Development Ethics Declaration in Korea

- ☒ However, as modern Western medical systems began to be introduced, this type of thinking from the Chosun era lost a significant amount of influence.
- ☒ General public's expectations: Although the traditional writings may not have explicit effects now, it can be said that the general public's expectations of the doctor and the doctor's own perceptions have not changed too significantly

10

Development Ethics Declaration in Korea

- ☒ Korea's declaration of medical ethics became established in 1961
 - ☒ a translation of the Geneva Declaration
- ☒ The examination and amendments to this declaration of medical ethics began in 1970's
 - ☒ Reflected the introduction of National Health Insurance system and its implication on medical practice
- ☒ The declaration of medical ethics was amended in February of 1997
 - ☒ Patient's Rights and medical advances

11

Development Ethics Declaration in Korea

- ☒ Declaration into codes of ethics: more specified and exercisable ethics developed(1997, 2006) by the KMA
 1. A devotion to human dignity.
 2. Self-control in medical treatment and proper conduct.
 3. The pursuit of awareness and public health.
 4. The guarantee to the patient's right to decide for oneself.
 5. The protection of the patient's privacy, rights and interests.
 6. Rejecting unnecessary medical actions.
 7. Care and medical intervention for dying patients.
 8. The guarantee of safety and autonomy for medical research subjects.

12

Development Ethics Declaration in Korea

- ☒ Korea's declaration of medical ethics
 - Changes in doctors' understanding and acceptance of society's demand
- ☒ Efforts should be made for strengthening mutual communication and understanding with society

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Events That Changed the Landscape

1) The Boramae Hospital Case

- ☒ Self-determination right of unconscious patients exercised by surrogacy, patient's wife: patients' wife insisted on "discharging against medical advice", patient discharged and expired of brain edema after 5 minutes.
- ☒ The patient's wife and the hospital staff in charge of the patient were charged with homicide and were prosecuted as joint offenders in this case
- ☒ On June 24th, 2004 the Supreme Court asserted that the doctor knew that if treatment was discontinued the patient would die, yet he still followed the demands of the guardian and permitted the patient to be discharged. For this, the doctor was sentenced to one year and six months in prison and two years probation.

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1) The Boramae Hospital Case

- ☒ The patient's ethical position was accepted as the obvious thing to do.
- ☒ But doctors now have a new duty to treat patients as an autonomous individuals. → decision making in withdrawing life-support treatment, now requires to follow the ethical and legal guidelines.
- ☒ But it has not to be regulated yet through legislation. The delay may indicate that there is a problem achieving mutual understanding between doctors and society.

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2) The Separation of Dispensary from Medical Practice

- ☒ Conflicts between the doctors, pharmacists and government involving the separation of dispensary from medical practice provoked the national doctor's strike of 2000 and became a national issue that raised much conflict and interest.
- ☒ Beginning on February 17th as a one day strike, it went on for five rounds, up to nearly four month long specialists' strike.

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2) The Separation of Dispensary from Medical Practice

- The different views between the doctors' interests and the government's policy came into effect.
- It was surprising to see the main body of protesters was comprised of doctors.
- It still remains to be seen as a fair protest for the justifiable rights of doctors or as an unjust exercise of power for the societal point of view.
- This can be taken as an opportunity to debate society's values regarding medicine and the medical professionals' role.

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Conclusion

- Professionalism and the doctor's role in society
- Ethics must be continually discussed so that doctors can present justifiable views and knowledge.

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[Macau]

Continuing Development in Ethics and Professionalism



Nai Chi CHAN*¹

CONTINUING DEVELOPMENT IN ETHICS & PROFESSIONALISM

DR. NAI CHI CHAN
DIRECTOR OF THE MACAU ASSOCIATION OF MEDICAL PRACTITIONERS
PRESIDENT OF THE MACAU SOCIETY OF HEMATOLOGY AND ONCOLOGY

PROFESSIONALISM

- Essence of professionalism is self-governance and self-regulation
- Medicine is a moral enterprise grounded in a covenant of trust

MAIN CHARACTERISTICS OF LEARNED PROFESSIONALS

JAMA. 1995;273:1539-1541

- Self-governance individually & as a group
- Service to the poor without expectation of compensation
- Delivering quality
- High level of learning
- Autonomy of activity-earned autonomy

Cont'd

- Altruism
- Self-sacrifice
- Not ripping people off
- Heroism as needed
- Ethical practice with public accountability

*1 Director of the Macau Association of Medical Practitioners. President of the Macau Society of Hematology and Oncology (drj@macau.ctm.net).

PRESENT SITUATION IN MACAU

- We are much less trusted by the public
- We have been much more frequently complained of or even sued by the patients
- We are much more aware of our error-proneness
- Many of us use the defending attitude when seeing the patients

REASONS WHY THIS SITUATION OCCURS

In Macau we are weak in self-governance & autonomy of activity leading to:

- Delivering decreasing quality services (can not control the registration of medical practitioners)
- Obtaining poor reputations
- Being in poor financial situation

CONT'D

- Without high level of learning
- Poor altruism & self-sacrifice
- Poor ethical practice with public accountability

HOW THIS SITUATION CAN BE IMPROVED

- The essence of professionalism in medicine, i.e. self-governance & self-regulation, has to be emphasized & implemented in Macau
- The ethical practice with public accountability can only be improved in Macau only if the essence of professionalism has been successfully implemented

[Malaysia]

Continuing Development in Ethics and Professionalism by Malaysian Medical Association



Siang Chin TEOH*¹

Introduction

A profession sets standards of competence and behaviour and is self-regulating. The administration of the Hippocratic Oath is the student's introduction to the ethics and behaviour expected of a physician. The public believes that the profession has the Oath as the ultimate guide for physicians. Such codes of behaviour are characteristic of professions and over the centuries, the Oath has been modified to reflect the changing mores of society.

At the same time, the business of medicine has produced guidelines of behaviour between physicians and their patients that indicate how to practice medicine and these are used to govern medical practice. These guidelines have often been made into standards and regulations. The public has trusted that the profession applies these standards and ensures the proper practice of medicine.

Legislation governing medical practice is nothing new. The first example is seen in Mesopotamia, Babylon, whereby the ruler Hammurabi 1728–1686 B.C. had a code that applied to many legal matters including land-owning, divorce, boat building while a few deal with medical practice. For instance, regulations set the fees for treatment as well as the penalties for failure depending on the rank of the patient. This code is in the Louvre, Paris.

“If a physician has performed a major operation on a lord with a bronze lancet and has saved the lord's life . . . he shall receive ten shekels of silver; but if he caused the death of such a notable, his hand would be chopped off. A doctor causing the death of a slave would have to replace him.”

The modern code of ethics emerged in the

18th century with John Gregory (1724–1773) a Scot who became Professor of Physic at Edinburgh. He would lend his students his lecture notes and one of them arranged their publication in 1770. “Offices on the Duties and Offices of a Physician, and on the Method of Prosecuting Enquiries in Philosophy.”

In this, he advised on the moral qualities of a physician. The chief is humanity—*“that sensibility of heart which makes us feel for the distresses of our fellow creatures, and which, of consequence, incites us in the most powerful manner to relieve them.”*

He drew attention to sympathy, gentleness of manners and compassion. He advised that the physician develop a composure and firmness of mind so as not to be enervated. This was what was to be known as Osler's Aequanimitas.¹

The Profession of Medicine

Medicine is the branch of health science and the sector of public life concerned with maintaining or restoring human health through the study, diagnosis, treatment and possible prevention of disease and injury. It is both an area of knowledge—a science of body systems, their diseases and treatment—and the applied practice of that knowledge.

The practice of medicine combines both sciences as the evidence base and art in the application of this medical knowledge in combination with intuition and clinical judgement to determine the treatment plan for each patient.

Central to medicine is the doctor-patient relationship established when a person with a health concern seeks a physician's help; the ‘medical encounter’. Other health professionals similarly establish a relationship with a patient and may

*1 President, Malaysian Medical Association, Kuala Lumpur, Malaysia (mma@tm.net.my).

perform various interventions, e.g. nurses, radiographers and therapists.²

Values in a Doctor

High standard of ethics

From the time of Hippocratic oath, medical practice has always had a very strong ethical foundation, and rightly so, as it is one of the key features of a profession. More than ever, the ethical principals associated with clinical practice need to be debated and clarified. New procedures and ethical dilemmas arise constantly. Greater public awareness of the issues means that the debates are no longer confined to professional audiences and it is appropriate that the wider public is included. There is greater scrutiny of professional practice, and standards are now openly discussed in the media and public fora. The profession has nothing to fear from such debates as long as it is not defensive or secretive.

Continuing professional development is an issue, which is broader than continuing education. It is concerned with personal growth and satisfaction with professional work. It is an issue, which has been neglected, in recent years but, with the changing role of the consultant, it is one, which will need to be looked at afresh in the near future.

Ability to work in a team

As medicine and health care increases in complexity so it becomes even more necessary to be sure that all the skills of professions other than medicine are utilized to the full. This means working and learning in teams, but it does not mean relinquishing the key patient-doctor relationship, which is so central to the therapeutic process.

Concern with health as well as illness is a key issue. Are doctors to be concerned only with those who are ill or do they have a wider role in the community?

Patient and public focused

The purpose of medicine is precisely to do with serving the patient and the public. Perhaps we should be more willing to say this explicitly rather than implicitly. There is great energy and power in this process if it can be harnessed effectively.

Concern with clinical standards, outcomes, effectiveness and audit

More and more of the care given to patients and the treatment offered will be based on proper outcome based evidence. This is not to deny innovation or to stifle research and development. Rather the opposite. Standards record where we are now; research and innovation should take us to new levels of quality and care. It is clear from many studies that there are variations in treatment and outcomes across Britain. Some of these are understandable and explainable. Others are not. It is this aspect which from a public point of view requires resolution. Audit is a tool, which has value in measuring that quality of care provided. It is only one tool but an important one to assure quality. As part of professional practice, all doctors should be involved in auditing clinical work.

Ability to define outcomes

Outcomes in some instances are not easy to define but are an important professional challenge. The use of guidelines, which can be seen as no more than the formalization and clarification of good clinical practice, is part of the process of care and is not an end in itself. Guidelines need to be feasible, to encourage local involvement, and not to inhibit new methods of management. Rather, they should be a base from which to build. They should help us to understand and explain variations in care.

Interest in change and improvement, research and development

Medicine cannot and should not stand still. It is continually evolving and improving. All doctors need to be involved in changing and improving clinical practice. Indeed, they have an obligation to be so, though this does not mean that all need to be involved in "research." This key value, however, emphasizes the importance of academic input and of teaching.

Ability to communicate

Of all complaints against doctors, problems of communication must be one of the greatest. Yet, it is perhaps the key part of the function of the doctor if you accept that making a diagnosis, assessing prognosis, and defining treatment are central roles for the doctors. Arrogance and discourtesy

reflect badly on a profession whose primary purpose is to care for the patients. The importance of communication (a two-way process) is increasingly being recognized in medical schools, and role models (Consultants and General Practitioners) must also recognize the effect of the “hidden agenda” (their attitudes and behaviour) on medical students and post-graduates.

Definitions

Professionalism⁴

“The term professionalism is used to describe those skills, attitudes and behaviours which we have come to expect from individuals during the practice of their profession and includes concepts such as maintenance of competence, ethical behaviour, integrity, honesty, altruism, service to others, adherence to professional codes, justice, respect for others, self-regulation, etc.”

“In Canada and the United States the social basis of the extraordinary grant of occupational authority and independence to professionalized occupations such as medicine and law has been a social contract between the profession and the public. Professionalism is the moral understanding among professionals that gives concrete reality to this social contract. It is based on mutual trust. In exchange for a grant of authority to control key aspects of their market and working conditions through licensing and credentialing, professionals are expected to maintain high standards of competence and moral responsibility.”

“We think of professionalism as an activity that involves both the distribution of a commodity and the fair allocation of a social good but that is uniquely defined according to moral relationships . . . Three core elements of professionalism, each different in nature, are necessary for it to work properly. First, professionalism requires a moral commitment to the ethic of medical service, which we will call devotion to medical service and its values. This devotion leads naturally to a public, normative act: public profession of this ethic. Public profession of the ethic serves both to maintain professionals’ devotion to medical service and to assert its values in societal discussion. These discussions lead naturally to engagement in a political process of negotiation, in which professionals advocate for health care values in the context of other important, perhaps competing, societal values.”

It is clear in these statements that professionalism is above all an ethical concept. Its distinguishing features are those of a profession: a strong commitment to the well being of others, high moral standards, mastery of a body of knowledge and skills and a high degree of autonomy. These features clearly apply to the individual members of a profession. Their application to the group as a whole, including professional associations, is less evident.

Ethics

Put simply, ethics is the study of morality — careful and systematic reflection on and analysis of moral decisions and behaviour, whether past, present or future. Morality is the value dimension of human decision-making and behaviour. The language of morality includes nouns such as ‘rights’, ‘responsibilities’ and ‘virtues’ and adjectives such as ‘good’ and ‘bad’ (or ‘evil’), ‘right’ and ‘wrong’, ‘just’ and ‘unjust’. According to these definitions, ethics is primarily a matter of knowing whereas morality is a matter of doing. Their close relationship consists in the concern of ethics to provide rational criteria for people to decide or behave in some ways rather than others.

Since ethics deals with all aspects of human behaviour and decision-making, it is a very large and complex field of study with many branches or sub-divisions. Medical ethics is a branch of ethics that deals with moral issues in medical practice. Medical ethics is closely related, but not identical to, bioethics (biomedical ethics). Whereas medical ethics focuses primarily on issues arising out of the practice of medicine, bioethics is a very broad subject that is concerned with the moral issues raised by developments in the biological sciences more generally.⁵

Ethics and Professionalism in Medicine

Medical professionalism affects just about everybody — physicians, patients, other health providers, health care administrators, governments and the general public (as taxpayers, potential patients, relatives of patients, etc.). Some of its features may be good for some of these groups but not for others. For professionalism to be preserved and enhanced, it will likely have to be seen as serving the overall good of society, not just one or two groups.

Ethic of service

“Professionalism in medicine requires the physician to serve the interests of the patient above his or her self-interest. Professionalism aspires to altruism, accountability, excellence, duty, service, honor, integrity and respect for others.”

This fundamental characteristic of professionalism is clearly in the interests of patients, who are its primary beneficiaries. Society also benefits, by having those who control the knowledge and skills for providing such an essential service as medical care do so not primarily for their own gain but for the good of others. The benefit of the ethic of service to physicians is less direct but still of considerable importance. It entitles them to the trust, respect and gratitude of their patients and of society (even if these are not actually bestowed). For the profession as a whole, the ethic of service contributes to the credibility of its advocacy work.

Clinical autonomy

“Professional autonomy has been the highest ethic of the medical profession for much of the twentieth century.”

This viewpoint is reflected in the World Medical Association Declaration on Physician Independence and Professional Freedom. Although the power of physicians to control their own work and to direct others involved in the care of their patients has diminished in recent times, it still exceeds that of many, if not most, other occupations. This is clearly a desirable feature of professionalism for physicians, in that it allows them to act as medical expert and healer on behalf of their patients.

This benefit is always obvious to others. Many patients want their physician to do what they think best, not necessarily what the physician recommends. However, patients need their physicians to exercise clinical autonomy in making recommendations about what is best for them, whether or not they accept the recommendations. Hospital administrators and third-party payers may consider physician autonomy to be incompatible with prudent management of health care costs. However, the restraints that administrators and third-party payers attempt to place on clinical autonomy may not be in the best interests of the patients. Furthermore, restraints on the ability of physicians to refuse demands by

patients or their families for inappropriate medical services are arguably not in the best interests of either patients or society.

Self-regulation

If there must be restrictions on their autonomy, physicians prefer that they be imposed by their peers rather than by non-physicians. They have traditionally been granted this privilege by society on the grounds that only physicians know medicine well enough to determine appropriate standards for its practice; they can be trusted to set and enforce appropriate standards of physician behaviour; and this is the most effective way for society to achieve the good it desires from medicine. In this regard, it is important to note that society has benefited from physician self-regulation too, not least because relatively few resources have to be devoted to the surveillance of physicians.

However, there have been many accusations that the profession has abused the privilege of self-regulation by failing to deal fairly with complaints against physicians. If self-regulation is to be seen as serving the overall good of society, not just that of physicians, the profession has to accept its burdens as well as its benefits, i.e., physicians have to undertake the tasks required by self-regulation, including meting out penalties to their errant colleagues, and must also be seen to do so.

William Sullivan, a prominent medical sociologist: *“Neither economic incentives nor technology nor administrative control has proved an effective surrogate for the commitment to integrity evoked in the ideal of professionalism.”* Without question, the medical profession itself wishes to function within a system dominated by a healthy and flourishing professionalism. As Sullivan and Friedson points out, there should also be substantial advantages to society in preserving professionalism as an effective value-based system. The original reason for the use of the profession as a means of organizing healthcare was because of the complexity of the knowledge base, the difficulty in regulating it, and the presumption that the profession would be altruistic and devoted to the public good. We believe that nothing in the past 150 years has altered that fact. Thus, both society and the profession should wish for the same type of physician — competent, moral, idealistic and altruistic. This is best guaranteed by

a healer functioning as a respected professional.⁶

The practice of medicine has a special characteristic not found in so pronounced a manner in other occupations. Doctors deal directly, and at the time when a person is most vulnerable, with the immediate issues of life and death, health and illness. The patient is heavily dependent upon the technical knowledge and integrity of the doctor. The doctor thus has a unique involvement with the patient, but this relationship between doctor and patient is not balanced. The patient's attitude is a complex of trust (which comes from perceived competence and integrity of doctor) and paradoxically also that of distrust which comes from the state of uncertainty and vulnerability.

This ambivalence in doctor-patient relationship is addressed by medical ethics, which tries to guarantee the patient that the doctor will not abuse his dominance in the relationship. Thus, medical ethics is essentially a regulatory mechanism that makes the doctor commit publicly that though medical practice is the source of his living, he will strive to the utmost for the benefit of the patient and not be driven by just for mere personal aggrandishment.

It is normally accepted as a rule that ethics is something more than law. The formulation of various aspects of ethical code is based on ethical principles, which are in many ways different from legal principles. Ethics govern conduct. Principles based on it thus delve into fine aspects of the conduct of doctors. Ethics and its principles also come into play to resolve recurrent ethical dilemmas in medical practice. As the occurrence of a particular dilemma increases and as its resolution in a certain manner gains general acceptance within the profession, it gets integrated into the code itself. This creates a dynamic mode which makes the ethical code progressively more elaborate. Laws are circumscribed. Their elaboration by the judiciary is also greatly limited. Since the profession acts as lawmaker as well as its implementing agency, its elaboration is wider.⁷

Teaching Ethics and Professionalism

Medical schools, teaching hospitals and those responsible for continuing medical education should teach professionalism as a subject formally identified in the curriculum. The material to be taught will change in different cultures and certainly with time. The teaching of professional-

ism should include several components.

1. Identifiable educational content in the undergraduate medical school curriculum devoted to professionalism, which should be reinforced in postgraduate programmes and in continuing medical education. The subject should be part of the evaluation of all students.
2. The concept that to be a professional is not a right but a privilege with a long history and tradition of healing and service.
3. The separate but linked concepts of the physician as healer, and the physician as professional, and the fact that society uses professional status as a means of organizing the delivery of services.
4. A clear definition of professionalism and its characteristics.
5. Professionalism as an ideal to be pursued, emphasizing its inherent moral value. The concept of altruism and "calling" must be highlighted as essential to professionalism.
6. An understanding that proper professional behaviour is essential for the healer to function fully and to maintain the trust of patients and society.
7. Knowledge of codes of ethics governing the conduct of both the healer and the professional, as well as the philosophical and historical derivations of these codes.
8. The essential nature of the autonomy of the individual doctor, along with the legitimate limitations that have always existed. The degree of autonomy will vary in different societies, but a minimum is required for a doctor to exercise the necessary independent judgement to best serve the patient.
9. The nature of collective autonomy of the profession, along with its legitimate and inherent limitations.
10. Relevant material drawn from sociology, philosophy, economics, political science and medical ethics as related to professionalism, including interpretations of both the historical course of events and of doctors' behaviour that are critical of the medical profession. The profession must not be allowed to build and maintain its own myths while avoiding ideas challenging them.
11. The link between professional status and the obligations to society that must be fulfilled to maintain public trust. These obligations should be explicitly outlined and included in

the teaching. They include obligations to know and be guided by the applicable codes of ethics and national and regional laws; to participate in more effective and transparent self-regulation; to address health issues of concern to society; to maintain competence throughout one's medical career, to be prepared to be fully accountable for all decisions taken; to expand and ensure the integrity of medicine's knowledge base by supporting science in its broadest sense; to insist on the maintenance of sufficient individual and professional autonomy to enable the doctor to act in the best interests of the patient; and to be governed by professional standards of conduct no matter what role is being filled — private practitioner, employee of the state or corporation, manager, administrator, or a mixture of roles. Finally, of course, the obligation to put the welfare of the patient and of society above one's own is paramount.⁸

Ethics and Professionalism in a Changing World

Our professionalism is shaped by the context in which we work. First and foremost, medical knowledge and skill have expanded at an unprecedented rate. This, together with the revolution in information technology, has huge implications for the profession.

People know more about health matters because they have independent access to clinical information and because their interest has been stimulated by media attention. More patients want an open relationship with their doctors; they want to be well informed and involved in decisions about their care.

Doctors are no longer alone in the clinical management of patients. Multi-professional teamwork, the philosophy behind modern shared care, has to be reconciled with the personal nature of doctor-patient relationship.

Doctors' attitudes are also changing. For example, more doctors attach as much importance to the quality of their lives outside medicine as to their medical work. Part-time practice has become more common for both men and women. Such developments have major implications for continuity of care and the organization of medical work.⁹

Doctors today are experiencing frustration as changes in the health care delivery systems in virtually all industrialized countries threaten the very nature and values of medical professionalism. At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all physicians, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways.¹⁰

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[New Zealand]

International Code of Medical Ethics



Ross BOSWELL*¹

At the 2006 General Assembly of the World Medical Association, a revision of the International Code of Medical Ethics was adopted. The statement of the current version on confidentiality is:

“A PHYSICIAN SHALL respect a patient’s right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.”

In New Zealand, there are a number of situations where doctors are required by law to provide confidential patient information. Examples are:

- Where the patient has some notifiable disease such as meningococcal infection, campylobacter enteritis, syphilis, gonorrhoea etc.
- Where the police have the authority of a search warrant to seize records in the investigation of a crime
- Where cervical screening audit investigators have authority to examine records of a woman who has developed cervical cancer.

These circumstances fall far short of the very stringent requirement in the current International Code for “real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.”

The current NZMA Code of Ethics has a rather less stringent requirement:

“Protect the patient’s private information throughout his/her lifetime and following death, unless there are overriding public interest considerations at stake, or a patient’s own safety requires a breach of confidentiality.”

and in the explanatory and advisory notes to the NZMA Code:

“Doctors should keep in confidence information derived from a patient, or from a colleague regarding a patient, and divulge it only with the

permission of the patient except when the law requires otherwise, or in those unusual circumstances when it is clearly in the patient’s best interests or there is an overriding public good. Patients should be made aware of the information sharing which enables the delivery of good quality medical care. Where a patient expressly limits possession of particular information to one practitioner, this must ordinarily be respected. Patients should be made aware in advance, if possible, where there are limits to the confidentiality which can be provided. When it is necessary to divulge confidential patient information this must be done only to the proper authorities, and a record kept of when reporting occurred and its significance.”

The draft of the International Code prepared by the drafting committee and recommended by the Council to the WMA Assembly contained a further statement:

“It is ethical to disclose confidential information when the law requires or allows it.”

This was struck out by the Assembly, because of concern that in some countries, lawmakers might inappropriately legislate to damage confidentiality.

The NZMA proposes that a middle ground, allowing for the possibility of reasonable disclosure without dire emergency and without explicit patient consent, could be reached by amending the current version of the code by the addition of the following:

“It may be ethical to disclose confidential information when the law requires it”

so that the whole item reads:

“A PHYSICIAN SHALL respect a patient’s right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality. It may be ethical to disclose confidential information when the law requires it.”

*1 Chairman, New Zealand Medical Association, Wellington, New Zealand (nzma@nzma.or.nz).

Such a revision would allow for the reasonable disclosure of information for public health needs, while allowing a National Medical Association

to declare that some laws proposed or enacted in its country are against the principles of medical ethics.

[Philippines]

Continuing Development in Ethics and Professionalism



Jose Asa SABILI*¹

CONTINUING DEVELOPMENT IN ETHICS AND PROFESSIONALISM

Philippine Medical Association

By
Jose Asa Sabili, M.D.
PMA President 2006 - 2008

ETHICS AND PROFESSIONALISM

General Principles :

- Health is a fundamental human right and it is the obligation of society to make it possible for the individual to attain a level of health consistent with the resources of the community he lives
- The physician must respect the dignity and individuality of his patient as a human being regardless of stage of development, status in life, religious - political beliefs or racial background
- The physician in the performance of his duties will also have to consider other groups, such as patient's families; his colleagues and non physician in the health profession

PMA Commission on Ethics

- Lectures (Roundtables, Regional Assemblies)
- Seminar Workshops (Training the Trainers)
- Leadership Training Seminars (Officers of Chapter Societies)
- Ethics Commission on Specialty (Specialties, Subspecialties and Affiliates)

PMA Code of Ethics

- Doctor - Patient Relationship
- Doctor - Doctor Relationship
- Doctor - and other Allied Health Professional Relationship
- Doctor - Pharmaceutical Relationship

*1 President, Philippine Medical Association, Manila, Philippines (medical@pma.com.ph).

**INTERNAL RULES OF PROCEDURES OF PMA
COMMISSION ON ETHICS**

General Provisions :

- Only cases falling under the Provision of PMA Code of Ethics of Medical Profession shall be cognizable by the commission
- In cases involving medical on surgical management the cases should be referred further to the appropriate specialty & subspecialty for their comprehensive deliberations
- Commission shall act only on a written complaint addressed to the commission on ethics. Unsigned and anonymous letters shall not be entertained

CONDUCT OF PROCEDURES

1. Complaint
Every complaint shall be given a docket number containing the division number to which the case is assigned.
2. Answer : Period to submit an answer
Respondents shall be given fifteen (15) calendar days from the receipt of the complaint
3. Hearings
The Division shall calendar a hearing of the case to discern more the issues of the case
4. Resolution
Decisions based on Provision of the Code of Ethics of Medical Profession
5. Reconsideration
A request for reconsideration may be filed with the Commission on Ethics within 5 days from the Receipt of the Decision

Seminars Conducted on Ethics & Professionalism

- 17 Regional Assemblies with attendance of 250 - 350 physicians
- Annual Ethics Seminars for 117 component societies, 8 specialty division, 54 subspecialties & 34 affiliates
- Regular workshops on Ethics on hospital based doctors thru the Medical Staff Organization = Government Hospital - Department of Health - Private Hospital - PHIC Requirement

COMMISSION ON ETHICS

**CASES FILED AND RECEIVED BY THE PMA
COMMISSION ON ETHICS**

	2005	2006
DISMISSED	43	35
REFERRED TO PRC	8	3
PENDING	5	2
TOTAL NUMBER OF CASES	56	38

The basic tenet of life is “ No man is an island “ and we are all part of a team like a symphonic orchestra, if each one plays his part correctly, ethically and follows the score the whole ensemble, the whole team, gives out beautiful inspiring music

THE END

Thank you for listening
Mabuhay ang CMAAO
I LOVE YOU ALL !!!!!

Dr. Jose Asa Sabili
PMA President

[Singapore]

Continuous Professional Development (CPD) Programmes on Medical Ethics and Professionalism in Singapore



CHONG Yeh Woei*¹

Continuous Professional Development (CPD) programmes on medical ethics & professionalism in SINGAPORE

42nd CMAAO Mid-term Council Meeting
SINGAPORE

Major milestones

- Centre for Medical Ethics & Professionalism (CMEP) - year 2000
- Beginning of monthly medical ethics and health law seminars in TTSH (from 2001) and SGH (2003)
- Recognition of SMA as a national leader in advocating medical ethics and professionalism, → appointment of CMEP to conduct a mandatory course for advance specialist trainees in 2005
- Singapore Medical Council – awards core CME points to programmes on medical ethics

Overview of programmes

- Mandatory course for advance specialist trainees on medical ethics, professionalism and health law (includes module on good doctor-patient communication)
- Annual ethics convention
- Monthly bioethics symposium (2001-2004)
- Ad hoc courses
- Ethics consultation services

Overview of programmes

- Mandatory course for advance specialist trainees on medical ethics, professionalism and health law (includes module on good doctor-patient communication)
- Annual ethics convention
- Monthly bioethics symposium (2001-2004)
- Ad hoc courses
- Ethics consultation services

*1 1st Vice President, Singapore Medical Association, Singapore (sma@sma.org.sg).

Premise

- Ethical competency is just as important as technical competency in the practice of medicine.
- Advocating medical professionalism is not an option, but an obligation.
- Knowledge in basic health law is an essential to good professional practice.
- Communication skills is an essential tool that facilitates optimal health care of the patient.
- The specialists-to-be today are the role models and clinical teacher of tomorrow.

Canadian Medical Education Directions for Specialists (CanMEDS 2000) Project

The Royal College of Physicians and Surgeons of Canada

As a professional, the specialist should be able to:

- Deliver the highest quality care with integrity, honesty, and compassion.
- Exhibit appropriate personal and interpersonal professional behaviours.
- Practice medicine in an ethically responsible manner that respects the medical, legal and professional obligations of belonging to a self-regulating body

Canadian Medical Education Directions for Specialists (CanMEDS 2000) Project

The Royal College of Physicians and Surgeons of Canada

As a communicator, the specialist should be able to:

- Establish a therapeutic relationship with patients, including the ability to establish and maintain rapport and fostering an environment characterized by g, trust, empathy, and confidentiality.
- Elicit and synthesize relevant information from the patient, their family, and/or community about his/her problems.
- Discuss appropriate information with the patient, his/her family, and other health care providers that facilitates optimal health care of the patient.

Curriculum

- **Module 1**
 - Fundamental principles and concepts in health care ethics, health law & professionalism
- **Module 2**
 - further applications of principles and concepts in health care ethics, health law & professionalism
- **Module 3**
 - A professional approach to managing challenging issues in doctor-patient communication

Module 1

1. Goals and social contract of medicine, medical professionalism and doctor-patient relationship
2. Incorporating ethics and ethical analysis into clinical practice
3. Privacy and confidentiality in medical practice
4. Informed consent and refusal of medical interventions
5. Singapore Health Law – a brief overview
 - An overview of the principles of health law in Singapore
 - An overview of important health statutes in Singapore
 - Legal responsibilities of doctors and the Private Hospital and Medical Clinic (PHMC) Act

Module 1 (cont'd)

6. Duty of care, standard of care and medical negligence
 - Legal bases of medico-legal liability
 - The tort of negligence, duty of care
 - Standard of care - Concept of professional peer review, the Bolam principle / test, Bolitho
 - Risk management and defensive medicine
7. Professional practice and legal issues in medical practice
 - The coroner system, death certification
 - Duties as an expert witness
 - Legal responsibilities of doctors and the Private Hospital and Medical Clinic (PHMC) Act

Module 2

1. Truthful disclosure of medical information to patients
2. Disclosure of medical errors and quality assurance
 - Truthful disclosure of medical errors
 - Rules on discovery
 - Quality assurance systems in hospitals
 - MOH Sentinel event review
3. End-of-life issues and medical futility
 - euthanasia, physician assisted suicide
 - medical futility, withholding and withdrawal of futile treatment, DNR
 - palliative or comfort care
 - advance care planning, advance medical directives, Singapore AMD Act

Module 2 (cont'd)

4. Inter-professional relationship – cultivating healthy collegiality, and the Medical Registration Act
5. Research ethics
6. Ethical issues in clinical genetics
7. Ethical issues in HIV care and the Infectious Disease Act
 - Public health considerations versus individual rights of autonomy
 - ethical issues in the management of HIV positive patients
 - ID Act and clinician's responsibilities under the ID Act
8. Conflicts of interest in patient care, research and education
9. Ethical issues in the allocation of health care resources

Module 3 - Communications

1. An overview of doctor-patient communication – conceptual, ethical and practical aspects
2. Understanding and managing emotions in doctor-patient communication
3. Breaking bad news – challenges and practical skills
4. Risk management and legal issues in negotiating informed consent to treatment

Path to becoming a specialist in SINGAPORE

- Housemanship / Internship 1 year
- Basic specialty training (BST) 3 years
 → M Med, MRCS, MRCP, MRCPsy, MRC(PPaeds), etc
- Advanced specialty training 3 years
 → exit certification
- Registration with Specialists Accreditation Board

Ultimately...theory → practice

To shift the learning and application of:

- ethical analysis
 - concepts and values of medical professionalism
 - professional communication skills
- room classroom and lecture theatres to bedside and clinical conferences.

Overview of programmes

- Mandatory course for advance specialist trainees on medical ethics, professionalism and health law (includes module on good doctor-patient communication)
- Annual ethics convention
- Monthly bioethics symposium (2001-2004)
- Ad hoc courses
- Ethics consultation services

Annual ethics convention

- **SMA Lectureship**
- **Professional practice symposium**
- **Symposium on specific topics**
- **Ethics essay awards**

Overview of programmes

- **Mandatory course for advance specialist trainees on medical ethics, professionalism and health law (includes module on good doctor-patient communication)**
- **Annual ethics convention**
- **Monthly bioethics symposium (2001-2004)**
- **Ad hoc courses**
- **Ethics consultation services**

Overview of programmes

- **Mandatory course for advance specialist trainees on medical ethics, professionalism and health law (includes module on good doctor-patient communication)**
- **Annual ethics convention**
- **Monthly bioethics symposium (2001-2004)**
- **Ad hoc courses**
- **Ethics consultation services**

Ad hoc courses

- **Course on becoming a clinical ethics consultant**
- **Course on becoming a teacher in clinical ethics**
- **Course on ethics, professionalism and health law for senior health executive and clinician leaders**
- **Collaborations with:**
 - **Bioethics Advisory Committee**
 - **Medico-legal Society**

Overview of programmes

- **Mandatory course for advance specialist trainees on medical ethics, professionalism and health law (includes module on good doctor-patient communication)**
- **Annual ethics convention**
- **Monthly bioethics symposium (2001-2004)**
- **Ad hoc courses**
- **Ethics consultation services**

Ethics consultation service

Ethical issue or case brought to attention of SMA

→ deliberation by Ethics Committee or CMEP

→ advice

→ General advisory for members and doctors

Challenges

- Perception and culture
- Prevailing forces against medical professionalism
- Practice driven by legal pressures > ethics-driven professionalism
- Lack of positive role-models
- Communication skills
- CPD programmes
 - Lack of competent trainers and mentors
 - Outcomes beyond mere raising awareness and sharing of information

THANK YOU

[Taiwan]

Ethics as Core Competence: Continuing development in ethics and professionalism on Taiwan



HUANG Ying-chia*1, LIU Peggy*2

Ethics as Core Competence:
Continuing Development in Ethics and
Professionalism on Taiwan
CMAAO, 2006/11/26

Huang, Ying-Chia
Liu, Peggy
Taiwan Medical Association
Asia University, Taiwan

• Huang YC,TMA

Consumerism vs.
Professionalism

**The Rise and Growth of
Consumerism in Health Care Sector**

- Consumers Not Always Patients
- Consumers as More Active Social Role with Power and Rights
- Consumers Demands for Participation and for Changes in Health Care Decision-Making
- Growing numbers of Health Care Consumer Groups

3

**The Changing Character of Medical
Profession**

- Deprofessionalization
- Proletarianization,
- Corporatization

4

*1 Taiwan Medical Association, Taipei, Taiwan, ROC (intl@tma.tw).
*2 Asia University.

Deprofessionalization

- Losing Monopoly over Domain Knowledge,
- Losing Public Belief in Their Service Ethos,
- Losing Expectations of Work Autonomy and Authority

5

Proletarianization

- Rise of Investor-owned Health Care Corporations
- Revolt of Institutional Buyers

6

Corporatization

- Complex Organizations and Financial Arrangements
- Incentive Pay and Reward System,
- Peer and Utilization Review,
- Restrictions on Practice Patterns

7

SARS episode

...2003 Spring, SARS episode impacted medical professionals and induced the movement of reconstruction medical ethics and professionalism



8

The Health Care Consumer Movement

- Being Informed and Heard
- Right to Quality Care, to Seek 2nd Opinions, to Freedom of Choices
- Choice-based vs. Rights-based Consumerism
- The Myth of Consumer Sovereignty: Physicians Withhold Their Recommendations
- Healthcare Organization Ethics

9

Balance between Physician Power and Consumerism

- Changing Expectations and Attitudes of Both Sides
- Growing Consumerism and Skepticism on Physician Authority
- Win-win between Physician Power and Consumer Right
 - Enhanced Autonomy Model/Mutual Participation Model
 - Responsibility and cooperation shared between both sides

10

MEDICAL (HEALTH CARE) ETHICS : 3 LEVELS OF RELEVANCE



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11

UNDERGRADUATE AND POSTGRADUATE MEDICAL EDUCATION REFORMS

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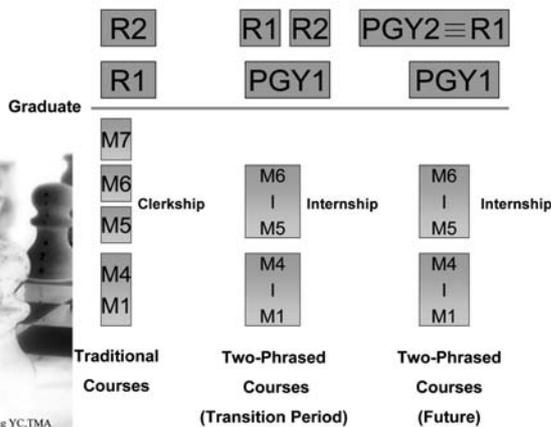
13

Undergraduate Medical Education Reforms

- Picking the right people to be doctors
- Integrate courses to establish Professionalism
- Enhance the courses of bioethics and medical law
- Enhance the psychosocial and community medicine courses

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15

How to change our basic Medical Education?

National Yang-Ming University Medical School Courses 2001



National Yang-Ming University Medical School Courses 2002



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Medical School Courses after 2002

24-Credit Courses in Medicine and Humanity Fields

- 1.Society Concerns.
- 2.Physician-Patient Relationship.
- 3.Oral History.
- 4.Humanities.
- 5.Bioethics

Medical Terminology, Cell Biology.

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General Medicine Basic Training Courses

context	credit
Medical Ethics and Law	12
Evidence-Based Medicine	8
Infection Control (including SARS-Related Courses)	8
Medical Service Quality and others (Medical Economy, Insurance, Policies)	8

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Medical School Courses after 2002

- Using Problem-Based Learning (PBL) as the Core Value
- Active Problem-Finding Habit
- Problem-Solving Ability
- Becoming a Lifelong Learner
- Multiple-Facet Development Potential
- Decrease the Unnecessary Duplication of Lecturing

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Medical School Courses after 2002

Emphasize on:

- 1.Clinical Techniques.
- 2.Clinical Decision Skill.
- 3.Medical Ethics.
- 4.Communication Ability.

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General Medical Training Program after Graduation

Year	Required Courses	Basic Courses	Integrative Courses of Basic and Clinical Medicine	Clinical Medicine	Clerkship	Internship	PGY1	PGY2	Specialty Training
2003-2004	Basic Medical Science Courses								
2005-2010?	Basic Medical Science Courses						PGY1		
2011?	Basic Medical Science Courses						PGY1		
2012?	Basic Medical Science Courses						PGY1	PGY2	

21

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WMA Medical Ethics Manual (John R. Williams)

- Since its official launch in January 2005, Taiwan Medical Association published a translation in Traditional Mandarin and every member got one copy.
- Every medical student gets one copy at his/her commencement since 2006.

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PGY 1

- the DOH, since 2003, has actively promoted the plan for the Training in General Medicine after Graduation.
- The plan offers physicians a 3-month course in general medicine, one month in general internal medicine, one month in general surgery, and one month in community medicine.

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PGY 1

- to realize the concept of the patient-centered holistic medical care
- the organic disease-oriented care models of physicians can be corrected.

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Postgraduate Continuing Medical Education Reforms

Postgraduate Medical Education Reforms

- PGY1 plan strengthens the community medicine and holistic medicine, general internal medicine and surgery
- Specialization and qualification of Physicians
- Teaching hospital accreditation
- Physician License renewal

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Specialization and Qualification of Physicians

- Article 7-1 of the Physician's Act
- guidelines established on June 29, 1988.
- Under these guidelines, the DOH (Department of Health) has entrusted professional medical societies to screen the qualifications of specialist physicians.

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Specialization and Qualification of Physicians

- A resident physician quota plan
- Beginning in 2001, the reassessment and accreditation of teaching hospitals
- up to the end of 2004, 25 specialties had been established, the DOH had issued a total of 34,039 specialist physician licenses.

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Regulations Governing the Licensing and Continuing Education of Physicians

- Formulated and announced in 2003,
- Article 9 Practicing physicians shall receive a minimum of 180 hours of continuing education coursework every six years on the following:
 - Medical courses;
 - Medical ethics;
 - Laws and regulations related to the practice of medicine; and
 - Quality of medical care.

Continuing education course credits for Subparagraphs 2 through 4 shall be at least a total of 18 points.

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Health Care Institutional Ethics

Hospital Accreditation

- Beginning in 1978
- Nationwide Hospital Accreditation since 1988
- the DOH established 'Taiwan Joint Commission on Hospital Accreditation (TJCHA)' in 1999.

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Patient Safety

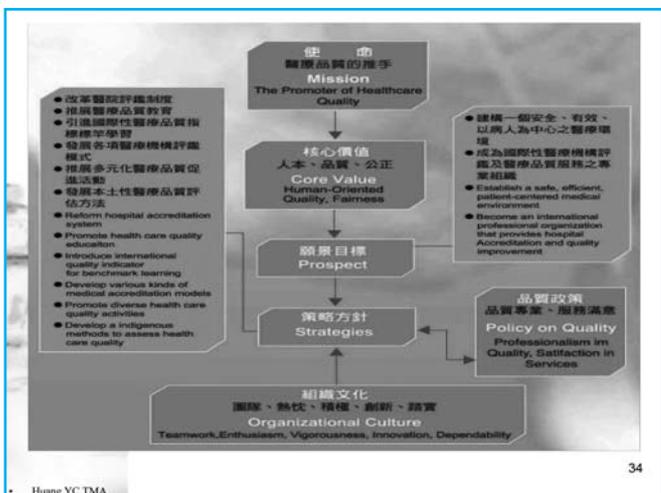
- Taiwan: 80,000 medical lesions/ 20,000 medical malpractices/ 5,000 disputes/ 300 legal suits every year
- Patient Safety Oriented Accreditation since 2001 (TJCHA)
- DOH setup 'Patient Safety Committee' in 2003
- NHRI: National Health Policy Conference in Oct, 2003 formulated 'Patient Safety Plan'

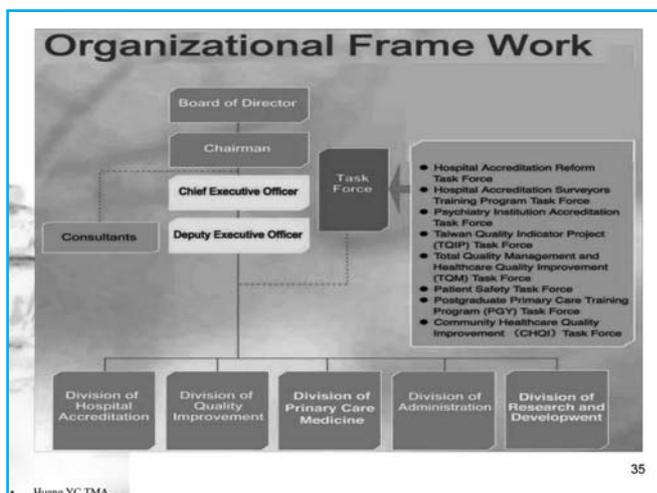
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Taiwan Joint Commission on Hospital Accreditation (TJCHA)

- DOH granted the funds in 1998 and the Commission was registered in 1999.
- Patient Safety Oriented Accreditation since 2001
- In July 2003, the fourth division, named "Primary Care Medicine" which is responsible for promoting "Post-graduate Primary Care Training"

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National Health Research Institute (NHRI)

- Corporate Health R&D institution: Forum and Advocacy for Biomedical Ethics
- NHRI: National Health Policy Conference in Oct, 2003 formulated 'Patient Safety Plan'
- In 2004,formulating Guidelines Governing Accreditation of Institutional Review Boards (IRB)
- Hospital IRB (> 100),Joint IRB, Non-hospital IRB in 2004

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Recent Regulations and Codes

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Recent Regulations and Codes

- 2001.5, DOH Setup Medical Ethics Committee (TMA advised)
- 2001.11, Ethical Code Governing Health Care Institutions and Professionals to Disclose Medical Information and Research Reports
- 2001.11, Guidelines Governing the Health Care Institutions' Media Interviewing

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Recent Regulations and Codes

- 2002.2 Ethical Guidelines Governing Stem Cell Research
- 2002.5, Hospital Accreditation Enforcing Health Care Institutions to Setup Medical Ethics Committee
- 2005 DOH issues 'Clinical Ethics Committee Q&A'

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Recent Regulations and Codes

- 2003.4 Regulations Governing the Licensing and Continuing Education of Physicians
- 2006.8, Ethical Code Governing Physicians' or Other Medical Professionals' Brokerage of Overseas Organ Transplantation
- 2006.9, Guidelines Concerning the relationship between Physicians and Commercial Enterprises

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Recent Regulations and Codes

- 2006.10, 'Discharge Consent Form for the Dying Patient'
- 2006, DOH entrusts FMA to formulate 'the Project of constructing Taiwan clinical ethics networks'
- 2006, DOH entrusts KMU to formulate 'The clinical ethics consultation systems of advanced countries and their practice'

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Dilemma between Professional Obligations and Patient's Good Death

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Hospice-Palliative Care

- Medical Care Act:
- Article 60: Hospitals and clinics shall provide emergency medical care and necessary precautions within the capability of personnel and facilities to emergency patients, and shall not delay without cause.

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Hospice-Palliative Care

- Physicians Act
- Article 21 :A physician may not without reason delay treatment according to his professional abilities of a critically ill patient, nor may he without reason delay the adoption of necessary measures.

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Hospice-Palliative Care

- 1989.3, DOH didn't allow DNR (Do not resuscitate, DNR)
- 1996.11, DOH allow DNR
- Hospice-Palliative Care Act (Promulgated on June 7, 2000)
- Enforcement Rules for Hospice-Palliative Care Regulation Act (Promulgated on April 25, 2001)
- NHI pay for hospice-palliative care since 2000

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Hospice-Palliative Care Act

- Article 7 The non-administration of cardiopulmonary resuscitation must conform with the following:
 - 1. Two physicians must diagnose and ascertain the patient at terminal stage.
 - 2. The consenter must sign a will of consent. If the consenter is a minor, the will must have the consent of his or her legal agent.

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Hospice-Palliative Care Act

- Article 8 When administering hospice-palliative care to patient at terminal stage, the physician shall inform the patient or his or her family of the course of treatment. However, the physician shall inform the patient of his or her condition when the patient has clearly expressed his or her wish for the knowledge.



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Challenges and Strategy



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Recent Challenges to Taiwan Medical Professionalism

- Mass media, especially electronic media, SNG.
- Political Power & Cynical Party
- Internet and world wide web
- Monopoly buyer: BNHI (Bureau of National Health Insurance)

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Mass media, Cable TV

SNG

Satellite News Gathering



- Health care is viewed as a product to be bought and sold
- TV stations engage in placement marketing for certain pharmaceutical companies, hospitals or physicians.
- Broadcasting misleading information about drugs, illness, or suicide.
- Reporters recklessly enter hospitals and disturb patients' peace and hospital operations.

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Internet and World Wide Web



- Health-care information on the Internet
- 'rumours' and 'medical/ pharmaceutical advertising'
- Anonymous, privacy, confidentiality, quality assessment, liability and responsible medical practice.
- Self-regulation bodies and voluntary codes of conduct try to ensure minimum standards and professionalism.

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Monopoly Buyer: BNHI



- Distorted peer review system
- Distorted Global Budget Payment System
- Doctor-shopping: Low co-payment makes people see 3 doctors for the same ailment, but not to obtain a 2nd opinion.

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Ethics as a Strategy

- Enhance the Public Trust
- Enhance the Professional Autonomy
- Enhance the Self-regulation



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Ethics:
Not Only Strategy,
But Also Core Competence



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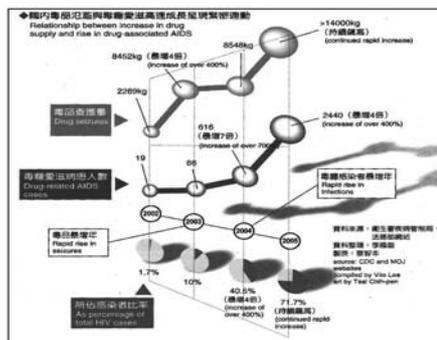
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Recent TMA Milestones

- 2001 TMA advised that DOH Setup Medical Ethics Committee.
- 2004 Relationship between Physicians and Commercial Enterprises
- 2005 TMA published a translation in Traditional Mandarin WMA Medical Ethics Manual
- 2005 TMA issued 'Bioethics and Health Policy' White Paper
- 2006.11 TMA participated to revise WMA Ethics Code.

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Drug-associated AIDS



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Healthcare for the Remote Rural Area, and Solely Lived Elders



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**Thank you for
your attention!**

3Q 0rZ



• Huang YC, TMA

[Thailand]

Continuing Development in Ethics and Professionalism in Thailand (2006)



Wonchat SUBHACHATURAS*¹

Amidst the Globalization and Economic Competition nowadays, medical profession has received a reflection in both positive and negative reactions. In the positive arm, medical profession has been making progressive and modernized development in both technical and educational areas. New technologies have been developed to help creating more precise and accurate diagnoses, safer and more effective treatment resulting in the better quality of life. However on the other arm, the negative side, competition leads to a more advertisement, over usage of investments and more marketing in the field of medicine. Human resources in health care services are inevitably affected by the changes. Health industry was named and progressively replacing ideal health professionalism.

Thailand, as a developing country, is unquestionably, also being affected by the said global development. Many newly graduated doctors put themselves dependent more on machines and technological equipments than mutual attitude and relationship. It is true that competition is inherited deep in human midbrain as a natural instinct but it is also true that to have a person living together with others in a community, discipline is needed to be set.

The control of Medical Ethics in Thailand is under the care of three organizations.

1. The Government, via the Ministry of Public Health, takes actions through legislation, law, by-law and regulations.
2. The Medical Council, empowered by the law, takes actions through professional registra-

- tion, enforcement and professional penalties.
3. The Medical Association, a professional non-governmental self controlled body, works as a socially compromising and connecting people among health providers and health consumers. Stimulating all teaching bodies to educate undergraduates in ethical lessons and professional responsibilities. Encourage and boosting up the issue by insinuation the matter in professional meetings and publications.

The three-party committee has been set up in Thailand composing of the leading representatives from the three organizations to work together in the issue of medical ethics and professionalism. Meetings for discussion have been made 3–4 times a year to strengthen the good and ethical medical practice and also to solve the concern problems.

Inequity and under payment for Medical Professions are also the matters of concern these days in Thailand. Health reform has been practicing for 5 years since 2001, aiming at the creation of universal coverage and equity of health care services among Thai citizen in general. However after a period of practice, some unpredictable situations and problems were experienced and the newly reform system, the National Health Insurance, needs some corrections and tailoring to fit the needs of the public and the spending of the country.

More prevention leads to less need for curative but more ethical providers in the field is still the big challenges of the country.

*1 International Relation, Medical Association of Thailand, Bangkok, Thailand (wonchats@bma-gap.or.th).

[Sri Lanka]

Development of Ethics and Professionalism in Sri Lanka



Suriyakanthie AMARASEKERA F.R.C.A.*¹

A code of Ethics is one of the hallmarks of a profession. Prior to 1992, the Medical Ordinance of Sri Lanka, laid down by an act of parliament in 1927, was the only document that promulgated a code of behavior for doctors. The Ceylon Medical Council performed the regulatory function of monitoring ethical behavior in the medical profession.

In 1992 the Sri Lanka Medical Association formed an Ethics Committee with the objective of dealing with General Ethics relating to professional practice. An Ethical Review Committee was formed a few years later, to deal with research ethics.

Recognizing the importance of incorporating good ethical principles in our day to day practice, the SLMA published the Declaration of Health in 1995.

The Committee also published Ethical Criteria for the promotion of Medicinal Drugs and Devices in Sri Lanka in the same year.

The Ethics Committee, comprising of medical professionals representing the different specialist Colleges and Associations, representatives of the legal profession and members of the public meets monthly. Various ethical issues that have been referred to the committee from the Council are taken up for discussion and appropriate action taken. The committee also organizes Symposia and Workshops on ethical topics, and publishes articles in the monthly News Letter of the SLMA, drawing the attention of the medical profession to current ethical problems.

Problems that have been dealt with in the cur-

rent year are

- Complaints that inadequate time is spent on consultations with specialists
- Prevention of Medical Negligence
- Informed Consent
- Broadcast Publicity
- Advertising by professionals and institutions

Other areas of activity

- SLMA has representation in the Ethics Committee of the Sri Lanka Medical Council which has produced a document on "Provisional Code of Practice for assisted Reproductive Technologies"
- SLMA has representation in the National Bio Ethics Committee of the National Science Foundation and is involved in drafting a Human Reproduction and Genetics Act
- National Bio Ethics Committee which is chaired by the Chairperson Ethical Review Committee of the SLMA is currently examining the deficiencies in the current regulations dealing with Human Genetic Data Collection
- Involved with the ERC of the Faculty of Medicine Colombo in the formulation of Uniform Guidelines for Ethics Research Committees

The Sri Lanka Medical Association is justly proud of its achievements so far in initiating, monitoring and propagating high standards of ethical behavior and professionalism in the medical profession in Sri Lanka. As the national medical association, we are committed to ensure continued progress in this field by keeping up with emerging ethical issues in medical practice and research.

*¹ President, Sri Lanka Medical Association, Colombo, Sri Lanka (suri.amarasekera@gmail.com).

Development of Ethics and Professionalism in Sri Lanka

Dr. Suriyakanthie Amarasekera FRCA
President
Sri Lanka Medical Association

Milestones in Ethical & Professional Development

- Medical Ordinance of Sri Lanka - 1927
- Formation of Ethics Committee SLMA – 1992
- Formation of Ethical Review Committee – 1993
- SLMA Declaration of Health – 1995
- Ethical Criteria for the Promotion of Medicinal Drugs and Devices in Sri Lanka SLMA - 1996

Declaration of Health

People have the right

1. to life that they can enjoy in good health and with dignity;
2. to live in an environment free of pollution;
3. when ill, to be treated always with care and compassion, by the attending health professionals in particular and by the members of society in general; and
4. to expect that fees that are charged from patients and other users for services rendered are reasonable.

Declaration of Health Contd.

5. Receive relevant information on matters concern-ing health and health services, such as:

- facilities available for the promotion of health, prevention of diseases and their treatment, both in the public and private sectors, at regional and central levels;
- the individuals considered qualified by the State to promote health, to prevent disease and to treat the sick;
- the individuals, institutions and business establishments considered competent by the State for the manufacture, sale and dispensing of medicinal drugs;
- the functions of qualified medical, paramedical and other health workers in the public and private sectors;

5 Contd■

- the assistance that could be rendered to the sick by lay persons;
- the duties and responsibilities of all persons in the promotion of health and the prevention of disease in the community;
- one's illness, its principal complications, available methods of investigation and treatment, and their advantages, disadvantages and costs;
- medication that is prescribed, (name, cost and significant side effects etc.) in a manner that is compatible with established ethical criteria and the capacity of the person to understand;
- research projects concerning individuals or communities;
- the constituents of cosmetics and foods;
- accurate information in media advertisements of over-the-counter healthcare products;

Declaration of Health Contd.

6. be referred to an appropriate professional or institution when referral is indicated;
7. be afforded confidentiality and privacy during consultation, examination, investigation and treatment;
8. be competently and adequately assessed by their medical professionals;
9. request and to receive a second opinion, when appropriate;

Declaration of Health Contd.

10. receive, wherever possible, their preferred mode of treatment from among those proven to be effective;
11. keep in their custody reports of investigations pertaining to their illness, or where this is not feasible, a summary of pertinent investigations, together with the diagnosis and treatment; and
12. participate in influencing health related policy.

Declaration of Health Contd.

People should

13. strive to do everything in their power to keep the environment free of pollution;
14. support all efforts to maintain the balance of nature and its biodiversity;
15. refrain from using, or promoting the use of, toxic substances in the preparation of food and cosmetics;
16. refrain from smoking or chewing tobacco and from abusing drugs and alcohol, and should encourage others to do likewise;

Declaration of Health Contd.

17. co-operate fully with those involved in the promotion of health, the prevention of disease and in treating the sick;
18. render assistance to the sick whenever possible; and
19. be willing to participate in approved projects re-searching health promotion and the prevention and cure of disease.

SLMA Ethics Committee

Problems taken up for discussion

1. Inadequate time spent on consultation with specialists

Statement published in news letter

The Ethics Committee wishes to impress upon all doctors the need to conduct their clinics in a fashion that does not discredit the profession.

Respect your patients as human beings who come to you for help be considerate

Structure your appointment system to reflect your actual arrival times and the time you spend with your patients

Your Patients will be grateful

Problems taken up for discussion
Contd.

2. Prevention of medical negligence
3. Informed Consent
4. Broadcast Publicity Guidelines regarding Publicity
5. Publicity by professionals and Institutions

Guidelines on Publicity

SLMC September 2000

1. A doctor may publish books and articles, write on medical topics in the lay press in ones own name, and he can also participate in discussions on medical subjects on radio and television provided:
 - (a) there is no professional advantage accruing
 - (b) there is no breach of professional confidence

Guidelines on Publicity

Contd.

For radio and TV programmes

A programme should preferably feature a number of participants

Participants should be from recognized institutions

Names, speciality and professional status of participant disclosed in the interest of authenticity once only at the commencement of the programme.

Other Areas of Activity

Interaction with

- Ethics Committee of the SLMC
- National Bio Ethics Committee
- Ethical Review Committee of the Faculty of Medicine

THANK YOU

The Physician-Patient Relationship Desired by Society

JMAJ 50(3): 259–263, 2007

Hiroyasu GOAMI*¹

Abstract

A physician-patient relationship based paternalism is still deeply rooted in today's Japan. However, it is also true that "patient-oriented healthcare" is beginning to be emphasized in the clinical field here. Demand by patients for the disclosure of medical information is growing year by year.

However, looking at the current situation in clinics in Japan, we are still far from receiving a pass score of "Good enough." This may be due to the existence of a large communication gap between physicians and patients. Results of a questionnaire of physicians and patients indicate that physicians believe that they display an attitude of respect and consideration for patients, and provide patients with sufficient informed consent, but the patients themselves do not share this view. Thus, there is a large gap between the self-image of physicians and the image of physicians held by patients.

In the first place, there is the wall of "information asymmetry" between physicians and patients. The optimum conditions for medical care are not achieved unless physicians polish up their communication skills and accompany their patients through the treatment process. At the same time, there is a strong need for patients to abandon the attitude of "leave-it-to-the-doctor."

Key words Patient rights, Communication gap, Information disclosure, Patient responsibility

Introduction

More than one million people die in Japan each year. In fact, a "rapidly aging society" is also a "many-death society." The number of people requiring healthcare will steadily continue to increase in the future, and the health standards demanded by society are always likely to increase, never decrease.

Behind this are such factors as patients' increased awareness of their rights, spreading awareness of self-determination manifested in the desire of patients to "decide matters that concern them for themselves," and spreading awareness of costs arising from increasing co-payment of medical expenses. Demand for information disclosure is also growing stronger.

Changes in the medical environment toward

"patient-oriented healthcare" have indeed become a pressing issue. Unfortunately, however, the medical environment in Japan is not sufficiently prepared to respond to such changes. This paper discusses the ideal form of healthcare in Japan focusing on the relationship between physicians and patients.

Communication Gap

The phrase "informed consent" has become firmly established in the clinical field, and it seems that physicians spend more time than previously explaining to patients about their health condition.

This is a move that should be welcomed by patients, but the issue remains as to whether or not the physician's explanation is truly getting through to the patient. A one-way explanation peppered with medical jargon will not be easily

*1 Editor, City News Department, Yomiuri Shimbun, Tokyo, Japan (goam0114@yomiuri.com).

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understood by the patient and will not dissipate their feelings of insecurity.

One study has produced some thought-provoking findings. The Office of Pharmaceutical Industry Research conducted a questionnaire of 1,131 medical consumers and 1,101 physicians on the communication between physicians and patients during medical examinations, etc., and patient satisfaction levels.

According to the survey results published in July 2005 (Research Paper No. 29),¹ some 72% of physicians felt that they were “sufficiently providing informed consent,” but only 45% of medical consumers felt that this was so. Although 81% of physicians said that they “made efforts to create an atmosphere conducive to asking questions,” only 26% of medical consumers felt that this was so; and although a very high proportion (83%) of physicians believed they “respected patients’ wishes,” a mere 30% of medical consumers felt that this was so.

Moreover, 77% of physicians said that they “explained treatment procedures in an easy-to-understand manner,” but only 33% of medical consumers felt that this was so; 76% of physicians said that they “answered questions in detail and respectfully,” but only a mere 32% of medical consumers felt this was so.

Analysis of the survey results shows that “physicians believe that they are highly skilled at interacting with patients and that they display an attitude of respect and consideration for the patient when they are interacting, but this is not recognized to be the case by medical consumers; in other words, there is a large gap between the self-image of physicians and the image of physicians held by medical consumers.”

Patients are vulnerable when their bodies are weak from injury or illness and can be easily wounded psychologically and discouraged by an off-hand remark from a physician. The more serious the situation, such as when they are being informed they have cancer, the more unsettled the patient will be and the more difficult it will be for them to make decisions rationally. At such a time, the patient will only become confused and will not be able to understand if “informed consent” is being given in a rapid string of medical jargon. Even so, if the physician asks, “Do you understand?” the patient almost automatically responds with, “Yes, I understand.”

However, after the patient has returned home

and had some time to think and consult with people around them, various questions and concerns surface. When they bring these issues up with the physician, often the response is “I told you that last time” or some other negative reaction. With such a response, it is difficult for the patient to ask further questions even if they have more they would like to ask.

Patients very strongly “want to avoid being disliked by the physician.” It is therefore imperative that physicians are aware that there is a large communication gap between physicians and patients.

Conventional physician training is dedicated to the acquisition of specialized knowledge and skills, but can not necessarily be said to be equally dedicated to the acquisition of communication skills, which enable physicians to listen to their patients and understand their hearts and minds.

The website of the Shizuoka Cancer Center states that, as part of “patients’ rights,” patients may not only see their medical records but also tape-record the physician’s explanations as well as seek a second opinion, explaining the rights of patients, including the right of patients and their families have to receive support in their battle against the disease. With such consideration taken, it becomes easy for patients to ask physicians questions about any doubts they may have or to request to see their medical records or seek a second opinion.

The new advanced clinical training program, which became compulsory in 2004, aims to establish better relationships between physicians and patients and their families in addition to providing necessary knowledge, skills, and attitudes for basic medical examinations. It is hoped that the entire medical field will pour its energies into training physicians who really understand how patients feel.

Although it is true that there is “information asymmetry” between physicians, who have specialized training, and patients, who know little about medicine, even prior to this there is a psychological wall lying between the two, and it is the task of medical professionals to break down this wall through day-to-day efforts.

Understanding Patients’ Pain

In Japanese, the kanji character for patient comprises the character for “heart” being stabbed by

the character for “skewer.” How far, I wonder, do physicians understand the pain in the skewered hearts of patients?

The writer Shusaku Endo, who proposed “warm-hearted healthcare” and strongly and consistently called for “patient-oriented healthcare,” included an essay entitled “Know Patients’ Pain” in his essay collection “Nautical Table of the Heart.”² Although this was merely based on his impressions upon seeing the film, the American film “The Doctor” (1991) provides much food for thought when considering the relationship between physicians and patients.

“The Doctor” features an elite surgeon who develops laryngeal cancer. Until then he has only encountered illness from the perspective of a physician, but after diagnosis, he must face his illness from the perspective of the patient and for the first time notices various problems with healthcare. Having himself experienced long periods in waiting rooms and physicians’ arrogant attitudes as well as the patient’s sense of isolation, the fully recovered surgeon returns to his profession and insists that the interns under his supervision put on patients’ hospital gowns and experience for themselves intravenous drips, enemas, and various other tests. Using such slightly rough methods, the surgeon teaches the young physicians the importance of understanding the patient’s perspective.

When Shusaku Endo himself underwent a bronchial tube examination, the experience was so uncomfortable he reflexively coughed. He writes that the physician scolded him, saying, “Why did you cough when I told you not to?” Endo also suggested that, like the protagonist in “The Doctor,” young physicians undergo as part of their qualifying examinations (1) a bronchoscopy, (2) drawing of blood from the back of the hand, (3) a rectoscopy, and (4) an intravenous drip (for more than one hour). It is 10 years since Endo passed away, but his deeply felt desire for physicians to “understand patients’ pain” unfortunately cannot yet be said to have sufficiently penetrated the clinical areas.

For example, the spread of palliative care, which relieves the pain of terminal cancer, is lagging behind. In Japan, some 600,000 people are diagnosed with cancer each year. Patients who are told they have cancer must deal with fears of dying and the pain and discomfort of treatment with anticancer drugs. However, there is little

psychological support such as counseling available for cancer patients and their families that might lessen their fears. Even though use of the pain-relieving drug morphine has increased, the dosage per patient in Japan is still said to be one-tenth of that in Canada. Although the rate of palliative care being offered is more than 30% in the United States, while in Japan it is less than 10%.

It seems that in Japan the overwhelming belief is that the sole mission of physicians is to cure disease. Consequently, there appears to be a tendency for physicians to disregard the pain and discomfort patients experience during treatment as inevitable and unavoidable. However, there are a number of diseases that cannot be cured, no matter what efforts are made to do so. Medical care may be advancing in leaps and bounds, but there is a limit to human life.

I have often heard stories of physicians who had frequently visited their patient’s hospital room until the patients were diagnosed with terminal cancer, after which the physician avoided making such visits. It may be that these physicians feel they should give priority to patients who can be cured with treatment over patients with terminal diseases. However, patients who cannot be cured need even more psychological support than patients who can be cured. If a patient knows that they will recover, they can better tolerate bad-tempered physicians and unfriendly nurses. In contrast, terminal patients with no hope for the future may despair or lose the will to live at an offhand comment or gesture from a physician or nurse.

In the near future, the Ministry of Health, Labour and Welfare intends to introduce a new medical system for the purpose of implementing at all levels, from early-stage to terminal cancer treatment, palliative care that relieves the physical pain and psychological strain experienced by terminal cancer patients. Specifically, this will involve the establishment of medical teams comprising physicians, nurses, and medical psychology specialists at core hospitals for cancer treatment in each region in 135 locations throughout the country, as well as the initiation of experimental medical treatments, including palliative care, for 5,000 cancer patients selected from model areas.

Applying the latest medical treatments and proactively curing diseases is an important role of healthcare. Further improvement of ad-

vanced medical technology and emergency care is imperative.

Relieving patients' pain and providing psychological support for terminal cancer patients and other patients whose diseases can no longer be treated are also important tasks in healthcare.

Limitations of Medical Treatment and Patient Responsibility

What kind of physician do patients desire? A national opinion poll published in the Yomiuri Newspaper in February 2006³ provides some clues.

According to the poll results, of the 50% of respondents who said they "had a physician they could trust," the reason given for this from among multiple choice answers were "Because they explained properly about my illness and treatment methods" (82%), "Because their words and attitude encouraged me and gave me courage" (30%), and "Because they respected my opinion and opinion of my family regarding treatment" (28%).

In contrast, of the 42% of respondents who said that they "distrusted their physician," the reasons given for this were "Because they did not properly explain my illness and treatment methods" (55%), "Because their words and/or attitude were hurtful and/or unpleasant" (41%), "Because they misdiagnosed my illness" (26%), and "Because they did not respect my opinion and opinion of my family regarding treatment" (19%).

The poll also found that people who "distrusted their physician" tended to feel that "the burden of medical costs was heavy" more than people who "had a physician they could trust."

With regard to the kind of information patients wanted when choosing a hospital or physician, 43% of respondents wanted to know "If and how informed consent was implemented," 38% wanted to know "the hospital/physician's medical care policy," 33% wanted to know "evaluations of the hospital or physician," 29% wanted to know "the response and attitude of physicians and nurses to patients," 29% wanted to know "the hospital/physician's performance record, such as the number of operations performed and recovery rate," and 29% wanted to know "the hospital/physician's specialties."

The poll results show that patients want a response from physicians that provides sufficient

information and understanding, and that when they do not receive this kind of response they tend to feel distrust and dissatisfaction. An increasing number of medical institutions are disclosing their performance records for treatment, etc., but still there is a strong demand among patients for medical professionals to more thoroughly disclose information and improve their communication skills.

Behind the distrust of and dissatisfaction with physicians is the reality that patients hold excessive expectations of medical care. Patients tend to demand "perfection" from medical care, which is by nature imperfect, and so clashes are inevitable. The larger the gap between the level of expectations the patient holds and the reality of their medical care, the greater their distrust of and dissatisfaction with their medical care will be.

In order to realize patient-oriented healthcare, good communication between physicians and patients is imperative. Physicians must make efforts to improve "accountability" and to "assure transparency," but patients also must acknowledge the limitations of medical care and not hold such excessive expectations.

The Consumer Organization for Medicine and Law (COML) has compiled a list of "10 Points On Consulting a Physician" for patients, which presents the kind of desirable relationship between physicians and patients that not only patients but physicians should also think about.

- (1) Prepare notes on what you want to say to the physician.
- (2) Begin the exchange with a greeting.
- (3) As the patient, you also have responsibility for creating a better relationship.
- (4) Subjective symptoms and clinical history are important information that you must tell the physician yourself.
- (5) Ask about the prognosis.
- (6) Make efforts to keep the physician informed of any changes in your condition.
- (7) Make notes of important things and check them.
- (8) When you are not satisfied, keep asking questions until you are.
- (9) Understand that medical care has limitations and is fallible.
- (10) You are the one who decides your treatment method.

The above 10 points require patients to "make efforts to understand" their medical condition,

have the “will to make decisions for themselves,” and “improve their skills of communicating with health professionals.”

Conclusion

The relationship between physicians and patients is not antagonistic and should not be so; it should be a three-legged race with the physician and patient battling the disease together hand-in-hand.

Recently in Japan, some medical institutions have begun to refer to patients not as “kanja (patient)” but “kanja-sama (respected patient).” Simply adding the suffix “-sama,” though, will not create patient-oriented healthcare. What is important is that patients and physicians leave behind “paternalism” and “leave-it-to-the-doctor” attitudes about treatment, respectively, and build a cooperative relationship based on mutual trust.

To achieve this, there needs to be a complete revision of physician training, from entry to medical school to post-graduate training, specialist

training, and then continued education, so that a system for nurturing “good physicians” with excellent communication as well as technical skills can be implemented as quickly as possible.

Revision of the nominal specialist program also cannot wait. Clarification of evaluation standards for treatment methods and results and the standardization of medical care, as well as the creation of a computerized database for medical information are all issues that must be addressed immediately.

The challenge is for us to see how far Japan’s healthcare—which has been described as a “black box”—can be made more transparent and how much its quality can be improved. “Medicine should begin with the patient, continue with the patient, and end with the patient.” These are the words of Sir William Osler, the man who built the foundation for modern medical education, and they should be deeply engraved on the hearts of all professionals involved in healthcare.

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Activities of the Tochigi Medical Association

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Takeshi FUKUDA*¹

Located in the north of the Kanto Region, Tochigi Prefecture is a comfortable, convenient place to live that experiences few natural disasters. The prefecture has a population of 2.01 million and 3,916 doctors, with Tochigi Medical Association membership at 2,058 (of which 2,019 are also members of the Japan Medical Association). From among the many activities carried out by this association, in the following I will introduce the features of the rules of the Hospital Doctors Division which was established in 2006, the Shiobara Hospital which is now being renovated, internal and external promotional activities, and the association's unique activities concerning health insurance.

Rules of the Hospital Doctors Division Established in 2006

Amongst medical associations in recent years the role and responsibility of hospital doctors has become broadly recognized and each medical association has been setting up their own hospital doctor division. The Tochigi Medical Association established its Hospital Doctors Division in 2006, and rules with the following features were adopted to ensure that the division's activities would be fruitful.

1. Rules were established enabling the opinions of hospital doctors to be reflected in appropriate sub-committees of the Tochigi Medical Association. As a first step in conveying the opinions of hospital doctors to the Japan Medical Association, an official route for conveying the details of decisions to appropriate sub-committees within the prefectural medical association is necessary. For this reason, the terms of the activity description of the division



rules include “items related to the participation of the members of committees established by the prefectural medical association.”

2. Rules were established enabling the establishment of special committees that can intensively discuss items of interest. Three special committees to consider the role of hospital doctors and medical associations, to consider community health care, and to consider the work environment of hospital doctors are planned for the first year.

Doctors in private practice and hospital doctors working together as members of the medical association will ensure the association becomes more assertive towards government authorities and is also sure to raise the general public's understanding of the association and its aims.

Construction of the New Shiobara Hospital

In 1972, the Tochigi Medical Association established the Tochigi Medical Association Hot Springs Research Institute Shiobara Hospital in Nasu-Shiobara City (formerly Shiobara Town).

*1 Executive Board Member in charge of Academic affairs, Tochigi Medical Association, Utsunomiya, Japan (tochigiken-toci@tochigi-med.or.jp). This article is a revised English version of a paper originally published in the Journal of the Japan Medical Association (Vol.134, No.12, 2006, pages 2398–2399).

In 1997 the hospital merged with the neighboring National Shiobara Hot Springs Hospital following transfer of administrative control, becoming the New Shiobara Hospital (for general, recuperation and treatment use with 199 beds).

The hospital is characterized by outdoor rehabilitation that takes advantage of the beautiful natural environment and hot springs rehabilitation that uses the plentiful and good quality hot springs of the area. However, because the buildings had aged, the idea emerged in 2001 to construct new hospital facilities. Based on the recommendations of the Tochigi Medical Association Committee on Future Hospital Ideas and the New Hospital Construction Committee, the Assembly of Delegates approved construction of a new hospital, the Tochigi prefectural authorities included the project in a government plan (Rehabilitation of Core Functions for Northern Tochigi) and the construction of a new hospital was decided upon.

The new hospital is scheduled to open in July 2007. With treatment centered on the rehabilitation center and recovery phase rehabilitation, the hospital will provide high-level, specialized rehabilitation that other hospitals in the region have difficulty in supplying, as well as extending support and guidance for other local medical institutions as a core hospital for rehabilitation treatment in the region. The hospital is also to provide sports medicine rehabilitation and hot springs rehabilitation.

Promotional Activities

The Tochigi Medical Association undertakes promotional activities both internally and externally making use of the characteristics of various information propagation media, such as our Internet website, e-mail magazine, the Tochigi Medical Newspaper, local newspapers (the Shimotsuke Shimbun), radio, and pocket tissue distribution.

Internal promotion

The main media for internal promotion is the Tochigi Medical Newspaper and the Tochigi Medical Association website and e-mail magazine. The newspaper was first issued on July 5, 1953 as the Tochigi Medical Association Bulletin and throughout the 47 years since then has been the main organ for promotional activities aimed towards association members. Of special note is

that the newspaper is issued thrice-monthly and disseminates in a timely and swift manner. The e-mail magazine was started in 2002 and as of November 2005 had 559 registered subscribers. In general the e-mail magazine provides the same content as the Tochigi Medical Newspaper but even more swiftly.

External promotion

The main media for external promotional activities are the Tochigi Medical Association website and public communications in the Shimotsuke Shimbun (local newspaper). On the website's top page we have listed such headings as "Medical Institution Information Services" (1,014 medical institutions in Tochigi) and "Medical Institutions Providing Treatment for Quitting Smoking." Recent publications such as "Emergency Treatment of Children Guidebook" and "Getting a Family Doctor" are listed on the Health Information Column and various other information services are provided for the convenience of prefecture residents. In future, we hope to expand the website's role and make it our main medium for external promotion targeting residents of the prefecture and will make further improvements based on an assessment of the informational needs of residents.

Public communications are placed in the Shimotsuke Shimbun three to six times annually, providing health information and messages from the medical association on a regular and timely basis.

The Tochigi Medical Association's Unique Activities Concerning Health Insurance

A major characteristic of the activities of the association concerning health insurance is the existence of a forum called the "Five-Way Talks." This forum comprises five members—the Social Insurance Bureau, Tochigi Prefecture National Health Insurance Department, Medical Fee Payment Fund, National Health Insurance Organization and Prefectural Medical Association—and ensures that discrepancies between payment amounts and national health insurance do not arise in the processing of medical service fee invoices. The forum has been meeting virtually every month since its inception in 1972. Forum decisions are compiled in a booklet entitled

“Results of the Five-Way Talks” and distributed to all forum members and related organizations as well as being posted on the association’s website. In order to increase transparency, it has been possible for general members to participate in forum meetings as observers since February 2005.

Another activity worthy of mention is the “Health Insurance Workshop” that was set up in 2004 with the aim of improving the understanding of members and medical institutions about the medical insurance system. Two Executive Board Members of the Tochigi Medical Association in charge of health insurance visit all the county and city medical associations throughout the region and provide lectures on such topics as the Medical Practitioners Law/healthcare regulations, interpretation of medical fee schedule,

and important points in drawing up and submitting receipts. Training related to medical safety measures, such as the construction of medical safety systems at clinics, is also provided and questions and requests from medical institutions are also answered as the need arises. Moreover, by the Social Insurance Bureau using the first 40 minutes of these training workshops to provide lectures classified as “collective individualized instruction,” the association is also utilizing these training workshops as an alternative to “collective individualized instruction” for high-score medical institutions.

This concludes my brief description of some of the activities of the Tochigi Medical Association that may be somewhat unique and in which we are making special efforts.

Activities of the Gunma Medical Association

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Toshiro IKEYA*¹

This article outlines the activities of the Gunma Medical Association, focusing on the efforts that have been made in 3 specific areas.

Academic and Continuing Education Activities

Physicians at the forefront of healthcare services are continually required to keep apace with the latest medical knowledge and medical technology. The Gunma Medical Association, in cooperation with county and municipal medical associations, the Gunma University Doctors' Association, and various specialty groups, has been providing opportunities to attend lecture meetings and training seminars on timely topics to learn such knowledge and skills. In addition, semiannual medical conferences are held jointly with the Gunma Prefectural Government. The Spring Conference features lectures on general topics in medicine, while the Fall Conference consists of study presentations by members and special lectures on clinical themes.

Recently, emphasis has been placed on hands-on training seminars. During the 2004 Spring Conference, we held a training seminar on ACLS (advanced cardiovascular life support). The participants of this seminar attended lectures on emergency life-saving procedures and treatment in the afternoon of the first day, and then spent the whole of the next day putting the actual procedures into practice. Despite the very tough schedule, 41 members participated in this seminar. After this event, ACLS training seminars were held one after another by county and municipal medical associations, and many members were able to practice life support procedures. We are convinced that the ACLS training seminar had



great significance, setting a precedent for hands-on training seminars in Gunma Prefecture. The proceedings of the medical conferences have been published in the periodical journal “Gunma Igaku” so that the information is also available to members who could not attend the conferences.

Memory Loss Test Project

Senile dementia is emerging as a serious social problem, requiring an approach based on early detection and early treatment. Starting from 2000, the Gunma Medical Association has been cooperating with the Health and Welfare Department (the present Bureau of Health, Welfare and Food) of Gunma Prefecture and Gunma University Faculty of Medicine in conducting a memory loss test project. In this project, we identified various problems, such as citizens' misunderstandings about senile dementia and reluctance to seek medical advice, the insufficient responses of health, medical, and welfare organizations, and the lack of cooperation between family doctors and specialists, and we started to introduce various measures to solve these problems effectively.

*1 Director, Gunma Medical Association, Maebashi, Japan (t-ikeya@maebashi.jrc.or.jp).

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The memory loss test was conducted both in the forms of mass examination and individual examination. First, a screening was performed using a brain health checklist consisting of 20 items compiled by specialists in dementia, based on their experience and data. A person who is positive for 5 or more items receives the MMSE (mini-mental state examination). If the MMSE score is 24 or less, the family doctor evaluates the need for differential diagnosis and the need for treatment and care. If considered necessary, a differential diagnosis can be made at a specialized medical center. Thereafter, the patient is referred back, and starts to receive treatment and care provided through cooperation with care facilities. In the case of mass examination, a checklist is mailed from the local government agency. After self-reporting of the checklist, an MMSE is conducted by public health nurses and the patients are handed over to their family doctor.

The examination was first conducted in 2001 in 5 municipalities, covering 3,084 individuals in the first year. The examination was expanded to 8 municipalities in 2004, and is planned to cover the entire prefecture in the future.

Construction of Community Healthcare Information Network

The Gunma Medical Association has been promoting close networking among members through the biennial issuance of a member directory. Since 1996, we have also been publishing a directory of doctors working for university, public, and private hospitals to provide information on doctors to all healthcare-related facilities as well as members. However, because many of the doctors in hospitals are working in positions with short tenures at universities in Gunma Prefecture and those in the Kanto region, the usefulness of these directories as a source of timely information has been limited. In addition, the announcement of health services provided at each medical institution has not been standardized, and the volume of information varies from hospital to hospital.

Given this situation, the Gunma Medical Association concluded that the construction of a database containing items shared across the prefecture would facilitate the acquisition of healthcare information, including that about human resources, and stimulate referrals from clinics to hospitals and from hospitals to clinics. A project to build such a database was set up in April 2004. One of the purposes of this project was to make some of the information available for use to support citizens seeking health care. Because the database system contains personal information about doctors, ensuring its security was an essential requirement for this system to be operated via the Internet. For this reason, information for doctors and information for citizens have been separated in the system. The information for doctors is protected by access restrictions with authorization using the LDAP server, and the security in daily data management is protected by double authorization using an i-key and an ID.

Because doctors working for large hospitals are frequently moved to different positions, the maintenance of up-to-date information is a difficult task. This problem was solved by the use of a data entry tool, with which each medical institution can update its relevant data fields. We also encountered the problem of differences in organizational size and capabilities among county and municipal medical associations, but we have been supporting the buildup of an IT environment through consultation and phased explanatory meetings.

The system has been operated since July 1, 2005, and our achievement was reported in a national TV program and local newspapers. A questionnaire survey conducted 3 months after the start of the system indicated that local medical associations had completed entry of about 70% of their data. We intend to take further measures to broaden the use of this database and build an efficient and useful system to support mutual linkage among the providers of regional healthcare.

Presidential Address at the 57th WMA General Assembly (Summary)^{*1}

JMAJ 50(3): 269–271, 2007

Nachiappan ARUMUGAM^{*2}

It is a great honour and privilege to be elected as the President of the World Medical Association (WMA). I would like to thank you for electing me and giving me the opportunity to serve as the President of the Association.

The WMA in its mission statement clearly states the objective to provide a forum for its member associations to communicate freely, to co-operate actively, to achieve consensus on high standards of medical ethics and professional competence, and to promote the professional freedom of physicians worldwide.

In any large organisation generally the bigger and more vocal members will tend to dominate discussion and influence. The establishment of the recent regional meetings should provide opportunities and impetus for the smaller member national associations to play a more active role in the affairs of the WMA. As universal participation is a necessity for any healthy organisation, in the coming year I will work with Council to find ways to stimulate contribution of some of the dormant and smaller members of the Association.

Many National Medical Associations are unable to allot sufficient time to the concerns and activities of the WMA as they have their own demanding schedules and activities. Many individual physicians of National Medical Associations are not aware of the workings and the significance of the WMA. Physicians nowadays belong to many different medical societies, especially specialist/subspecialty societies, related directly to their work and they do not see the immediate relevance of the WMA. I therefore strongly urge all of you to incorporate the activities of the WMA in as many ways as possible, in the activities of your national associations, thus

making the WMA more visible to the physicians of the world.

Ethics derived from a basic view of humanity, has been a part of medical practice from the beginning. Ethical medical practise refers, to the appropriate treatment of a patient maintaining a high standard of medical ability and skill with a caring and moral obligation. Doctors are taught to be dedicated to the service of humanity and subscribe to the caring spirit when entering the profession of medicine.

Medical practice has attracted much criticism on unsympathetic personal, uncaring attitudes and inappropriate treatments. That this probably applies to a small minority of doctors, compared to the huge number of doctor-patient contacts each day, gets overlooked and the profession as a whole is discredited. The WMA has emphasized the core values of the profession of caring, ethics, science, compassion and universal accessibility. Over the years the association has achieved reasonable success in promoting these values not only to the profession but also to the public and relevant authorities.

During the last two years under the Caring Physicians of the World initiatives doctors from various countries were nominated, selected, and recognised. A book published in conjunction with the initiative highlighted their contribution to society. This was a worthy project as it highlighted the caring aspect of the profession. To continue this initiative and to motivate more doctors to follow these exemplary footsteps and to recognise those who have dedicated their life to the care of the needy it is time we institute a World Physicians/Doctors Day. On this day the WMA should honour a doctor from each of

^{*1} This Assembly was held in Pilanesberg in South Africa from October 11th to 14th, 2006.

^{*2} President, World Medical Association. Malaysian Medical Association, Kuala Lumpur, Malaysia (aarrum@gmail.com).

the five regions of the world for their care, compassion and contribution to society. The day will help to emphasize, promote, develop and help to maintain the tradition of caring.

Since the end of the Second World War, more than half a century ago there have been remarkable discoveries and inventions in medicine, which have led to unparalleled improvement in health of the population of the world. We are able to control and treat deadly infectious diseases which were causing fatalities and unthinkable suffering around the world with newly discovered medications. We are also through innovative procedures and operations able to correct congenital abnormalities and acquired disabilities.

The medications and treatment modalities have helped relieve suffering, improve the quality of life of the individual, the family and the nation. Changes in the living standards of many countries in the world further contributed to healthier populations. Eradication of polio and the discovery of medicines to treat deadly infections gave hope and optimism to the people of the world that they were going to enjoy uninterrupted improving good health.

These achievements and improvements seem to have been short lived and the world is again faced with new epidemics and challenges. The health of the population of the world seems more vulnerable and more hazardous than ever before in recent history. The last decade has not only seen a resurgence of deadly infections like Acquired Immunodeficiency Syndrome (AIDS) and Severe Acute Respiratory Syndrome (SARS) but also a chronic serious epidemic commonly termed as life style diseases.

The number of patients afflicted with Obesity, Hypertension, Diabetes Mellitus, Dyslipidaemia and related diseases has been increasing at an alarming rate the world over. This surge in life style diseases has not been confined to the wealthier and more developed countries but has been spreading at an alarming rate in the developing and poorer countries. This current epidemic, affecting people in their prime of life, causes untold misery to individuals, families and countries. The immense drain on the financial resources of the families and the nations has jeopardised the development of sustainable healthcare systems in many countries. The WMA should through its various member organisations lobby relevant authorities and governments to

emphasize the necessity for change, as governments are not doing enough as they have either not recognised the enormity of the problem or have been reluctant to face reality.

The new millennium was awaited with eagerness and globalisation was the buzz word of the new century. Newer technologies especially electronic communication, the internet, the media and air travel all have contributed to shrinking the world at a staggering pace. Nations were being more connected and interdependent than ever before. International business was thriving and there was high expectation for improvement of international understanding, cooperation and unity in the world. Increasing pace of international travel, liberalisation of national borders and increasing changing migration patterns was moving the world towards to a more homogenous society.

Suddenly the world was shattered by events never seen before and turmoil set in and now terror reigns. Ideological differences, religious extremism, racial confrontations, economic disagreements have resulted in extreme provocation and excessive retaliations. These actions have divided the world and ushered in an era of anguish and unpredictability which has affected all of us in many ways.

South Africa, which has probably experienced one of the most traumatic periods in modern history, under the apartheid regime was liberated after a long and protracted struggle. The liberation of South Africa and the transition to a prosperous and successful democracy gives hope that old differences can be put aside and a new beginning benefiting all can be established.

The Centenary celebration of the start of the civil rights struggle, started by one of the pioneers in the liberation struggles in South Africa, Mohandas Karamchand Gandhi, was held a few weeks ago here in South Africa. Mahatma Gandhi as he has now come to be known was the pioneer of *Satyagraha*—resistance through mass civil disobedience, strongly founded upon *ahimsa*—non-violence, becoming one of the strongest philosophies of freedom struggles worldwide. It has been noted that Gandhi remained committed to non-violence and truth even in the most extreme situations.

Numerous medical groups through the years have served in areas of disasters and conflicts to help the needy and suffering irrespective of their

allegiance to any political or religious grouping. The events of the last few years should make the profession reflect on its role as curing the sick and use its unique position to explore the greater possibility of helping to re-establish unity and harmony in the world and thus healing wounds of the people both physical and mental.

Emergencies and crisis are a part of medical practice and intermittent outbreaks of epidemics has occurred throughout history. What is new in the recent emergencies was the scale and ferocity. The world in general and the Asia Pacific region in particular has experienced unprecedented calamities, over the last five years. Many of these have been caused by environmental degradation in the name of progress and must be halted and health must be given the rightful priority it deserves.

These are challenging times to practice medicine as the widening gap between what medicine can do today and what the individual or the society can afford has shaken up the fundamentals of medical practice. The changes in the last few decades especially on the mode of health delivery, commercialisation of medicine and the

growing disparity of medicine in populations, due to the staggering cost of new developments, all put the doctor in an unenviable position between the patient and systems. Increasing public demand for medical services, with counter demands by payers to control costs has put tremendous pressure on doctors the healthcare professional.

The patient's quest for perfect results, often not fathoming the unpredictability of medical procedures, has put further tension on the doctors while escalating medical indemnity costs. The increasing control of the profession by administrators, regulatory authorities, governments and third party payers has caused much annoyance and uneasiness. Private hospitals are generally managed by commercial interests and the difference between commercial values and professional values often leads to conflicts. It is important for doctors to be objective, balanced and keep the interest of the patients foremost at all times. In spite of the uphill task and emerging challenges the profession must stand and work together to achieve the best working conditions for the profession while delivering efficient and caring treatments to patients.

Healthcare System Reform in the United States

—Analysis based on this year's State of the Union Address and Budget Message—

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Kenya NISHIHIRA*¹

Introduction

In his State of the Union Address on January 23 this year, the 7th since he assumed office, President Bush announced the government's agenda for healthcare tax reform and reform of the public healthcare system. He then announced specific proposals for these policies in the Budget Proposal for 2008 (Budget Message) released on February 5. This paper first of all provides a brief introduction to the differences between the healthcare systems in Japan and in the United States, then based on this year's State of the Union Address and Budget Message, reports on the healthcare reforms that the United States is considering.

Basic Comparison of Health Care in the United States and Japan

Unlike Japan, which has a universal healthcare system, public health insurance is limited to the elderly and low-income earners and is not universally available to all citizens in the United States. Consequently, 59.5% of citizens have health insurance provided by their employers, with an additional 9.1% of citizens being individually enrolled in private health insurance plans, so that some 67.7% of the American people have some forms of private health insurance. The proportion of citizens covered by Medicare (national healthcare for the elderly), Medicaid (state healthcare for low-income earners), and other public health insurance plans (including government employee

insurance) is 27.3%, and 15.9% of the population (approximately 45.6 million people) are not enrolled in any insurance plan; in other words, they are uninsured.^{1,*2}

With regard to outlay for medical services, healthcare expenditure in Japan in 2004 was approximately 320 billion dollars,^{2,*3} whereas healthcare expenditure in the United States for the same year was approximately 1.74 trillion dollars — approximately 5.4 times the amount in Japan. In terms of a proportion of GDP, healthcare expenditure in the United States is 15.3% of GDP (2004), which is high compared to the level of healthcare expenditure in Japan, which is 8% (2003), and high even compared to other OECD member countries (average 8.9%).³ Moreover, medical expenditure per person in Japan is 2,249 dollars, while the average for OECD member countries is 2,550 dollars. In comparison, medical expenditure per person in the United States is a very high 6,102 dollars — 2.7 times the amount in Japan (all figures are for 2004).

If one compares the healthcare provision systems in Japan and the United States, both Japan and the United States have fewer doctors per 1,000 citizens (2 and 2.4, respectively) than the average for OECD member countries (3) (all figures are for 2004). Looking at the number of nurses in both countries, Japan has 9 nurses per 1,000 citizens (2004), slightly more than the 7.9 per 1,000 in the United States (2002) and the average of 8.3 per 1,000 for OECD member countries. With regard to the number of hospital beds, Japan has 8.4 beds per 1,000 citizens, whereas the United States has an extremely low

*1 Director, JETRO New York, Health and Welfare Dept. NY, USA (Kenya_Nishihira@jetro.go.jp).

*2 Because there are people covered by multiple insurance plans, the figures for each of the groups do not add up to 100%.

*3 Medicare (US national insurance for the elderly) benefits include expenditure for nursing care facilities and home services, and so nursing care expenditure (6.3 trillion yen) is included in healthcare expenditure for Japan (yen/dollar exchange rate 1 dollar = 120 yen).

2.8 beds per 1,000 citizens (the average for OECD member countries is 4.1 beds per 1,000 citizens).

Direction of Healthcare System Reform in the United States

As mentioned above, the healthcare system in the United States has two major problems: (1) nearly 16% of the population is uninsured, and (2) high medical costs. The reform proposals have been made addresses these two problems.

Measures to reduce the number of uninsured

As part of measures to reduce the number of uninsured people, a reform of the health insurance tax system has been proposed.⁴ Under the current system, when an employer provides health insurance to employees, the amounts of insurance born by the employer and/or partly by the employee are not regarded as part of the income of that employee and thus are not subject to taxation. In contrast, in the case of individual enrollment in health insurance, the insurance cost cannot be excluded from calculations of personal income, and tax is levied on the insurance cost paid.

The current proposal seeks to change this system so that regardless of the insured person's income, their insurance provider, or the actual amount of insurance paid, a fixed income deduction is made for all insured people (of 7,500 dollars for individuals and 15,000 dollars for families; this amount is to be adjusted annually with CPI). Furthermore, it is proposed that the unequal treatment of people insured by their employers and people insured privately under the current system be remedied, by regarding the health insurance subsidies provided by employers to employees who are not being taxed on their health insurance as income for those employees. Under these changes, both people who are insured by their employers and people who are privately insured will be eligible to receive the same deductions for healthcare, stimulating enrollment in health insurance plans in the private health insurance market. According to government calculations, this is expected to reduce the number of uninsured citizens by between 3 million and 5 million people.

The Bush Administration has also proposed

reforms of the Health Savings Account (HSA) system that was institutionalized in 2003. HSA is an income deduction that people who are insured receive when they enroll in a High Deductible Health Plan (HDHP), which has a higher annual deductible than traditional health plans. Under existing laws, when the insured person is enrolled in a health insurance plan under which the deductible amount is more than 1,100 dollars and less than 5,500 dollars for an individual insured person (or more than 2,200 dollars and less than 11,000 dollars for insured person and their family), 2,850 dollars (or 5,650 dollars for insured person and their family) may be deducted annually from their taxable income and contributed to their HSA. Use of this contribution is limited to expenses for specified medical treatments, and if used for any other purpose the amount is regarded as income and therefore taxable, with a penalty tax of 10% also being added.

Under the current proposals, an insured person would also be eligible to receive HSA tax benefits when they are enrolled in a health insurance plan, under which the insured person pays 50% or more of the cost at the time of the insurance payment instead of a high deductible setting. In addition to this proposal, the Bush Administration has announced several other proposals for revisions about HSA and tax cuts of approximately 3.74 billion dollars have been estimated with the next 5 years.

Meanwhile, over the past few years states have also begun in rapid succession to implement their own measures to reduce the number of uninsured people, by passing laws aimed at uninsured people, beginning with Maine in 2003 then followed by Maryland and Massachusetts in 2006. This year, California, the most populous state in the United States, announced policies aimed at reducing the number of uninsured people, and New York and other state governments are also beginning to take similar action.

The national government is also planning budget proposals to support these state efforts. Concrete financing and aid methods are to be decided through negotiations between the head of the Department of Health and Human Services (HHS), Congress and each state governor. It is anticipated that states will, for example, become eligible for aid toward (1) insurance premium subsidies; (2) establishment of risk compensation for insured people with serious illnesses

(risk pool, reinsurance, etc.); and (3) negotiations between insurers and groups in coordinating individuals and employers of small and medium businesses. The national government has yet to announce the specific details of this funding, but looking at the content of the proposals, it appears that part of the compensation of medical fees provided by public insurance plans such as Medicare and Medicaid to medical facilities will be cut.

Regarding the State Children's Health Insurance Program (SCHIP), which is publicly-run like Medicare and Medicaid, the Bush Administration has announced a year-on-year increase of approximately 18% (1.22 billion dollars) to 6.65 billion dollars in national government expenditure for the SCHIP budget as part of revisions for the 2008 fiscal year (5-year period; 3rd term).

Healthcare expenditure containment measures

In addition to measures aimed at reducing the number of uninsured people, the government also announced policies for containing healthcare expenditure. Specifically, first of all, funding of Medicare and Medicaid together is to be reduced by 101.6 billion dollars over the next 5 years, aiming for growth rate reductions of 6.5% to 5.6% and 7.3% to 7.1%, respectively.*⁴

In the case of Medicare, the government indicated a policy of containing compensation to healthcare facilities through the amendment of indexes in compensation calculation. With regard to insurance expenditure paid out to recipients (Part B), the government is considering raising the proportion of insurance expenses borne by the recipients by lowering in practical terms the baseline for the high health insurance burden borne by high income earners, and it plans to use the same mechanism for Part D insurance expenses.

In the case of Medicaid, through legal amendments the government proposes (a) to standardize national government expenditure on operational costs to a uniform 50% and (b) to lower the upper limit for the reimbursement price (FUL) for pharmaceuticals for which there are multiple products with the same medicinal effects. Furthermore, with regard to the executive powers of the head

of the Department of Health, (a) the back-flow of funding from state hospitals to state governments is to be eradicated*⁵ and (b) Graduate Medical Education (GME) is to be abolished.

These are the proposals relating to containing expenditure on Medicare and other public insurance plans, but the government has also announced policies aimed at containing overall healthcare expenditure. For example, the aforementioned healthcare tax reforms are also expected to lead to the containment of medical expenses. In other words, under the current system in which a third party (the employer) provides health insurance, incentives for an insured person (an employee) to enroll in inexpensive healthcare plans are weak. By changing the system so that people who are enrolled in less expensive insurance plans can receive greater income tax deductions, it is anticipated that insured people will naturally become sensitive to health insurance costs, leading to the containment of healthcare expenditure overall.

Summary

According to Center for Medicare and Medicaid Services (CMS) estimations, the total amount spent on healthcare by Americans in 2006 was 2.1 trillion dollars, and is expected to reach 4.1 trillion dollars in 2016, representing 19.6% of GDP.⁵ Moreover, over the next few years the number of uninsured people is expected to increase from 15% to 16%. This is hardly a sharp increase, but is nonetheless a definite upward trend.

In response to such trends in American healthcare, President Bush appears to be aiming to achieve both the containment of national medical expenses and a reduction in the number of people who are uninsured through consumer-led cost-containment and consequent market competition stimulation. In other words, this could perhaps be called an experiment in stimulating insured people's (consumers') cost orientation and consequently invigorating competition in the medical insurance market through the enforcement of healthcare tax reforms and promotion of HSA. Of course, implementing reforms in a market that opens up the healthcare system requires

*⁴ Total 2008 budget for Medicare, Medicaid, and SCHIP combined was 595.1 billion dollars.

*⁵ Medicaid is financed jointly by funding from the national and state governments, with the national government matching the amount of funding by each state as a general rule. Under this system it is possible for state governments to increase national government contributions by increasing their own apparent contributions and then siphoning the increased amount from healthcare institutions under the pretext of tax.

the disclosure of information about the quality of medical care and the computerization of health-care information, as well as the standardization of health care fees by medical facilities, so that consumers can choose healthcare services for themselves. President Bush can be praised for having proactively implemented reform relating to healthcare information since assuming office.

Are these reform proposals likely to be accepted by the Democratic Party, which took control of both legislative houses in the 2006 mid-term elections, and to be legislated sometime this year? In order to contain growth in funding to Medicare and Medicaid, the Bush Administration's 2008 budget proposal includes even stricter containment than that of last year, when Congress was controlled by the Republican Party. Even if there are some slight differences of opinion within the Democratic Party over indi-

vidual policies, in general the vast majority of Democrats are standing their ground against the president, and in such an atmosphere it will be extremely difficult for President Bush to promote the health care policies outlined above.

Furthermore, the current budget proposal contains much bad news for state governments. With regard to the tightening of income baselines for SCHIP in particular, the budget proposal indicates concern that the number of uninsured children will rise. However, with regard to the national government funding of state measures to reduce the number of uninsured people that President Bush outlined in his State of the Union address, the government has yet to announce concrete methods or directions for debate on this issue, and there remains concern over the relationship between the national government and the individual states.

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WMA Mid-term Council Meeting in Berlin

The 176th WMA Council Meeting was held in Berlin, Germany, from May 10 to 12, 2007. As the demand for WMA activities has been increasing, the number of representatives attending the WMA Council Session grew from 14 at the previous Session to 21. The WMA Council, which had been steered under the leadership of the former Chair of Council, Dr. Blachar of the Israeli Medical Association, is now being led by the new Chair, Dr. Hill of the American Medical Association. Under their leadership, the cooperative framework is being continued by WMA Secretary-General Dr. Kloiber of the German Medical Association, Vice-Chair of Council Dr. Iwasa of the Japan Medical Association, WMA Treasurer Dr. Hoppe of the German Medical Association, and other relevant WMA members and staff.

Apart from official agenda items, several relevant issues that physicians currently face were addressed during the Session. These included the rising demand for IT progress and human rights as the proposed themes for the WMA General Assembly in Copenhagen in 2007 and in Seoul in 2008, respectively.

It was an honor for us to have the recent renewal of the JMA Journal, reviving its original philosophy, highly praised by the NMAs during the discussion focused on the plan to revamp the World Medical Journal.

There was also a heated discussion about such issues as the securing of sufficient human and monetary resources faced by many medical associations, and immigration problems involving physicians in some Latin American and Caribbean countries which contravene international medical ethics. Regarding the latter problem, the WMA Council urgently adopted a resolution at this Session.

Quite some time has passed since the reunification of East and West Germany, but it seems that the reconstruction of Berlin amidst the disaster and destruction in the aftermath of World War II has taken place in a healing manner using modern methods. It is deeply meaningful for the WMA that this Council Session was held in Berlin with peaceful aims based on humanitarianism.

The Kaiser-Wilhelm-Gedächtniskirche, located very close to the venue for the Council Session, remains strong in my memory as a monument of a tragic era for mankind, as too are Hiroshima and Nagasaki.

Masami ISHII, Executive Board Member, Japan Medical Association (jmaintl@po.med.or.jp), Secretary General, Confederation of Medical Associations in Asia and Oceania (CMAAO), Council Member, World Medical Association.

Introduction of JMA Journal Staff

The JMA Journal is prepared by the JMA's International Section. The staff members put form to a broad diversity of ideas and broad-ranging visions of the JMA.



(From left to right)
Mahoko IMAMURA, Yoshie KONDO, Mieko HAMAMOTO (Senior Editor), Hisashi TSURUOKA (Managing Editor), Shusaku UCHIYAMA, and Nobuhide SAKUMA