SMC NEWS

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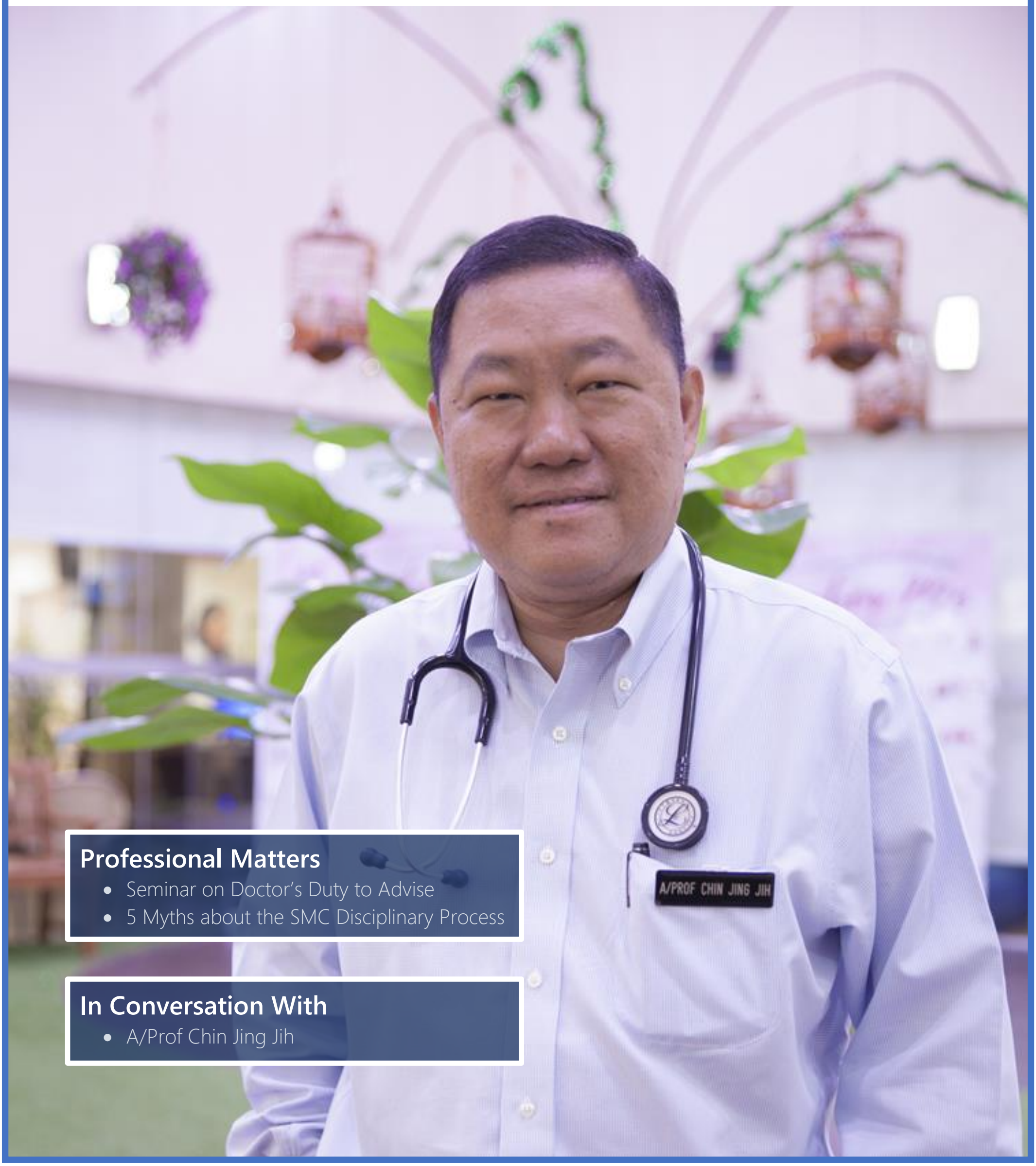

Professional Matters

- Seminar on Doctor's Duty to Advise
- 5 Myths about the SMC Disciplinary Process

In Conversation With

- A/Prof Chin Jing Jih

Message from President

Welcome to our 9th edition of the SMC News.

As 2017 draws to a close and we usher in the new year, it is timely to reflect and remind ourselves of the moral and ethical obligation to protect and uphold our patients' welfare and interests.

In this edition, we share with you the five myths about SMC's disciplinary process and the Modified Montgomery Test. This new legal test looks into the standard of care in respect of a doctor's duty to advise.

We also feature A/Prof Chin Jing Jih who had served on the Singapore Medical Council from 2008 to 2017. During his tenure as Council member, he had provided valuable advice especially on ethics-related matters.

We would like to take this opportunity to highlight several key areas for doctors to take note such as the changes to the SMC registration and supervisory framework, and the fees revision which will take effect from April 2018.

I hope you will enjoy reading this edition of SMC News, and wishing all a good year ahead.

Professor Tan Ser Kiat
President, Singapore Medical Council

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Singapore Medical Council Physician's Pledge Affirmation Ceremony Saturday, 30 September 2017

Speech by SMC President, Professor Tan Ser Kiat

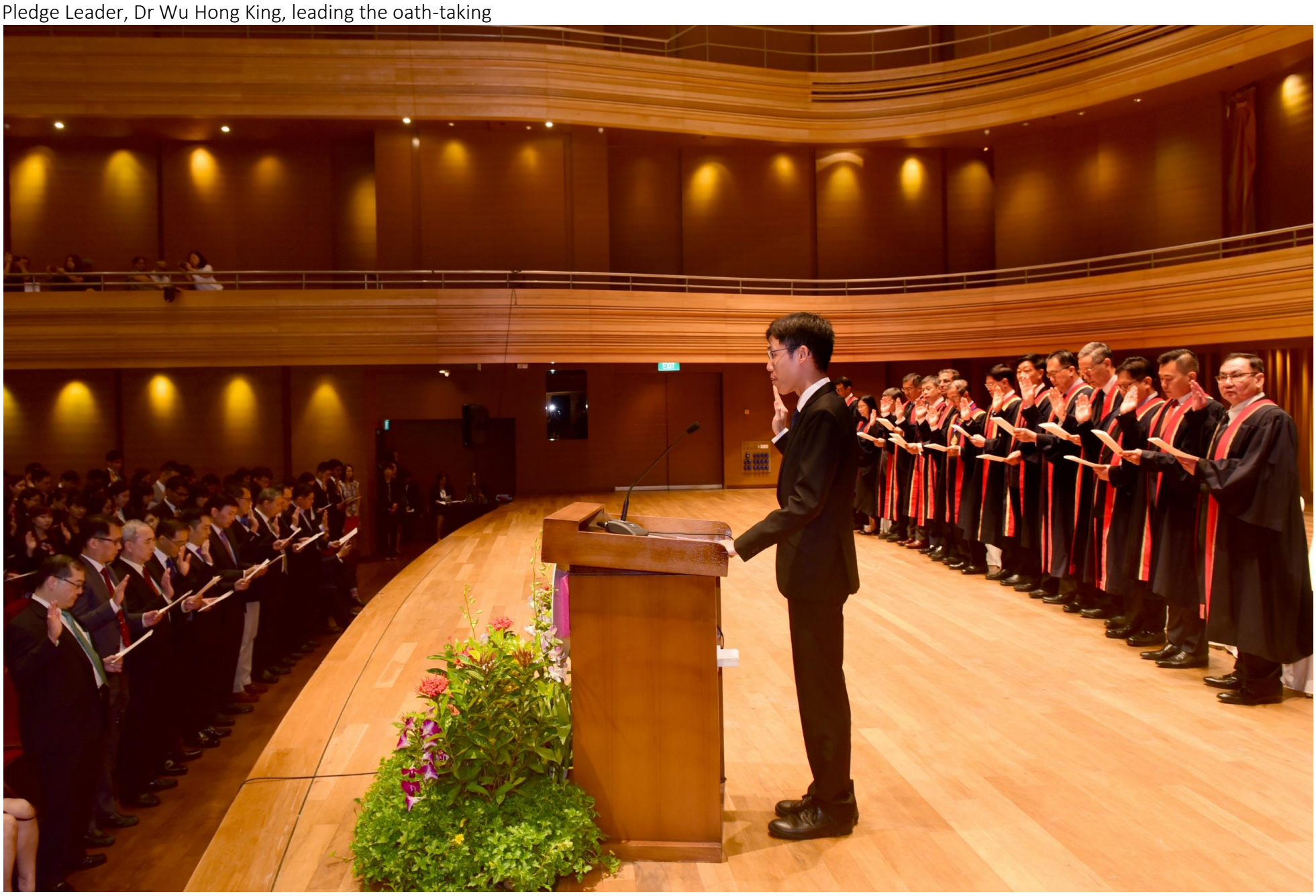
Professor Tan Ser Kiat addressing the doctors and guests at the ceremony

It is a pleasure to be here with you at today's Physician's Pledge affirmation ceremony of the Singapore Medical Council (SMC). This is a very important occasion as you will be taking an oath, our equivalent to the original Hippocrates' Oath which ancient Greek physicians took when they commence their practice.

Today we have about 14,000 doctors on our register, of which about 5,000 are Specialists and 2,000 Family Physicians.

The SMC registers new medical graduates provisionally (otherwise known as Postgraduate Year One or PGY1, formerly known as the housemanship year) for practice before being fully or conditionally registered.

Pledge Leader, Dr Wu Hong King, leading the oath-taking



SMC also conditionally registers international medical graduates (from overseas medical schools which are on our Schedule II) who have completed their housemanship from countries recognised for their training for PGY1.

PGY1 is a very crucial and integral component of your basic foundational training to become an independent medical practitioner no matter which specialties you would be pursuing as a career. It forms a very important part of the foundation of your medical practice.

Continuing Medical Education

Medical science and technology has advanced by leaps and bounds with each passing year as scientific breakthroughs and major biomedical discoveries enable doctors to better understand the nature of diseases. This will be translated into better diagnostic and therapeutic modalities in the physician's management armamentarium. Hence it is absolutely essential that clinicians keep pace and be up-to-date with latest advances and discoveries.

It is for this reason that SMC introduced mandatory Continuing Medical Education, or CME in short, in 2003 to ensure that all practitioners continue to maintain and strengthen their medical knowledge and skills so as to remain relevant. Doctors who are fully or conditionally registered must obtain the requisite CME points through various accredited educational, teaching and training programmes before they can renew their practising certificates on a biennial basis.

However, we do know that CME in its current form alone is not sufficient to ensure doctors maintain their skills and competency. Other forms of assessments have been developed by some jurisdictions to help better address this insufficiency. For this reason, SMC has formed a committee with representation from the medical professional bodies to help address this concern.

Let me now touch on another important issue as illustrated by a number of cases reported in the media recently that may affect the profession's repute and standing.

Maintaining ethical practice and professionalism

As qualified doctors, you have the moral and ethical obligation to protect and uphold your patients' welfare and interests. Your sole consideration in treating your patients is to provide the best medical care possible under the circumstances. The care provided should be effective, safe and evidence-based, and delivered with compassion and professionalism with the highest ethical and moral standards. You should never allow any other considerations to override this. It is only through such practices that you will earn the trust and respect of your patients and society.

SMC's Ethical Code and Ethical Guidelines (ECEG) provide the guiding principles for you to do this throughout your entire medical career. Our ECEG was updated and revised to keep pace with technological advances and the changing practice environment. It is easily accessible through SMC's website and I strongly encourage you to read it regularly.

> **By ensuring that you practise within our Ethical Code and Ethical Guidelines throughout your career, you will uphold, maintain and safeguard the trust and respect the public has for the profession.**

By ensuring that you practise within our Ethical Code and Ethical Guidelines throughout your career, you will uphold, maintain and safeguard the trust and respect the public has for the profession, one that is held in the highest regard by society. You must never betray this trust through practice that is not ethically and morally correct.

As you take your Oath today, perhaps it is timely to remember the original Hippocrates Oath, written in the 4th Century BC in Greek.

There are several modern English versions of which the one you are taking today is one of them. However, many have included the phrase:

“ **Primum Non Nocere** ”

which in Latin means “First Do No Harm” though this is not found in the original Hippocrates Oath.

In closing, on behalf of Council, I would like to thank SMS Chee Hong Tat for being here to grace this special occasion in spite of his extremely busy schedule.

Thank you.

From left: Prof Tan Ser Kiat (President, SMC), A/Prof Lim Boon Leng (DIO, Singapore Health Services), Dr Hee Hwan Ing (front) (SMC Council Member), Dr Ngoi Sing Shang (back) (SMC Council Member), SMS Chee, Adj A/Prof Ganesh Ramalingam (SMC Council Member), Prof Venkataraman Anantharaman (SMC Council Member), A/Prof Tay Yong Kwang (front) (ADIO, SingHealth Residency), Dr Tan Sze Lee (back) (President, CFPS), Dr Leong Choon Kit (SMC Council Member) and Dr Tay Miah Hiang (SMC Council Member).

Singapore Medical Council Physician's Pledge Affirmation Ceremony Saturday, 30 September 2017

Speech by Guest-of-Honour Senior Minister of State for Health, Mr Chee Hong Tat

From left: Prof Tan Ser Kiat (President, SMC), A/Prof Benjamin Ong (Registrar, SMC), SMC Council Members Prof Chee Yam Cheng, A/Prof Chen Fun Gee, A/Prof Chew Suok Kai, Dr Chia Kok Hoong, and SMS Chee.

This afternoon's affirmation of the Physician's Pledge is a significant milestone for our medical professionals as you progress on in your career. I am honoured to be here to witness this important occasion.

This afternoon, I would like to touch on three issues. First, how to improve our residency training programme. Next, how to achieve the right mix of specialists to meet Singapore's long-term healthcare needs. And lastly, whether it is really necessary for our public healthcare institutions to go through JCI accreditation.

Residency Training Programme

Let me start with the residency programme. Before we had the current residency training system, postgraduate specialist and family medicine training was structured in an apprenticeship model with high stakes summative examinations. We had adapted this from the British system and it had served us well for many years.

Several years ago, MOH was concerned that this model could result in a longer time for a junior doctor to become a specialist, as the

> **Good intent alone does not necessarily lead to good outcomes.**

first-time passing rate for the summative examinations was low. The Ministry studied the training models of other countries and adopted the American residency system in 2010. The intent behind this change was to provide a more structured framework with regular supervision and formative assessments that provided opportunities for trainees to improve their competencies progressively. It was also felt that as the annual number of doctors graduating from our medical schools increase, it would be beneficial to introduce a more structured post-grad training system.

Unfortunately, intent is not always the same as outcome. Good intent alone does not necessarily lead to good outcomes. As the residency system was adapted from the US, there were challenges to fit its different elements into our system in Singapore during implementation. I remember my former boss Mr Lim Siong Guan used to remind us that "implementation is policy". The effectiveness of a policy is not measured by how elegant it looks on paper, but how it is translated into reality during implementation.

Doctors and guests at the Physician's Pledge Affirmation Ceremony

On this yardstick, we have to be honest and acknowledge that while the residency programme has its advantages and good points, some of the outcomes have not been as positive in practice as what we had originally hoped for. As with all major changes, what could have been better was a more gradual, step-wise implementation, with appropriate channels to acknowledge concerns of the medical fraternity, and to consider the impact of the changes from a holistic systems perspective.

> **“We want to retain the positive elements of the residency programme while taking concrete steps to address the problems we have encountered and improving the outcomes for our doctors.”**

After having some years of experience with the residency programme, the time is right for MOH to now review the programme. We want to retain the positive elements of the residency programme while taking concrete steps to address the problems we have encountered and improving the outcomes for our doctors. For this effort to succeed, we need to work closely with our professional bodies and doctors to listen to your feedback and see what we can do together to enhance the system. We need your help to work with us to achieve better training outcomes for our doctors and deliver quality care to our patients. I hope we can count on your support to embark on this review together.

Right Mix of Specialists

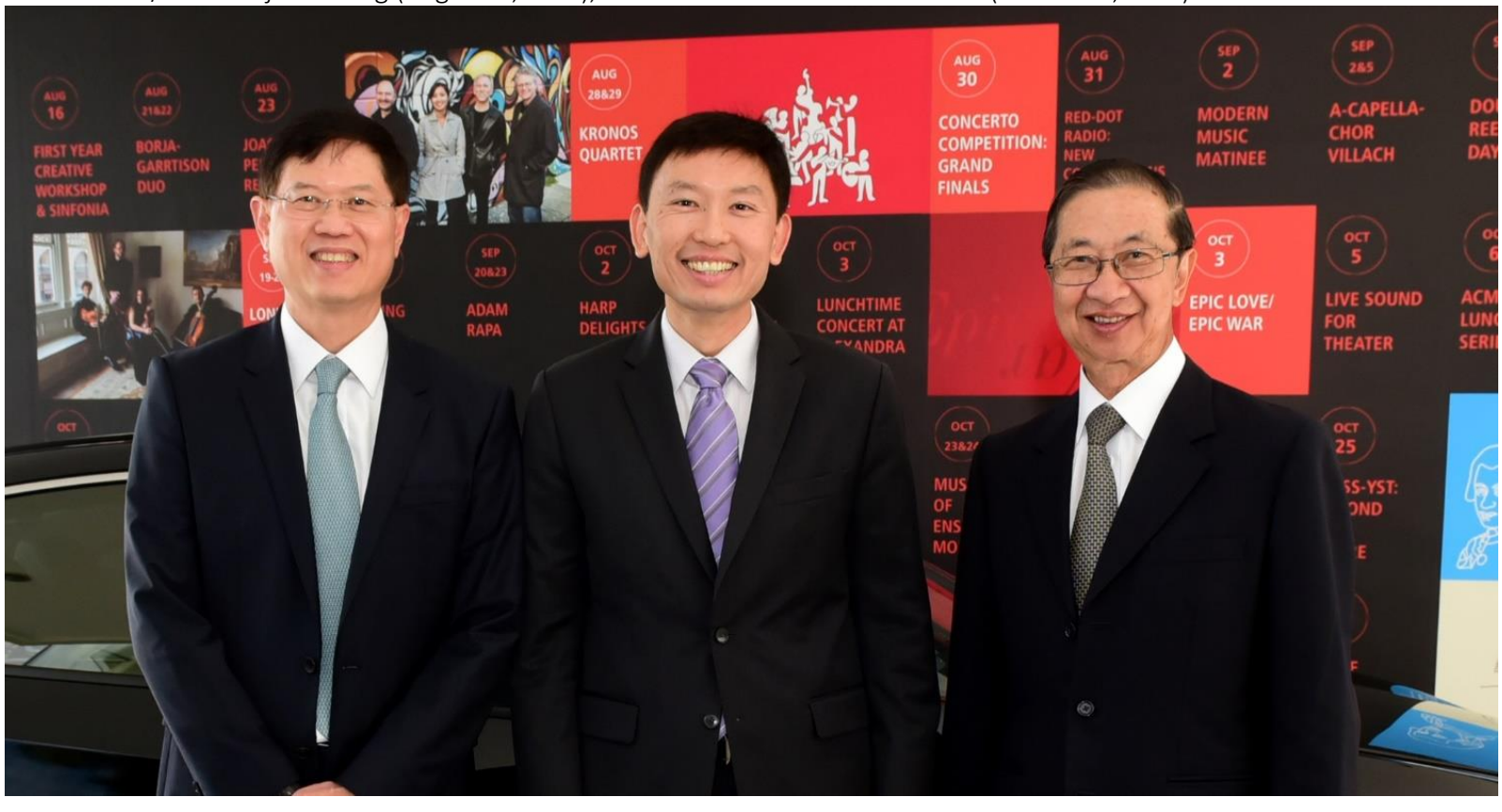
Next, I would like to touch on having the right mix of specialists to meet Singapore’s long-term healthcare needs as our population ages. There is general agreement amongst healthcare professionals that we need to evolve our healthcare system to emphasise health promotion and upstream prevention; strengthen primary care; and improve the care integration between hospitals and community.

In my view, the key issue is not whether we want more specialists or generalists.

We need both groups of doctors to provide care for patients in different settings. Or the same patient would need generalist care at some times, with specialist care at other times. The patient will benefit from having a co-ordinating doctor, looking after his overall care needs. So we are not discouraging doctors from specialising, there remains an important need for different groups of specialists in our healthcare system. What we want is to have the right mix of specialists, including larger numbers of doctors specialising in areas such as family medicine, internal medicine, geriatrics and palliative care, to meet the healthcare needs of our ageing population.

We also need to train doctors who can lead and work in multidisciplinary teams across boundaries and settings, to provide integrated care for patients. I understand it is a challenging task in practice to get the right balance as there are many factors at play. The process will be an iterative one, there will likely be mistakes made along the way in some of our estimates and projections, but I believe we can move closer to our optimal target over time if we continue to work closely with our clusters, professional bodies and medical professionals on the ground, share data with one another and engage in open communication.

From left: A/Prof Benjamin Ong (Registrar, SMC), SMS Chee and Prof Tan Ser Kiat (President, SMC).



JCI Accreditation

The third and final issue I would like to touch on is JCI. One of the reasons our healthcare institutions go for JCI accreditation is to regularly benchmark themselves and continually improve processes and outcomes. I support this objective, but we have to ask ourselves if it is still necessary and desirable for our public healthcare institutions to pursue JCI accreditation, especially when some of the JCI components are US-centric and not applicable to our local context. Over time, we may have reached a point of diminishing returns as healthcare institutions have already put in place many of the systems and processes, and also embarked on value innovation and other quality improvement initiatives as part of their core operations.

One unintended consequence of JCI is that it encourages healthcare institutions to "chase awards" in the name of quality improvement. Different groups of healthcare professionals have told me frankly that they worry JCI has lost its original meaning.

During the audit period, institutions would operate in a way which is quite different from day-to-day practice. This is not the true spirit of healthcare quality, which is about doing the right thing even when nobody is looking. Furthermore, it is also a costly and time-consuming exercise to go through the preparation and audits.

If there are more relevant and less resource-intensive methods of achieving the same objective, MOH and our public healthcare institutions should be prepared to drop JCI. We may not need to develop new initiatives, as my sense is that our institutions are already closely monitoring different safety and outcome indicators, and have developed strong organisational cultures that encourage continuous quality improvement. So perhaps it is time to consider stopping JCI completely, so that we reduce unnecessary administrative burden for our healthcare institutions and healthcare professionals, and allow them to focus on more important outcomes like improving patient care and enhancing value for patients.

Conclusion

Today's affirmation ceremony is a timely reminder of the ethical values and professional standards that you have pledged to uphold. Singapore society accords a high degree of respect for our doctors, based on the trust and confidence built over many generations. The bedrock of your professional practice must therefore always rest on maintaining this sacred trust through high standards of care, conduct and behaviour. Let's continue to work together to help Singaporeans achieve better health and a better life.

Thank you.

In Conversation with A/Prof Chin Jing Jih

Deputy Chairman, Medical Board and Senior Consultant Geriatrician at Tan Tock Seng Hospital

What brought you into the field of medicine, specifically in geriatrics?

My interest and decision to study medicine did not crystallize until my pre-university days. Until then, I was more easily thrilled by theoretical physics and mathematics.

But as I developed a better insight into my own personality, I became aware of my need to interact with people and the joy and satisfaction in engaging and helping them. I realised that I was clearly more suited to a service-oriented profession. Coupled with my inclination towards the so-called "pure science" subjects, this made selecting medicine a natural and logical choice.

When I started out as a young doctor, I became inspired and enthused by a group of doctors called "geriatricians" who consistently adopted a person-oriented and holistic approach in the care of their patients. Gradually, I realised that treating the medical diagnoses of older patients do not necessarily restore and sustain their overall health, unless the practical and social issues of their daily lives are adequately addressed. Being close to my grandmother in my childhood days also helped me in my interactions with elderly patients. So when I decided on the internal medicine path, specialising in geriatric medicine became a rather natural choice.

You had a great wealth of experience in Ethics-related matters. Why did it interest you to be an Ethicist?

I honestly do not qualify, formally or informally, as an Ethicist. If anything, I am just a doctor with an interest in issues related to medical ethics and professionalism. Maybe my interest in medical ethics is linked somewhat to my intellectual curiosity in law and moral philosophy, and I find myself frequently driven to read more and to reflect deeper on not just the 'how', but also the 'why' in medical decisions. I find that this need is particularly magnified in specialties such as paediatrics, psychiatry and geriatrics that deal with the more vulnerable population.

After a few years of training in geriatric medicine, I felt that despite being a seemingly "scientific" discipline, the actual application and practise of medicine is after all a human activity wrought with complexity, uncertainty and even fallibility. Therefore, my interest in medical ethics is also motivated by a desire to understand how it can be used to rationalise and explain the decisions, values and culture of the profession, with the ultimate goal of enhancing trust between doctors and the patients they serve.

What was the greatest challenge that you have encountered in the course of your medical career?

To me, the greatest challenge in my career lies in remaining adaptable and positive in the face of rapid changes in the practice environment. When these changes are revolutionary rather than evolutionary both in pace and magnitude, and especially when they are outside of the areas of medical science, there is a need to quickly unlearn and relearn, which naturally generates quite a lot of discomfort and even resistance among doctors.

One example is the increasing call by patients and their families for shared decision making in medical treatment. From a sociological angle, this is a positive development. But the real challenge lies in addressing the information and technical asymmetry, and the increasing post-modernist distrust for the medical profession and its practitioners. The challenge also lies in convincing doctors that we can no longer turn back the tide, and moving forward, we now need to equip ourselves with the appropriate practice model and communication skills so that our patients can be vital partners in trusting doctor-patient relationships.

Other examples where adaptability is critical are the use of technology in medical practice and patient information management, adoption of quality improvement and safety frameworks in our daily practice, and compliance with new legal standards of informed consent.

Being a doctor is not easy. Being a good doctor is even harder. What kept you motivated throughout this journey?

I guess it has to be the values and passion that have kept me going. I often tell my students and trainees that not many people can claim to have a job that is anchored by the right values, provides the satisfaction of always helping someone in need, and remunerates well and fairly. I think that being a doctor does meet most of the above, and that most doctors love their work more and more each day.

Undeniably, there is always a part of any job that you can feel quite mundane as it becomes more predictable and repetitive. But I think it is for us to seek stimulating elements and retain a sense of intellectual curiosity and wonder in our daily work. You will feel satisfied if you are able to simultaneously help patients in need and improve systems to benefit even more patients. That should keep you feeling energised daily to meet new challenges.

Did you have a mentor or role model whom you could seek guidance and learn from and who played an important role in your career in medicine?

Medicine is a unique profession where you never forget the generosity and kindness of those who have taught or trained you. I have been fortunate to have had the opportunity to learn from many seniors, colleagues and even patients and caregivers. But in particular, I would like to mention two mentors who have made an impact on me as a doctor, and whom I am always grateful.

My first role model is Associate Professor Suresh Sahadevan, who has in the past two decades, provided me with not just professional guidance, but mentorship and friendship. Through his own high standards of patient care and scholastic excellence, he has taught me the importance of professional integrity and intellectual honesty. Suresh has, in many critical crossroads of my life, provided me with a moral compass to navigate difficult professional and personal situations.

I am probably not a worthy apprentice to Suresh, but it is truly my honour and great fortune to have learnt the virtues of medical practice personally from him – trustworthiness, compassion, practical wisdom, justice, temperance, humility, fortitude, integrity and self-effacement, and not forgetting the joy and passion of teaching medicine to the next generation of doctors.

My other role model is Professor Philip Choo, whom I have learnt over the years the importance of treating not just a patient, not just an entire clinic or ward of patients, but the entire system and model of care so that as many as possible will benefit. His macro view of the healthcare system and passion for public healthcare service have kept me motivated all these years.

If you were to give a single piece of advice to our young doctors, what would that be?

I would humbly suggest that they constantly revisit, reflect and rekindle the passion and enthusiasm that once motivated them to work hard in their pre-university examinations in order to earn a place in the medical school.

That first feeling and love for medicine need to be sustained, constantly renewed and nourished in order to transform a tough and demanding profession to a truly meaningful, fulfilling and life-long vocation. Once you love your job, it will be easier to do it well in a manner that serves the needs and interests of patients, and due remuneration and rewards will follow naturally.

It would be useful to remember that medicine is not a private or individual business entity, but an institution with a set of organisational values and ethical framework designed to collectively sustain the trusting relationship between doctors and the patients we serve.

Seminar on Doctor's Duty to Advise

The Modified Montgomery Test

First Seminar on "The Doctor's Duty To Advise" held on 20 September 2017 at College of Medicine Building.

Introduction

The Ministry of Health (MOH) and the Singapore Medical Council (SMC) jointly organised two seminars on "The Doctor's Duty To Advise" on 20 September 2017 and 2 December 2017. The seminars concerned the recent Court of Appeal decision in *Hii Chii Kok v Ooi Peng Jin London Lucien and NCCS*[1] (*Hii Chii Kok*), which set out a new legal test for the standard of care in respect of a doctor's duty to advise.

During the seminars, an explanation of the *Hii Chii Kok* decision was provided, followed by a Q&A session with our panellists[2]. This article summarises some of the key takeaways from the seminars.

[1] [2017] SGCA 38.

[2] The members of the panel were (i) Clin A/Prof Peter Manning VCMB Clinical Risk Management & Medico-legal, National University Hospital (20 September 2017 session), (ii) Associate Professor Chin Jing Jih, Deputy Chairman, Medical Board, Specialist in Geriatric Medicine and Senior Consultant, Department of Continuing & Community Care Tan Tock Seng Hospital, (iii) Ms Chua Ying-Hong, Director (Legal) MOH and (iv) Mr Adrian Loo, Director (Legal) SMC.

Second Seminar on "The Doctor's Duty To Advise" held on 2 December 2017 at Health Sciences Authority Building.

Reasons for the new test

In *Hii Chii Kok*, the Court noted that there has been a seismic shift in medical ethics, and in societal attitudes towards the practice of medicine, from one where it might have been generally true that the patient remained passive through all the phases of his interaction with the doctor to one where the discussion of which treatment to pursue is now best seen as a collaborative process involving the doctor and the patient.

The Court therefore adopted a new legal test for doctors' duty to advise. The Court retained the *Bolam-Bolitho*[3] test for diagnosis and treatment.

[3] Under the *Bolam-Bolitho* test, a doctor would be found to have met the required standard of care if he had acted in accordance with the practices of a responsible body of doctors skilled in the particular area, and if those practices were supported by a logical basis.

What is the new test?

The new legal test for doctors' duty to advise is known as the "Modified Montgomery[4]" test. The Modified Montgomery test comprises three stages, each of which has to be satisfied before a doctor may be found to have fallen short of the standard of care expected of him.

Stage 1: Patient must identify the exact nature of the information he alleges was not given to him and establish why it would be regarded as relevant and material from his perspective

At this stage, the onus is on the patient to identify the *exact* nature of the information that he claims was not given to him, and establish why it would be relevant and material. In this regard, information which doctors ought to disclose is (a) information that would be relevant and material to a reasonable patient situated in the particular patient's position, and (b) information that a doctor knows is important to the particular patient **in question. Examples of relevant and material information would include:**

(a) The doctor's diagnosis of the patient's condition;

(b) Prognosis of that condition with and without medical treatment;

(c) Nature of the proposed medical treatment;

(d) Risks associated with the proposed medical treatment; and

(e) Reasonable alternatives to the proposed medical treatment, and the advantages and risks of these alternatives.

Although the Court's evaluation will take into account the personal circumstances of the patient, such circumstances would only be relevant to the extent that the doctor knew or ought reasonably to have known of them. Any guidance promulgated by professional bodies as to what information should be elicited from patients will be given great weight.

The doctor has no open-ended duty to proactively elicit information from the patient, and will not be at risk of being found liable owing to idiosyncratic concerns of a patient unless this was made known to the doctor or the doctor has reason to believe it to be so (e.g. where the patient has in fact asked particular questions or otherwise expressed particular concerns). In the final analysis, the question of whether the information is reasonably material is one that would have to be answered with a measure of common sense, and it would generally be safe to omit information that reasonable people would regard as immaterial or irrelevant.

[4] ***The test was adapted from the test laid down by the UK Supreme Court in Montgomery v Lanarkshire Health Board [2015] UKSC 11.***

Stage 2: Determine whether the doctor was in possession of the information

If the Court is satisfied that the information is relevant and material, it will determine whether the doctor possessed the information. This is a purely factual assessment.

If the doctor did not possess the information, the issue would be dealt with as (potentially) negligent diagnosis or treatment, not (potentially) negligent advice. The *Bolam-Bolitho* test would then apply.

Stage 3: If the doctor possessed but did not disclose the information, determine whether the doctor was justified in withholding the information

If both Stages 1 and 2 are satisfied, the Court will consider whether the doctor was justified in withholding the information. The Court will have regard to the doctor's reasons for withholding the information, and consider whether this was a sound judgement having regard to the standards of a reasonable and competent doctor. This inquiry is physician-centric, which means that the expert evidence of doctors seeking to justify the withholding of such information as a matter of medical practice and judgement will assume some significance. The Court acknowledged the concern that even in the dispensation of information, there is an element of professional judgment involved. Examples of situations where a doctor would be justified in withholding information include where the patient has waived his right to hear further information, in emergency situations and where therapeutic privilege applies.

Key takeaways from the seminars

A doctor's duty to advise only covers that which would enable the patient in question to make an informed decision. A doctor is not under a duty to provide his patient with an encyclopaedic range of information in relation to anything and everything which a patient might wish to know.

While the Modified Montgomery test introduces a more patient-centric perspective in Stage 1, the standard is not unattainable or unreasonable. In fact, in *Hii Chii Kok* itself, Dr Ooi was found to have sufficiently discharged his duty under the new legal test. This case concerned a patient who suffered life-threatening complications after undergoing a major pancreatic surgery (the Whipple procedure) that turned out to be unnecessary. The patient alleged that he had not been advised of 14 points of information, including the number of times the Gallium PET/CT scan (which revealed the lesions on his pancreas) had been used and its diagnostic value in circumstances where no corresponding mass was detected on the CT and MRI scans. However, the Court found that many of these points were not relevant and material, and did not even pass Stage 1 of the Modified Montgomery test.

On the facts, the patient had been advised of the likelihood and magnitude of consequences of the risks associated with the Whipple procedure, the uncertainty as to whether the lesions were in fact cancerous, and the existence, advantages and disadvantages of alternatives to the Whipple procedure (including further diagnostic tests). This was sufficient to discharge the duty to advise. The fact that the Court adopted a Modified Montgomery test therefore did not change the outcome.

The Panellists: From left, A/Prof Peter Manning (VCMB Clinical Risk Management & Medico-Legal Matters, NUH), A/Prof Chin Jing Jih (Senior Consultant, TTSH), Ms Chua Ying-Hong (Director, Legal, MOH) and Mr Adrian Loo (Director, Legal, SMC).

The SMC's 2016 Ethical Code and Ethical Guidelines (ECEG) already requires doctors to inform patients of the purpose of tests, treatments or procedures, the benefits, significant limitations, material and more common risks (including those that would be important to patients in their particular circumstances) or possible complications, as well as the alternatives which are available. The 2016 ECEG also expects doctors to keep records of all clinical details, discussions of investigations and treatment options, informed consents, results of tests and other material information. Accordingly, doctors need not see the *Hii Chii Kok* decision as something that drastically alters how they practise.

During the seminars, A/Prof Chin Jing Jih shared that it was good practice for a doctor to find out about a patient's occupational history, hobbies and aspirations as part of his history-taking. This information would help the doctor determine whether a specific risk was relevant and material to the particular patient. However, the panellists also emphasised that the doctor did not have an open-ended duty to proactively elicit information from the patient. The doctor only had a duty to disclose risks that were of special significance to the patient if he was informed or ought reasonably to have known of the patient's special circumstances.

As part of his presentation during the seminar on 20 September, A/Prof Peter Manning also shared the following additional question that doctors can include as part of their consent-taking process under the Modified Montgomery test:

> *"I have explained what I think you should know purely from a doctor's standpoint, including the most common and the most serious possible complications, but I am not you - what is especially important to you about the planned operation or treatment that I might have not mentioned?"*

An area of concern raised by participants was how they should discharge their duty to advise to their patients when the patients wished to delegate the decision-making process to their relatives. The panellists explained that only the patient (assuming he has mental capacity) can consent to treatment, and a doctor should always involve the patient in the decision-making process, unless the patient clearly waives his right to participate in the decision-making process. The panellists further advised that such waiver should be expressly and properly documented.

Conclusion

In essence, the modified Montgomery test requires doctors to take *reasonable* care to give patients the information they need to make informed decisions, in a way that they can understand. Doctors are not expected to meet "unrealistic standards of behaviour", and the Modified Montgomery test is not intended to make medical practice more difficult. Rather, in the words of the Court itself, "*the ultimate aim [of the Modified Montgomery test] is for patients to have sufficient information to understand the consequences of their decision*"[5].

[5] [2017] SGCA 38 at [156].

5 Myths about the SMC Disciplinary Process

Myth 1: The SMC decides whether a doctor is guilty of misconduct and determines the appropriate punishment.

Reality: In line with the principle of self-regulation, doctors are judged by their peers.

Every complaint received by the SMC is first investigated by a Complaints Committee (CC). Each CC is chaired by a Council member, but consists also of another senior doctor and a lay person nominated by the Minister for Health. Therefore, when a complaint against a doctor is referred for an inquiry by a Disciplinary Tribunal (DT), it is not the SMC which makes that decision, but a committee made up primarily of doctors.

To preserve the independence of the DTs, Council members do not sit in DTs. Instead, every DT comprises a chairperson appointed by the Minister and at least two senior doctors. The DT's determination at the end of the inquiry thus represents the judgment of the profession, and not the SMC.

Myth 2: Whenever a complaint is made against a doctor, the SMC will side with the complainant/patient and discipline the doctor.

Reality: It is a CC which investigates each complaint, and patient safety is the foremost concern. In reality, very few complaints result in a DT inquiry.

Last year, the SMC received 182 complaints against doctors. Under the Medical Registration Act, a CC must inquire into every complaint. At the end of its inquiry, the CC can, inter alia, refer the matter to a DT, issue the doctor a letter of advice or a letter of warning, refer the matter for mediation or dismiss the complaint.

Due to the media's coverage of DT cases, there is a misperception that complaints inevitably result in DT inquiries and the doctors involved being disciplined. On the contrary, of the 137 complaints concluded by the CCs in 2016, only 10 percent were referred to a DT. Over 50 percent of complaints were in fact dismissed, with the remainder mostly resulting in the issuance of a letter of advice or a letter of warning. The CCs' chief concern is patient safety, and they neither side with complainants/patients nor doctors.

Myth 3: Doctors will be punished if they make minor mistakes or errors of judgment.

Reality: Doctors will only be found guilty of misconduct if the mistake or error constituted serious negligence.

In a recent case, it was widely (mis)reported in the media that a paediatrician had been disciplined for failing to diagnose a child with Kawasaki disease (KD). As a result, many doctors became worried that they too could be punished if they failed to diagnose a patient correctly, even when it was a difficult diagnosis. However, the paediatrician's misconduct did not lie in her failure to diagnose the child with KD (which parties agreed was not a straightforward diagnosis), but her failure to order supportive tests to determine if incomplete KD or KD could have been excluded as called for by an internationally accepted guideline the paediatrician had claimed she followed.

The nature of doctors' work does mean that their mistakes come under greater scrutiny than in other occupations due to the potentially catastrophic consequences. However, a doctor will only be found guilty of misconduct if he or she was seriously negligent.

Myth 4: When an expert is approached for an opinion, he or she must testify against the doctor being complained against.

Reality: An expert should provide his or her objective opinion on the doctor's conduct, even if it absolves the doctor of any fault.

Some complaints may necessitate the CC seeking an expert opinion on whether a doctor's conduct was appropriate. Very often, experts approached decline to assist due to a misconceived notion that they are being asked to testify against a fellow doctor. This difficulty in finding experts has led to significant delays in the investigation of certain complaints, and is unfair to complainants as well as the doctors complained against.

An expert only needs to provide his or her objective opinion of the doctor's conduct, and CCs will generally defer to the expert's assessment. Experts who refuse to assist without good reason do a disservice not just to their fellow professional but to the profession as well. Ultimately, for the medical profession to regulate itself effectively and avoid allegations that doctors protect their own, doctors must be prepared to step forward and offer their expert opinions when called upon.

Myth 5: Investigations into complaints take many years.

Reality: Investigations into most complaints are completed within two years.

The length of time taken to investigate complaints against doctors has come under scrutiny recently as a result of comments by the Court of Three Judges, but this must be evaluated in the context of several constraints:

(a) Complaints may involve numerous allegations that require thorough investigation;

(b) Medically complex complaints require the input of experts, who are sometimes difficult to find;

(c) The doctor complained against must be given an opportunity to address the allegations, and often request more time to do so;

(d) Other issues may emerge in the course of investigation which necessitate further inquiry; and

(e) CCs consist of volunteers who are full-time professionals, and who have to find time outside of their work to meet and deliberate.

Complaints that do not require expert opinions are usually resolved within six to nine months. CCs naturally need longer to investigate more complex complaints as the process of obtaining an expert opinion will take a few months at the very least. Even then, the majority of complaints result in an outcome within two years. Nevertheless, there are ongoing efforts to improve and speed up the process to avoid undue delay for both complainants and the doctors involved.

Key Areas to Note

Changes to the SMC Registration and the Supervisory Framework for conditionally and temporarily registered doctors

As part of the regular review to maintain the high standards of practice of medical practitioners and to ensure patient safety, the SMC has recently reviewed the criteria for applications for Full, Conditional and Temporary Registration as well as the Supervisory Framework for conditionally and temporarily registered doctors.

To find out more, click on the links below:

- SMC Circular
- Summary of Changes
- Annexes to the Circular

Key Areas to Note

Fees Revision with effect from 1 April 2018

In October 2017, it was announced that fees for registration and practising certificates (PCs) for most categories of doctors will increase from 1 April 2018. Only doctors who apply for registration and practising certificates from 1 April 2018 onwards will pay the increased fees.

SMC last adjusted its fees in 2012. With rising operational expenses which include, manpower, systems, services, operations and maintenance, the fees revision will help to cover basic operational costs to regulate the medical profession.

Category	Application Fees	
	Current Fee (S$)	New Fees (S$) (from 1 April 2018)
Registration		
Full Registration	250	300
Conditional Registration	300	300 (unchanged)
Temporary Registration	250	300
Temporary Registration (Renewal)	100	300
Provisional Registration	135	150
PCs		
Practising Certificates* • One-year PC • Two-year PC	 400 800	 450 900
Lower PC Fee**	150	150 (unchanged)

*This refers to the PC fees for doctors on full, conditional, temporary or provisional registration. Doctors on lower PC fee category are not affected.

** The Lower PC fee is only available for doctors who fulfil conditions e.g. they are not in active practice. The mandatory conditions to be eligible for a lower PC fee are: a) doctor is not working as a locum; b) does not collect any fee for his/ her services; and c) does not run a medical clinic.

Key Areas to Note

Practising Certificates (PCs) Renewal

Fully and conditionally registered doctors whose PCs are expiring on 31 December 2017 and who have yet to submit their PC renewal application are advised to login to the SMC's website at www.smc.gov.sg to do so promptly.

PC Renewal Criteria

To renew his/her PC, the doctor must fulfil the following criteria:

- Obtained sufficient Continuing Medical Education (CME) points within the qualifying period; and
- Must not have any outstanding fine for not voting in previous SMC's Elections (only applicable for fully registered doctors).

Example:

When a doctor's existing two-year PC is valid from 1 January 2016 to 31 December 2017, any CME points accrued for approved CME activities during the qualifying period between 1 January 2016 and 31 December 2017 can be counted towards his/her PC renewal.

Late application fee charges

A late application fee of $80 is chargeable in addition to the PC renewal fee for applications that are submitted in the month of December. Under the Medical Registration Act, doctors are required to hold a valid PC before they can practise.

Feedback

For feedback and comments, please contact us at smc_newsletter@smc.gov.sg.

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