RESOLVING ETHICAL DILEMMAS IN PRIVATE FAMILY PRACTICE IN SINGAPORE

Dr Leong Choon Kit

ABSTRACT

A family physician in private practice in Singapore faces many situations where ethical dilemmas have to be made during the consultation. From an ongoing discussion of a group of 5 doctors on-line, these situations have been broadly classified into four: conflict due to administrative imperatives and the doctor's professionalism; conflict of patient's choices and best practice; and conflicts between the patient's wishes and the doctor's professionalism. In resolving these dilemmas, it is most important to always put the patient as the central focus. The choice of action could be defended from a set of four ethical solutions: the theory of decided path; the preferred path; the lesser of two evils; or slippery slope. It is proposed that a two tier framework formed by firstly, identifying the ethical dilemma and secondly, finding the choice of action can aid the busy family physician in private practice to arrive at a decision more quickly and soundly when faced with an ethical dilemma. This framework can also be used to collect data to form a pool of unique experiences pertaining to family practice in Singapore. Such a framework of classifying ethical dilemmas will allow, over time, ethical discussions to be better guided. In addition, the archived ethical dilemmas and experiences can form a rich resource for reference that could be retrieved efficiently.

Keywords: Ethics, Private, Family Practice, Singapore, Dilemma

SFP2006; 32(3): 56-62

INTRODUCTION

The report is the results of a project submitted for the fulfillment of one requirement of the MCFP by certification. The objective of the project was to attempt to describe the common dilemmas, classify them, and attempt to develop a framework to deal with the dilemmas.

An ethical dilemma in the family practice context refers to a situation where a family physician has to choose between two or more difficult options. This presents itself whenever there is a conflict of interest between any of the parties involved.

Family physicians in private practice in Singapore would have to decide on the resolutions of such dilemmas on their own. Often they are also required to decide spontaneously as these situations do not grant them the luxury of time to seek the opinions of other colleagues.

While the approach to medical ethics developed by the Americans Beauchamp and Childress[1,2], which is based on four prima facie moral principles and attention to these principles' scope of application is often cited, these principles are too general to apply in a busy family practice. There is the lack of a framework for application to take place. For example, for the end of life, Jonsen's 4-box model is a framework for ethical decision making at the bedside (Jonsen, Siegler, and Winslade, 1998)[3].

There is also a lack of a collection of the commonly encountered dilemmas in family practice in Singapore and their resolutions for reference by medical students, residents and family physicians. Perhaps, the dilemmas could have been too trivial or mundane, or too amorphous to be worthy of archival.

METHODOLOGY

The first of the project was to set up an initial online forum to discuss various scenarios (eight in total) which require the physicians to exercise ethical decisions. Five doctors, who were all family physicians in private practice in Singapore agreed to participate. All of the participants run their own practice either as a solo proprietor or as a partner in their clinics. They have also been working at their present practice for at least 2 years.

The next task was to get the discussions going. As the discussions went on, the group agreed to put two main things in order before the meaningful discussions as well as ease of documenting the different opinions. These two components are the agreed components of medical ethics and a framework to guide and record the discussions according to these components.

For the agreed components of medical ethics, the established four prima facie moral principles developed by Beauchamp and Childress was chosen[2]. – respect for autonomy, beneficence, non-maleficence, justice and fidelity – but found it too general and too theoretical to apply in the discussion of ethical dilemma resolution in a private family practice.

The above prompted the group to develop a classification of situations where certain ethical principles predominate. The 3 lists of clinical tenets described by Tunzi[4] were used initially. These are shown in Table 1. The result of our discussions at this stage was a set of 4 categories as shown in Table 2.

Next, various scenarios that were started with were used, and actions used to resolve the dilemmas and supporting ethical arguments were discussed. A synthesis of these arguments allowed the group to develop a set of four actions based on the ethical arguments. These are shown in Table 3.

Finally, a framework consisting of a 2-tier decisions: firstly on the categories of ethical dilemmas; and secondly on the actions based on the ethical arguments was applied using the set of 8 case studies that were started off on the on-line forum. The processes of reasoning were summarized and presented in the results.

LEONG CHOON KIT, Family Physician, Mission Medical Clinic

Table 1. Tunzi's 3 lists of clinical tenets of practice

First list — the 4 major goals of medicine – to cure illness, improve health, decrease suffering, and prolong life (Callahan, 1996)[5].

Second list — 4 questions the provider asks himself – What does this patient want from me today? What other medical care does this patient need from me – either today or in the future? What preventive care should I offer this patient? What psycho-social issues might help this patient and family handle so that they feel better?

Third list — the 6 components of the patient-centred clinical method (Stewart et al, 1995[6]. – explore both the disease and illness experiences, understand the whole person, find common ground regarding management, incorporate prevention and health promotion, enhance the patient-doctor relationship, and be realistic.

Source: Tunzi, 1999[4]

Table 2. Categories of Ethical Dilemmas

AI **Administrative Imperatives** — scenarios which arise as a result of clinic administration requirements.

V **Values** — The values held by the patient and the practitioner. These values include religious conviction, upbringing, family background, cultural and national values.

C **Choices** — These are the choices preferred by the patients. To be able to exercise choice confers autonomy to the patient. However, we would also add that this autonomy should come with information.

P **Professionalism** — This refers to everything to do with professionalism of the doctor – scenarios may touch on clinical management issues, doctor's competence and handling of the scenario[7,8,9].

Table 3. Actions based on ethical arguments

A. **Decided Path** — the action is really pre-determined and there is little choice left for the practitioner. Example is legal provision. Acting in manners contrary to the law would put the practitioner in trouble.

B. **Preferred Path** — Actions taken are the clearly better choice. These actions are usually correct ethically and would have no adverse considerations and consequences.

C. **Lesser Of the Two Evils** — All the options are less than ideal and the practitioner is choosing a course of action which has lesser damage.

D. **Slippery Slope** — Actions which will lead to something undesirable rather quickly even though the initial action may not be that detrimental.

RESULTS

Defining The Categories Of Ethical Dilemmas

Upon agreeing on the principles of medical ethics, a 2 step framework was set up to discuss scenarios of ethical dilemmas: Firstly, scenarios were classified into one of four categories with some scenarios belonging to more than one category. The categories are Administrative Imperatives (AI), Values (V), Choices (C) and Professionalism (P). The definitions of these categories are described in Table 2.

Defining the ethical actions backed by ethical arguments

The next step is the action that one would consider based on ethical argument. The four arguments selected to justify the actions are the argument of chosen path, the argument of preferred path, the argument of lesser of the two evil and the argument of slippery slope (Table 3).

Framework For Resolving Ethical Dilemma

With the classification of the scenarios and the justification of the actions, a 2-tier framework for ease of maneuvering through ethical dilemmas has been obtained (Table 4).

The 8-case studies that was started with in the on-line forum were used to test out the framework and the processes were summarised and presented below.

Table 4: Two-Tier Framework for Ethical Dilemma Resolution in Family Practice

First Tier	Second Tier
AI Administrative Imperatives	A. Decided Path
V Values of Patient and Doctor	B. Preferred Path
C Choice	C. Lesser of Two Evils
P Professionalism	D. Slippery Slope

Case Study 1

Scenario: An 18-year-old Chinese girl presently studying at a local polytechnic visited her family physician to ask for oral contraceptive pills as she intends to live with her boyfriend.

Category of dilemma (Tier 1 decision): The main ethical dilemma here would be the conflict of values between the physician and the patient (V), the autonomy of the patient (C) and the professionalism of the doctor (P).

Resolution of the dilemma: The doctor may find difficulty in prescribing the pills as it is against his moral value. However, as the patient is above 18 years of age and there is no clear contraindication to the pill, should the patient not be allowed to have her autonomy against the doctor's values? If so, the patient should reserve the right to consume the pill.

Action and ethical justification (Tier 2 decision): The best ethical justification is the preferred path of patient's autonomy before doctor's values.

What if the patient is not given the pill because the doctor's values trump the autonomy of the patient? Arguments could still be raised against the doctor's action in that should the patient not be given the pill and she gets pregnant and decides to go for an abortion, the consequence may be more problematic. In this case the ethical argument of the lesser of the two evils is used to make the case for letting the patient's choice decide the case.

Caveats: However, it is agreeable that the patient needs to be counseled about the potential side effects of the pill, the chances of contracting sexually transmitted diseases and the potential fall out with family should her parents find out. This is to help the patient make an informed choice. The patient needs to have her own autonomy but is believed that she must be given the chance to be informed correctly. One does not qualify to be fully professional with failure to do so.

Case Study 2

Scenario: A 30-year-old Chinese gentleman who works as an executive in a multinational company would like to finish using his health allocation of $300 for the year. He is otherwise well.

Category of dilemma (Tier 1 decision): The ethical dilemma occurs because the doctor considers that the patient is exploiting the patient's entitlement from his company. The dilemma can be seen to fall within the categories of administrative imperative (AI), values (V), and professionalism (P).

Resolution of the dilemma: In this scenario, the participants in the discussion group felt that the patient's request must not cause any harm to his life and does not violate any existing laws.

The products or services requested must also be delivered on the date stipulated. The money should not be used to pay for services rendered in the future or for services rendered to people other than the patient.

While the physician is not obligated to the company, he is still bound by the profession own ethical code as well as the law of the state. The doctor must also make sure all the requests are clinically indicated. Examples of clinically indicated services would include executive screenings and elective procedures.

As long as the above conditions are met, the dilemma could be resolved. The physician should not play moral police and judge the patient. At the same time, the physician should also make sure that they do not play the part of an accomplice.

Action and ethical justification (Tier 2 decision): The central ethical argument for all these actions is really the preferred path. However, if not handled professionally, all these actions can lead to slippery slopes. The doctor therefore needs to make sure that there is professional justification for the request to do tests to use up the entitlement.

Case Study 3

Scenario: A 40-year-old Chinese lady who was recently diagnosed to have contracted helicobacter plyori infection by a surgeon in a local private hospital. She was given a week of Nexum 40 mg on and was told to continue taking Nexum for 6 weeks together with the other component of the triple therapy. She came to the family clinic to fill up the prescription for the next 5 weeks. However, the family clinic does not stock up on Nexum but have generic omeprazole.

Category of dilemma: (Tier 1 decision): The ethical dilemma did not seem obvious at the beginning. However, the main conflicts would come when the physician tries to convince the patient to use a similar drug he has stocked up in his practice (AI) as opposed to the one prescribed by the specialist (P).

Resolution of the dilemma: The process of convincing the patient may also involve some ethical maneuvering. The physician must present the specialist, the drug and the drug company appropriately to the patient.

Another situation which the group felt could involve some ethical decision would be when the patient chooses not to be followed up by her specialist or when the patient decides to be followed up by the family physician instead.

Action and ethical justification (Tier 2 decision): The ethical dilemmas in this situation can be categorized into administrative imperative and professionalism. Ultimately, in this scenario, the patient must exercise her autonomy. The physician's role is merely to facilitate and to provide her with all the medical knowledge she needs. This should also be done with full understanding of the background of the patient, especially her economic considerations. The physician may also provide the option of giving a private prescription for the patient to fill up at the pharmacy if she so chooses. All these should be done so as the physician would not be seen as poaching patients. All the actions mentioned could be justified by the ethical action of preferred path – let the autonomy of the patient rule.

Case Study 4

Scenario: A 24-year-old Chinese man is planning to go for a one month disaster relief trip to the tsunami hit Aceh. He came for vaccinations and some medications. The doctor has recommended several vaccinations including oral cholera, typhoid, hepatitis A and B, tetanus, polio and malaria. However, he is concerned about cost and wish to have only the cheaper vaccinations.

This scenario was brought up during the time when many well meaning Singaporeans volunteer themselves for disaster relief in neighboring countries hit by the tsunami.

Category of dilemma: (Tier 1 decision): This rather straight forward scenario is complicated by financial reason which in turn affects the patient's decision (C). The doctor needs to exercise his professionalism (P).

Resolution of the dilemma: The consensus among the focus group is that all necessary vaccinations, precautions, chemical prophylaxis as well as other necessities such as travel insurance must be advised by the physician (P).

However, should the patient decide that he does not want certain vaccinations because of budget constraint, the role of the physician will then have to help him decide based on his limited budget and the potential risks he is exposed to (P).

In this particular instance, the most immediate health threat at that time was malaria and cholera. Even though the cost is relatively higher than the rest of the vaccines, they are advised (P).

In the end, the physician must allow the patient to exercise their own autonomy too (C).

The focus group also felt that if the physician is not familiar with travel medicine or disaster, he should either refer the patient to a fellow family physician who is more familiar with these areas of family medicine or should seek advice from them.

The ethical dilemma highlighted in this scenario can be categorized into choices (C) and professionalism (P).

Action and ethical justification (Tier 2 decision): Some of the actions taken can be justified by the theory of preferred choice while some, like the choice of vaccines, really hinges on the choice of the lesser of the two evils.

Case Study 5

Scenario: A 72-year-old Chinese gentleman was brought by his family to a family clinic because of shortness of breath. He has a past history of bronchial asthma and cancer of the stomach with secondaries to the lung. His family members requested that the doctor does not tell the patient of his terminal disease and condition.

Category of dilemma: (Tier 1 decision): This situation happens quite commonly in a society like Singapore where Asian value of filial piety is upheld (V). The doctor has a responsibility of keeping the patient informed (P).

Resolution of the dilemma: The patient has the right to know his diagnosis. However, a third party comes into the dynamics now. Not only does the third party know the diagnosis, but is also requesting the diagnosis be held back from the patient.

The patient will have lost his choice as far as the diagnosis is concerned and lost his choice of whether a third party should know his diagnosis.

The doctor's professionalism can also come under scrutiny.

Action and ethical justification (Tier 2 decision): The argument in the decision to accede to the family members' requests will be the lesser of the two evils. However, the preferred path would be when the doctor decides to tell patient ignoring the family members' request. A good compromise would be to delay telling the patient and discuss with the patient's family members about their requests and negotiate with them.

Another way to approach the scenario is to deal with dilemma using the 4-box model proposed by Jonsen et al, which is made up of the 4 areas of: medical indications, patient preferences, quality of life issues, contextual features – religious, financial, or legal matters – as a framework to help make a decision. By getting the weightage one would give to the 4 boxes a decision based on the preferred path can be arrived at.

In the case above, the analysis will be as follows: (1) as for medical indication – point for letting the patient know because he is still able to understand and so his autonomy should be maintained; (2) as for patient's preferences, the practitioners do not know what are his wishes; (3) as for quality of life, the family's view is that he may be adversely affected if he knows the diagnosis – point for withholding the bad news; and (4) as for contextual features – if he has property that needs to be settled legally, then there is a point for telling him. This will trump all other decisions. Failing that, the decision hinges on the quality of life being affected by the bad news. If the impact of this is not great, the points will be for the disclosure of the patient's medical condition to him.

Case Study 6

Scenario: A maid came for routine medical examination as required by the Ministry of Manpower. She was found to be pregnant.

Category of dilemma: (Tier 1 decision): This case study is a good example of what is commonly done by doctors but ethically may not be so. In this scenario, the apparent ethical dilemma would be the dilemma of who is to inform. It is the tussle between professionalism (P) and administrative imperatives (AI) and this becomes clear in sorting out the dilemma.

Resolution of the dilemma: The apparent primary relationship seems to be between the doctor and the patient. Thus, the responses in the focus group is first to help the maid (P).

Many actions were proposed. Among the more popular one is to send the maid back to the country of origin. That way, the practitioner would not have to be guilty of encouraging an abortion. Legally it seems that we have also fulfilled the requirement.

On closer examination, this scenario should be categorised under administrative imperative (AI) and professionalism (P). The maid medical examination is a statutory examination. The law requires that the employer send the worker for compulsory medical examination (AI). Thus, the contract for medical service is between the employer and the doctor and not between the maid and the doctor. Thus, the doctor must explain all his findings to the employer.

The final decision of whether the maid would be repatriated home or whether she would go for an abortion and remain working in Singapore is not decided by the doctor.

Action and ethical justification (Tier 2 decision): The only action the doctor could ethically follow is to inform the employer. It is a decided path.

As Ministry of Manpower does not require the doctor to notify them about pregnancy, the doctor is absolved from any responsibility should he decide not to do so.

Case Study 7

Scenario: A foreign worker came to the clinic for medical examination to apply for a work permit. He was found to have a positive VDRL result.

Category of dilemma: (Tier 1 decision): This situation is similar to the one in case study 7. However, this scenario is often resolved by the patient requesting treatment and a repeat test done to clear the medical examination. An ethical dilemma arises because sexually transmitted disease is a notifiable disease. Once the authority is notified, there may be a chance that the medical examination results may not be accepted.

Resolution of the dilemma: However, having detected the infection, the doctor cannot afford to leave the infection alone. He must treat the patient. So, he will have to enter into a formal doctor patient relationship. And the doctor must notify

the relevant health agencies under the infectious disease act. After the disease has been successfully treated, the patient would return for the medical examination as required by the Ministry of Manpower for the application of his work permit.

Action and ethical justification (Tier 2 decision): So, while the first action seems to be a decided path as required by the law, the doctor is also required to treat. From that instance, the argument will then become a preferred path.

A repeat test could be done after the treatment and the new results submitted for the statutory examination. This really is the rule of lesser of the two evils.

Case Study 8

Scenario: A patient visited the clinic for a laceration over the forearm while working at a nearby construction site. At the registration counter, patient was not able to produce his work permit and he confesses that he enters Singapore illegally.

Category of dilemma: (Tier 1 decision): This final scenario is difficult to resolve. Is this a struggle between professionalism and administrative imperative?

Resolution of dilemma: As the patient appears at the clinic with an emergency, the only action a doctor would take is to treat the patient. Ethically, this would be justified as preferred path.

However, the laws also require all patients to be registered. Although technically the practitioner is not harbouring an illegal immigrant, it should be the duty of all citizens to report the presence of one.

The ethical dilemma involves administrative imperative as well as some professionalism.

Action and ethical justification (Tier 2 decision): As far as action is concerned, it is agreed that the doctor must treat the patient first regardless of whether he could produce a valid work permit. This is the preferred path for the clinical action. The preference of the lesser of the two evils also rules as the doctor would take the risk of treating without fully registering the patient.

Most of the practitioners would not report the patient to the authority since the patient did not leave any contact telephone numbers or address. It will be futile for the authority. Besides, most of them felt that they should be doctors and not policemen.

DISCUSSION

The Complex World Of Practice

The world is changing rapidly. With the internet facilitating the access to medical information, patients become more knowledgeable and more sophisticated. As Singaporeans become more affluent, they also demand more from their physicians. Perception on health, well being and fitness takes on a whole new meaning.

Coupled with rapidly advancing medical technology and ever-increasing competitive medical businesses, ethical dilemmas of all sorts present themselves daily. It becomes more difficult for the solo private physicians to make spontaneous decisions when they surface.

Doctors are often reminded that the patient is central to all clinical encounters[10]. The doctor's role is to assist the patient in ensuring that he or she gets well safely. Thus, the unique and important doctor-patient relationship needs to be guided by sound medical ethics by the two parties[11]. In any family medicine practice, there are at least two stakeholders, the patient and the doctor. In some instances, there are other third parties such as family members of the patient, health insurance companies, managed health care and the company the patient works at[12].

Exposure To Ethical Concepts And The Real World

The undergraduate curriculum has a medical ethics module and all graduates of the local medical school are required to attend the ethics seminar before commencing work. There is also an introduction module in the lecture series for those pursuing the Graduate Diploma in Family Medicine and Master of Medicine in Family Medicine. These are very important elements built into our medical education system. Beyond these theoretical exposures, doctors in Singapore have very little life experiences in handling ethical dilemmas.

Ethical Dilemmas Defined And Explored

What then is an ethical dilemma? An ethical dilemma arises when what is required of the doctor is in conflict of his knowledge, values and affiliations to national, cultural and religious background. These same factors need to be considered too during ethical dilemma resolution. The views of the patient as well as that of the practitioner should be considered together.

In private practice, one encounters ethical dilemmas daily. These are often regarded as trivial or mundane problems. The ad hoc way employed in dealing with them is often unsatisfactory because the reasoning behind the actions is amorphous. Indeed, the nature of the dilemma was often not categorized as the starting point for logical reasoning.

Doctors also do not have an ongoing forum or interest group to continue discussing these dilemmas, collating them for future reference and future generations of family physicians. This project is therefore to make a start in first defining the more commonly encountered ethical dilemmas, and then work out the ethical arguments on the action that one would take to resolve the dilemmas.

The Reality Of Practice

Living in a cosmopolitan city like Singapore where it is a melting pot of people with varied cultures, backgrounds, country of origins, religions, values and ages, resolutions of these issues can become very complicated. All these do not favour the unprepared family physicians in the private practice.

Ideally, there should be a priority list of ethical actions. In reality, the priority is difficult to set. Financial stress can be

exerted by the company paying the doctor for his services. The doctor may also make clinical and management decisions depending on the company's ability and willingness to pay[12].

In an Asian context where families are highly valued and parents are revered, the doctor may experience pressure from parents to divulge their children's medical information. Or, the children may demand that diagnosis be held back from the patient in the name of filial piety[13]. All these factors contribute to ethical dilemmas in a family practice in Singapore.

Many of the encounters with ethical dilemmas happen spontaneously and an immediate response from the doctor is required. Sometimes, ethical dilemmas can happen so subtly that even the doctor may not have thought about it until after the patient has left the clinic.

The local scene for family physicians has also been very competitive in the last few years. It will most probably continue to be so in the future. When competition threatens survival, new paradigms and ideas emerged. Along with these, the family physician will face many more new ethical dilemmas in uncharted waters[14].

Using A Group Of Doctors As Sounding Board

Medical ethical discussions are qualitative in nature and can be very subjective. Every private medical practitioner may also have their unique experiences in resolving similar conflicts. Focus group discussion as a methodology would thus be useful to glean the experiences of various medical colleagues[15,16]. The focus group discussion is a qualitative research method, as opposed to quantitative methods which many medical people are familiar with. It is useful in researching soft topics where it is not easy or not possible to assign numerical values to them.

Sometimes the focus group method is also used by researchers to find out what qualities to investigate before embarking on a quantitative survey or study. This is helpful in investigating ideas or testing hypothesis in new areas[17]. A focus group interview is a structured group process used to obtain detailed information about a particular topic. It is particularly useful for exploring attitudes and feelings and to draw out precise issues that may be unknown to the researcher[18]. It is useful that the information of the discussions be recorded and presented. In some instances the results may also be tallied[19].

In this project, the decision was to use a group of doctors as one would do in a focus group. However, it is likely that the discussion cannot be completed in a sitting of 1-1.5 hours as would normally happen in a focus group. The solution that was used here was an online forum for interaction.

What Was Learnt Along The Way

Throughout the discussions, medical practitioners are recognized as merely guardians and stewards of medical knowledge and skills. They should thus dispense their medical knowledge and skills to their best ability and do so with absolute integrity.

In addition, the recognition that central to all one do as doctors is the life of the patient was noted[10, 20]. It is the basis of the profession. Therefore, in all our medical ethics discussion one always assume the sanctity of life to be the foundation.

The patient should be able to make his or her own choices or medical decisions with the necessary medical knowledge and analysis of their conditions from their doctor. This would thus translate into patient's autonomy[21] and empowerment.

Patients must be deemed as individuals. Not only do they have the autonomy to make informed decisions, but also the autonomy to choose who they can confide with. Thus, the importance of patient confidentiality comes into play. Patient confides in practitioners to allow them to help them medically. Beyond that, they do not have that liberty until the patient grants them his approval.

Thus, the criteria based on the established four prima facie moral principles were chosen to form the basis of medical ethics for discussing ethical dilemma resolution in a private family practice in this project.

Many ethical dilemmas in the private practice arise from seemingly trivial matters and requests. Often, these matters and requests require the practitioner to decide immediately a course of action. This is made more difficult in a busy family clinic. Under such stressful situations with limited resources to draw upon, the practitioner's task is not enviable.

A framework for resolving ethical dilemma would allow the physician to size up the situation quickly and gives the practitioner a handle on the situation. It would help him evaluate his options quickly. This framework would also help in discussions among fellow practitioners, in documenting and referencing the scenarios and resolutions and in the training of future generations of medical students, residents and family physicians. The framework that has been developed will hopefully fulfill this need (Table 4).

Processes Of Decisions Making

There is a need to test out decision making processes in using the framework that had been created. The framework seems to be able to survive the 8 case studies that this project started with. Further application of this framework will be useful in testing its robustness to help the private medical practitioners in his encounters with ethical dilemmas.

Limitations Of This Project

This has been a very fruitful and interesting project. It started off as a focus group to discuss only specific ethical dilemma. As the discussions went on, the group felt the need for a more practical interpretation of the principles of medical ethics. The group also felt the need for a framework to guide, to record and to aid reference. The group came up with the basic framework above and hope to fine tune it to suit the needs of family physicians with more focus group discussions.

Focus group as a research method requires the group to comprise members who are relatively homogenous. With that, sometimes, the views may be narrowed or skewed. One solution is to reduce the inclusion criteria and relax the exclusion criteria. Another solution is to repeat the same questions to more groups. That way the group are able to benefit from more opinions. The flip side of it would then be a more complicated summary of the resolution.

Future Considerations Of A Databank

Family medicine is facing an exciting future as more doctors are embracing its principles and concepts. The patients will definitely benefit from the family medicine system as doctors become more holistic and complete. As the patients reap these medical benefits, they should also take comfort that we as family physicians are ready to help them resolve any potential medical ethical dilemma during and beyond the consultation. The trust that comes out of a better patient-doctor relationship will bring family medicine to a higher level. In order to achieve that, a data bank of case studies would be helpful for reference, learning and posterity. This databank should be digitalized for ease of contribution, presentation as well as retrieval. The framework proposed earlier will help in the storing and classification of these data. It will also help to create a useful search engine.

In addition to a digital data bank, regular meetings such as focus group discussions and interest group meetings among private family physicians could be organized to help fine tune some of these suggested resolutions. Medical ethics is not an exact science and options of resolution will also increase when more knowledge about technology, culture, religions and so on are made available.

As family medicine develops as a discipline in Singapore, medical ethics theories will have to be made practical. When that happens, the teaching and training of medical ethics among medical students, residents and family physicians will have to take on the form of clinical ethics[4,21].

CONCLUSIONS

Ethical issues and dilemma present themselves often in private family practices in Singapore. Many of these dilemmas are unique to family medicine. A two tier framework has been developed to help deal with such dilemmas.

To develop the framework further, more qualitative research and discussions would be needed. Regular papers on this issue in local scientific / medical journals would also be useful. A databank of real life case studies would be beneficial to the profession and future generations of family physicians.

REFERENCES

1. Gillon R. Philosophical Medical Ethics. Chichester. Wiley, 1986. *(From a 26 part series in BMJ from* 1985;290:1117-9 to 1986;292:543-5.
2. Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 3rd ed. New York, Oxford: Oxford University Press, 1989.
3. Jonsen AR, Siegler M, Winslade WJ. Clinical Ethics. 4th ed. New York, NY:McGraw Hill Book Co; 1998.
4. Tunzi M. Ethical Theories and Clinical Practice – One Family Physician's Approach. Arch Fam Med Vol 8 Jul/Aug 1999; 342-4.
5. Callahan D, project director. The Goals of Medicine. Hastings Cent Rep. 1996;26:S1-S28.
6. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. Patient-Centered Medicine: Transforming the Clinical Method. Thousands Oaks, Calif: Sage Publications; 1995.
7. Characteristics of Professions and Concepts of Professionalism. Singapore Medical Association June 2001. www.sma.org.sg/cmep/professionalism/PFA/PFA1.html
8. Ethical Code and Ethical Guidelines. Singapore Medical Council.
9. An Ethical Approach to Financial Issues in Medical Practice. The National Medical Ethics Committee. Jan 2000.
10. Lee SY. Judicious Approach In Medical Practice. Singapore Med J 2003 Vol 44(12):620-4.
11. Chin JJ. Doctor-Patient Relationship: A Covenant of Trust. Singapore Med J 2001 Vol 42(12):579-81.
12. Chin JJ. Ethical Sensitivity and the Goals of Medicine: Resisting the Tides of Medical Deprofessionalisation. Singapore Med J 2001 Vol 42(12):582-5.
13. Lee A, Wu HY. Diagnosis Disclosure in Cancer Patient – When the family says "No!". Singapore Med J 2002 Vol 43(10):533-8.
14. Singh K, Goh LG, Sandhu K, Cheong PY. 1996 Survey of Housing Estate Practice Costs and GP Fees In Singapore. Singapore Med J 1997 Vol 38(5):192-9.
15. Jenny K. Qualitative Research: Introducing Focus Groups. *BMJ* 1995;311:299-302.
16. Lee KH. Qualitative Research, Its Relevance and Use of Focus Group. The Singapore Family Physician Jan – Mar 2002; Vol 28 (1); 44.
17. Pope C, Mays N. Qualitative Research: Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. BMJ 1995;311;42-5.
18. Britten N. Qualitative Research: Qualitative Interviews in Medical Research. BMJ 1995;311;251-3.
19. Green J, Britten N. Qualitative Research and Evidence Based Medicine. *BMJ* 1998;316;1230-2.
20. Singer PA. Recent Advances: Medical Ethics. BMJ 2000;321;282-4.
21. Chin JJ. Doctor Patient Relationship: from Medical Paternalism to Enhanced Autonomy. Singapore Med J 2002 Vol 43(3):152-5.