

## COMMENTARY

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## Thinking About Medical Ethics in a Privatised Context

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### ABSTRACT

Prompted by personal observation and experiences, this article argues the need to rethink medical ethics for medical personnel working in the private healthcare sector. Although medical personnel are bounded by the Code of Medical Ethics, private healthcare providers are not subjected to a similar code. Within such a context, would medical personnel be able to adhere to their ethics? Should private healthcare providers also be subjected to a similar set of ethics?

**Keywords:** *Medical ethics, Private healthcare, Ethical dilemma, Conflict of interest, Malaysia*

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I am a non-medical personnel and this is written strictly based on personal observation and real-life experiences of family and friends, which challenged me to start thinking about medical ethics. As Wikipedia defines, medical ethics is a system of moral principles that apply values and judgements to the practice of medicine (1). In Malaysia, the Malaysian Medical Association (MMA) has its own Code of Medical Ethics, which was adopted at the 2001 Annual General Meeting. The Malaysian version Code of Medical Ethics comprises of eight sections, among which include: good medical practice, ethical obligation of doctors to the patient, doctors and his colleagues, relationship of doctors with other professionals, relationship of

doctors with commercial undertakings, advertising and canvassing, setting up practice, and ethics committee of MMA (2). However, what I am going to discuss is a grey area that perhaps has not been adequately covered by the MMA Code of Medical Ethics, but an area that is critical for the healthcare system of Malaysia: specifically medical ethics in private healthcare.

Malaysia has a two-tier healthcare system of government-supported universal healthcare system as well as private system. In 2013, there were 149 government-supported hospitals and 3,122 health and mobile clinics, while concurrently, there were 214 private hospitals, 54 ambulatory care centres and 6,801 clinics. Yet, almost 70%

of private hospitals are located urban areas of Klang Valley, Penang and Johor Bharu. Interestingly, while there has been significant growth of private hospitals and medical facilities, the government's proportion of health expenditure has remained constant in the range of 50% and 60% between 2000 and 2011 (3). Hence, under the Economic Transformation Programme, healthcare has been identified as one of the 11 economic sectors and Malaysia aspires to become a destination for medical tourism through the private sector. Although there is the Private Healthcare Facilities and Services Act 1998 (Act 586), this legislation mainly focuses on the ways to establish and regulate private healthcare providers by the Government.

Let me begin by sharing some observations and real-life experience to illustrate the need to reconsider medical ethics in private healthcare. These examples include both for-profit and non-profit private healthcare providers. First, a lady in Malaysia who realised that she is pregnant visits an obstetrician in a private hospital possibly in the second month of the pregnancy. In the first visit, she would be required to take a urine test and the obstetrician would have used the ultrasound to 'check' on the foetus. Almost immediately, the obstetrician would have recommended a battery of tests for Down syndrome, where the patient is briefed of the pros and cons of the various tests, when these tests can be administered, its risk, results and most importantly the cost. Upon deciding on a specific test, a highly efficient nurse would within a minute or so got an appointment for the patients to do the test. The patient would also be immediately scheduled for the next consultation with the obstetrician, usually within three weeks to a month. For every consultation, there would be charges for the obstetrician consultation, use of medical device i.e. the ultrasound, and supplements such as folic acid, calcium and multi-vitamins; amounting to approximately MYR150 for the three items on the bill.

To illustrate my point from this case, let me share another example of a similar situation

but in a different context. Now, if the same lady, who is now in England, realised that she is pregnant, would have to visit the General Practitioner (GP) whom she is registered with. She would be required to take a urine test to determine the pregnancy and given a package of information by the National Health Service (NHS). The GP would first determine whether the pregnancy was planned and intended, and having done so, would then provide the necessary information to the patient in terms of arrangements with the midwife and other appointments for test. For the next nine months, there were three appointments with a midwife, two appointments with the GP, and two ultrasound tests. It is suffice to mention that the only cost incurred to the patient throughout the pregnancy was mere GBP10 to purchase the picture of the ultrasound, and even that was optional. I do not intend to compare the cost involved in the duration of pregnancy as NHS is a government-supported system alike to public healthcare in Malaysia, and such comparison with private healthcare would not be fair.

However, the frequent consultation and use of medical device raises a fundamental ethical question: Is the obstetrician in a private hospital prescribing 'more care than needed or required'? Is it necessary for the obstetrician, a trained specialist, to use an ultrasound to 'check' on the foetus; considering that GPs and midwives in England did not rely on such device? Beside the question of necessity, the more frequent use of ultrasound contradicted a fundamental principle of medical ethics of 'doing no harm'? All these ethical questions have to be considered in a larger context where the medical personnel may have conflict of interests between his or her duty as a doctor in prescribing care for the patient, and his or her financial interest as an owner, shareholder or employee of a private healthcare provider.

Second, let us fast forward the story of the pregnant lady to the due date of the pregnancy. If the patient is in a Malaysian

private hospital, she would first be asked to choose a delivery package. The options provide are normal or Caesarean delivery, as well as either a single, double or 4-bed room. However, there are private hospitals which offer normal or emergency packages, which the patient has to choose before the big day. Interestingly, the normal package refers to the expected due date and has to be within a specific window of working hours of the particular day. Anything outside of that window, for instance the day before or after the expected due date, the patient would have been considered as an emergency case and subject to additional charges. This is perhaps a case of confused identity, where the private healthcare provider may be thinking that the organisation is providing a glorified hotel with the theme of a hospital, and not running a private hospital as prescribed in Act 586 as “a premise, other than a Government hospital or institution, used or intended to be used for the reception, lodging, treatment and care of persons who require medical treatment or suffer from any disease...that requires hospitalization”.

Third, this is a story of a private hospital which is located next to a court building. One fine morning, a man was declared bankrupt in the court and upon hearing the verdict, suffered a heart attack. However, knowingly that the person could not afford medical care, would the private hospital and all its medical personnel have the responsibilities to react to this emergency? Many similar incidents have been reported not only in Malaysia but elsewhere in the world, whereby when a patient does not have insurance coverage or financial means to pay for medical facilities at a private healthcare provider, to what extent does the private provider has the obligation and ethical responsibilities to provide medical assistance? The last I heard about the man, an ambulance from a government-support hospital was called, instead of from the private hospital next door.

While a doctor has to abide by its Code of Medical Ethics, does he have sufficient

consideration as to what extent can the doctor abide to this code in a private healthcare organisation or environment, especially when there is potential conflict of interest? Equally crucial, does private healthcare providers have a similar set of code of medical ethics in which their owners, stakeholders, managers and administrators also have to abide by? If there is, are the two codes of medical ethics of doctors and healthcare providers compatible? If there isn't, then why are healthcare providers not required to have a code of medical ethics whereby the providers have a crucial role in the provision of healthcare and medical practice? My contention is the examples above are not a question of right and wrong from a legal point of view, and therefore cannot be adequately addressed through legislations and regulations. Instead, they relate to the fundamental concern about medical ethics that require more elaborated consideration and rethinking, given the many codes of medical ethics such as the Hippocratic Oath have existed before the privatisation of healthcare. Certainly this is also a crucial area to consider in the education of doctors and other medical professionals on the subject of medical ethics.

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