Towards a "One Country Two Systems" medical ethics for the regulation of practice promotion: Hong Kong as a case study

Introduction: a challenge to the medical ethos of Hong Kong

Hong Kong is marked by robust free-market competition. It is a social space in which advertising abounds, where various providers of goods and services promote their products openly. Among the exceptions to this general rule are stringent regulations imposed on the medical profession by the Hong Kong Medical Council that prohibit all but the most limited and restrained dissemination of information regarding medical and hospital services.[1] Recently, however, challenges have been mounted to this long-established prohibition against practice promotion in Hong Kong society.

In February 2003, Dr Siu was interviewed regarding the use of laser light for cosmetic purposes by a special reporter from Ming Pao (a local newspaper) and in a television interview. The television interview later appeared in a TV advertisement in March 2003 for a local beauty clinic where Dr Siu was then employed as a consultant to the clinic.[2] In response to a charge of practice promotion by the Medical Council, Dr Siu argued through his attorney[3] that the Council's restrictions violate a right protected by both the Bill of Rights and the Basic Law, and which guarantees freedom of speech and freedom of publication, including commercial speech.[4,5] Were such a defense to prevail, it would lead to a radical recasting of the ethos of medical practice in Hong Kong.

This controversy raises the question of whether the general guarantee of freedom of speech and of publication extends to commercial speech, including practice promotion and the advertisement of medical services. Furthermore, there are additional concerns raised recently within the Hong Kong medical community regarding how properly to acquaint patients in the Mainland, under the "One Country Two Systems" ethos, about the availability of quality medical services in Hong Kong.

Setting the context for reconsidering rules bearing on practice promotion by physicians

This article will examine the issues raised by these challenges, putting them within the larger concern to maintain physician integrity and medical professionalism. We argue for the establishment of two sets of standards for the regulation of practice promotion: one to govern advertisements by physicians and hospitals in Hong Kong, and another to govern elsewhere, for example, the Mainland. The former might retain much of the current restrictions of the Hong Kong Medical Council, thus avoiding disruption of the established medical ethos. The latter would however provide a more liberal approach, allowing Hong Kong hospitals and physicians to compete on an even footing with other physicians and hospitals who can advertise their services to patients on the Mainland.

Allowing a different set of norms of medical etiquette for Hong Kong hospitals and physicians when disseminating information to Mainland China and Hong Kong might raise objections of morally unjustifiable double standards. By developing a better appreciation of the important distinction among three different kinds of norms in medical practice: (1) norms of medical ethics; (2) norms of bioethics; and (3) norms of medical etiquette, this article argues that one can justify different rules or etiquettes according to context while still taking the basic norms of ethical professional conduct seriously. Currently, medical advertising in Mainland China is permitted and jointly regulated by the State Administration for Industry and Commerce, and the Ministry of Public Health.[6] The proposed revision would be a robust recognition that China is one country, but with two systems of medical etiquette.

Medical ethics, medical etiquette, and professional identity

The history of medical ethics is considerable. In the West, it began with a remarkable growth of literature bearing on the deportment of physicians in the late 16th century.[7,8] Similarly, in China a number of classical texts explicitly address proper physician deportment.[9] By the mid-19th century, these concerns with medical morality developed into a movement in the West to codify medical morality,[10] resulting in a number of formal articulations of norms for the appropriate behaviour of physicians. Though the accent was often on general moral concerns, many of the early codes of medical ethics explicitly recognise themselves as codes of etiquette.[11,12]

Formalised rules of etiquette, as quasi-legal constraints for a professional community, fulfill two cardinal functions. On the one hand, they identify role-specific obligations and virtues that define a professional ethos and identity. For example, rules restricting practice announcements to limit commercialism, or rules forbidding the financial exploitation of patients, encouraging courteous response to patients, requiring the reliable treatment of patients independently of their social status, and the avoidance of sexual relations with patients. In another sense, rules of medical ethics and etiquette articulate an internally directed set of norms that mark contact with other professionals to uphold commitment to collegiality. Such rules prohibit publicly criticising

other professionals, encourage respectful collaboration with others, and discourage self-promotion of one's own practice at the expense of others.

Though the exact content of norms of etiquette, just like actual rules of law, is in its specific character arbitrary and changeable, it is equally important to note that any critical re-examination of medical ethics must begin with a careful assessment of the likely impact of any changes in these externally and internally directed norms. A sense of professionalism and professional identity is, like all cultural achievements, precarious and easily undermined.

The marginalisation of medical ethics and the emergence of bioethics

A number of changes occurred in American society in the 20th century that both contributed to the marginalisation of medical ethics, and the undermining of the capacity of the medical profession to maintain its integrity and professional ethos. Beginning in 1943, the United States Supreme Court holdings removed the medical profession's de facto standing as a quasi-guild and required that it be governed at law by the norms and expectations of a trade in open market competition. As a consequence, it had to operate in the market like any other commercial trade offering its services. The community of physicians could no longer place any constraints on advertisement, medical marketing, and practice promotion, as long as these involved factual, verifiable statements.[13] But the more fundamental implication is the transformation of the status of organised medicine, so that it could no longer continue as self-regulating and self-governing.

These legal changes did much to undermine the authority of physicians and medical ethics in the United States. As this was occurring, the United States was also passing through other major cultural changes, most significantly through a transformation from being a de jure religious society to a de jure secular society. From the resultant moral vacuum, bioethics emerged in the early 1970s.[14]

There were many consequences to this development; among them was a loss of the appreciation of the importance of medical etiquette and its role in shaping the identity and professionalism of physicians. Bioethics' focus on patient autonomy brought further foundational alterations in the nature of American medical ethics,[15,16] which if brought to Hong Kong would radically recast its medical ethos with uncertain consequences for commitments to professional identity and obligations.

One medical ethics, one bioethics, and two approaches to medical etiquette

The concern in Hong Kong regarding the appropriate scope and limits to be set by the Hong Kong Medical Council on practice promotion by hospitals, clinics, and physicians should be critically approached against the background of the history of medical ethics, while attentively considering local culture, legal systems, and expectations. Any revision of the rules set by the Medical Council for practice promotion of medical services in Hong Kong should take into consideration not only (1) a preservation of a collegial spirit among Hong Kong practitioners and (2) an avoidance of undue competition and commercialism, but also a recognition that (3) this very collegiality that is appropriately highly valued may in part depend on maintaining the vigor and strength of Hong Kong's private health care sector. In addition, it will be important to recognise that allowing Hong Kong's private health care sector more adequately to compete on the Mainland may both (1) strengthen the entire health care community in Hong Kong and (2) allow Hong Kong to play its appropriate role as a centre of medical excellence for China as a whole.

There should be a robust and creative recognition that the Hong Kong medical profession will sooner or later need to adapt to the circumstance that China is one country with two economic, social, and legal systems. A possible policy approach would be to allow Hong Kong physicians to announce their services in Mainland China, governed by a set of norms appropriately adapted to that environment. Though rules of medical etiquette could be maintained for Hong Kong that recognise its developed context and sense of community, keeping in place considerable limits on medical commercial speech, the medical community could at the same time establish rules of medical professional deportment that take this diversity of contexts seriously.

The commitment to collegiality among medical professionals is an important moral goal. However, just as there is one China with two systems of law, announcements in Mainland China of the availability of medical services in Hong Kong need not be controlled by the same norms of etiquette as those governing announcements in Hong Kong. One China can have two standards of law and etiquette, not in the invidious sense of a double standard, but in the positive sense of two appropriate adaptations to the provision of information concerning the availability of medical services in two different contexts. In two different environments with different economic, legal, and social conditions, it is only appropriate to consider having two different ways of balancing professional commitments. In particular, the Hong Kong Medical Council, along with the Hong Kong SAR Government, has an opportunity for creative review and adaptation of its medical etiquette on the model of Hong Kong's integration into China.

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Answers to CME Programme

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I. The prevalence of microalbuminuria among patients with type II diabetes mellitus in a primary care setting: cross-sectional study

A	1. True	2. False	3. False	4. True	5. False
B	1. True	2. True	3. False	4. False	5. True

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II. Suicides in general hospitals in Hong Kong: retrospective study

A	1. False	2. True	3. False	4. False	5. True
B	1. False	2. False	3. True	4. True	5. False