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Medical
Council

Handbook on Medical Ethics

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Preface

This publication is an educational resource on medical ethics. It contains an introduction to the principles of medical ethics, information to help determine what is meant by “patients’ best interests” and a discussion of the ethical challenges that medical practitioners in modern medical practice face.

Two types of information can be found in this Handbook on the requirements of medical ethics and how they are applied in a variety of situations.

The first type of information is designed to help you understand the rationale behind the ethical guidelines in the publication, the 2016 edition of the **Singapore Medical Council (“SMC”) Ethical Code and Ethical Guidelines (“ECEG”)**. This information expounds on what the guidelines mean and how the “you must” statements may be applied. You can also find explanations and elaborations here in the Handbook that are not part of the 2016 ECEG.

You may take reference from this Handbook when evaluating whether you have successfully met your ethical obligations under the 2016 ECEG in a particular set of circumstances. However, if there are any apparent inconsistencies between the 2016 ECEG and this Handbook, the 2016 ECEG will prevail.

SMC encourages medical practitioners to study this Handbook in conjunction with the 2016 ECEG to improve your understanding of medical ethics and ultimately improve how you manage patients.

The second type of information is a discourse on the ways in which you could achieve the ethical and professional standards embodied in the 2016 ECEG. The phrase “you should” is extensively used and indicates advice on a variety of best practices. The phrase “you should” is also used where the principles may not apply in all situations, for instance, where there are factors outside your control that affect whether or how you can follow the guidelines.

If you are not able to do as stated by the “you should” statements and suggested “best” practices, it does not necessarily mean that you have failed to uphold the basic requirements of the 2016 ECEG. Each case will be judged by its particular facts and circumstances. This Handbook aims to help you to continually improve your practices and provide a framework for thinking through ethical dilemmas that you may face.

Introduction

This section introduces you to important concepts to help you understand what shapes medical ethics and provides a brief scan of the types of ethical challenges you may face in modern practice. The topics covered are:

1. The foundation of medical ethics
2. Patients' best interests
3. Ethical challenges facing the profession

1. The foundation of medical ethics

The principles of medical ethics generally transcend an individual medical practitioner's (hereinafter referred to as "doctor") philosophy, politics, religion, moral beliefs and/or personal attitudes. Four principles form the foundation of medical ethics and they are, in no order of priority:

(a) Beneficence

You are committed to helping your patients by providing medical benefit through your activities. You need to be sufficiently educated and trained in the appropriate fields of practice to ensure that you are competent enough to offer patients your services. Over time and with technological advancements, your level of medical competence ought to be maintained through the continued acquisition and practise of knowledge and skills.

(b) Non-maleficence

You are required to do no harm to patients, or in your treatment of patients, to minimise harm whilst maximising possible medical benefit. To provide a net benefit to patients and for you to be able to act in the patient's best interests at all times, you need to have the requisite knowledge of and experience in your field of practice. Your treatment of patients ought to be based on a combination of reliable and established medical knowledge together with the experience and wisdom of the medical profession.

(c) Respect for autonomy

Patients have a right to decide for themselves what treatment to accept. To help patients make informed decisions, it is your duty to provide them with relevant information and advice on the alternative treatment options available, benefits and risks involved. You need to ensure that patients' decisions are voluntary, made in a conducive environment with sufficient time for the patient to understand the information and advice provided in a setting free of coercion.

Since your advice to patients is based on medical information given to you in the context of your professional relationship, you have an obligation to preserve patient confidentiality. You ought not deceive or mislead patients who desire to understand medical information about themselves. You are also not to undermine your patients' autonomy by misrepresenting your qualifications, capabilities or the expected outcomes of your care. Effective communication is a key component of respecting patient autonomy. It is important to note, however, that patient autonomy is not absolute, because respect for autonomy includes respecting the autonomy of those who may be potentially affected, such as you or other healthcare professionals and members of the wider community.

(d) Justice

You are required to treat patients fairly and equitably, according to their medical needs, with neither preference nor prejudice. You need to work with the resources available to you and your patients (distributive justice), with respect for people's rights (rights-based justice) and for the laws of the country (legal justice).

While you should generally be guided by the four principles above, how you prioritise the relevance of the principles and apply them to individual cases can vary considerably depending on the situation.

You are required to exercise your best judgment whenever ethical dilemmas present themselves, as far as possible, based on the four principles.

The principle of peer review requires the appropriateness of your professional behaviour to be determined by the opinions of fair and reasonably minded doctors of suitable qualifications and experience based on how they would behave in similar circumstances. Peers will take into account the precise circumstances in which you found yourself to determine the range of acceptable responses consistent with the ethical guidelines in question. Even if laypersons are involved in the assessment, they would generally defer to the opinions of the medical peers on the medical acceptability of your conduct.

The ultimate indication of the respect laypersons have for the opinions of medical peers is the treatment of such opinions by the courts. It has been affirmed time and again that the courts would be slow to disagree with or dismiss the opinions of the medical profession on issues of medical ethics or standards of professional conduct, unless the courts find that these opinions are unsafe, unreasonable, or contrary to the evidence.

2. Patients' best interests

You are expected to act in your patients' "best interests". This obligation forms the foundation of the relationship between you and your patients. You are required to focus on what your patients would consider to be in their best interests and not what you would consider to be in your best interests if you were in the same position.

Your duty is therefore to provide patients with the necessary information and disclosures so that they can, with the help of your clinical judgment and professional advice, make personal determinations as to the best course of action to take.

Patients' "best interests" are representative of their right to autonomy. For patients who may not necessarily possess the capacity to make decisions, your duty to act in patients' "best interests" remains relevant. When asked for your professional advice on what would be in patients' "best interests", you should take into consideration the relevant non-exhaustive factors below while giving weight to each depending on the precise circumstances:

- (a) The benefits expected from the proposed intervention.
- (b) Patients' previously expressed preferences or wishes.
- (c) Patients' personal views, values and beliefs which should be ascertained insofar as the patient is able to shed light on them or has previously expressed.
- (d) The background culture or religion of the patients that may influence the decision in question.
- (e) The opinions of other healthcare workers, caregivers or immediate family members of the patients, or other professionals involved in the patients' care.
- (f) The values of society.
- (g) The option which least restricts a patient's future choices in situations where there are multiple appropriate options that may potentially be in patients' best interests.
- (h) Resource availability and limitations on the part of both the healthcare provider and patients.

You may find the following helpful in determining a patient's "best interests":

- (a) Advance Care Planning.
- (b) Provisions under the Singapore Mental Capacity Act.
- (c) Advance Medical Directive under the Advance Medical Directive Act.
- (d) Any advance statement made by patients on care or treatment that they might accept or refuse in particular circumstances.

You should familiarise yourself with and become competent in the relevant processes and legislation such as those listed above. You should discuss with your patients and encourage them to make their values and wishes known well before they are unable to do so or to make decisions about their own care.

3. Ethical challenges facing the profession

SMC has updated the 2002 edition of the ECEG to reflect current thinking on how doctors need to bring ethical standards up to date to align with new practice patterns and societal expectations.

In view of the constantly evolving nature of medical practice, society and technology, it is challenging to keep abreast of developments and work out how ethical principles apply to new situations. Some recent changes include:

(a) New developments

The major issues confronting you in these modern times include the commercialisation of medical practice and the move beyond preventing and curing diseases to “wellness” or the enhancement of appearance or function. An increasing number of different treatment modalities have become available, including complementary and alternative medicine, some varieties of which may be acceptable in the treatment and care of patients. However, there also exist many other non-conventional treatments which either do not have an established scientific basis or do not have convincing supporting evidence of their efficacy and safety. Hence, these are not widely accepted by the profession. Engaging in these unconventional treatment modalities may lead to ethical pitfalls.

New media platforms present a further challenge to the maintenance of professional patient-doctor relationships, quality of consultations, marketing and your public image. While new media are powerful communication channels and may be used for the benefit of patients, their pervasive and persuasive nature is open to abuse in advertising. You have to resist the tendency to utilise these opportunities in ways that mislead patients or take advantage of them.

Telemedicine is now becoming increasingly common as a component of the treatment of patients. However, it poses several ethical dilemmas and it is important to bear in mind that the use of telemedicine technology should not diminish your responsibilities to the patient.

(b) The business of medicine

If you are involved in either medical or non-medical businesses (be it your own practices, extended medical practices involving other practitioners and allied practitioners or even non-medical businesses either in association with your practices or acting as entirely separate entities), you may face many competing interests that could lead to compromises in professional standards and behaviour. Although there are clear legal distinctions between your status as an individual doctor and any registered company that you may direct or manage, you nonetheless need to be careful to ensure that any financial or commercial interest in your business does not adversely influence the way you treat patients. SMC takes the view that you cannot hide behind the fact that your company is a separate legal entity when your practices or your companies conduct business in a fashion that breaches medical ethical principles, brings disrepute to the profession, or otherwise damages the dignity of the profession.

Your relationships with pharmaceutical or device companies can be complex. You may be:

- Appointed as consultants or onto the advisory boards of companies.
- Subject to pressures from business relationships through offers of gifts, entertainment or sponsorships for meetings and conferences.
- Working with commercial firms for the development and marketing of your inventions or discoveries.

All such relationships with other entities or industries are liable to be scrutinised by the public and it is important to be honest and transparent with patients about your financial arrangements or interests in such companies that are material. It is equally important that your treatment and professional advice are based on patients' best interests, resisting any biases that may arise from your interactions with such companies.

Advertising of medical services and products or programmes has burgeoned in the past decade. There is an emerging trend of advertising that goes beyond mere provision of information about doctors' services and which is not in keeping with the image of the profession, or which wrongly generates demand through playing on patients' vulnerabilities. You have an obligation not to engage in such marketing practices.

(c) Beyond medical duties

SMC-registered doctors, whether or not they are still practising, may have duties of a more administrative nature, for example, they may be running healthcare organisations or involved in formulating healthcare policy. These roles may sometimes be undertaken by non-doctors. The focus of practising doctors will be on providing their individual patients the treatment they need, while healthcare administrators and policymakers may be more concerned about finance or resource allocation. As a doctor who takes on policy-making or management roles, you have the added responsibility of ensuring that decisions and policies generally conform to the principles of the ECEG where patients' best interests are concerned.

You may also often act in a "third party" capacity, either for the purpose of statutory or insurance health screens, or evaluating patients for administrative, insurance pay-out or medical classification purposes. You may also be asked to be an expert witness. In such circumstances, you may not be the managing doctor of the patients, but you still have obligations to discharge such roles professionally and ethically when you make decisions in your capacity as a medical professional.

(d) Globalised medicine

Finally, in a globalised world, you may travel widely, whether to participate in lectures, seminars and conferences, or to market or advertise your services to overseas medical institutions or patients. Some of you may travel to render medical services to overseas patients for fees or on a humanitarian basis. Regardless of the purpose of your engagement, you have to uphold the reputation of Singapore-registered doctors and abide by the laws and regulations of the country you are in. For example, foreign regulations may require you to be registered or licensed to practise in the country. Besides the ECEG, you have to abide by the local professional code of conduct, ethical guidelines and/or its equivalent. You may be subject to disciplinary action in Singapore based on complaints or information received from foreign countries or regulatory bodies of unprofessional or unethical conduct while you are abroad.

To sum up, modern medicine encompasses issues which are complex, controversial and tinged with ethical considerations. As contentious issues emerge with time, you need to keep abreast of developments and try your best to apply ethical analysis to practical problems associated with these issues.

A - GOOD CLINICAL CARE

Good clinical care refers to good practices for clinical care that are in patients' best interests. While there are many aspects to good clinical care, the following will be discussed in this section:

- 1. Duty of care**
- 2. Clinical evaluation of patients**
- 3. Practising within competence, maintaining and improving performance, and offering the current standard of care**
- 4. Delegation and referral of patients**
- 5. Working in teams**
- 6. Telemedicine**
- 7. End-of-life care**

A1. Duty of care

Your duty of care to patients includes providing competent, compassionate and appropriate care.

You are also expected to provide a comparable standard of care if your contribution to a patient's care is indirect (examples would be those in laboratory and radiological specialties).

You are obliged to do what you can to provide care in a timely manner to prevent suffering or deterioration of patients' conditions.

This refers to:

- (a) Seeing patients in a timely fashion according to their needs.
- (b) Arranging appropriate and timely investigations.
- (c) Ensuring that results of tests are communicated to patients.
- (d) Providing the most appropriate management expeditiously.

It is understood that in a system of care, you may not have control over timeliness in managing your patients but you should, where it is within your ability, try to ensure timeliness. For example, you can plan review appointments according to patients' clinical needs, subject to availability of time slots. Where timely review of patients is not possible due to logistical constraints, you should try your best to get your patients seen by other appropriate healthcare professionals who can assist your patients in a timely manner.

If you avail your patients of any supporting medical services, you need to ensure that the services are licensed or accredited by the relevant authorities and to be reasonably confident that the services are reliable and of adequate standard.

Medical services that operate in Singapore are required to be accredited and licensed by the Ministry of Health (“MOH”) and these would not be in doubt. However, if you intend to use a service that is in an overseas jurisdiction, this ought to be accredited by a local accreditation body approved by MOH.

MOH maintains information on approved overseas laboratory accreditation bodies and you should visit their website to ensure that the overseas service you propose to use is accredited by an accreditation body approved by MOH.

In any case, you should satisfy yourself that the quality of service provided is good enough for your patients, i.e. despite a service being licensed or accredited, if you have doubts about the service quality, you should avoid using it for your patients.

You are obliged to provide a standard of medical care that is rational and based on a balance of evidence and accepted good clinical practice.

Your management should be based on your evaluation of evidence wherever it is available and of sufficient quality. Where evidence is scanty or unreliable (and it is accepted that many well-established treatments are indeed without good scientific evidence but are well accepted as beneficial), you should exercise judgment, taking reference from best practices among your peers.

The treatments you offer your patients need to be beneficial. Treatments are not legitimate just because there is little evidence of harm or because they are widely used. You ought to have sufficient reason to believe that they are beneficial to your patients.

Pervasiveness of practice does not legitimise untested or unproven practices. It is not appropriate, for example, to offer facial injections of Vitamin C even though many doctors offer them based on thin evidence. Among these doctors, they would no doubt say that it is accepted practice. However, as long as the evidence is of insufficient quality, such treatments are not considered legitimate.

If you are managing referred patients or have some aspects of the care of patients delegated to you, you are obliged to provide the same quality, standard and duty of care for the aspects of care which you are responsible for as you would offer your own primary patients.

Regardless of whether a cure is possible, you should ensure that your patients have relief from pain and discomfort as soon as possible.

A2. Clinical evaluation of patients

A2.1 - Need for adequate information

In general, you need to ensure that you have sufficient information about your patients derived from good history-taking, adequate clinical examination and other relevant investigations or information sources, before you offer any opinion, make management plans or offer treatment.

In conventional consultations, where there is no intermediating doctor or other healthcare professional to provide necessary and reliable information, a thorough assessment of new patients' conditions is usually only possible through good history-taking and thorough clinical examination conducted in person by you.

Only in exceptional or emergency circumstances (for example, when a lay third party comes to you asking for advice for a casualty in an emergency situation but you are unable to see the patient in person at that point), should you offer any opinion or a diagnosis or treatment without in-person contact and without the intermediation of another doctor or healthcare professional who can provide you with reliable information.

Sometimes relatives come to you for a second opinion, without the patients being present (perhaps ill and hospitalised elsewhere) but with extensive medical records, copies of doctors' medical reports, blood test results, imaging reports and even films and DVDs. Regardless of the details available, it would be impossible to form a firm opinion about a course of action without actually being able to see the patients. Any opinion you give needs to be qualified.

A2.2 - Handling requests for remote consultations

When contacted remotely by patients previously unknown to you and there are no attending doctors or healthcare professionals who can intermediate and provide good quality information, you are obliged to inform the patients that your opinion is qualified and limited to what you can assess from information available to you.

There may be situations in which previously unknown patients could, on an ad-hoc basis, initiate contact with you, without the intermediation of attending doctors or healthcare professionals. This could occur by email, phone call, or through websites which have portals for the public to connect with you.

Sometimes, these previously unknown patients may come to you in person but outside of a formal consultation, such as at the end of a medical talk, with detailed information such as images or laboratory data, requesting an opinion. You may respond but make it clear to patients that your opinion is qualified and limited to what you can assess from the available information. If the information is unsatisfactory, you should advise patients that without a personal consultation, you cannot give any specific recommendation, but can only give advice of a general nature.

In general, a remote first consultation, or one that is casual, is unsatisfactory as it is difficult to obtain all the information you need. In such circumstances, you should offer to see new patients in person before providing your definitive opinion or offering specific treatment.

If you deem that the information available through intermediating doctors or other healthcare professions is satisfactory, then you can proceed to offer definitive opinions or management plans to patients you have never seen.

Such information could be in the form of very detailed accounts of history and physical examination conducted by the intermediating doctor or healthcare professional where you are able to ask questions to obtain further information or clarification to your satisfaction. A typical example is a consultation initiated by another doctor on behalf of a patient who is overseas, asking your expert opinion to help solve diagnostic or management dilemmas in difficult cases.

A2.3 - Remote consultations during follow-up

Remote follow-up of patients well-known to you is acceptable. However, you need to ensure that there is no evidence to suggest that your patients have any clinically serious deterioration or developed new problems or complications, in which case you ought to see them in person, or ensure that they are assessed by doctors or other appropriate healthcare professionals to whom you can delegate this responsibility.

If you have already established sound professional relationships with patients, previously established the diagnoses and the patients have commenced treatment, remote follow-up is acceptable when it is for the purpose of monitoring patients' stability. For example, it would be acceptable for you to evaluate a patient you are treating for hypertension by phone or email, whereby you can receive their records of blood pressure measurements taken by an automatic machine or by an attending healthcare provider.

However, you need to be sensitive to evidence suggesting that your patients have any clinically serious deterioration, developed new problems or complications. For example, if a diabetic patient were to report a higher than acceptable blood sugar level, provided there is no evidence of a more serious complication, you could advise adjustment of the dosage of medicine or insulin. However, if these patients were to say that they felt lethargic, drowsy or had a fever, you would need to ensure that a proper in-person evaluation is conducted because the patients may have an infection or be in diabetic ketoacidosis. It would then be your responsibility to see the patients personally, or ensure that they are seen by another doctor or appropriate healthcare professional.

In practice, this means that you should communicate with patients, or at least other responsible healthcare professionals involved with the patients so that you have sufficient information to make clinical management decisions. If you have any doubt, you should refrain from making clinical decisions until you have enough information.

A3. Practising within competence, maintaining and improving performance, and offering the current standard of care

To ensure that patients are well-managed, you are obliged to practise within the limits of your own competence. You are not to engage in unsupervised practice of an area of medicine without having the appropriate knowledge and skills or the required experience.

You are obliged to keep your knowledge and skills up to date throughout your working life, so as to always provide care that is generally accepted as current.

To remain current in your practice, you should:

- (a) Engage in continuing medical education.
- (b) Familiarise yourself with up to date research data, clinical guidelines and the current standard of medical care.
- (c) Associate with other doctors in the same area of practice for mutual learning, such as in journal clubs, case discussions or conferences.
- (d) Participate in audits and reviews of your work.

Where treatment beyond your competence is required, you should offer to refer your patients to other doctors with the necessary expertise as this is in your patients' best interests.

For example, not all hospitals offer paediatric cardiac surgery. It would be right for cardiothoracic surgeons who do not have sufficient experience in paediatric cardiac surgery to refer their patients to others who do, provided that these services are reasonably accessible to the patients.

You may advise patients that you require the participation of other doctors who may have the required skills or expertise to supplement your treatment of the patients and seek patients' consent for the involvement of the other doctors. If the patients still decide to remain in your care, you should only continue managing them if you can meet the minimum required standard of care.

For obvious reasons, it is dangerous to practise an area of medicine without having the appropriate knowledge, skills and experience to do so.

In practice, there are few restraints on doctors practising whatever they wish, which is why insight into your own capabilities is important. Hospitals may have credentialing criteria for doctors performing specialist procedures in their premises. However, doctors often have free reign in clinics. You should be conservative in assessing your own competence in providing treatment.

You are obliged to provide information to your patients of options for their care that are generally accepted to be more beneficial to them than what are available to them where you practise.

Patients have the right to be offered diagnostic and therapeutic services that represent current thinking on what is most appropriate or beneficial for them. You are therefore required to provide the current standard of care.

It is, of course, not required that you provide the most up to date modalities of treatment, since these may be very new in literature or have been adopted in only a few places. However, once a sea-change in the paradigm of treatment has occurred, you would be expected to provide the current standard of care.

For example, in the past, only open heart surgery and coronary artery bypass grafting were available for heart patients. With medical advances, this is no longer the case. Patients should be offered angioplasty and coronary artery stenting if they can benefit from these.

If you cannot provide services that are necessary or most beneficial for your patients, you ought to offer to refer them to other doctors or institutions which can provide the most appropriate care.

A4. Delegation and referral of patients

Delegation involves asking another person to provide some aspect of treatment or care on your behalf.

You may delegate some aspect of care to another healthcare professional to provide but you have to take reasonable care to ensure that the healthcare worker (who may be a doctor, nurse or ancillary service provider) possesses the requisite qualifications, knowledge, experience and skills to carry out that aspect of care or procedure to the required quality and standards.

If you delegate care, you retain responsibility for coordinating and overseeing the overall care of your patients, as well as your decision to delegate, although you are not accountable for the decisions and actions of those to whom you delegate.

If you are delegated aspects or portions of care, you are required to provide patients an appropriate standard of care for the areas you accept responsibility for, even though these patients remain primarily under the care of the delegating doctors.

You should communicate adequately with the principal doctor so that the delegated care is appropriate to the overall clinical needs of the patient.

A patient's care should only be delegated to a person in training in the context of a legitimate training programme and you should exercise effective supervision over this person. Alternatively, this person should be overseen by an appropriate supervisor.

Referral involves transferring some or all of the responsibility for patients' care to other doctors. Referrals can be temporary, for example, for a specialised investigation or specific treatment modality, or can be for the purpose of handing over substantial or full responsibility for the care of the patients to the other doctors.

In referring patients for specific tests or treatments, you retain substantial responsibility for coordinating and overseeing the overall care of the patients. If you are handing over substantial or full responsibility for the care of the patients to another doctor, you have far less responsibility for the outcomes, although you retain responsibility for your decision to refer.

It is also necessary for you to make reasonable provisions to ensure that patients have sufficient medical care and treatment to see them through until their care is taken over by the doctor to whom they have been referred.

For more substantive referrals where most, if not all of the responsibility for the continued care of a patient is transferred to another doctor, it will be sufficient for you to provide an appropriate referral document containing sufficient information and make the necessary appointments for the patient (unless the patient expresses the wish to do so personally).

For example, if a patient is to see a doctor referred to within a month, it would be reasonable to provide a month's medicine to the patient. If the patient does not see the new doctor within the agreed timeframe, it would be the patient's responsibility to ask you for more medicine and not your responsibility to track the patient.

When patients are referred to other doctors, you have to inform them of the reasons for the referral and give them relevant information about the other doctors so that they can consent to the referral.

As patients will have to make the effort to see another doctor and perhaps incur expenses, such information would reassure the patients that the referrals are necessary and in their best interests. Formal consent is not required as patients would normally express implicit consent by agreeing to see the doctor referred to and take the referral document along.

A4.1 - Transferring care of patients

Such transfers may occur between:

- (a) General practitioners ("GPs") and specialists or among GPs and specialists.
- (b) Wards and units in institutions.
- (c) Doctors handing care over to other doctors on a rotating shift or on-call system.
- (d) A change of doctors for any reason, whether initiated by doctors or patients.
- (e) Teams that manage patients in turn.

When you transfer patients to other doctors, continuity of care is essential. The minimum standard of care necessary is the sharing of sufficient medical information for the receiving doctors to continue providing good medical care.

It is also essential that patients have sufficient medical care and treatment to see them through until their care is taken over by the doctors to whom they have been transferred.

If you transfer care to doctors of your choice, you should facilitate the making of appointments. If patients wish to choose their own doctors or make their own appointments, it may be sufficient to give them the necessary medical information and leave it to them.

Except in institutional care where transfer of care to the on-call team or a new team on a roster is routine (and if asked, it would be sufficient to tell patients the general type, level and experience of doctors involved), patients should be informed of your intention to transfer care to other doctors and your reasons for doing so. Where it is not routine, you should give patients sufficient information about the other doctors so that they can consent to the transfer.

A5. Working in teams

You may work in teams that include other doctors, nurses and other healthcare professionals. Multidisciplinary teams provide many benefits to patients, but working in teams also poses challenges.

If you work in teams, you have to ensure that your management of patients under your care for the portion of time or the aspects for which you are responsible meets the quality and standard of care expected of you.

Because your responsibility is shared, you need to have good communications with other team members so that the team as a whole can provide the best care possible.

In addition, the care you provide ought to be appropriate to your capability or role within that team. If the requirements exceed your capability, as part of good communications within your team, you should inform your team leader so that appropriate steps can be taken to ensure that the patients receive the required standard of care.

If you are working in structured or formal teams (for example, in public healthcare institutions or structured teams in the private sector), you have a responsibility to do what you can to improve the team's performance, correct deficiencies and improve quality of care.

If each member of the team embraces this responsibility, then the team can function optimally. If members of the team selfishly regard their own roles in a silo and do not care about the contributions of other members, this is a recipe for failure of team care, with the risk of harm to patients. For example, within a team, the attitude of "not my responsibility" should not be embraced by any team member. You should consider that assisting other members of the team to fulfil the overall goals of management is one aspect of your responsibilities. To ensure that patients receive necessary care, you should cover another team member's lack of attention or failure to perform. However, if this problem persists, you should approach your team leader to take steps to rectify the deficiencies of that member of your team.

If you are a leader of such a structured team, you have the additional responsibility of ensuring the overall performance of the team. The care provided needs to meet required standards. If necessary, when you become aware of deficiencies, it is your responsibility to take action to ensure quality of care, including arranging for the redeployment or substitution of team members who are unable to perform to the required standard.

This may sound onerous in busy practices where you may have little say in choosing the team members assigned to you. Yet, for patients' safety, you cannot ignore this responsibility on the grounds of inconvenience and administrative hassle. You should therefore monitor and coach your team members so as to improve their performance and identify deficiencies which you need to address.

It is also your responsibility to ensure that in your handing and taking over of different aspects of patient care within the team, or between teams, sufficient information is shared to facilitate good quality continued care.

In addition to the general requirements for good team care discussed above, to enhance the benefits of team care, you should:

- (a) Be clear about your role and the parts that you and other members play in the team.
- (b) Explain to team members their roles and the parts that they play in patient care if you are in charge of the team.
- (c) Be aware of the team members' capabilities or limitations and compensate for them when delegating care within the team (for example, getting more senior team members to oversee junior ones).
- (d) Communicate clearly and effectively and share necessary information about patients among team members and outside of the team as necessary.
- (e) Update other team members of your actions, decisions or recommendations as necessary for the team to provide the best possible overall care.
- (f) Provide patients with sufficient information to understand team members' roles and the aspect of care that each team member is responsible for and be clear as to who has overall responsibility for patients' care.
- (g) Encourage discussion, mutual learning, joint decisions and risk management within the team.
- (h) Monitor and regularly review the team's performance and take steps to correct deficiencies and improve quality.

In teams where you are associated with allied health professionals, if you have any material financial interest with respect to the services of the allied health professionals, you are obliged disclose this conflict of interest to your patients.

It is possible that doctors have business relationships with, or even employ allied health professionals. Examples include Ophthalmologists with Optometrists/Opticians, Endocrinologists, Gastroenterologists or Surgeons with Dieticians or Orthopaedic surgeons with Physiotherapists. Because you may benefit financially from the services provided by the allied health professionals you are associated with, you need to be transparent with your patients by informing them of the relationships so that patients may exercise their autonomy to accept your referral and you avoid appearing to act out of conflict of interest.

A6. Telemedicine

A6.1 - What is telemedicine?

Telemedicine refers to the systematic, structured use of telecommunications and information technology to deliver medical services or information over distances, across geographical or legal borders, with or without an intervening or intermediary healthcare professional. The essential characteristics of telemedicine are that interventions, diagnostic and treatment decisions and recommendations are based on data transmitted across distances by electronic, digital and other transmission systems. Telemedicine also affords the possibility of engaging in education and research by means of transmitted information.

There are, in general, four levels of telemedicine, although further alternatives may be developed from time to time:

- (a) Consultations with a doctor.
- (b) Interpretations, review or monitoring of laboratory or other medical data, including vital signs or clinical parameters of patients.
- (c) Remote guidance of medical procedures performed by local doctors.
- (d) Robotic surgery from a remote location.

Telemedicine involves a doctor interviewing, examining within the limits of the system or with the help of another doctor or healthcare professional who is with a patient, advising and/or treating a patient who is not at the same location as the doctor. Telemedicine can also take the form of a consultation where one doctor provides an opinion to another doctor elsewhere who presents clinical data for the opinion.

Telemedicine also includes the practice of outsourcing diagnostic interpretation of results, for example, laboratory or radiological results, or other medical assessments of a patient, to a service provider or doctor in a different country.

A6.2 - Standards required in telemedicine

Telemedicine is recognised by the World Health Organisation as a cost-effective and practical method to avail patients of better access to medical care.

It is important to ensure that patients being managed through telemedicine are provided a high quality of service. The provision of telemedicine constitutes the practice of medicine.

You are therefore obliged to endeavour to provide the same quality and standard of care in telemedicine as in-person medical care. This includes ensuring that you have sufficient training and information to manage patients through telemedicine. Otherwise, you need to state the limitations of your opinion.

There are potential difficulties in maintaining the standards of care required under the ECEG and protecting patients' best interests when engaging in telemedicine. The following are some guidelines regarding the use of telemedicine:

(a) Need for training

You need to be reasonably trained in the use of technology and equipment needed for the practice of telemedicine and have sufficient information to manage patients through telemedicine.

As technology is the interface between you and your patients in telemedicine, you should be properly trained in the use of hardware or software that may be involved. Often, companies providing telemedicine platforms will offer such training which you should avail yourself of. For example, it would not be in patients' interests if, due to unfamiliarity with equipment or software, you cannot access the ECG of a patient with chest pain at home or the blood pressure reading of a patient suspected of having hypertensive crisis.

In addition, you should learn the appropriate behaviours and communication skills required to interact appropriately, efficiently and reliably with patients over telemedicine communication channels. For example, it might be necessary to always have someone verify the identity of the patients since they are not physically present with you, or ask for chaperones to be present if you request patients in front of cameras to remove clothing and expose sensitive areas of the body to view clinical signs.

(b) Information sufficient to form opinions

Information shared through telemedicine platforms may not be sufficient or of adequate quality especially when the performance of clinical examinations may be difficult if not impossible.

To provide a definitive opinion, you need to be reasonably confident that any physical examination of the patients conducted by you personally is unlikely to add critical information that could change your opinion or the course of management.

If you are of the view that a physical examination is necessary, you should have a doctor who is physically present with the patient to conduct the examination on your behalf and provide you with the findings.

If you feel that you may not have received sufficient information, you ought to give a qualified opinion pending the availability of more information.

(c) Monitoring known patients

If you use telemedicine to monitor or follow-up on remote patients who are well-known to you and already under your care, the quality or completeness of information transfer is less critical as very specific parameters may be involved, examples would be monitoring of patients' falls at home via motion sensors, ECG of cardiac patients etc.

If you provide interpretations of medical data via telemedicine to patients who are remote from you, or depend on such data received through telemedicine to form an opinion, you should first be reasonably confident that the data is sufficient to provide an opinion and that any information from a personally taken history and clinical examination would not be likely to change your opinion. If you are not certain of the adequacy of the data, you should only give a qualified opinion.

You should also do your best to ensure that important interpretations are communicated to patients in a timely manner so that they can seek medical help as necessary.

(d) Providing remote guidance

If you perform remotely guided medical procedures or give remote guidance to others to perform procedures, in general, both you and the person to whom you are providing remote guidance need to be duly qualified and experienced to provide and follow the guidance respectively.

However, in emergency circumstances where no one has any suitable training and experience, it could be justifiable for you to carry on either providing the remote guidance or carrying it out. An example is a surgeon in a major city hospital guiding via audio-visual means a solo GP in a rural and isolated location in conducting an appendicectomy on an emergency patient who cannot be evacuated to the city in a timely manner.

(e) Remote robotic procedures

The performance of robotic procedures from a remote location carries the same obligations of competence and care as if you performed the procedures in person.

A doctor who refers patients for such procedures performed remotely by another doctor is deemed to have delegated care to the operating doctor and retains responsibility for the overall care of the patient. This is because it is not possible for the remote doctor to coordinate the overall care of the patient who remains with the patient's own doctor. However, since remote robotic procedures reflect the direct work of the operating doctors, they would be responsible for the competent performance of the procedures and the outcomes that are related to the procedures.

(f) Consent for telemedicine

Consent for telemedicine is conceptually no different from consent for any other medical test or treatment and you need to give patients sufficient information to consent to it. In addition, you need to make patients aware of any limitations of telemedicine that may affect the quality of care in relation to their specific circumstances.

Consent for telemedicine starts with ensuring that patients understand the nature of telemedicine and any limitations that may be inherent in the systems used as the interface between them and their doctors. Having understood the limitations, patients may then consent to pursuing such a consultation or method of monitoring. Such consent is often obtained by the telemedicine service platform provider as the intermediary between patients and doctors. As a doctor who engages in telemedicine, you should check that such consent has been given by patients if you are not in a position to obtain the consent. If you are not sure, you should ask during your consultation if patients are aware of the limitations of telemedicine and, once informed, if they do proceed with the consultation or method of monitoring, they have given implicit consent.

Apart from remote robotic surgery, you are usually not the doctor providing tests and treatments to patients across the telemedicine interface. Your role is usually to provide your opinion and your recommendations which other healthcare providers, where the patients are, can implement. Consent for such tests and treatments are then the responsibility of those healthcare providers.

If you are conducting remote robotic procedures, the hosting doctor who is with the patient has the responsibility of obtaining consent for treatment in the usual way. The information provided should include any limitations or risks of remote robotic treatment, including the possibility of systems crashing in the midst of the procedures and how "rescue" from such a situation may be carried out (perhaps by the host doctor taking over the procedure, if necessary without the use of the robot).

(g) Patient confidentiality in telemedicine

You need to take reasonable care to ensure confidentiality of medical information shared through technology. You also need to comply with applicable existing legislation and regulations governing personal data.

The requirements for medical confidentiality and protection of personal data in telemedicine are no different from those in conventional patient management. In addition, you should be aware of limitations in information security of the telemedicine platforms employed to transmit and store medical information. Where you have doubts as to the confidentiality of patient information, you should take steps to have your concerns addressed or else reconsider your participation.

(h) Training patients to use technology

If you require your patients to be in control of some components of equipment used in telemedicine, you need to ensure that they are sufficiently trained to do so. You need to ensure that assistance is promptly available in case of equipment failure or inability of the patients to operate the systems, where such failure or malfunction poses material risks to the patients' well-being.

Equipment in telemedicine may include computers, cameras or devices that record various patient parameters. For example, patients with heart conditions should know how to operate ECG monitoring devices at home and how to transmit the information to the appropriate recipients. It could be disastrous if, due to unfamiliarity with equipment or software, communications could not be initiated by patients when they experience chest pain.

A7. End-of-life care

End-of-life care begins when there is a consensus that a cure can no longer be reasonably expected and death is imminent. There should be a smooth transition from managing patients with the intent to cure to managing patients with priority being accorded to palliative care.

Medical advances have made it possible to prolong life regardless of the ultimate prognosis of an illness. The use of such interventions is often not straightforward and is complicated by considerations of the prospect of reversibility of the medical condition, patients' view on quality of life, the likelihood of the interventions achieving the desired outcome, resource management and the patients' values and wishes.

Good palliative care is becoming increasingly important as the end-of-life phase of a patient's care is given increasing emphasis. Quality end-of-life care is a duty doctors owe to their patients, as is providing support for them to die with minimum anxiety and suffering, in a manner that is in accordance with their own values and wishes, whenever possible.

The period within which end-of-life care occurs is generally taken to be after a point at which reversal of a terminal illness cannot reasonably be expected. Whether this point has been reached may be clear in some cases, but less clear in others. If you are unsure, you should obtain a second opinion from appropriate colleagues or consult an Ethics Committee.

In general, good end-of-life care means that you ensure patients' welfare is not compromised, patient autonomy is preserved where possible, their best interests are upheld and patients do not suffer harm inappropriate to their clinical conditions and the natural course of disease.

The provision of end-of-life care is complex and is often delivered at a time of high emotional distress for patients and their families. There may be ethical dilemmas that complicate decision making and you should do all you can to resolve them. Again, if possible, you should seek an ethics consultation if these issues cannot be clearly resolved.

The circumstances surrounding end-of-life care are complex and varied and you will need to make judgments and difficult decisions based on the specifics of each case.

The following are some of the elements of good end-of-life care:

- (a) You need to engage patients through good communications to elicit their preferences and goals of treatment while helping them to understand the limits of medical treatment. You are obliged to offer good palliative care where necessary to minimise suffering in the course of their life-limiting illnesses.**
- (b) You have to respect patients' wishes not to receive specific treatments. At the same time, you are not obliged to provide or continue treatments that you deem inappropriate, non-beneficial or even harmful in view of the natural course of the underlying disease.**
- (c) If patients do not have the capacity to decide what end-of-life care they want and have not previously expressed their views, you are obliged to act only in their best interests.**

The following are best practices to achieve these standards in end-of-life care:

- (a) You should communicate:**
 - With patients honestly and with compassion. Give them all the information that they wish to have to be able to make decisions for themselves should they be competent to do so.
 - Bad news to patients and their families with sensitivity and compassion, recognising that there may be dilemmas to resolve when families request that you delay or refrain from informing the patients the bad news. In this situation, you should bear in mind that your first responsibility is to the patients, not the family members and that consent for any treatment is invalid if you have not given patients sufficient information. You should be sensitive to the families and you should assess as accurately as you can how much the patients want to know and how best to deliver the information.

- With relatives and those close to patients when patients can no longer make decisions, for the purpose of obtaining information about the patients' known or likely wishes, preferences, feelings, beliefs and values. You should not give the relatives the impression that they are being asked to make the decisions.

(b) You should understand:

- The goals of therapy and the limits of medicine in providing care to these patients and helping patients and their families to understand these limits and to have realistic expectations. You should not cause patients to have unrealistic expectations or false hope, especially in relation to treatments that have poor or no evidence of efficacy. You should refrain from offering such treatments.
- Patients' values, concerns and wishes in managing their illnesses. If patients are no longer able to make decisions, you can either refer to recorded statements of the patients' preferences at a time when they were able to give these, or through an earlier process of Advance Care Planning, or through legislative provisions such as the Advance Medical Directive Act and the Mental Capacity Act.
- That you do not have a duty to prolong life at all costs, but that you should exercise proper judgment in determining when to initiate and when to cease attempts at prolonging life, a decision which should be made bearing in mind patients' values and wishes. This would also apply to considerations about whether clinically assisted nutrition and hydration and cardio-pulmonary resuscitation might be appropriate.
- The difference between treatment for reversible inter-current conditions (such as a chest or urinary tract infection or loss of diabetic control) which may reasonably be given and life-prolonging treatment for irreversible illnesses. Decisions to intervene in inter-current conditions should be made after careful consideration of their appropriateness in the circumstances with due regard to patients' best interests.

(c) You should support patients by:

- Making decisions based on a consideration of overall benefits, risks and burdens for the patients which may not be limited to purely clinical considerations, and avoiding biases based on your own beliefs and sense of values.
- Providing or arranging appropriate palliative care to provide them relief from pain or distress.
- Ensuring the best quality of life possible. This is admittedly a subjective determination that would entail not only an understanding of the patients' expressed or imputed values and preferences, but also your own judgment of the patients' best interests.

- Being prepared to certify the cause of death of your patient if you have sufficient medical information to do so.

You are not permitted to commit or participate in any act where your primary intention is to hasten or bring about death.

There is a clear distinction between acts and omissions that lead to death. Whereas acts that are specifically designed to cause death are not permitted, omissions are in a greyer zone. Context and intent are key in considering the ethics of acts and omissions.

If in a certain context, an omission would have clear and unambiguous consequences, then even a conscientious “omission” could be as grave as an “act”. In law, it is “murder” to kill a person by starving him, even though no act of killing has been committed. In medicine, in the context of an omission (denial or discontinuation) of potentially life-saving treatment for terminally-ill patients who would likely not benefit, the omission could be viewed as appropriate or done in the patients’ best interests, as opposed to being viewed as intending to hasten death.

B - GOOD MEDICAL PRACTICE

Good medical practice is about the way we deliver care. There are many areas of good medical practice. In this section, we will consider the following:

1. Decisions about providing services
2. Medical investigations
3. Medical records
4. Medical certificates
5. Prescription of medicine
6. Untested practices
7. Non-treating doctors performing assessments for third parties
8. Medical research
9. Complementary and alternative medicine
10. Aesthetic practice

B1. Decisions about providing services

B1.1 - Non-discrimination of patients

You are obliged to provide access to medical care and treat patients without unfair discrimination, based on race, gender, religion, creed, social standing, disability, sexual orientation, socio-economic status or any other personal characteristic.

You need to be careful not to allow your personal prejudices and biases to influence your management of your patients.

If you are aware that you are not being objective, and you feel unable to continue your care for the patients, you should communicate this to the patients in a non-judgmental, inoffensive manner. You should also inform them that they are free to seek care elsewhere. If the patients request to be referred, and you are able to help, you should refer them to another doctor able and willing to care for them.

You are obliged to avoid making moral judgments about your patients' habits or lifestyles in deciding whether to provide treatment and how you would treat.

There will be patients whom you believe have lifestyles or habits that may have contributed to their illnesses or whose illnesses you deem to be “self-inflicted”. Examples would include alcoholic liver disease, smoking-related lung diseases, heart disease or cancer and sexually transmitted diseases including human immunodeficiency virus (“HIV”). Your responsibility is to manage these patients according to clinical needs and outcomes. You have no role in “punishing” patients for their lifestyles or habits.

Your decisions ought to be based on an objective assessment of clinical needs and likely effectiveness of treatment options.

You may base decisions to provide treatment on whether patients are likely to reliably give up particular habits or lifestyles when you reasonably believe that clinical outcomes would be significantly adversely affected by such habits or lifestyles. If you decide not to treat the patients for these reasons, you should get a second opinion to support your decision.

To illustrate: It would not be justifiable to deny any treatment to patients with chronic airways disease even if they persist in smoking. This is because, they will receive some benefit from treatment even if they continue to smoke and any suffering can be alleviated to some extent. To achieve such benefits, their consumption of medical resources and the cost to society, although higher than they might have been, are not so overwhelming that rationing, or the denial of treatment, can be justified on the balance of public good.

It is different for cases such as liver transplantations for patients with liver failure who continue to abuse alcohol. The long-term outcome of liver transplant in such patients has been established to be very poor. Cadaveric livers are so scarce and the waiting list in most countries is so long that it would be necessary to prioritise which patients get cadaveric livers ahead of others. Even for living donors, the material risks, including death, to the donors would mitigate against a transplant for a patient who continues to abuse alcohol.

As a doctor, you have to be prepared to provide timely treatment to patients who have infectious diseases, examples such as HIV, Hepatitis B or C, tuberculosis, and not refuse out of prejudice or on the basis of fear of contracting the diseases.

If the treatment does not involve exposure to body fluids, there would be no good reason to refuse care for any patient (for example, through the normal process of taking history, performing a clinical examination and prescribing medicine). The risks are higher with examinations that expose you to body fluids, such as endoscopy and surgical procedures, especially exposure-prone procedures. You have the right to ensure that you have adequate personal protection to minimise any infection risk before you treat such infectious patients. You are not obliged to put yourself at risk through inadequate protection measures. In situations where you cannot be assured of adequate protection and you assess that you are at an unacceptable infection risk, you should inform the patients and either defer treatment to another time when you have the necessary protective equipment, or else arrange for the transfer of their care to another facility where doctors have the requisite protection. Clearly if it is an emergency or urgent situation, such transfer of care should be expeditious to ensure timely treatment.

B1.2 - Care for self and those with whom you have close personal relationships

Self-prescribing or dispensing of medicines for your own consumption is discouraged, but it is acknowledged that doctors often do treat themselves. You may also be asked to prescribe medicines for or treat relatives or friends for different complaints and medical problems. When this is done on an informal basis without proper and adequate clinical evaluations and documentation, there are inherent risks, such as:

- (a) There may be a history of drug allergy that has not been volunteered or enquired about.
- (b) The medicines may not be, or may no longer be, in terms of type or dosage, appropriate for the medical conditions they are meant to treat.
- (c) The patients may be mistaken in their diagnoses.
- (d) The patients' medical conditions may have changed and require review, but providing medicine leads to complacency.
- (e) There is no continuity of care.

The risk of treating persons emotionally close to you is that your judgment may be impaired and you fail to act in patients' best interests. While you may feel that you have the right to help those close to you, equally, as patients, those close to you have the right to expect clinical objectivity from you. Your obligation to provide objective and appropriate care is not waived even if the patients who are close to you agree to take the risk of not receiving objective care from you. Where you feel that your judgment may be impaired due to your close relationships with the patients, you should seriously reconsider whether to provide treatment.

Certain circumstances are clearly inappropriate for you to treat yourself or those close to you, when they involve:

- (a) Controlled drugs and any drugs with significant potential for dependence.**
- (b) Psychotropic medicines.**
- (c) Psychiatric treatment.**
- (d) Medical certification for yourself.**

To avoid the appearance of conflict of interest, you should not issue medical certificates to your immediate family members (spouse, children, siblings or parents).

You may provide self-care or care to those close to you when:

- (a) It is routine replenishment of medicines for stable conditions.
- (b) It is for simple, minor conditions, such as common colds, gastroenteritis or simple lumps and bumps.
- (c) It is an emergency situation, or you can help save a life until appropriate help is available.
- (d) There is an urgent need to avoid serious deterioration of a medical condition or a need to ensure the patients' health.
- (e) There is a need to alleviate otherwise unbearable pain.

To ensure appropriate care to yourselves and those close to you, you should:

- (a) Make an objective evaluation of the medical condition and maintain objectivity throughout the course of your care.
- (b) Document the diagnosis and management in medical records if the medical condition is serious or chronic. Although it is never good practice to treat without making medical records, for simple treatments for minor acute conditions, it is acknowledged that this may be impractical. You should therefore exercise judgment in this.
- (c) Seek another opinion when indicated and certainly when intervention is a significant one such as surgery.

When in doubt, you should ask the patients to return to see their doctors or refer to other doctors.

If you choose to provide significant care to those close to you, such as major surgery, you have an obligation to ensure that your objectivity, judgment and professionalism in medical decision making are not compromised to patients' detriment due to your emotional proximity.

It is also not uncommon for relatives or friends to ask you to prescribe or dispense medicines or other treatments as a favour to their own relatives or friends. You should discourage this, explain the pitfalls of doing so and not raise expectations that you can help.

It is wholly inappropriate for you to provide treatment to people you have never met and whom you have no personal knowledge of, let alone professional relationships with.

B1.3 - Relationship with systems of care

B1.3.1 - Systemic limitations versus best care for patients

Every doctor practises within a national system of healthcare that is governed by legislation and regulations and where national policies may also decide the distribution of limited national healthcare resources to patients. While you need to abide by laws, regulations and system limitations, you should also endeavour to provide the most appropriate treatment and act in patients' best interests while working within such constraints.

You may also be working within local institutions or healthcare organisations that have their own policies regarding allocation of resources for patients. Third party payers too may constrain doctors to offer a limited range of treatments.

You may face constraints in managing patients within these frameworks. If the system you are involved with could harm patients or lead to unacceptable clinical outcomes or consequences, you should act first in patients' best interests and not subject your patients to harm. You should also strive to correct deficiencies in such a system.

The following are some of the elements that constitute good care within such systems. You should:

- (a) Continue managing patients according to evidence and accepted best practices as far as possible and, at the very least, ensure that treatment adequately addresses patients' needs and is of a quality acceptable to the profession.
- (b) Base your advice to patients on the best interests of individual patients and not on system constraints. Patients should be advised on what options are or are not available to them. Where adequate and professionally acceptable treatments are available within that system, the patients need to be advised accordingly. If not, you should explain this clearly to patients so that they may seek such options elsewhere if they wish and it is feasible for them to do so. You should then actively refer these patients to a place or to a doctor where they can receive the necessary care.
- (c) Advocate for your patients to have the most appropriate treatment within the system of care in which you are involved and seek with reasonable diligence to bring about improvements where possible.

B1.3.2 - Managed care

Managed care has the potential advantage of being less expensive for patients than traditional fee-for-service schemes. Managed care options may grow more attractive as the cost of healthcare increases and patients or employers seek more economical options. Many managed care options, however, restrict the patients and providers' choices by varying degrees.

In addition, there may be fees that you need to pay to managed care companies for every patient referred to you. You need to be careful that the fee arrangement is not so onerous that you are pressured into compromising your standard of care (for example, under or over treating patients) to remain financially viable.

You may enter into arrangements with managed care companies bearing in mind:

(a) The need to ensure appropriate clinical management in patients' best interests. This includes these principles:

- **Professional independence is inviolate and you are obliged to always treat and manage patients with their best interests in mind.**
- **Your clinical management of patients has to be appropriate. You cannot allow any financial or other arrangements inherent in managed care to pressure you into making decisions that would compromise the required standards of care.**

Specifically, where prior approval of investigations or treatment of patients is required from the managed care company, you should not allow the denial of payment for investigations and treatment to influence your recommendations to your patients.

You should be honest with the patients about the best and most appropriate options, so that the patients may, if they choose, seek care elsewhere.

If, after due counselling, the patients insist on receiving only what the managed care companies will pay for, you may provide this, as long as this still meets the acceptable standard of care and there is no significant risk to the patients' welfare in doing so. When necessary, you should assist the patients to receive necessary care elsewhere if you are not able to provide it under the managed care framework.

(b) Your role in advocating for patients. This refers to:

- Avenues for appeal within the managed care contract for specific patients to have medically necessary treatment paid for by the managed care companies. In most cases, the limitations are generally fair but, in particular circumstances, such limitations may result in denial of care which, in your opinion, would materially benefit or prevent harm to patients. In such cases, you should advocate that your patients receive the necessary care.

(c) The need to avoid excessive financial pressures. You should:

- Not place yourself in a position to be beholden financially, or in any other way, to the work provided by managed care companies or to become obliged to comply with these companies' requirements when these would entail you breaching your obligations to patients. If necessary, you should be able to withdraw voluntarily, as provided for in your contracts, from arrangements made with managed care companies.
- Reconsider your participation in a particular managed care contract if the constraints you face are such that an acceptable standard of care to patients is not possible.

(d) Your responsibilities when acting on behalf of managed care companies. You:

- May act on behalf of a managed care company to pre-approve treating doctors' management plans for the purpose of payment. Since in such a context, you are not a treating doctor, your obligations to patients are more remote. However, you should not make any decision that interferes with or intervenes in the clinical management of the patients which could result in harm to them.
- May give your approval to the range of options you are able to approve if they are within reasonable standards and generally accepted practice.
- Should communicate with the doctors requesting to prescribe treatments to patients outside of the range usually allowed to understand why such options may be in the best interests of the patients. If you decide that these are indeed best for the patients, you should do what you can to facilitate patients' access to such treatments.

You should be aware that patients' best interests would be compromised if:

- (a) You are not the appropriate doctor to meet the patients' needs, but you have been sent the patients only because you have agreed to pay fees to managed care companies or third party administrators. In such cases, you should reconsider your participation in the patients' care and should offer to refer the patients to appropriate colleagues rather than persist in managing them.
- (b) You under-treat patients due to financial pressures.
- (c) You over-treat patients to make higher revenues to cover the fees you must pay.
- (d) You grossly over-charge patients in order to redeem high business costs due to such fees.

B1.3.3 - Acting in policy-making, management or administrative capacities

You have to ensure that those who directly manage patients under your direction are able to provide or facilitate access to the required standard of care. You also have the responsibility to ensure that these colleagues do not find it impossible to abide by the ECEG because of your decisions.

You may work in policy-making, management or administrative positions at the national or local levels, in the public or private sectors. However, as a doctor, you continue to have professional responsibility although this responsibility is more remote than when you are directly treating patients.

If you are so constrained by political, legal or administrative policies or restraints, or systemic resource limitations that you believe that your decisions or actions would lead to patients being harmed, or lead to doctors being unable to fulfil their obligations under the ECEG, you should advocate for change to the best of your ability so that patients' best interests are upheld.

B1.4 - Treatment of patients in an emergency situation

If you are alerted to a credible medical emergency while you are at work or on duty, you have to do the best you can to provide medical help, unless you are unable to while caring for other patients and cannot reasonably disengage to respond.

A medical emergency may be defined as a medical condition requiring immediate professional response and care to prevent gross disability, pain, distress or death.

You may encounter such a situation while at work or on duty:

- (a) By having patients enter your practice with a medical emergency.
- (b) Through being notified while you are in your practice or on duty of such an emergency nearby.

When faced with a request to respond to an emergency:

- (a) You cannot ignore the request. You should quickly assess the situation and determine whether it is a genuine emergency. In the absence of the patients, you may rely on information provided by a third party. When in doubt, you should assume it is an emergency until proven otherwise.
- (b) Unless you are unable to help while caring for other patients and cannot reasonably disengage to respond (for example, in the midst of procedures or dealing with another emergency), you have to respond to the emergency and apply your professional skills to the limit of your competence in an attempt to save lives, to prevent suffering and to take all necessary steps to help ensure that patients have the best chance of good outcomes.
- (c) If you cannot attend to the patients, you should try to ensure that another doctor responds to the emergency or an emergency service is summoned in a timely manner.

Whilst outside of your place of practice or off duty, you may chance upon an emergency by, for example, encountering any person who has suffered an emergency medical condition or who has suffered serious injury through any kind of incidents (examples such as fire, road accident, building collapse, terrorist attack, etc). Sometimes, a public appeal for medical assistance is made (for example, in a theatre or on an airplane).

When you encounter an emergency situation in a public place, although you do not have an obligation to give assistance, you should help such patients where possible, taking into account a reasonable assessment of:

- (a) Your personal safety.
- (b) Your competence for dealing with the problem.
- (c) The apparent urgency of need for treatment.
- (d) The medical resources available.
- (e) Whether there are better options available for the patients' care.

In general, the standard of care expected under the ECEG when you are responding to a crisis situation with an unknown patient (for example, scanty medical history or limited information) and in an environment which may be less than ideal (for example, without equipment) is less stringent than in a normal clinical setting. You should simply do the best you can under the circumstances.

B1.5 - Working in epidemics, pandemics, disasters and mass casualty situations

In disaster and mass casualty situations anywhere, it is acknowledged that the circumstances are less than ideal. Yet, you are obliged to provide the best standard of care possible in the circumstances and within your ability. You have to, as far as it is reasonably within your ability to do so, ensure that patient welfare is sustained and you do nothing to disrupt the ability of medical teams to provide care.

Doctors play a vital role in epidemics, pandemics, disasters and mass casualty situations. You may be required to work flexibly, with manpower and resource constraints, often with overtime and during unsocial hours. Even if you are without specific competencies and experience, you may still be required to manage patients as best as you can. Such situations may put the medical system and yourself under considerable stress. However, you are expected to provide the best standard of care possible under the circumstances. When engaged in such situations, you should:

- (a) Place the interests of patients ahead of other duties such as research, administration or teaching.
- (b) Endeavour to protect patients who are not already affected from contracting infections or protect victims from further sickness or injury.
- (c) Work constructively with colleagues.
- (d) Respond responsibly and reasonably to the circumstances presented.
- (e) Do your best, within the limits of your competence and experience and ask for help when your capabilities are exceeded.
- (f) Take all reasonable steps to protect yourself and your family from harm while continuing to discharge your duties.
- (g) Keep up to date with legislation, national or local plans and strategies for dealing with the situation and comply with such laws or plans.

- (h) Not abandon your duties or place of work abruptly, unreasonably or without justification in such a way that patient care is compromised.

It is recognised that, under such extreme circumstances, it is sometimes difficult to meet the normal standards expected of doctors in situations where you might be forced to make many judgments under difficult conditions. Your constraints in the circumstances would be understandable, provided you do your best in the circumstances and try to ensure that patients are not harmed and the system of care, such as it is in such a scenario, is supported and not disrupted by your own actions or inactions. You should also, to the best of your ability, cooperate with and work to support other healthcare professionals and try to ensure that your colleagues also do not come to harm.

Examples include: Raising the alert that personal protective equipment has run out so that replenishment can be obtained for your colleagues; being diligent to abide strictly by protocol when doffing personal protective equipment so as not to contaminate the environment, thus putting others at risk, and manning your station until relieved so as not to disrupt the chain of medical evacuation or treatment of victims.

B2. Medical investigations

You need to ensure that patients have sufficient information about medical investigations to be able to provide their consent. You then have to communicate and explain the results or any significant findings to patients in a timely manner, commensurate with the importance or urgency of the result.

Investigations are part and parcel of the medical management of patients. Medical investigations may be invasive and costly, so judicious use and patient consent are important. If investigations or tests are conducted by agencies outside of your practice or institution, there needs to be a system in place to ensure that results are received in a timely fashion.

You have the following responsibilities in availing patients of investigations:

- (a) Ensure with reasonable care that the appointed facility conducting the tests is competent.**

This is a reasonable assumption to make if the laboratory is licensed in Singapore. If it is an overseas facility, then it needs to be accredited by a relevant authority in that jurisdiction that is recognised by MOH. Information on such accreditation bodies overseas can be found on the MOH website. However, despite licensing and accreditation, if you doubt the service quality, you should avoid using it.

(b) Explain to patients what tests you propose, their purposes and benefits so that they can provide their consent to the tests.

If there are possible significant adverse effects, you should inform your patients. The cost of tests should also be disclosed, especially if the tests are expensive or you are aware that the patients would view such information as important.

It is not always necessary to obtain formal consent to the tests. However, the consenting process should be more detailed for more complex or invasive testing procedures.

You should explain to the patients that they are responsible for attending the tests and any preparations that they may have to take.

(c) Ensure within your ability that the waiting time prior to the taking of tests is reasonable, so as to avoid a delay in diagnosis that may be harmful to patients.

You also have the following responsibilities in handling the results of investigations:

(a) Ensure that patients (or those responsible for them such as parents) are notified promptly of results that are clinically significant or important so that appropriate follow-up action may be taken to prevent harm to the patients, or to others if the patients' illnesses are contagious.

You should ensure within your ability that the test results are returned to you in a timely manner.

If there are policies or procedures specific to your institution or medical practice on how patients should obtain their test results (whether normal, negative or adverse), patients should be informed of these.

An example of an important result that requires urgent action to prevent harm to others is the discovery of tuberculosis in a healthcare worker who is in contact with many patients.

(b) If results are important, you need to make reasonable efforts to trace difficult-to-contact patients, with greater efforts made if the results are very important or there is a clinical urgency.

When working within teams or with associates in a practice or when referring patients to another doctor for further management, it remains your responsibility to inform your colleagues to follow-up on test results especially in situations where significant pathology is being investigated or where the results are important to the management of the patients.

In the event the test results reveal information that may affect the rights of a third party, you should make a judgment on the best course of action to be taken based on the individual patients' best interests. However, in evaluating your duty as to the level of disclosure, you should also consider and balance the rights of the third party. There are some scenarios in which you are allowed to disclose confidential patient information to third parties. Typical examples include: HIV-positive patients who intend to engage in unprotected sex with partners, thus putting them at serious risk; persons with severe dementia who are still driving and risking the lives of others on the roads. In such cases, you should engage the patients to take appropriate actions and, if they refuse, you should evaluate the degree of risk to third parties in deciding whether to take actions to protect the third parties.

Individuals may present themselves directly to imaging or laboratory facilities for tests without being referred by other doctors (or they may be referred by non-doctors such as complementary or alternative medicine practitioners).

If you are a radiologist, pathologist, clinical biochemist, etc., and you accept walk-in patients for tests, you will be deemed to have entered into patient-doctor relationships with these individuals, with all the responsibilities that this relationship entails. You have the responsibility of ensuring that important results of the medical tests are reliably and expeditiously transmitted to patients so that they may seek medical care.

You should, where you are able to, explain important findings to patients so that they understand them and know what kind of care to seek if they wish. You should offer to refer them to other doctors for further management as indicated.

If patients are sent by non-SMC registered doctors such as complementary or alternative medicine practitioners, you may inform them of the results if you are clear that the patients would want you to do so. However, if the results are important, you should make the effort to inform the patients themselves.

B2.1 - Health screening

Screening for potential or early disease has become a common practice and is often provided on a commercial basis. Screening candidates do not present themselves with any symptoms for investigation but are interested in undergoing consultations and medical investigations in order to detect health risks and evidence of potential or early disease for the purpose of early interventions.

For patients with no known diseases or illnesses at presentation that require treatment, you have special responsibilities when enrolling these apparently healthy, asymptomatic persons into screening programmes.

In offering health screening, you have the following responsibilities:

- (a) Ensuring that tests are validated by good quality evidence of benefit and are clinically appropriate.**
- (b) Informing patients of important results in a timely manner.**
- (c) Offering follow-up as necessary.**

If you are involved in health screening of children (minors) such as in school health screening programmes, you should work through the schools to ensure that the parents or legal guardians are informed about the screening and the results.

Medical investigations may come with risks of harm (examples such as the use of x-rays, intravenous contrast media, invasive clinical examinations, endoscopic or other procedures with attendant sedative or anaesthetic risks, etc). Hence, if you offer screening to patients, you should be judicious in your choice of tests.

In addition, you should:

- (a) Take a detailed history and perform a thorough clinical examination to detect health risks and plan appropriate screening tests.
- (b) Advise patients on which general and specific aspects of health and disease you recommend testing for, based on the clinical consultation.
- (c) Determine the aspects of health and disease which patients are interested in testing.
- (d) Explain to patients the purpose of screening and the scope of screening proposed.
- (e) Educate patients on the uncertainties and limitations of testing modalities, the difficulties in the interpretation of positive, negative or indeterminate results and the possible need for further tests.
- (f) Inform patients about the benefits, risks and alternatives to the testing modalities recommended and take written consent for the more invasive testing means where appropriate.
- (g) Advise patients on any important medical, social, psychological, financial or insurance implications of undergoing the tests and the results that will be received. This is especially important in the area of predictive genetic testing.
- (h) Provide information on the follow-up plans for patients, including the availability of medical care, support and counselling services.

If you advertise health screening services, you need to do it responsibly as you are offering medical services to otherwise well patients with no known medical needs that require them to be put through the risks of the more invasive tests.

Your advertising of health screening services cannot exploit the public's vulnerability to unreasonable and unjustifiable anxiety about their current or future health and longevity, nor offer unreasonable expectations as to the benefits that might be gained from medical tests offered in order to encourage uptake of screening services.

Factual information on the benefits of selected health screening tests can be given to the public and indeed is to be encouraged. Examples of common diseases include:

- (a) Diabetes mellitus where blood sugar screening is appropriate.
- (b) Hypertension for which, blood pressure screening is justifiable.
- (c) Colon cancer, which is very prevalent in the community and therefore for persons above the age of 50 faecal occult blood testing or colonoscopy would be justifiable.

With this type of information, the public can make rational decisions to undergo appropriate screening tests.

However, advertising is unacceptable if it plays on primal fears and invite irrational responses. For example, you should avoid phrases such as “Avoid dying young”, “Beware the silent killer”, “Live longer through health screening”, “Live to see your grandchildren” or “You may be a walking time bomb”.

B3. Medical records

You are obliged to maintain clear, legible, accurate and contemporaneous medical records of sufficient detail to ensure quality continuity of care for your patients. Contemporaneous means that you ought to make your records at the time of your engagement with patients, or as soon as possible afterwards.

Medical records form the basis of good management and communication between doctors and other healthcare professionals in ensuring the quality of continuing care. Medical records are also legal documents and will be referred to in any inquiry or court proceedings.

Medical records need to include all clinical details about your patients, discussions of investigation and treatment options, informed consents, results of tests and treatments and other material information.

In general, medical records need to document the subjective elements of a consultation such as a patient’s symptoms and history of illness, the objective findings of clinical examinations, relevant investigative data, analysis with diagnosis and treatment plans. It should also include a summary of all information given to patients, important details of the consent taking process and the consent received from patients. Medical records include medical reports which you write to another doctor, another healthcare professional, insurance or third party payer organisations or the patients themselves.

If patients request for information not to be documented, you may accede to their request but you need to be sure that this does not adversely impact their own care or the safety of others.

Patients may sometimes request that some information not be recorded for some reason (for example, because of embarrassment). You need to decide if such information is material to the management of the patient or may be potentially harmful to other healthcare professionals if it is withheld from them (for example, an infectious disease). If so, you should persuade a patient to leave the information in the record, assuring the patient of confidentiality. If a patient refuses, you should seriously consider whether you are able to continue with the management of the patient. In particular, you should be very careful not to abet a patient who may be attempting to deceive an insurance company, a third party payer or any other parties through the omission of essential information.

Medical records ought to be written in neutral, objective language without showing disrespect for patients, or otherwise disparaging or insulting patients in any way.

Medical records need to be objectively written and you need to show respect for patients in how you write them. It is inappropriate to write in a biased or prejudiced manner, insulting or disparaging patients in some way. Although most patients may never get to view their original medical records, there may be instances where what you write will be made known to them, such as when you give over the records in court cases or official inquiries. Firstly, patients may be very offended, which is bad enough and itself a breach of your ethical obligations to patients. Secondly, the way you write may negatively impact the outcome of your case, should you give the impression that you had negative sentiments about the patients. Examples of inappropriate records include phrases such as, “FON” which is an acronym for “Full of Nonsense”, “TATP” which means “thick as two planks” or “LCT” which stands for “long chong tia”, a Hokkien term suggesting that the patients are full of complaints about every part of their bodies and therefore not to be taken seriously.

You are not to amend medical records in order to hide anything, or to otherwise mislead. You may only amend medical records to make genuine corrections or amplifications.

Any legitimate correction you wish to make to a medical record should be inserted alongside the original entry. You should sign off (either in writing or electronically) as the doctor making the amendment and date it with an annotation as to why the amendment was made (for example, to clarify, amplify or change a patient history that was mistakenly given or recorded at first).

The standard of medical record keeping is the same regardless of the nature of the record, whether on paper, or in electronic or other means. Unfamiliarity with a particular method of data capture is not an acceptable excuse for poor quality medical records.

If medical records are made on your behalf by another doctor or an assistant, you need to take reasonable steps to ensure that the notes written on your behalf are up to the required standards.

In some practice arrangements, you may not have a choice as to who writes your notes. Nonetheless you need to take reasonable steps to ensure the quality of medical records since you are the doctor responsible for the care of your patients.

Within your own ability you need to ensure that your medical records are kept safely and securely and are not at risk of unauthorised access thus breaching medical confidentiality.

Medical records are highly confidential. Where they are stored in institutions where you have no control over the systems of storage used, your responsibility is to abide by all the security protocols in place. If you are responsible for the storage of patients' records, then you need to ensure that they are in a safe and secure location where unauthorised persons cannot access them. Examples include locked rooms, locked filing cabinets and if stored electronically then there need to be passwords and other authentication measures to control access.

You are obliged to provide patients with their medical information when they request it. You ought to make information from the records available to them in a way that best suits their needs, such as in a medical summary or report.

In general, patients do not have the right to see the original physical or digital medical records. They belong to the institutions or to your practice. If patients request for their original records or printouts of digital records, you may accede to their requests according to your assessment of the situation, but you are not obliged to. You should bear in mind that your medical records may contain short-hand phrases, abbreviations that only you can understand or that your handwriting may be illegible. Patients may not be able to understand the original records by reading it, although other doctors that patients show the records to might be able to make sense of them. To avoid confusion and misinterpretation it is usually better to write proper medical summaries or medical reports appropriate to the purpose that the patients request them for.

B4. Medical certificates

The issuance of medical certificates is a clinical decision. Hence, you are responsible for ensuring that any medical certificates you issue to patients are justified on proper medical grounds and that you had arrived at your decision through good clinical assessment.

Medical certificates are issued either to promote patients' recovery from medical conditions, or to protect third parties against possible harm from the patients' medical conditions. Unless there are clinical reasons for issuing medical certificates, well patients who consult you in your clinic should only be given certificates of attendance for their employers.

The issuance or contents of a medical certificate ought not to be influenced by extraneous considerations such as the individual or organisation which initiated the request, who pays for the consultation, the benefits the patients may receive, employers' preferences or any other factors outside of medical considerations.

It is inappropriate to issue medical certificates to patients of durations that are too short for the illnesses or injuries suffered. Sometimes doctors limit their medical certificates for workers according to requirements of the Ministry of Manpower for employers to report injuries, so that the employers do not have to report. Considering employers' preferences in such situations is wrong. Even if you arrange for reviews at short intervals, you should consider that having patients come back frequently when not clinically necessary would not be in the best interests of the patients. Another example of the wrong use of medical certification is to indicate a longer duration on a medical certificate than is necessary, or when they are not strictly necessary at all, simply because patients may wish to avoid National Service fitness tests or recalls.

Medical certificates ought to be given directly to patients themselves.

This is because your responsibility is to your patients and no other party. It is the patients' responsibility to hand the medical certificates to the appropriate persons at their places of work or study. Only if patients specifically request, or consent to it, should you send medical certificates to their employers.

The medical certificate which is issued should specify the expected period of illness being covered and, where necessary, whether the severity of the illness renders the person unfit to attend court.

If you are certifying that the patients are fit to return to work but with limitations on their level of activity at work, to the best of your ability you need to be assured that the patients' work conditions allow this and that duties appropriate to their limitations are in fact available.

If you are certifying a limitation of activity at work, the description of the limitations should be as detailed as possible (beyond merely the use of overly-broad short phrases such as "light duties") so as to help the employers understand the constraints faced by your patients. You need to establish within your ability, that the limited work you recommend is actually available at the workplace for your recommendations to be meaningful. There being a wide range of "light duties", it is possible that even if the employers are trying to be helpful, the lightest work available for the patients is beyond their limited capabilities while they are ill or injured. This could be harmful to them. A typical example is a construction site worker for whom the lightest duty available may be to push a wheelbarrow of materials rather than to actually do climbing and building. While this may seem reasonable to the employer, if an injury to a limb is significant, this activity may be completely inappropriate and could aggravate the patients' conditions. Hence, if you know that appropriate "light duty" is not available, you should order complete rest.

The date of issue of medical certificates has to be the day of consultation or medical treatment. Post or back-dating the day of issue is not allowed.

For the period of coverage, generally the start date is the day of issue. However, the date you begin coverage may be before the date of issue where it is clear that the patients' absence from work prior to the date of issue is consistent with their clinical presentation.

The period of coverage of medical certificates should generally not begin after the date of issue. The principle is that coverage should not be “anticipatory” in nature. Although coverage ought to start at least from the date of issue of the medical certificate, there may be sensible reasons for you to post-date the start of coverage, such as when patients see you after work on the day of issue, thus not requiring coverage on that day, or seeing you at the start of a weekend or public holiday, when coverage is also not necessary. If you post-date the coverage of a medical certificate, you should document your reasons for doing so.

You must not amend the particulars on medical certificates issued by other doctors. If you disagree with the provisions of other doctors’ medical certificates, you may issue new medical certificates. However, you must only do this after assessing the patients yourself to determine that this is justified on medical grounds and, where appropriate and possible, consulting the other doctors before you do so.

There may be instances where you are asked to review patients who bear medical certificates issued by other doctors but you disagree with the provisions of the medical certificates. Your disagreement should not be based on suspicion (for example, suspicion that a national serviceman has feigned an illness and is malingering) but ought to be based on your own clinical assessment of the patients.

It is often helpful for you to discuss the cases with the doctors who issued the original certificates, provided you are able to contact them, in order to understand their rationale for the certificates they provided. Sometimes they may have information or a perspective that is not obvious to you that would justify the original certificates. On the other hand, having heard your current assessment of the patients, the doctors may agree that your proposed changes are justified and agree with you.

Sometimes patients may have obtained the medical certificates while abroad, in which case there may be practical difficulties in contacting the doctors. How much effort you should make to contact the original doctors depends on how likely it is that they have information that would be material to your current assessment of the patients.

Once you determine that changes in the provisions of the medical certificates are medically justified, you may issue new medical certificates. You should not simply amend the provisions on the original certificates as they were not issued by you and you do not have the right to alter any detail on them.

For medical confidentiality you ought not to disclose the patients’ diagnoses on their medical certificates unless patients have consented to this.

In general, the persons to whom patients hand their medical certificates at their places of work or study do not have an automatic right to know their staff or students’ confidential medical information. As with all third party disclosures, patients need to consent to the disclosures. Sometimes employers will contact doctors to try to find out more about the patients’ medical conditions that are revealed on the medical certificates. Again, unless you have patients’ consent, such information cannot be revealed.

You need to sign medical certificates personally. If someone has filled in the details on your behalf, you need to be satisfied that the details are correct before signing.

Medical certificates are documents that carry professional and legal implications. Hence you have to sign them personally and not allow someone else to sign them on your behalf. If you signed a medical certificate with incorrect details written on your behalf, you would still be responsible for the information filled in.

You have to ensure that however medical certificates are generated, there are security measures and protocols to prevent fraudulent issuance of the certificates.

Medical certificates may be generated entirely on paper or electronically. The risk of fraudulent use may be higher when they are input into a computer system to be printed out elsewhere. Where you are in a position to control the systems in use, you need to ensure that no one can issue medical certificates without your knowledge. If you are not in control of the systems, your responsibility would be to abide by the security protocols in place so that you do not inadvertently provide an unauthorised person access to the system.

B5. Prescription of medicine

B5.1 - General responsibilities for prescribing or dispensing medicine

You are obliged to prescribe or dispense medicines only to patients under your care and not to persons with whom you have no professional relationships.

The prescription of medicine is a privilege you are accorded and one of the most important responsibilities you have.

You should only prescribe medicines that are either duly registered in Singapore or have the approval of the Health Sciences Authority for named patient usage of unregistered medicines. All legislation governing the use of drugs has to be complied with, including the provisions of the Misuse of Drugs Act and the relevant Acts relating to health products (such as Medicines Act, Poisons Act or the Health Products Act).

Your prescription or dispensing of medicines to patients needs to be based on clear medical grounds arrived at after consideration of sufficient clinical information and basing your decision on available evidence, as well as what is accepted by the profession as good clinical practice.

Prescription of medicines can only really be appropriate when you have sufficient information about your patients, either personally acquired or provided to you by another doctor or healthcare professional. Such information is usually obtained through good history-taking, clinical findings and/or relevant investigations. Apart from telemedicine, a decision to prescribe solely based on ad-hoc information provided by telephone or any electronic means should be reserved for continuing care or in exceptional situations where patients' best interests are being served by doing so.

The appropriate prescription of medicines is based on rational medical grounds. Such grounds are arrived at by considering available evidence of the drugs' efficacy and safety for the purposes prescribed as well as general acceptance by the profession that the drugs are of net benefit to patients. In the practice of medicine, the rationale for the use of drugs or any treatment is based on a combination of evidence and accepted practice, the balance between them being quite variable. Some treatments that have never been the subject of formal clinical trials are well-accepted to be of net benefit to patients and it would be unethical to now conduct such trials, given the time-tested benefits of these treatments and the possible harm to patients if not treated. In general, you should be able to explain your rationale for prescribing treatment.

You are required to inform patients of the purpose of the medicine prescribed, the expected results, the more common drug interactions or side effects, or those likely to be significant to specific patients.

Patients have a right to information about the purpose of their prescribed medicines, expected results, drug interactions and side effects and what to do in the event of adverse reactions or side effects. It is accepted that it might not be practical for you (or whoever you delegate the task) to discuss or set out every possible dispensation, drug interaction, adverse reaction or side effect. However, patients need to be at least informed of drug interactions or side effects that are common, clinically significant or likely to be of relevance to specific patients or circumstances. For example, Quinolone antibiotics have a rare adverse effect of rupture of the Achilles tendon. While this is quite uncommon, at a rate of 0.015% to 0.02%, if patients are competitive sports persons, even a low risk might not be acceptable and this potential adverse effect ought to be made known to the patients. Patients should also have the opportunity to seek clarification.

It is crucial to elicit a history of drug allergy. If the history is unclear, then it is necessary to consider whether it is justifiable to prescribe the drug or class of drugs.

Drug allergy can have serious consequences and can be fatal. A drug, or a class of drugs, which has caused a serious allergic reaction in the patient ought to be avoided. If patients have information to show that they have had serious allergic reactions to a drug or class of drugs before, it is necessary for you to carefully consider all appropriate options before taking the risk of prescribing the patients the particular drug or drugs in that particular class. Patients need to know the material risks and consent to taking them. Patients should also be given information on what to do if there is an allergic reaction. In some circumstances, you may need to monitor the patient when a drug is first administered or taken.

B5.2 - Written prescriptions

You have to ensure that your prescriptions are legible and unambiguous.

To prevent dispensing errors, abbreviations for drug names should not be used. Abbreviations for dosage, frequency and duration of treatment should also be avoided unless they are well understood within the system of care.

B5.3 - Electronic prescriptions

Increasingly, electronic medical records are being used. Many such systems allow you to prescribe medicine electronically. If you control the system that electronically generates and signs your prescriptions, you should ensure the security, integrity, accuracy and confidentiality of the system used. If you do not control the system, then your responsibility is to use it correctly and comply with the prescribed safeguards.

B5.4 - Remote prescriptions outside of a personal consultation

If you give remote or verbal orders, you have to be satisfied with the information about the patients and that the prescription is in the patients' best interests.

Prescriptions are best ordered through a reliable system of transmission to a pharmacy, dispensed to patients (or their carers) at the site of consultation, or personally given to patients (or their carers) to fill. Inaccuracies may occur when there are additional steps in the transmission of the prescription and medication errors can occur.

Remote orders for medicines, through telephone, fax, email, video link or internet, run the risk of communication problems leading to medication errors. You should only give such orders in circumstances where:

- (a) You are unable to provide a prescription to enable patients to be treated in a timely manner.
- (b) Patients are already under your care.
- (c) You are deputising for another doctor but you have adequate knowledge of patients.
- (d) You are able to have a dialogue with patients or other healthcare professionals attending to patients who can provide relevant medical information about the patients and assist with fulfilling your prescriptions.

In any event, you should ensure that there is appropriate and timely follow-up of patients.

When verbal orders are given, the receiving party needs to be clear about the drug name, dosage, frequency of administration and duration of treatment. The receiving party should be asked to repeat the order back to you and, where possible, have yet another person receive the verbal order independently from you to provide verification. The receiving party should be asked to write down the prescription on your behalf immediately or as soon as possible and you should personally countersign that order as soon as possible.

B5.5 - Repeated prescriptions or dispensing of medicine without consultations

Repeated prescriptions or dispensing of medicine without consultations is allowable if patients' clinical situations are reasonably believed to be stable and the patients require only replenishment of medicines.

You may prescribe or dispense medicines to follow-up patients without consultations under circumstances where:

- (a) The patients have been very stable and require only replenishment of medicines needed for maintenance treatment.
- (b) There is no evidence or information that the patients' clinical situations have changed. If they have, you should see the patients first.

However, repeated prescriptions or dispensing of medicine without consultations should not go on indefinitely. Clinical reviews should instead be conducted at intervals appropriate to the patients' diagnoses and medical conditions.

B5.6 - Prescription of medicine in the context of shared care

Patients may be under the care of different doctors or teams in institutions, or under several doctors of a practice. Patients may also be transferred between general practice and specialists or between practices, clinics or institutions.

If you first prescribe a medicine or change patients' existing drug treatment, you should ensure that your colleagues understand the reasons for your prescription to ensure safe and smooth continuity of care.

If you take over patients and repeat their prescriptions, you should be careful to ensure that the prescriptions continue to remain appropriate at such time.

B5.7 - Drugs of potential abuse, dependency or addiction

You have special obligations when patients are prescribed or dispensed drugs which have potential for abuse, dependency formation or addiction.

In general, you need to be careful not to prescribe or dispense medicines with potential for dependence or addiction in disregard of patients' circumstances or patterns of usage that ought to raise suspicions.

If you prescribe or dispense such medicines, you need to establish good clinical indications, give only appropriate amounts, review patients at short intervals and refer patients to addiction specialists if any abuse, dependency or addiction is suspected.

To safeguard your own practice and patients' best interests, you need to take the following precautions:

- (a) Be alert to the possibility that such medicines are being abused by patients to feed a dependency or addiction and that you may be manipulated by patients with such a problem.
- (b) Establish sound medical grounds and clinical indications for prescribing or dispensing these medicines on each occasion they are prescribed or dispensed. You should try to find safer alternative medicines to treat the patients if these are available.
- (c) Not supply, prescribe or dispense such drugs indiscriminately, recklessly or excessively, or in a manner that deviates significantly without justification from the practice of medical peers or established professional guidelines. You should therefore read and be up to date with the relevant professional guidelines found on the MOH website, or in academic publications.
- (d) Limit the dispensation of these medicines to as small quantities as possible, while appropriate for the medical condition of the patients, conducting frequent reviews and making it difficult for those prescribed such drugs to engage in secondary selling. Abuse of these medicines includes overdoses, sale to other addicts, etc. This would amount to trafficking.
- (e) Make every effort to wean patients off these medicines.
- (f) Refer patients to addiction specialists for help rather than persist in giving these medicines if you suspect that patients may be addicted or dependent on such medicines.

You should take care not to be deceived into providing medicines to addicted patients that feed their dependency or addiction by their hiding the fact that they are dependent or addicted, or by falsifying clinical presentations to receive treatment. While it is accepted that you may be an innocent victim of deliberate deception, you should nonetheless be aware of patterns of usage of medicines that may raise suspicions of potential abuse, dependency or addiction. If such patterns are obvious and highly suspicious, you need to protect yourself and your patients' best interests by not offering the drugs and referring them to the relevant addiction specialists for assistance.

B5.8 - Off-label use and use of unlicensed medicines and treatments

If you use “off-label” drugs, you need to be sure that it is justifiable for the medical indications and in patients’ best interests, that there is a rational basis and an acceptable risk profile. Patients need to give consent for such use, if they are able to.

You should generally offer medicines or treatments for their approved purposes. If medicines or treatments are offered for alternative purposes or “off-label”, the following are good practice points:

- (a) You ought to have considered all other appropriate and conventional medical options and deemed them to be less suitable in the circumstances.
- (b) You need to have a rational basis for the use based on some amount of evidence of efficacy and safety in such use of medicines or treatments.
- (c) Patients need to be informed and expressly give their consent (if they are able to do so) to the off-label use or use of unlicensed medicines or treatments.
- (d) The patients should be appropriately monitored for effectiveness and side effects of such use of the medicines or treatments.
- (e) Proper documentation of the information provided to the patients, their understanding and consent should be made in medical records.

Treatments that may well be valid may not yet be unlicensed. If you wish to use unlicensed drugs, devices or instruments on patients you need to first obtain the necessary approvals from the relevant authorities, ensure that it is in patients’ best interests and obtain patients’ consent (if they can give it, or their legal representatives’ consent) for the use of such medicines or treatments.

B5.9 - Drugs and sportspersons

You ought not to knowingly abet or participate in the trafficking, supply or administration of any drugs, substances or treatments (listed in the World Anti-Doping Agency, “WADA” Prohibited List) to sportspersons for the purpose of enhancing their sports performance or to obtain an unfair competitive advantage.

Enhancement of sports performance by drugs or medical treatments is a well-known problem in competitive sports. But there are also sportspersons who desire to enhance their own performance outside of the competitive arena. Whether or not the objective is to cheat in sports, the use of drugs purely for the purpose of enhancing patients’ sports performance is not acceptable.

You may use such treatments for legitimate medical reasons but you have to be careful not to give them to sportspersons in disregard of patients’ circumstances or patterns of usage that ought to raise suspicions.

If substances or methods specified in the WADA Prohibited List are legitimately indicated for the treatment of a medical condition in sportspersons, and you are aware that the patients are sportspersons, you should ensure that:

- (a) The medical indications are very clear and properly documented.
- (b) Alternatives to these drugs or methods of treatment have been considered and the chosen drugs or treatments are in your judgment the most appropriate for the patient.
- (c) You inform the sportspersons of your recommendations so that they can obtain a Therapeutic Use Exemption from the relevant authority before using the drug or method of treatment.

You should take care not to be misled into providing drugs, substances or treatments for the purpose of enhancing sports performance, by way of patients hiding the fact that they are sportspersons or by falsifying clinical presentations to receive treatment. While it is accepted that you may be an innocent victim of deliberate deception, you should nonetheless be aware of patterns of usage of drugs or treatments on WADA's Prohibited List that may raise suspicions. If such patterns are obvious and highly suspicious, you need to protect yourself and your patients' best interests by not offering the drugs.

B6. Untested practices

You are obliged to treat patients only according to generally accepted methods, based on a balance of available evidence and accepted best practices.

Treatments may be considered generally accepted by the profession if they are time-tested or well-documented or if there is a responsible body of medical opinion, logically held, that supports the use of the treatments. The risks of the treatments and the ability to control these risks should have a level of predictability acceptable to the medical community.

The test of a treatment being generally accepted cannot be based merely on whether it is practised by a large number of doctors. Illegitimate or unethical practices are not legitimised merely because large numbers of doctors engage in them.

Minor variances and adaptations in treatment techniques that address specific patients' needs are necessarily a part of medical practice. However, the variations cannot be so substantial that they would significantly increase the risks (or degree of ignorance of risks) to patients or render the technique novel, which would then by definition, not be generally accepted.

Treatments that are not generally accepted would necessarily include new inventions or new treatment modalities (examples such as devices, drugs, biologic agents etc.) that have yet to gain general acceptance through trials or documented experience.

Treatments that are not generally accepted may be offered to patients only in the context of formal and approved clinical trials. Such trials would be subject to the ethics of research.

B6.1 - Innovative therapy

In offering innovative therapy, you have to be sure that the situation is desperate or dire, and that conventional therapy has been shown to be unhelpful. There needs to be professional consensus on the use of innovative therapy in the particular clinical situation and consent needs to be obtained from patients if they are able to give it.

Defined as a completely novel or significantly modified standard therapy with little or nothing in the way of studies or scanty evidence of efficacy, effects or side effects, innovative therapy:

- (a) May be undertaken where there is some biological plausibility and professional consensus and in the best interests of patients who are in clinically desperate and dire situations. It is sometimes justifiable to consider innovative therapy when conventional therapy is deemed unhelpful.
- (b) Is similar to research in its experimental nature, but differs in its goals and context sufficiently to exempt it from direct governance by research ethics boards, in that innovative therapy is provided in order to benefit patients rather than to acquire new knowledge. Innovative therapy is nonetheless a legitimate part of the process of hypothesis generation in the advancement of medical knowledge and its evaluation could well form the basis of subsequent formal research protocols.
- (c) Is wholly inappropriate for elective treatment in the absence of any threat to life or pain and suffering.

Complementary and alternative medicine treatments are excluded from consideration under innovative therapies.

You may consider innovative therapy under these conditions:

- (a) The clinical situation is dire and desperate for the saving of life or amelioration of intolerable pain and suffering.
- (b) All other options have been considered and deemed unhelpful or inappropriate.
- (c) There is professional consensus (you should get at least one other opinion) that the little-known therapy should be offered as a last resort.

In addition, patients, if mentally competent, need to be advised objectively and honestly on the probability of benefits and adverse outcomes that may be expected, so that consent can be given for the therapy. In this particular situation, it is inevitable that the consent might be given under some duress, since the patient is facing a life-threatening situation or in some pain and suffering. In the circumstances, such consent would nonetheless be valid.

Where there are processes available in institutions or relevant authorities to evaluate and approve proposed innovative treatment, all requirements of the processes should be fulfilled where possible. If the processes take time, and if it is urgent, steps should be taken to expedite the approval or obtain fast-track approval. If ultimately such approval processes are more time-consuming than the patients' clinical conditions would tolerate, you may proceed in the patients' best interests.

Patients should be appropriately monitored for effectiveness and side effects of the innovative therapy and there should be proper documentation.

B7. Non-treating doctors performing assessments for third parties

Despite being a non-treating doctor, you still have professional responsibility to serve the patients' best interests. You need to ensure that you exercise due diligence, professional competence and skills to ensure the veracity of any documents written or signed by you.

You may be asked to provide medical assessments, not for the purpose of offering or advising treatment, but for the purpose of statutory or insurance health screenings, or to evaluate patients for administrative, insurance pay-out, compensation or medical employment classification purposes on behalf of third parties, or to provide expert advice in legal cases.

In some situations, your recommendations may impact patients' well-being if they lead to restriction of treatment options or to inappropriate work assignments that may harm patients.

In general, if you are making medical assessments of patients for a third party, doing so responsibly means to:

- (a) Have the necessary competence to perform such roles.
- (b) Be impartial and have no conflicts of interest. You ought not to allow any financial considerations on your own part or the patients' part to influence your assessment. You are obliged to report and act without regard to extrinsic factors such as who is paying for the assessment, who has engaged you or whether you are employed or remunerated by the third party.
- (c) Have sufficient information to make the assessment.
- (d) Be reasonably confident that not having personally taken histories or examinations of patients will not make a material difference to your assessment.
- (e) Ensure that your professional attitude towards these patients is not of a lower standard than that towards the patients you are treating.

- (f) Use your medical expertise to fairly and objectively evaluate the patients and not make decisions that are not supported by, or are contrary to the medical evidence before you.
- (g) Make medical recommendations that are appropriate for the purposes they are asked for.

You need to be careful that your recommendations do not result in harm to patients through consequent inappropriate restriction of treatment options or inappropriate work assignments.

In addition, best practices for such assessments would include:

- (a) Providing patients sufficient information so that they can understand your role and the purpose of your assessment. If you are the patients' usual doctor and you accept a request for a third party assessment, you should ensure that your patients understand the different role that you are undertaking.
- (b) Requesting additional medical information if the information before you is incomplete or unclear, so that a proper decision on clinical grounds can be made.
- (c) Resolving any discrepancy between any diagnosis, conclusion or recommendation found within the medical information available and your own assessment, and refrain from taking at face value any information found to be dubious until you are satisfied that your own conclusions can be supported.
- (d) Obtaining patients' consent for the transmission of medical information to the third party for whom the assessment is made.
- (e) Documenting your assessments properly.

B7.1 - Findings that are clinically important to patients

If you discover medical information important to patients, you have an obligation to take reasonable steps to ensure that the patients are made aware of such information so that they may seek medical care in a timely manner.

If the examinations or tests or assessments reveal significant medical conditions, or if you discover information that would prevent harm, but of which the patients may be unaware, even if you are not the treating doctor, you have an obligation to ensure that:

- (a) The patients are informed of the test results or information with explanations of their significance. This is so that patients have sufficient information to seek, if they so choose, medical care for the discovered conditions.
- (b) Although under such circumstances, the third party payer will usually have the patients' consent to have this medical information revealed to it, reporting this information to the third party is insufficient for the purpose of fulfilling your obligation to the patients. You need to proactively make reasonable efforts to inform the patients directly of the information in a timely manner so as to prevent harm to patients' health and well-being.

B8. Medical research

You are obliged to ensure that the best interests of research subjects are protected during medical research programmes and to uphold the profession's high standards in research so that the integrity of results is maintained.

Research is an important aspect of the professional life of doctors, in contributing to better understanding of diseases and better treatments for the future.

You are obliged to conduct medical research with honesty, objectivity and integrity, not allowing commercial, financial or other extraneous considerations to influence the integrity of your patient recruitment methods, research protocols, results, findings or plans to publish the results.

Much research is funded by the medical industry. You should not take any lead from such sponsors as to how to conduct research, how to write up your results or whether to publish. You may face pressures not to publish research with negative results. Such a practice would skew the medical literature. For example, meta-analyses would be inaccurate if all experiments regardless of their outcomes are not reported. You should also not allow your name to be associated with research papers where you do not have the ability to ensure the integrity of the conduct, interpretation or writing of the results. Some companies seek your good name to bolster the credibility of their papers, but in fact “ghost-write” it on your behalf and you do not have significant influence over the writing. This is unacceptable.

You are not to conduct or authorise any research on human subjects or trials of any treatments on patients not approved by the Institutional Review Board or Ethics Committee and are contrary to current Good Clinical Practice Guidelines, or other existing guidelines on human biomedical research.

If research does not involve human subjects, such as epidemiological or statistical research, then the issue of protecting patients’ well-being does not arise, although issues of confidentiality might still be relevant.

If you design, organise or participate in research involving experiments on human subjects or trials of treatment on patients, you need to:

- (a) Put the well-being and safety of research subjects as the foremost consideration.
- (b) Have the research protocols approved by an Institutional Review Board or an Ethics Committee.
- (c) Ensure that commercial, financial or other extraneous interests do not interfere with the integrity of your research methodology, results, findings or your plans to publish them.

In addition, you should:

- (a) Abide by the Good Clinical Practice Guidelines and any other guidelines that determine standards of research (for example, the Biomedical Advisory Committee's Guidelines for Human Biomedical Research).
- (b) Ensure that patients' decisions on whether to participate in the research trial do not compromise the patient-doctor relationship.
- (c) Declare any potential or actual conflicts of interest to the Ethics Committee.

B8.1 - Consent for medical research

You have to ensure that all requirements for disclosure and patient consent are fulfilled before starting on medical research. Subjects ought to be given sufficient information for them to understand the research so that they can give informed consent.

The standards of information provision, disclosure and consent taking are higher when conducting clinical research on human subjects than for medical treatment.

The following are some of the best practice principles of consent in clinical research:

- (a) Patients should be given full knowledge and understanding of the purpose, methods, potential benefits and risks of entering a trial.
- (b) Patients should be informed of the conventional treatments available and their right to have these treatments rather than the trial treatment.
- (c) Patients should be made aware of their right to non-discriminatory medical care should they refuse to participate in a trial.
- (d) The financial arrangements in terms of free treatments, reimbursements and what your patients need to pay should be made clear, so that they do not end up with unexpected or unanticipated costs.
- (e) There should not be excessive financial, material or any other kinds of inducements for patients to consent to participating in a trial. This does not preclude the provision of free treatment and reimbursement of expenses as part of the trial but patients need to be informed that the provision of free treatment per se should not be the sole basis for them to consent.
- (f) Patients should know that they retain the right to withdraw from the research at any time without fear of prejudice in receiving continuing treatment or subsequent care.

B8.2 - Research on persons with diminished mental capacity

Research ought to only be conducted on such persons if research on fully competent subjects will not yield the same benefits, for example, research that would specifically benefit persons with conditions of diminished mental capacity.

You need to give special consideration to proposed research on persons with diminished mental capacity by assessing whether they have sufficient mental capacity to understand and retain information for the purpose of consenting to participating in research.

You need consider these aspects:

- (a) Mental capacity should be within the meaning of the definition in the Mental Capacity Act (Cap 177A). Although such persons may have difficulty in recognising their best interests, expressing their needs or defending their rights, you need to determine whether these persons have sufficient residual mental capacity to understand and retain information for the purpose of making informed decisions for themselves. If so, they have the right to consent for themselves. If not, then it is sufficient to obtain consent from legally appointed persons with the requisite authority to make decisions for those patients with diminished mental capacity.
- (b) If there are no legally appointed persons with the requisite authority to make decisions for these patients, you may establish the likelihood that the persons would consent to research through their spouses, children, parents or legal guardians, siblings in that order of priority. In such instances, consent may be taken from one of these parties for research.

B8.3 - Research on minors

Research ought to only be conducted on minors if research on fully competent adult subjects will not yield the same benefits, for example, research that would specifically benefit young persons.

For minors with the capacity to understand information sufficiently to decide for themselves, it is necessary to involve them in making the decision to be research subjects.

If they do not have the capacity to consent, then consent needs to be obtained from at least one parent or legal guardian. Even then you ought to engage and explain to the minors in ways that they can comprehend so that any concerns may be addressed and any distress minimised.

Parents and legal guardians have authority under the law to make decisions on and consent to research participation by their children who are minors. However, this authority has to be exercised with the welfare of children and their best interests in mind and does not allow parents or legal guardians to give consent for research exceeding minimal risk.

For minors with the capacity to understand information sufficiently to decide for themselves, you are obliged to involve them in making the decision to be a research subject. Consent from one parent or legal guardian is also required unless an Institutional Review Board has given exemption to waive the requirement of consent from a parent or legal guardian.

If minors do not have the capacity to understand information sufficiently to decide for themselves, consent will have to be taken from at least one parent or guardian, provided that you have reasonable grounds to believe that research of comparable effectiveness cannot be carried out without the participation of that class of minors. As far as possible, engagement of and explanation to the minors are still important as they serve to allow the minors to express their concerns which should be addressed. Engaging the minors also help minimise potential risks associated with participation such as distress experienced while undergoing research procedures.

B8.4 - Research on persons under orders or in subordinate situations

You need to be vigilant to ensure that persons who are under military command or other subordinate positions are not participating in research under coercion.

As there are particular concerns regarding the participation in research of persons under military command or in other subordinate positions, you need to do your best to ensure that such persons give willing consent to participation in research. You need to be vigilant to ensure that such persons are not participating under duress or under the misconception that they are obliged to do so in their circumstances. If you are in doubt, you should consider getting neutral third parties to obtain the consent of those who are in subordinate positions so as to reduce the risk or perception of coercion.

B8.5 - Secret research

You may be involved in conducting research for organisations that have confidentiality obligations, for example, the Ministry of Defence or defence-related industries. Often, the results of such research are not published in the usual peer reviewed literature but are only used internally. If you conduct secret or unpublished research, you are not exempted from any of the ethical requirements of research. In this regard, if your professional conduct in doing such research comes to light and is challenged, it will not be a defence to claim that you were only obeying orders.

You are obliged to maintain due respect for human life. In this respect, you are not allowed to participate in research or any actions designed to injure or harm human beings.

This includes, but is not limited to, research or activities related to weapon development, interrogation techniques or the elucidation of any human characteristics for the purpose of utilising such knowledge to cause harm. Involvement in nuclear, biological or chemical warfare is of particular concern. You may be involved in medical defence against these, but you may not be involved in developing any of the harmful aspects of such unconventional warfare. If your professional conduct is challenged in this regard, it will not be a defence to claim that you were obeying military or other orders.

B8.6 - Other considerations in medical research

If you have first-hand information and reasonably believe that a colleague is engaged in scientific misconduct, you are obliged to report this to the relevant authorities.

This is to protect the integrity and reputation of medical research and to prevent possible future harm to patients who may be managed based on faulty recommendations arising from such falsified research.

Other than the ECEG, the ethical guidelines for research may be elaborated upon by other authorities such as MOH, National Medical Ethics Committee and the Biomedical Advisory Committee etc. Where additional national guidelines exist, they will also serve as reference points for the conduct of doctors who do research.

B9. Complementary and alternative medicine

B9.1 - Definition of complementary and alternative medicine

Complementary and alternative medicine (“CAM”) is a broad domain of purported healing resources that encompasses all health systems, modalities and practices with their accompanying theories and beliefs which fall outside conventional health systems and medical practice.

CAM is therefore heterogeneous and is variable in terms of scientific basis, efficacy as treatment options and general consensus as to applicability in patient care.

A practice previously regarded as part of CAM sometimes becomes accepted as mainstream conventional medicine through the acquisition of quality scientific evidence or general acceptance by the medical community. It then becomes an integral part of conventional medicine and may be offered by doctors as such. This section relates to those modalities that are either lacking in evidence or have equivocal evidence or only some supportive evidence, but which practice is based broadly on long-held historical or traditional practices.

If doctors who offer CAM do not wish to be held accountable to the standards of conventional medicine, they may withdraw their registration with SMC, after which the only standards applicable to them would be the CAM regulatory framework. In moving totally to CAM, these doctors will no longer be allowed to advertise their credentials in conventional medicine.

B9.2 - Doctors offering CAM

If you practise CAM, you can only practise those modalities that are specifically approved by SMC.

Information on which CAM modalities are approved by SMC for registered doctors to practise can be found on the SMC website.

The CAM modalities that SMC approves for practice is based on a range of criteria which includes, but is not limited to, the following:

- (a) There is some evidence of efficacy and safety.
- (b) There are consistent systems of understanding of the functioning of the human body and assessments, diagnosis and management principles commonly applied by practitioners.
- (c) There is a sufficiently large body of practitioners locally and worldwide for international standards to be available and for local expertise to become organised enough to contribute to regulation through professional bodies.
- (d) There are training opportunities through institutions or professional bodies that have high standards and comprise content that can be accredited and validated by an academic or regulatory body.
- (e) There is a public register of such CAM practitioners through which members of the public may examine individual practitioners' training, competence and accreditation.
- (f) CAM practitioners are required to have a set of standards and a code of good practice, including defining limits of competence.
- (g) There is continuing education in the modality and there are means for determining continued competence.

If you offer CAM, your medical qualifications and SMC registration status may give your patients the impression that the CAM treatments are appropriate, safe, efficacious and legitimate. Thus, you are obliged to act with the highest integrity with regard to offering SMC-approved CAM services.

B9.3 - Training, accreditation and licensing for CAM practice

Practitioners of CAM have to be duly trained and registered with the CAM-specific regulatory agency or professional body that is recognised by SMC.

You need to be trained and to have acquired the same degree of proficiency as non-doctor CAM practitioners in the CAM therapies you wish to offer and you ought to have undergone, in full, qualification courses that non-doctor practitioners need to undergo to be certified. You are not entitled to “discounted” or “fast tracked” CAM training on the basis that you are medically qualified. A few abbreviated weekend courses will probably not be sufficient. The qualification has to be accepted by the relevant CAM regulatory body that accredits non-doctor CAM practitioners.

B9.4 - Ethical standards for doctors practising or offering CAM

You are obliged not to mislead patients as to the appropriateness of use and expected benefits of CAM through taking advantage of patients’ trust in your SMC-registered medical qualifications.

Equally, you do not have the right to claim superiority of your service merely because you offer CAM alongside conventional medicine.

Patients need to objectively decide to accept CAM service on the basis of their knowledge of CAM and the competence and reputation of the CAM practitioner who is offering it. CAM is not more legitimate merely because SMC-registered doctors offer it and CAM is not necessarily practised more competently by SMC-registered doctors.

When doctors become involved in CAM, there is a likelihood that patients are easily persuaded as to the legitimacy or benefit of CAM through trust in a doctor’s SMC-registered credentials.

As an SMC-registered doctor, you are obliged to ensure that there are sound medical reasons for offering CAM to your patients. You need to ensure that you are acting in patients’ best interests and that there are no medical contraindications.

From the point of view of conventional medicine, CAM is a justifiable alternative to conventional medical therapy when conventional therapy has been tried and failed, or there is no better alternative in conventional medicine. Examples include chronic headaches or backaches with no diagnosable diseases, which cannot be cured, only alleviated by conventional medicine. It is reasonable to try, say, acupuncture to see if this can help. CAM can also be an added modality to conventional medicine. Examples include helping cigarette smokers to stop smoking as part of management of chronic lung disease and for symptomatic relief of side effects of cancer chemotherapy that are difficult to alleviate by conventional means.

It is not acceptable for you to use CAM on your patients in flagrant disregard of medical needs that ought to be met through conventional medical practice. If you cause harm to patients by action or inaction, it is no defence that your CAM practice condones or supports the management of your patients under an alternative health system or philosophy.

Doctors who practise conventional medicine and extend SMC-approved CAM services to patients within their practice have specific ethical rules that apply to their SMC-approved CAM practice. It is not appropriate to absolve doctors of any outcome arising from their practice of CAM (albeit one approved by SMC for doctors to practise) just because they are under a separate regulatory framework which may indeed find that their practice of CAM is competent and accept the kinds of outcomes that conventional medicine would not.

To put it another way, regardless of whether SMC has approved a particular CAM for registered doctors to practise, the outcomes will be judged according to the standards applicable to conventional medicine.

For example: under CAM, a displaced, closed fracture of the humerus may sometimes be treated by poultices and wraps. However if this ends up with mal-union and loss of future function, the failure to refer to an orthopaedic surgeon for conventional reduction and fixation cannot be excused by the fact that CAM practice would support poultices and wraps.

Patients may request that you treat them with CAM rather than conventional medicine, if you can offer both. However, if you deem that patients' best interests are not served by CAM treatment, you should at least offer necessary conventional medical treatment. You should advise them that conventional treatment is necessary to avoid harm and you should persuade them to accept it. Of course if patients refuse conventional treatment despite your explanations, you should respect their decisions.

Example: A patient with dangerously uncontrolled diabetes may ask for CAM treatment only but if you deem that only conventional treatment is right for the patient, you need to offer this and explain why.

You are obliged to give patients sufficient information about the SMC-approved CAM treatment that you are offering, so that they can give informed consent.

Because CAM is by definition not conventional medicine, if you offer it as an extension of your conventional medical practice, it is necessary to obtain consent for any CAM therapy you offer to your patients. Therefore your patients need to have sufficient information to give consent, whether expressed or implied. You should explain to patients:

- (a) The therapy being offered.
- (b) The reasons for recommending it.
- (c) The available options in conventional medicine.
- (d) The nature, limitations, benefits and risks of the proposed CAM treatment.
- (e) Any financial interest on your part.

B9.5 - Advertising CAM practice

If you are practising CAM, you are required to abide by all the ethical standards relating to advertising as for any other medical service. Specifically, you need to avoid any suggestion of superiority of your practice simply because you are able to offer CAM on top of conventional medicine. Your expertise in CAM ought not to be sensationalised or presented in a laudatory manner.

B9.6 - Delegating care to CAM

When you delegate care of your patients to CAM practitioners, you retain responsibility for the overall care of your patients unless they discharge themselves from your care in favour of being treated only by the CAM practitioners.

You are also obliged to only delegate patients to those CAM practitioners with approved credentials and of whom you have reasonable confidence in their competence.

When sending your patients to other practitioners of SMC-approved CAM modalities, you have only temporarily delegated the care of your patients to the CAM practitioners. As the CAM practitioner is not a doctor, it is not appropriate to refer your patients to be fully under the care of the CAM practitioners unless patients request this or you truly have nothing more to offer in conventional medicine. You should explain to patients any benefits of remaining under your care and if they insist, then you may discharge them to the care of the CAM practitioner.

You may recommend your patients only to CAM practitioners whom you have reasonable confidence are able to practise CAM to a sufficient degree of competence.

B10. Aesthetic practice

Aesthetic practice is defined as an area of practice involving any operation or procedure that focus on reviewing or changing patients' appearance such as colour, texture, structure or position of bodily features which most would consider otherwise to be within the broad range of "normal" for such individuals.

You are obliged to ensure that the aesthetic procedures you offer go beyond mere non-maleficence (doing no harm). The treatments have to be verified to be effective and safe, and your practice needs to be licensed to provide them.

Aesthetic practice, by its nature, is not in the usual realm of medicine which seeks to cure or ameliorate disease and illness. It does not usually improve a patient's health and safety. The reasons and motivations for patients consulting aesthetic practitioners are very different from those of patients consulting conventional doctors and it is often difficult to determine whether the aesthetic treatment is in the patients' best interests. While it is often claimed that treatments will improve patients' self-esteem, this is difficult to measure.

In aesthetic practice, there is much less justification for offering patients the procedures that come with significant risks. Correspondingly, among aesthetic procedures, there are many treatments available for which evidence of benefit is scanty or absent. Such treatments ought not to be offered to patients. Patients have the right to be offered only treatments that have been shown to be effective and safe.

Patients seeking aesthetic procedures may be susceptible to accepting procedures that may not have scientific evidence supporting them or which are not generally accepted by the medical profession. Also given the nature of the practice, patients often come with heightened expectations of a completely subjective nature and correspondingly, practitioners may be prone to encouraging such expectations for commercial reasons.

Aesthetic practice does not cure or ameliorate disease or illness. Neither are aesthetic treatments medically necessary. Therefore the usual acceptable balance between benefit and harm to patients is modified. You need to advise patients of the side effects and adverse outcomes beyond those that are more common. You also need to disclose risks that are lower than those required to be disclosed in conventional medical treatment.

For example: while wound infection, delayed healing or dehiscence may be rather uncommon in blepharoplasty (infection in about 0.2%), such complications ought to be told to patients because when it happens, it is devastating to the patients, who came to improve their appearance in the first place.

B10.1 - Designations of doctors who engage in aesthetic practice

As aesthetic medicine is not a recognised specialty, you are obliged not to mislead the public into thinking you are a specialist in aesthetic medicine.

A doctor who engages in aesthetic practice cannot be called an aesthetic medicine specialist, aesthetic practitioner or any variation of such a title. If you are a plastic surgeon, dermatologist, family physician or GP who engages in aesthetic practice, you may only continue to make yourself known to the public by the relevant SMC-approved designations.

B10.2 - Provision of aesthetic procedures

You are obliged to evaluate patients carefully to determine whether aesthetic procedures are in their best interests, and to exclude psychological or psychiatric pathologies involving self and body image that are motivating the patients.

This obligation may be fulfilled by you becoming competent in applying appropriate assessment tools to counsel vulnerable patients, or if you are in doubt, referring patients for formal psychological or psychiatric assessments. If significant psychological or psychiatric morbidity is found, you ought not to offer aesthetic treatments to these patients and they should be referred for appropriate specialist treatments.

B10.3 - Training, expertise and experience required

Aesthetic practice is offered by a wide variety of doctors. If you offer aesthetic services, you need to be adequately trained and experienced. Not being a specialty or sub-specialty, there is no professional body to regulate the standards of training, competence and experience required. There are, however, “Guidelines on Aesthetic Practices for Doctors”, which you are required to abide by.

B10.4 - Consent for aesthetic procedures

As all aesthetic procedures are elective, for the more invasive and surgical procedures, there must be a reasonable “cooling off” period between patients giving consent and the treatment.

Consent for aesthetic procedures requires a high level of disclosure of information which needs to be provided to patients in a way that they can understand.

Unlike traditional consultations, in aesthetic practice where a desired cosmetic outcome is the very reason for a consultation, the process of consent should begin from the very first consultation and not just prior to a procedure.

Unlike normal medical treatments, disclosure of risks in aesthetic procedures has to go beyond the most common ones. As the justification for accepting risk of harm is much lower than for other medical treatments, the threshold for disclosing risks in aesthetic procedures is necessarily lower than in conventional medicine.

Since there is no medical urgency in aesthetic practice, there cannot be time pressure on a patient to give consent. The appropriate “cooling off” period between giving consent and treatment may differ depending on the level of intervention the procedure entails. As a rough guide, a “cooling off” period of one week to 10 days for procedures requiring deep sedation or general anaesthesia and one to three days for those not needing these would be appropriate. However, every patient is different and you should exercise judgment to ensure that sufficient time is given for patients to decide on whether to proceed with treatment.

When you give advice on aesthetic procedures you need to recognise patients’ expectations and give objective and comprehensive information to them about the procedures as well as what outcomes may reasonably be expected.

Patients seeking aesthetic procedures often have heightened expectations about what can be achieved. Often they are then disappointed by the results, even if technically, the procedures are competently done. You should therefore advise patients that their idealised appearance may not be possible and they should have realistic expectations of the results.

You ought not to offer or perform aesthetic procedures on minors or persons with diminished mental capacity unless you have independent professional assessments indicating that these procedures are indeed in these patients’ best interests.

Minors who do not demonstrably have the capacity to fully understand information and lack demonstrable capacity to consent, as well as persons with diminished mental capacity, are of special concern (refer to the sections on managing such categories of patients). Even more so in aesthetic practice than in other fields of practice, there is little justification in offering or performing aesthetic procedures to these groups of patients, unless there are exceptional circumstances.

Some parents offer aesthetic procedures to their children as coming-of-age presents, or as rewards for academic performance. Sometimes, minors themselves request for the procedures. Since aesthetic procedures cure no illnesses and are always elective, parents' consent to such procedures to be done on their children cannot be taken at face value. Children may be immature in their self-image or may be influenced by teasing and taunts from their friends about their physical characteristics. They may not be able to understand that aesthetic procedures may not solve their problems. As examples, an overweight minor may ask for liposuction which is usually not the best solution to childhood obesity, or a teenager may request a double eyelids procedure.

Since many aesthetic procedures come with some risks, performing them on minors require considerable effort to determine that they are indeed in the minors' best interests. If minors or their parents are adamant after counselling, you ought to refer the minors for independent psychological assessments to determine whether the procedures are truly in their best interests.

The same considerations would apply to persons with diminished mental capacity.

B10.5 - Advertising aesthetic practice

When advertising aesthetic procedures, you are obliged not to exploit patients' vulnerabilities or insecurities about self-esteem or perception of body image.

Your advertising should contain objective and comprehensive information about the procedures and outcomes rather than play on the public's vulnerabilities in self-esteem and perceptions of body image.

C - RELATIONSHIPS WITH PATIENTS

A sound patient-doctor relationship requires doctors to display a high standard of professional conduct when interacting with patients. This section looks at the aspects that you need to consider in establishing and maintaining good professional relationships with your patients. These include:

1. Attitude towards patients
2. Good and effective communication
3. Personal beliefs
4. Propriety and sexual boundaries
5. Patients' right to information and self-determination
6. Consent
7. Medical confidentiality
8. Caring for minors (persons below age 21)
9. Caring for patients with diminished mental capacity
10. Visual or audio recordings of patients
11. Third parties in attendance
12. Relationships with patients and those close to them
13. Dealing with adverse outcomes and medical errors
14. Termination of a patient-doctor relationship

C1. Attitude towards patients

You need to treat patients with courtesy, consideration, compassion and respect and without coercion, discrimination, harassment or exploitation. You are obliged to always uphold patients' right to privacy and dignity.

The attitude with which you approach your patients determines the quality of the professional patient-doctor relationship. In turn, patients who trust you and are comfortable with you are more likely to benefit from your management.

You are not obliged to be subjected to abuse of any kind by patients, their family members or other accompanying persons.

Where abuse occurs, provided that there is no need for self-defence against physical harm, a professional attitude means that you should not retaliate, but end the engagement with your patient as quickly as possible, in an equanimous manner. If you feel that you have been abused by a patient or family members, you may formally terminate your professional relationship with the patient. Your right to take any reasonable action including legal action against the abuse is always reserved.

C2. Good and effective communication

Good and effective communication based on openness, truthfulness and honesty underpins a good patient-doctor relationship.

With good communication, you can work in partnership with your patients and their families to address medical needs effectively. It has also been shown that miscommunication underlies the basis of most complaints against doctors. Hence, good communication can maintain trust and goodwill even if things go wrong.

You need to communicate sufficiently well so that patients' welfare does not become compromised or they are deprived of autonomy, or suffer harm as a result of poor communication.

If you fail to offer sufficient information, or provide it in a clear manner, patients may not understand the nature or significance of their illnesses and may, to their detriment, fail to seek, or agree to treatment. Patient autonomy relies on patients having sufficient information and understanding to make decisions for themselves. Hence failure to provide the necessary information in a comprehensible way would deprive patients of the autonomy to make proper decisions.

Although it is acknowledged that doctors have their own unique communication styles, in general, you should ensure good and effective communication with patients for the purposes of safety and good clinical outcomes. You should strive to develop good communication skills, aspects of which involve:

- (a) Asking open-ended questions and listening attentively.
- (b) Encouraging your patients to explain things in their own words.
- (c) Being able to discern hidden meanings embedded within what the patient says.
- (d) Asking for and respecting patients' views, concerns and preferences; showing empathy.
- (e) Providing information about medical conditions and management plans according to your patients' ability to understand and in a way that your patients can understand.
- (f) Using interpreters where necessary, which may be provided by patients themselves, your institutions or your own practice.
- (g) Encouraging questions about aspects of your patients' medical management.
- (h) Respecting cultural differences.

- (i) Confirming that your patients understand what has been said.
- (j) Dealing reassuringly with patients' or their families' uncertainty, doubt and anxiety.
- (k) Handling your patients' emotions with sensitivity and compassion.
- (l) Keeping your patients updated about their test results and clinical progress.
- (m) Developing an atmosphere that encourages empowerment and involvement of your patients.

C3. Personal beliefs

C3.1 - Engaging a patient in a doctor's personal beliefs

You ought not to take advantage of your position to promote, persuade or foist your personal beliefs on your patients.

For the avoidance of doubt, "personal beliefs" in this context does not include reasonable and logical beliefs in evidence and good-practice based medical tests or treatments or acceptable variations to match individual patients' needs. The personal beliefs referred to here are those held by you on a personal basis (such as a set of religious beliefs) and not the sort of beliefs that generally guide doctors in how to manage patients.

As a doctor, you have influence over your patients who may then be susceptible to your own personal beliefs, whether they are religious, political or philosophical.

Discussion of personal beliefs per se is not disallowed. However, you are obliged to express your beliefs to patients in ways that do not exploit the patients' vulnerability and are not likely to cause distress or offence to the patients. Patients are vulnerable because they expect and hope that you can help them medically and they may also hold you in high regard as a doctor. Therefore, they may feel too intimidated to disengage from your discussion of your beliefs, say outright that they are not interested, or disagree with you. They may become distressed or offended if you state beliefs that contradict, challenge or demean their own beliefs. Essentially this would not be a discussion between equals, with the patient being in the more vulnerable position.

Patients will have their own beliefs, faith or spiritual concerns in addressing issues of illness, suffering, debilitation and dying. If you have a different set of beliefs from your patients, you ought not to try to change their beliefs or impose your own beliefs on them.

C3.2 - Advising a patient about any personal beliefs that affect management

If your personal beliefs or conscientious objections interfere with your ability to offer procedures or treatments to your patients, you need to inform your patients in an inoffensive and non-judgmental manner and inform them that they may seek medical treatment elsewhere.

If there are instances when your personal beliefs interfere with your management of your patients, such as when you have a conscientious objection to a particular line of treatment, you ought to explain this to your patients so that they understand your point of view and why you decline to treat them.

The treatments or procedures requested by patients may not be prohibited by law and may well be in their best interests as defined by the patients themselves and other doctors. However, you may have conscientious objections to doing so. A typical example is termination of pregnancy. In such cases, your responsibilities are to:

- (a) Explain to the patients your conscientious objection, in an inoffensive and non-judgmental way, while showing respect for the patients' dignity and views.
- (b) Help the patients understand that they have a right to see other doctors and if patients request it, you may provide them with information to help them find alternative care, so as not to leave them with nowhere to turn.
- (c) Not to obstruct patients' access to other medical service providers that offer the requested treatments or procedures even if you may not wish to actively support your patients accessing services that you have conscientious objections to.
- (d) Avoid giving patients the impression that such treatments are unavailable or that no other doctor would do them if this is not true.

It is understood that if you have a strong opposition to a course of action, you would not be obliged to refer patients to other doctors to carry out such treatments. Of course if what patients request are truly unacceptable to the profession in general, then it would be generally accepted that such treatments should not be done at all.

An example is colonic irrigation. Some patients request this of their doctors believing in its health benefits. As this treatment is not validated by respectable literature nor generally accepted by the profession as beneficial, it should not be offered by any doctor. In such a situation, you would decline to offer the treatment and even if you are aware that some doctors are unethically performing colonic irrigation, you would not offer to refer your patients to these doctors.

C3.3 - Beliefs, faith and spiritual issues in medicine

If patients request that you provide spiritual counselling or support, you need to be judicious in providing this yourself. Once you enter into a spiritual counselling or support relationship with patients, there is a risk that your objectivity, judgment and professionalism might be compromised, resulting in decisions that you might otherwise not have made.

If you assess that it is appropriate or helpful for you to provide spiritual counselling or support, you may do so while keeping the risks to your clinical objectivity clearly in mind. You need to ensure that your objectivity, judgment and professionalism in medical decision making are not compromised to patients' detriment.

If you sense that your professional relationship with patients would be compromised by engaging in spiritual counselling or support, you should reconsider providing it yourself and facilitate patients' access to counselling or support services from others.

Sometimes, due to their own beliefs, patients decline treatment or request some treatment which you believe is not in their best interests (based on your objective clinical judgment and not any conscientious objection on your part). Your obligation in such a situation is to first ensure that patients have sufficient information upon which to base their decisions.

Although you need to ultimately respect the patients' autonomy in making their eventual decisions on what treatment they wish to accept, you are not obliged to provide treatment that you strongly disagree with. If patients persist in demanding such treatment, you may sometimes find yourself unable to continue providing care to them. Although unfortunate, such a situation allows you to justifiably terminate your relationship with the patients and offer to refer them to other doctors.

However, in your attempts to change the patients' decisions, you ought to steer clear of denigrating their personal beliefs, faith or spiritual beliefs.

C4. Propriety and sexual boundaries

You need to maintain propriety and take care not to breach sexual boundaries when managing patients, through inappropriate physical contact, or any sexualised behaviour of any kind through words, gestures, actions or other behaviour designed to arouse sexual feelings or desires.

The patient-doctor relationship is based on confidence and trust. It is a unique professional relationship because it involves patients sharing intimate details of health and clinical history with you, undressing and permitting you to physically examine them, including examination of intimate parts of the body. It is important therefore that patients are placed in a position where they can feel comfortable and safe within the relationship. A breach of sexual boundaries will affect patient autonomy in that it erodes the trust in the patient-doctor relationship and makes it difficult for patients to take clear decisions about their own management. In addition, the patients may be harmed emotionally.

Propriety is not only about avoiding inappropriate physical or genital contact. It includes any sexualised behaviour involving words, gestures, actions or behaviour that arouse sexual feelings or desires, or which patients may find uncomfortable and wrong. Sexual boundary breaches can occur with both male and female doctors and with male or female patients.

You should be very careful to avoid:

- (a) Making an unsolicited request, either directly or by implication, for sexual favours.
- (b) Irrelevant mention of yours or your patients' sexual practices, problems or orientation.
- (c) Comments about sexual history that are not relevant to the clinical issue.
- (d) Requesting details of sexual history or preferences not relevant to the clinical issue.
- (e) Talking about your own sexual problems or fantasies.
- (f) Making suggestive or lewd comments about patients' appearance or body.

You need to take care not to make patients uncomfortable in terms of perceived breach of sexual boundaries. Patients differ in how they perceive your approach and you need to be alert to such sensitivities.

When asking questions about patients' private matters, intimate parts of the body, sexual history and functioning, related activities and preferences, or when you are about to examine intimate parts, you need to explain the need to do so and be sensitive to any discomfort or hesitancy on patients' part and reconsider your approach if they express discomfort.

To help ensure that your patients are at ease with your history-taking and clinical examination, you should:

- (a) Explain to your patients why particular questions need to be asked and why they are relevant to your history-taking. If your patients appear uncomfortable or decline to answer, you should not press them for a response. You should also be aware of the presence of other people who might hear their answers and ensure appropriate privacy of the patients in this regard.
- (b) Explain to your patients why particular body parts need to be examined, describe how the examination will be done and ask the patients for permission to proceed. If there is hesitancy or reluctance on the patients' part, you should reconsider whether you should proceed with the examination.
- (c) Ensure that the patient is provided a secure and private space to undress, shielded from other people, and that body exposure is kept to the minimum necessary for examination, for as short a time as possible.

Having a chaperone per se is not an ethical requirement but you need to ensure that your approach would leave reasonable patients feeling safe, secure and comfortable in your presence, without any misconception or fear that their modesty is being compromised or that you are taking advantage of them for your own gratification.

The use of chaperones is not uniform in medical practice. Sometimes clinics are short-staffed and a chaperone may not be available just when you want one, leading to delays in seeing patients on the list.

If your patients indicate that they would be more comfortable having a chaperone for clinical examination, or you assess them to be so, you have to have a chaperone present. In addition, when you need patients to undress for clinical examination, you have to ensure their privacy when doing so.

Patients may indicate their discomfort or reluctance to undergo clinical examination or to undress (especially if an intimate examination is proposed) in a variety of ways, whether verbally or more subtly through their body language. You should be sensitive to such signals from patients.

Sometimes, even if patients do not indicate any discomfort, you may judge from the situation at hand that you would prefer to have a chaperone present. You may then insist on having one. Here are some considerations regarding whether you should use chaperones.

- (a) If you are a male doctor, you should arrange to have a female chaperone present when you examine a female patient as the risk of accusations of inappropriate behaviour in this scenario is statistically higher than in any other. Patients need to be comfortable with the presence of chaperones or particular chaperones.

- (b) Sometimes, even if patients do not indicate any discomfort, you may judge from the situation at hand that you would be better protected from unjustified allegations of impropriety if you had a chaperone present. If so, you should ensure that one is present.
- (c) If patients express discomfort with the presence of chaperones, you should address this by, for example, explaining the need for a chaperone or limiting the presence of the chaperone to only the most sensitive parts of your interaction with the patients.
- (d) It is best to have a chaperone who is a member of your team. Otherwise, you may use persons accompanying the patients, provided you deem them fit to be chaperones.
- (e) If the patient is not comfortable with or refuses the presence of a chaperone, you may reconsider proceeding with examination and should advise the patient of the consequences and possible risks of not proceeding with the examination. You may insist on having a chaperone if you believe that this will protect both the patients' right to privacy and dignity, as well as yourself from complaints of inappropriate behaviour. If despite your explanations and reassurances, patients object, you may decline to examine them until a mutually acceptable chaperone is available.

If patients exhibit sexualised behaviour toward you, you are obliged not to reciprocate and to do all you can to discourage such behaviour.

When faced with a situation where patients display inappropriate sexualised behaviour, your response needs to be professional. You should:

- (a) Politely but firmly re-establish the professional relationship and boundaries.
- (b) Do nothing to encourage such behaviour.
- (c) End the engagement if necessary in a professional manner and, if the behaviour is recurrent, formally end the patient-doctor relationship.

C5. Patients' right to information and self-determination

C5.1 - Right to information

You are obliged to provide your patients information to the best of your ability, communicate clearly and in language that is understood by the patients, or through interpreters where necessary and in a way that best suits patients' needs, so as to allow them to make informed choices about their medical management.

You have to ultimately respect your patients' choice of accepting or rejecting advice/treatment that is offered, after steps have been taken to ensure that there is no language barrier and the patients understand the consequences of their choices.

You should also facilitate patients in obtaining a second opinion if they desire it. Sometimes it is helpful to proactively offer patients a second opinion from a colleague so that they can be reassured that your recommendation is supported by another doctor's independent opinion.

You are not allowed to deliberately deceive patients on any aspect of their diagnosis or management, but you are obliged to ensure that the information you give is presented in terms and at a pace that allows patients to assimilate, thereby enabling them to make informed decisions about their management.

In general, it is not appropriate to deliberately deceive patients about anything. Patients need to be provided with as much information as is necessary to make informed choices. Yet, it is acknowledged that patients vary greatly in their ability to assimilate medical information and in their reactions to medical information. Your information needs to be presented in terms that can be comprehended by them. It is your responsibility to determine how much information is appropriate to be disclosed at any given time. It is accepted that it is sometimes appropriate to give patients information in stages, rather than all at once, over a period of time in a manner commensurate with the amount of information patients are capable of receiving at a given time. Or you can tailor disclosure according to the patients' needs, expectations and preferences.

Consultation with the patients' families or those close to them, colleagues or an Ethics Committee may be helpful in situations where there is a need to balance the benefits and harms of delayed disclosure of information to patients. However, you should be careful to discern if your patients might not want their medical information made known to their families or friends, in which case you are obliged to respect patient confidentiality.

C5.2 - Handling requests to withhold information

You need to respect patients' autonomy when handling requests from their relatives to withhold information from the patients. You cannot do so unless you assess that patients will react in an extreme way leading to serious harm. You are obliged to explain to the family members why you cannot deceive patients while being sympathetic to their concerns and assuring them of your sensitivity in how you divulge information.

There may be instances of patients' relatives asking that medical information or a diagnosis be withheld from patients who are competent adults. This could be out of concern for the patients' reaction to knowledge of a life-threatening or socially embarrassing disease, or for any other reason. This is a difficult and sensitive matter that has its roots in societal values and culture. Most requests to withhold information are made emotionally out of concern over the patients' response. Such concerns may be justified in some cases, for example, where patients are known to be especially emotionally vulnerable or have a history of clinical depression or have attempted suicide. However, it is not sufficient reason to withhold information that may be necessary for decision making just because patients might be upset or distressed (which are normal responses), or decide to refuse treatment.

Therefore you need to always have as your first concern your patients' best interests when determining whether to withhold any information. You need to respect competent adult patients' autonomy and their right to be told all medical information about themselves and the right to have such information kept confidential, even to their own relatives. The only exception is when you have clinical reasons related to the patients' safety which justify withholding the information, such as when the patients' response is likely to be extreme and likely to result in serious harm to themselves.

Such requests to withhold information may occur before a diagnosis is known. Families may ask that the patient not be told or be told something more benign if a cancer is found. Such anticipatory requests are not uncommon, but you should resist them. In general, there should be no reason why patients' diagnoses would be released first to any party (including relatives) other than the patient. As a matter of good practice, you should not plan to release medical information to relatives for the purpose of checking with them whether they would want this information to be shared with the patients themselves, unless the patients have asked for you to do so.

If you are pressed by relatives to withhold information from the patient, you should approach such a situation as follows:

- (a) Explain to the family that your ultimate responsibility is to the patients and not their family members.
- (b) Once you are assured that patients agree to third parties such as family members being told of their medical information, you should engage them separately from the patients, to explain that it is in the patients' best interests to know the diagnosis and participate fully in management decisions. You should go over with the families how you would break the news and reassure them that this will be sensitively done. Relatives are often sufficiently reassured in this way.

- (c) If you judge that it is in the patients' best interests to be told the diagnosis and treatment, you should explain this to the families and you should act accordingly, even if this is against the families' wishes.
- (d) An effort should be made to determine how much patients wish to know or how much they already suspect and you should plan your disclosure appropriately. If patients ask in a direct and unequivocal manner for a diagnosis or why treatment or a particular treatment is being offered, you cannot deceive the patients or refuse to give an answer.
- (e) If you judge that it is not in the patients' best interests to be told about the diagnosis or treatment, you should record this and the reasons for your decision, and be prepared to justify your decision.

In the end, sufficient information needs to be given to patients to enable proper consent for treatment to be given, bearing in mind that consent given in ignorance or under deception is neither proper nor acceptable.

C6. Consent

An important aspect of patient autonomy involves ensuring that they give their valid consent (if they are able) to any test or treatment. It is your responsibility to ensure that patients under your care are adequately informed about their medical conditions and options for investigations and treatment so that they are able to participate in decisions.

Consent is necessary for all aspects of medical care, whether it is minor interventions with minimal risks or major interventions with significant risks or side effects. For minor tests, treatments or procedures that have low risks, oral consent or implied consent through compliance is sufficient.

Formal consent taking is not required for everything. In routine clinical practice, you depend on patients' acquiescence for simple tests, treatments or procedures. Patients might, for example, offer their arm for venesection or insertion of an intravenous line, or allow an ECG to be performed. They would subject themselves to a chest x-ray, 2D echocardiogram or abdominal ultrasound. They would also voluntarily accept and take simple medicines that you prescribe or provide. In all of these instances, compliance would imply consent and no formal consent taking is necessary.

If tests, treatments or procedures are considered complex, invasive or have significant potential for adverse effects, then formal documented consent needs to be obtained.

Whether formal consent is required for treatments and procedures often depends on institutional requirements. At the same time, it is a matter of clinical judgment. As with all matters of clinical judgment, there would be a range of what needs or does not need formal consent that would be generally accepted by the medical profession.

In general, anything that is invasive or has significant risk of harm or adverse effects or other consequences important to patients in their circumstances requires formal consent and proper documentation following detailed discussions with patients. This would include invasive tests such as endoscopy, angiography or needle aspiration/biopsy under imaging guidance as well as most surgical procedures.

It is less common for the prescriptions of medicines to require formal consent. Yet, there are some medicines that have significant potential for harm or adverse effects, for example, cancer chemotherapy or some forms of treatment for Hepatitis C. In such cases, you should consider taking formal consent or at least document in your medical records that the potential problems associated with such treatments have been discussed with the patients.

It is an important element of both a trusting patient-doctor relationship and patient autonomy that your patients are able to make sufficiently informed decisions about the care that they receive from you. Hence, it is necessary to provide information to patients that helps establish a level of understanding sufficient for patients to give consent to treatment.

C6.1 - Information to be given to patients

You need to inform your patients of the purpose of tests, treatments or procedures offered to them, 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 what alternatives are available to them.

It is acknowledged that information about risks of tests, treatments and procedures and possible adverse outcomes cannot, in many cases, be complete or comprehensive. The threshold level of risks that ought to be informed to patients varies considerably across specialties and procedures. In clinical circumstances, if generally uncommon risks become more likely, or are likely to be significant in patients' specific situations, then these risks need to be communicated to the patients. As an example, while the risks of complications of surgery to a hand may be of a very low level, if the patient were a concert pianist, any loss of function of the hand, even if otherwise considered minor, would be catastrophic to that patient.

You should also explain the risks of not proceeding with treatment.

Consent for tests, treatments or procedures ought to include consent regarding who (to the best of your knowledge) will conduct them, the amount of detail being in proportion to how invasive or risky a test, treatment or procedure is.

Of course if they are not invasive and carry low risks of harm, it would generally be sufficient to indicate to patients the general nature of the persons or teams that will conduct them (for example, it would not be necessary to tell the patient which Radiologist will be reading x-ray images beyond saying that it will be one of the qualified Radiologists in the service).

However, if the tests, treatments or procedures are invasive and have significant potential for adverse effects (typically invasive tests such as percutaneous organ biopsy, endoscopy, coronary angiography or surgery), it is reasonable that patients be given much more information about the persons conducting them. In general, patients need to know the level of expertise, if not the actual identity of the person conducting surgery and if there are other persons participating in a material way, they also need to be made known to patients. If other parties will be involved, such as trainees or medical students (if they are participating in a material way, beyond holding retractors for example), they should also be mentioned to patients.

It is not acceptable to present yourself as the doctor who will be conducting procedures on patients, and when patients are under anaesthesia or otherwise unaware, engage other procedurists who are unknown to the patients to either actually conduct the procedures or materially support you in conducting them.

This would not normally include the participation of second surgeons who assist you, unless they are going to perform a material part of the procedure. The obvious exceptions are urgent or emergency situations where you have to call for other doctors to assist in patients' best interests.

The scope of consent given by patients needs to be clearly understood. If further tests or treatments are contingent upon findings at the initial procedures, at a time when your patients may not be able to participate in decision making, the range of options or alternatives ought to be explained so that your patients' consent can be given in advance. Alternatively, they can set limits in advance on what they are willing to consent to.

In general, consent given for a procedure would normally include any additional or alternative actions that are directly related to the purpose of the original procedure. As an example, patients may decide in advance whether they want haemorrhoids discovered during colonoscopy to be treated by banding, diathermy or injection sclerotherapy.

On the other hand, in treating endometriosis and adenomyosis, if a patient has specified that she wants her uterus and ovaries preserved, then unless there is an emergency situation that dictates otherwise, the surgeon does not have the option of performing a total hysterectomy and oophorectomy no matter what he finds at surgery.

Patients' consent may be withdrawn or modified at any time and you are obliged to respect patients' decisions to withdraw or change consent unless you have reason to believe that their judgment is impaired by external coercion, illness, mental incapacity, or in an emergency situation while patients are under anaesthesia.

Ideally, information on fees or charges should be made known to your patients prior to their giving consent. If financial counselling takes place after the medical consent taking process, patients should be given the opportunity to withdraw or modify their consent.

C6.2 - The process of consent taking

As the treating doctor, you need to either take consent personally or if it is taken for you by a team member, you need to ensure the quality of consent taken on your behalf through education, training and supervision, as well as ensure adequate documentation of the consent.

The process of consent usually involves:

- (a) You and your patients making an assessment of the patients' medical conditions based on your evaluation and opinion.
- (b) Providing your input as a doctor, combined with the patients' understanding and attitude towards their conditions, to identify options for tests or treatments that are likely to be beneficial.
- (c) The patients weighing up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them, before deciding whether to accept any of the options.
- (d) Allowing a period of time to elapse during which patients may ask questions to clarify anything and to reconsider their decision or for you to inform patients of any new information that may make a difference to their decision.

The exchange of information between you and your patients is central to good consent taking. Patients vary in the amount of information they need, or indeed understand. You should consider the following when tailoring your discussion on consent with patients:

- (a) Patients' needs, wishes and priorities.
- (b) Their level of knowledge about and understanding of their conditions, prognosis and treatment options.
- (c) The nature and natural history of their conditions.
- (d) The complexity of the options for tests, procedures or treatments.
- (e) The nature and level of risk associated with these.

It is ideal for you to take consent personally if you are directly responsible for your patients' care or medical procedures. It is accepted that in team-based practice, this may not be practical and consent may be taken by other members of a team on your behalf. In such cases, you remain responsible (through education, training and supervision or your team members) for the adequacy of the consent taken and the quality of the documentation maintained on your behalf. In some situations, you may not have any say as to which doctors are appointed to your team (for example, in hospital training programmes). In training rotations, the doctors may change quite frequently. Nonetheless, if you allow your team members to take consent on your behalf, you have to accept the responsibility for the quality of the consent, even if this means training and checking on each and every new team member until you are satisfied.

You ought to obtain consent before a test, treatment or procedure is undertaken except in emergency situations.

Your patients are entitled to sufficient time to think over their decisions and to come back for further clarification if necessary. In general, consent should be taken before your patients enter a procedure room or operating theatre, unless of course the procedure is to be conducted in the consultation room.

The following are good practices to be considered.

You should provide:

- (a) Information in a balanced and objective manner and refrain from persuading patients to accept one course of action rather than another except where such advice is based on evidence of greatest benefit and least harm to patients in their circumstances.
- (b) Information for the purpose of consent to your patients in a language understood by them. An interpreter should be used when there is doubt about the patients' ability to understand you. It is ideal if patients come with persons who can act as interpreters. But if this is not the case, and you are unable to obtain one for the patient, you should be very careful about the validity of the consent you take. If the situation permits, you should ask the patient to come back later so that you can take valid consent in the presence of an appropriate interpreter.

You should ensure that:

- (a) Patients are not put under pressure by other parties, such as relatives, employers, managed care companies or insurers to accept a particular course of action.
- (b) Consent is documented by noting the details of your discussion with patients on a standard form or separately in the medical records. As a general rule, the more complex the case, the more details you should record.
- (c) You document any oral consent given. Oral consent is acceptable and in circumstances where you can only obtain oral consent, you should have a witness present who is able to verify that consent was properly obtained and valid.

You should check:

- (a) Periodically throughout the process that patients have understood the information you provided and whether or not they need more information. You should encourage patients to ask questions to clarify anything they are unclear about.
- (b) That consent taken on your behalf by a team member is adequate or valid. You should not make assumptions about this and you should confirm consent with patients and/or examine the documentation of the consenting process (for cases needing formal consent) before you start any test, treatment or procedure.

You should bear in mind that:

- (a) Standard consent forms are helpful but do not exempt you from having to conduct detailed personal discussions with patients.
- (b) Consent may need to be reviewed in the light of:
 - A change in your patients' clinical status.
 - Changes in the management plan.
 - New relevant information about treatment options or adverse effects.
 - Possible change of mind by your patients.

In such cases, you should be alert to changed circumstances and not assume that consent taken previously remains valid.

C6.3 - Further principles in consent taking

While giving information to patients, you should:

- (a) Ensure that there is no element of coercion on your patients to accept any test, treatment or procedure. However, if your patients, despite having a chance to consider their options, cannot decide or ask you for your advice on what to do, it is reasonable for you to state your professional opinion to assist them to come to a decision.
- (b) Not limit advice about tests, treatments or procedures or their alternatives to what is offered by your practice or your institution. If the most beneficial options (as determined by a balance of evidence and accepted good clinical practice) are not available at your practice or institution but are available in Singapore (or even abroad) where it is feasible and reasonable for patients to go to obtain this, you should inform your patients of these options. Your patients can then weigh the options and decide for themselves if they wish to seek care elsewhere.

For patients who refuse information relating to consent taking, you should:

- (a) Seriously consider whether it is appropriate to provide the treatment at all. The role of the family should be given due regard in such a situation (subject to your duty of confidentiality to competent patients who need to agree to such consultations) and you should also consider seeking the support of your colleagues for another opinion.

Acceptable scenarios for obtaining consent in emergencies include:

- (a) **In emergency situations where your patients are unable to give consent at all, it is acceptable for you to provide medical service without consent if you judge that the treatment is necessary and is in the best interests of the patients.**

Depending on the circumstances of an emergency situation, it may not be possible to obtain consent. If the patients are unable to give written consent, oral consent will suffice and should be documented. If only oral consent is taken, you should have an independent witness to verify the validity of the consent.

To establish patients' best interests, you should take reasonable steps to ascertain the views of your patients that were made known prior to their incapacitation, such as from medical records or from people to whom your patients are known (and if you need to check with these people, in an emergency situation, your duty of confidentiality is waived). In particular, you should seek information on whether patients have expressed any views about, or preferences for, treatment or otherwise, in the circumstances they are now in.

- (b) If during a procedure you encounter situations in which you want to perform further procedures (that are not reasonable extensions of the procedure within the parameters of the consent) at the same sitting but the patient is unable to consent to it, you may proceed if you deem that the patient's life is at risk unless the further procedure is done immediately.**

During a test or treatment procedure, additional problems or findings may occur while your patients are unable to participate in decision making as they are sedated or under anaesthesia. You may determine that further procedures at that sitting are required that are beyond the scope of your patients' original consent because the problems or findings may be potentially life threatening. In such circumstances, you may proceed without further consent from patients for the purpose of avoiding putting patients' lives at risk. You should document your reasons for deciding to do so. You should seek a second opinion from an appropriate colleague to support your decision, where it is feasible to do so in the circumstances.

An example is when acute appendicitis is suspected but on surgery there is in fact diverticulitis severe enough to indicate resection of part of the colon including the appendix. This would be acceptable. Or it may turn out that the patient actually has cholecystitis and the gallbladder needs to be removed. Since untreated cholecystitis is a risk to a patient's life, proceeding with cholecystectomy would be a reasonable decision.

For competent patients who refuse:

- (a) You are obliged to respect the choices of competent patients who refuse consent for investigations and treatment even if such refusal will be harmful or life-threatening to themselves, or could even lead to death. Patients have the right to refuse treatment.**

(b) You should give patients time (if time permits) to recover their ability to give competent consent before seeking consent from them. Such situations may occur when patients whom you may deem normally competent are incompetent to give consent at a particular time, such as when:

- The patients are under the influence of drugs.
- The patients are under pressure or duress exerted by other persons.
- Fear, panic and/or emotional stress have temporarily interfered with your patient's judgment.

If time does not permit (for example, in an emergency), or the patient remains impaired by these or other factors, you may proceed in patients' best interests. If possible and there is time, you should obtain a second opinion from an appropriate colleague, or send the patient for a formal assessment of mental competency.

C6.4 - Consent from minors (persons below age 21)

[Also refer to C8 – Caring for minors (persons below age 21)]

You ought not to assume that once consent is obtained from parents or legal guardians, minors have no rights to voice their opinions or make decisions for themselves about their management. You are obliged to give due consideration to the opinions of minors who are able to understand and decide for themselves.

In general, there is no legal age for consent and any young person below the age of majority (21) who has achieved the necessary level of maturity and understanding can give consent for treatment and sign the consent forms on their own behalf.

However, common practice is that consent for minors is usually required and taken from either parent (the parent having legal custody), or legally appointed guardians as the case may be.

It has been shown that even young children may have the capacity to understand medical information sufficiently to make their own decisions about their care. You should be able to establish whether minors have demonstrable capacity to understand by:

- (a) Giving information and explaining everything in simple language.
- (b) Aiding understanding by using pictures, drawings or diagrams.
- (c) Having the minors repeat what you have explained in their own words.
- (d) Having the minors articulate their interpretation of the information, their decisions and reasons behind them.
- (e) Repeating these steps over time (if time is not of the essence) to check for consistency of their understanding and their decisions.

If you remain in doubt about whether a minor has the necessary level of maturity and understanding, you should consider obtaining an opinion from an appropriate colleague such as a child psychiatrist, psychologist or counsellor.

If minors who can understand sufficiently to give consent refuse what you consider necessary treatment despite your explanations, you may proceed to treat the minors, with the consent of the parents, provided it is feasible to do so.

Some minors who have demonstrable capacity to consent may still refuse medical tests, treatments or procedures which you deem necessary and in their best interests, despite consent being given by their parents or legal guardians. The best approach is to take additional steps to reinforce the information already given or provide more information if necessary or more time for them to consider, to persuade them to accede to the tests and treatments. The role of parents and guardians is very important and their help should be enlisted if possible.

If, despite everything, the patients are adamant about not proceeding with the treatment, you should then make a judgment as to whether to proceed even without the patients' consent, albeit with the consent of the parents or legal guardians, provided it is feasible for you to do so. Despite not wishing treatment, some minors would reluctantly obey their parents or legal guardians and allow themselves to be subjected to the treatment. However, if a minor is resistant and physically able to fend you off, it would not be feasible to treat. Whenever possible, you should obtain a second opinion from an appropriate colleague or an Ethics Committee to support your decision.

On the other hand, if parents or legal guardians or minors make decisions you deem to be against their best interests despite your best explanations, you may need to bypass them to fulfil your obligation to prevent harm to the minors.

There can be instances where parents or legal guardians of minors make decisions that you deem harmful to or not in the best interests of the patients. If such a situation occurs, you should engage the parents or legal guardians in discussions and, if unsuccessful, you should obtain a second opinion if possible from an appropriate colleague or an Ethics Committee to support your recommendations to the parents. Only if you have exhausted all reasonable measures to persuade the parents or legal guardians should you take steps to bypass them. You can bypass parents or legal guardians by approaching independent advocates such as social workers or relevant government ministries, applying to the courts only as the last resort.

If minors have no parents or legal guardians (or if their parents or legal guardians are not readily accessible within a reasonable time for the purpose of consenting to treatment where immediacy or urgency of action is in the best interests of the patients) but demonstrably have the capacity to understand the information given and participate in medical decision making, you may take their consent and proceed with medical intervention. If you are in doubt, you should if possible obtain a second opinion from an appropriate colleague to confirm that the patients have a sufficient level of comprehension to give consent.

If minors are too young to understand but there are no parents or legal guardians available within reasonable time to give consent, you may proceed according to your best judgment of the patients' best interests.

A particular difficulty exists in obtaining consent from young children who lack the capacity to understand fully and give consent, where there are no parents or legal guardians (or if they are not readily accessible within a reasonable time for the purpose of consenting to treatment where immediacy or urgency of action is in the best interests of the patients). Often it falls to family members or even friends to make decisions on behalf of the patients and this may be the best that is available, at least in terms of understanding the patients' best interests. However, formal consent from these parties is inadequate. There may well be disagreements among family members and in any case, such consent may be legally challenged. In such situations, you should, obtain a second opinion if possible from an appropriate colleague or an Ethics Committee that medical intervention is indicated and justifiable and you may then make the decision on the patients' behalf to proceed.

C6.5 - Consent from patients with diminished mental capacity

In taking consent from patients with diminished mental capacity, you need to take into account their residual or fluctuating cognitive ability. If they can demonstrably understand, retain and use your information to make clear and consistent decisions and communicate them in a coherent manner, you have to take consent from these patients themselves.

Consent from patients who have diminished mental capacity is a difficult and complex area. It is appreciated that the ability of such patients to understand medical information and to make decisions lies on a wide spectrum. Some patients have sufficient residual capacity to understand and make clear decisions on the medical matter at hand, even though they may not be able to deal with more complex matters. Patients with diminished mental capacity may also have intermittent or fluctuating capacity to make rational decisions. In such cases, you should ensure that, over a period of time, the views of your patients are consistently held and can be relied on. If in doubt, a formal assessment of mental capacity by an appropriate neurologist or geriatrician should be undertaken, if time permits given the urgency of the clinical situation.

Patients with diminished mental capacity should be given medical information in a way that best allows them to understand their diagnosis and treatment options. If your patients demonstrate sound understanding of the nature, purpose and consequences of medical tests or treatments and express opinions that are credible, consent taken directly from the patients is valid. Otherwise, your patients' opinions, as far as they are able to express them, should be taken into account in making decisions based on their best interests.

Patients should not be deemed to be incompetent to make rational decisions merely on the grounds that their choice appears irrational or inconsistent with your opinion of what ought to be the "right" decision in the circumstances.

You should refer to the Mental Capacity Act for a fuller understanding of mental capacity and how it is defined. This Act defines when persons are unable to make decisions for themselves as when they are unable to:

- (a) Understand the information relevant to the decision.
- (b) Retain that information.
- (c) Use or weigh that information as part of the process of making the decision.
- (d) Communicate the decision (whether by talking, using sign language or any other means).

If patients demonstrate sufficient understanding to make autonomous choices and decide to refuse treatment, their decisions still have to be respected even though you deem the decision not to be in their best interests. You may engage the patients to ensure that they have every opportunity to review their decisions and you should bring in your colleagues to help explain and verify the credibility of your patients' decisions. However, if patients are adamant, you have to respect their decisions.

If patients have such diminished mental capacity that they cannot give consent, you have to obtain consent from persons with the legal authority to make such medical decisions for them, if feasible, given the urgency of the clinical situation. Otherwise you have to proceed according to your best judgment of the patients' best interests.

Where patients lack capacity to understand sufficiently to make decisions about their own treatment and there are no legally appointed persons with the authority to make decisions for them (or who are not readily accessible within a reasonable time for the purpose of helping you determine patients' best interests), you should if possible try to ascertain the patients' view of their own best interests from their relatives or friends who may know the patients well as well as obtain a second opinion from an appropriate colleague or an Ethics Committee, where time allows, to support your decisions. You may proceed with medical intervention if you believe as best as you can ascertain that there is reasonable justification to proceed and it is in the patients' best interests.

You should be clear that apart from persons with the legal authority to make decisions for patients, relatives or friends do not have the right to make the final decisions. You have to take these decisions in the best interests of the patients.

C7. Medical confidentiality

C7.1 - Responsibility to maintain medical confidentiality

You are obliged to respect medical confidentiality and not disclose information obtained in confidence or in the course of attending to your patient without the patient's consent, except in some specific situations as discussed below in C7.2 (*Disclosure of medical information without consent*) and C7.3 (*Legal scenarios where you may disclose medical information*).

You may not, without express consent from patients, disclose confidential medical information to third parties including:

- (a) Family members.
- (b) Friends of the patients.
- (c) Employers.
- (d) Human resource personnel.
- (e) Insurance companies.
- (f) Lawyers.
- (g) Any persons who cannot reliably be identified as those to whom your patients consent to provide information (for example, a voice over the telephone).
- (h) Any public officer outside of their statutory right to such information.

Such information includes the very fact of the consultation, since patients may not wish others to know that they are seeking medical help. For example, patients may be embarrassed if they are revealed to be consulting a Psychiatrist or an Infectious Disease doctor specialising in sexually transmitted diseases.

If the patients initiate or agree to disclosures that you are their doctor (for example, by posting or displaying pictures of you and them together – typically with new-borns in Obstetric clinics), this will not constitute a breach of confidentiality.

There may be implied consent for disclosure of medical information to another party when patients of their own free will are accompanied by other persons into a consultation. However, you should check with the patients that information relating to subsequent visits, results of tests or management plans may be divulged to the same persons, unless it has already been made clear that patients are agreeable to, or wish to have the information shared.

Where third party payers, insurance companies or any third parties not involved in the medical care of the patient require or request medical information about your patients, you need to ensure that your patients have given written consent for such information to be provided for specified purposes and note any restrictions your patients might make to the extent of disclosure. The risk of subsequent leakage of the information is borne by your patients in such circumstances as you have no control over how the information might be used by third parties.

You are not responsible for the security of information given directly to your patients, except to ensure that the means of transmission to your patient is reasonably secure. If you are not in control of the systems in use, then your duty is to use the systems responsibly and comply with all the security protocols in place.

You have to refrain from accessing confidential patient information if you are not involved in any aspect of the patients' care.

You have no right to access confidential patient information if you are not involved in the patients' care or do not have express consent from the patients to access it. Such unauthorised access, whether you disseminate the information or not, and regardless of what use you may make of the information, constitutes a breach of patients' medical confidentiality. As an example, your relatives or friends may ask you to find out about patients who are their relatives. It would not be legitimate for you to accede to such requests. You should advise them to first ask the patients themselves, or with the patients' permission, ask their treating doctors. Equally it would be unethical to satisfy your curiosity about a VIP or celebrity patient by asking their treating doctors for information (and they ought not to give it), or worse, attempting to access their information for yourself.

Sometimes, "grand rounds" for teaching or other patient presentations are conducted with medical staff who are not involved in the care of the patients. Where these involve ward rounds, patients retain the right to refuse to have their cases discussed in front of them, although it would obviously not be necessary to take formal consent from each and every patient in such circumstances since implied consent is given if they do not object. If the rounds are in the form of presentations outside of the wards, then anonymising of patients should be done unless there is patient consent for their identities to be divulged.

You are obliged not to allow patients' confidential information to be disseminated knowingly or unknowingly through carelessness or through your participation in social media.

You should exercise care over who has inadvertent and unintentional or casual access to your patients' information. For instance, you should not discuss patients in such a way or in a place where the information may be accessed by or disclosed to an unauthorised person. This would include information uploaded on internet social networking sites, internet forums, web chat sites, blogs etc. You should not place or display medical records (whether paper, electronic or some other form) carelessly in a place (either a physical place, or in cyberspace, for example, cloud storage) where they may be viewed, heard or otherwise accessed by an unauthorised person. Even if you do not actually name patients, if the sum of the information disclosed or allowed access to enables the patients to be identified, that would be a breach of medical confidentiality. Further, if you engage with patients in social networking sites in a way that allows others to access your communications, even if no medical information is shared, the revelation that you are the patients' doctor may itself constitute breach of medical confidentiality. For this reason, you should refuse requests from patients to join them in social networking media.

C7.2 - Disclosure of medical information without consent

There are circumstances when you need to disclose medical information without patients' consent and when you do so, you need to have sound justifications.

Medical confidentiality is not absolute. It may be over-ridden by:

- (a) Considerations of patients' best interests where patients' consent cannot reasonably be obtained.
- (b) Requirement of laws and regulations, including information disclosed for the purposes of compliance with court orders or statutory requirements.

You may decide to disclose confidential information to prevent potentially serious harm to:

- (a) Your patients themselves.
- (b) Persons involved in their medical treatment.
- (c) Other persons associated with the patients.
- (d) The community in the public interest.

In such cases, if an attempt to secure voluntary disclosure is unsuccessful, impossible, or contrary to the very purpose of disclosure, you may disclose such information without your patients' consent.

Examples of such circumstances include:

- (a) Strong suspicion of neglect or physical, sexual or emotional abuse of your patients who are vulnerable persons (such as minors or those with diminished mental capacity who cannot seek their own protection), or by your patients against vulnerable persons.
- (b) Information about infectious diseases, for example, information about HIV to a sexual partner.
- (c) Genetic disease risks.
- (d) Information that would help to prevent, detect or prosecute criminal activity.
- (e) Factors that might put your patients or others at risk of serious harm, such as serious drug or substance addiction, self-harm, medical unfitness to drive vehicles, an impaired colleague etc.
- (f) Information from children or young persons, or those with diminished mental capacity who request that parents or legal guardians not be told, but it would be in their best interests for the information to be shared.
- (g) Emergency situations in which patients are unable to give consent for information disclosure and you judge that it is in your patients' best interests to disclose information, or that public interest requires it.
- (h) Formal clinical audit procedures whereby your patients' information may become known to the auditors. You need to be assured that the audit team has given prior undertaking to maintain medical confidentiality before the audit of your patients can proceed.

Your judgment on whether disclosure is necessary in any particular situation would depend on your assessment of the risks and how serious the harm might be to others if they were not told. Certainly, except for statutory requirements and urgent situations (such as your knowledge that your patient intends to kill someone), you should be slow to decide to breach medical confidentiality. This is because if the threshold of disclosure is too low in the medical community, it would erode the relationship of trust between patients and doctors.

There are various kinds of formal clinical audits. Audits are often performed as part of the statutory duty of authorities, such as MOH's audit of patient dispensing records or records of treatment or procedures. Thus, these persons not involved in treating patients may need access to medical records or information. Another type of formal audit is a professional audit, where a doctor's fitness to practice is being assessed. In such cases, appointed doctors may sit in on consultations or attend procedures. Although it is ideal to ask patients for consent, where this is not feasible, provided the audits are based on requirements of laws, regulations or institutional requirements within the law, it would be permissible to proceed with the audits.

C7.3 - Legal scenarios where you may disclose medical information

You must have sound justifications if you decide to disclose patients' information without consent. Disclosure without consent is generally defensible when it is mandated by law, it is necessary in order to protect patients or others from harm, when the involvement of parents and legal guardians is beneficial to minors or where such disclosure is in patients' best interests.

In civil or criminal cases, or SMC disciplinary proceedings, where you are either the plaintiff, defendant, or accused, you are entitled to disclose the relevant medical information related to the cases in question. However, you are obliged to limit your disclosures to the extent that it is relevant to the context of the cases.

You may disclose medical information to the extent that is relevant to the discussion at hand but not anything more than is necessary in the context of the case. It would be an abuse of this privilege if information is used merely as a means to embarrass or otherwise pressurise any party involved.

If medical records of other patients are important for you to support your case, you need to make an application to the court for waiver of consent and for the use of these medical records. If the court does not order waiver of consent, then you need to obtain the patients' consent for disclosure, and if appropriate, ask for consent premised on conditions such as redaction of identification details in the copies produced for use in court to ensure anonymity.

If there is a court order requiring disclosure of patients' information, under the law, you are protected against breach of medical confidentiality.

You should not disclose medical records simply because a subpoena to produce documents is served on you and you do so to avoid court attendance. The subpoena stipulates a date and time to attend court to produce the documents. At the hearing, you have to ensure that there is a court order specifically requiring you to disclose the documents.

If you provide patient information in response to requests by the Complaints Committees and Disciplinary Tribunals of the SMC, which have the power to call for medical records relevant to their respective inquiries, you are protected under the law.

C7.4 - Responding to complaints or allegations in the public domain

When responding to complaints or allegations in the public domain, your duty to maintain your patients' medical confidentiality is not waived. When defending your reputation, you are obliged not to refer to patients' information beyond what is reasonable and relevant.

You may face complaints, criticism or allegations in various media including internet media such as blogs, discussion groups and doctor review websites. In constructing your defence, you are not to refer to your patients' medical information beyond what is reasonable for making that defence. In addition, you have to limit the disclosures only to what is specifically relevant. For information that is already in the public domain, you do not have the responsibility of maintaining its confidentiality.

C7.5 - Storage of medical information

You need to take steps, within your ability, to ensure that the means by which you communicate or store confidential medical information about patients is secure and the information is not accessible by unauthorised persons.

This is particularly relevant to sending or storing medical information by electronic means, via a website or by email, in cloud storage, or to services involving telemedicine.

While it is acknowledged that within institutions or organisations, you may have little influence over the means of information storage or compliance with legislation governing personal data, you should nonetheless take reasonable precautions to secure storage and management of patient information. Where you are entrusted with governance or management responsibilities within an organisation, you should do everything in your power to ensure that the organisation puts in place the most secure means of storage possible in the circumstances. You should also have in place protocols and processes to ensure information is not accessible or accessed by unauthorised persons.

C7.6 - Information used for research and education

In recruiting patients for and conduct of clinical trials, you need to abide by the confidentiality requirements of the Institutional Review Board and any other requirements (for example, ECEG) when handling information relating to research subjects.

Information which identifies patients may not be released for research or educational purposes without their express consent. In the case of minors, where appropriate, the consent of their parents or legal guardians should be obtained. Consent should likewise be obtained from legally appointed persons with the requisite authority to make decisions for patients with diminished mental capacity. Unlike in clinical treatment where you may sometimes justifiably, in their best interests, proceed to treat minors or patients with diminished mental capacity without their consent or that of parents, guardians or those with legal authority to make such decisions, valid consent for research is always necessary. This is because research is not for patients' specific best interests but in furtherance of knowledge to benefit the community as a whole.

Information that is obtained during research should preferably be aggregated, anonymised or coded when used in research and education.

Research activities that do not involve patients in clinical trials may not require the same level of information protection as those involving clinical trials. Such research could be in the areas of epidemiology or public health, or require only data from medical records or registries. Where the likelihood of harm to patients is extremely low and where breach of medical confidentiality is very unlikely, it may be permissible to proceed with the research without patient consent. However, such waivers should be approved by the relevant Institutional Review Board or equivalent authority.

In teaching, you are obliged to take all reasonable steps to ensure that students or trainees only access patients' information for legitimate educational purposes. You also need to respect the rights of patients, or their legal representatives, to decline to participate in teaching or give access to their information.

In the conduct of medical education, undergraduate or graduate medical healthcare professionals will require access to patients and their information (which includes history-taking and examination of medical records). It is good practice for students or trainees to introduce themselves to patients to elicit their consent and cooperation to being interviewed, examined and to look at their medical records. Although it is common for students or trainees to scan medical records in advance to decide on which patients to even approach (based on how interesting the cases are), this falls far short of the ideal and is to be discouraged. During group case presentations and discussions, if it is by the bedside, patients give implied consent by acquiescing to the teaching session. If it is done elsewhere, it is good practice to anonymise the cases being presented even though you would already have obtained the patients' consent for such use of their medical information.

Patients (or where appropriate, parents or legal guardians for minors, or legally appointed persons with the requisite authority to make decisions for patients with diminished mental capacity) have the right to refuse such access. You need to make every reasonable effort (such as by clearly briefing and instructing students or trainees as to their obligations) to ensure that students only take possession of information that is required for their training and that they maintain patient confidentiality by never sharing such information outside of their educational context.

C7.7 - Communication of information to other doctors

You may disclose information to healthcare team members or other doctors who are directly involved in the patient's care.

Such disclosures would include briefings to other members of a medical team that is managing the patients, sharing of information during change of shift, handing over patients to the care of doctors on call and providing medical reports to referring doctors. Such disclosures are only legitimate among doctors and recognised allied healthcare professionals. Non-doctor practitioners of CAM are not included.

Patients may request that information be withheld from other doctors or team members, in which case you need to explain to the patients the benefits of sharing information by the team and the possible adverse consequences otherwise. If the patients still object, you have to comply with their wishes unless it is necessary to disclose this information to prevent harm to the patients, or other healthcare professionals treating the patient or the public.

For example, you ought not hide from other healthcare professionals the fact that patients have, say, HIV, Hepatitis B or C or tuberculosis, as these healthcare professionals have the right to protection against acquiring these infections. It is also in the patients' best interests for their illnesses to be treated holistically together with these known conditions, rather than in isolation. For example, it would be inappropriate to refer a patient with gastrointestinal bleeding to a specialist without disclosing known chronic Hepatitis B, since it is hugely relevant to how the patient is diagnosed and treated.

It is acknowledged that disclosure of medical information may be inevitable in a large institution where a large number of medical, nursing and administrative staff (including students or trainees in the team) may need to have access to patient information as a routine part of their work. However, within your ability, you should ensure that only those who need to know have access to patients' information. Where you have responsibility for the security of information systems, you should ensure that the systems are secure against unauthorised users. If you are a user, it is your responsibility to abide by the terms of use and all the security protocols in place.

C7.8 - Medical confidentiality after death of patients

In general, your obligation of medical confidentiality towards patients continues even after they have died.

Your duty of confidentiality towards patients continues after their death except in the following circumstances:

- (a) Where parents, close family members or executors of the estates of the deceased ask for the cause of death or other medical information, this may be disclosed to the extent that you consider reasonable, unless you have reason to believe that this would be against the wishes of the patient.
- (b) For the purposes of legitimate clinical audit, education or research, in which case you are bound by other applicable laws such as the Private Hospitals and Medical Clinics Act and the Personal Data Protection Act.
- (c) In connection with coroner inquests, other official inquiries or requests where such disclosure is required by law.

For other requests for information, you should determine the purpose of the disclosure and whether disclosure is likely to be something to which the deceased patients would have agreed.

C8. Caring for minors (persons below age 21)

[Also refer to C6.4 – Consent from minors (persons below age 21)]

C8.1 - Capacity to understand and participate in medical decision making

You need to respect and uphold minors' desire for privacy, their need to know about their medical conditions, to be heard, and to participate in decisions on their care.

Minors ought to be regarded as autonomous individuals and hence they need to be respected in the same way as an adult but with the consideration and protection required for their level of maturity and understanding. Caring for minors comes with additional responsibilities, due to their varying ability to understand medical diagnoses and advice and ability to make informed decisions on their own care. Minors may also be vulnerable and need protection.

Special consideration needs to be given to the opinions and wishes of minors who have sufficient maturity and understanding capacity. These need to be engaged in greater depth.

C8.2 - Best interests

Assessing the best interests of minors is not always easy and there are multiple factors to consider, including the following:

- (a) Their personal expressed views, whether in the present or the past.
- (b) The views of their parents or legal guardians.
- (c) Their cultural and/or religious beliefs and values and those of their parents or legal guardians.
- (d) The views of other healthcare professionals who have been caring for the patients.
- (e) Your own views about which choices would be most appropriate for the patients or which least restrict future options.

C8.3 - Effective communication

You are obliged to facilitate minors' understanding, give them time to express themselves and then make decisions based on their best interests. You need to work with parents and legal guardians to achieve this.

Effective communication with minors may not be as easy to achieve or as straightforward as with adult patients. Although the level of comprehension of minors may vary, it is often surprising how much children can understand and how able they are to participate in decisions about their management. Hence, you should not make assumptions that your minor patients cannot understand sufficiently.

To ensure good communications with children and young persons you should:

- (a) Treat them with the respect you would accord an adult patient and not dismiss their concerns and queries.
- (b) Be sensitive to whether they might prefer to speak with you without the presence of parents or legal guardians and facilitate this accordingly, if you do not think this is inappropriate or against the patients' best interests.
- (c) Use simpler language, diagrams, drawings, or signs as appropriate to enhance your patients' understanding.
- (d) Listen closely to their replies and give them time to express themselves.
- (e) Give them opportunities to ask you questions and answer them honestly.
- (f) Have them repeat to you what you have said to confirm their understanding.

C8.4 - Medical confidentiality

You are obliged to maintain the medical confidentiality of minors except when you deem that it is their best interests for their parents or legal guardians to be informed.

Your obligation to maintain medical confidentiality is the same whether your patients are minors or adults. In the case of minors who are your patients, it is usually in their best interests that parents or legal guardians are kept informed of the patients' care so that the latter can participate more effectively in decision making and in providing necessary family support to improve outcomes and prevent future problems. If you are in doubt whether parents ought to be informed, you should seek an opinion from an appropriate colleague or consult an Ethics Committee.

C8.5 - Health and safety

Where you have reasonable grounds to believe the presence or risk of abuse or neglect, you have to take necessary steps to protect the minors, including, but not limited to, reporting your suspicions to the relevant authorities responsible for child protection.

The health and safety of children and young persons who are your patients need to be safeguarded. You need to be alert to neglect, possible abuse of any kind, or a significant risk of neglect or abuse.

Occasionally, you may have a duty to minors even if they are not your patients. If you have reasonable grounds to believe that your adult patients may be impaired in their capacity to care for, or may be involved or at risk of being involved in abuse or neglect of their minor children or wards, you need to also manage them with a view to reducing or removing any risks to their children. If you assess the risks to be continuing, or a real and present danger to the minors under their care, you have to take necessary steps to protect them, including, but not limited to, reporting your suspicions to the relevant authorities.

When you are uncertain about the strength of your grounds of belief, you should consult your colleagues or enlist the assistance of the relevant paramedical or social services to evaluate the situation.

You should also keep updated on when you may have a statutory duty to report certain facts to the authorities, and the boundaries of your statutory duty. For example, under the existing law, you have a statutory duty to report a case of under-aged sex to the authorities "in the absence of reasonable excuse".

In all cases, you should document your grounds and decisions well. If you decide to report the matter to the relevant authorities, the parents or legal guardians involved should be notified of your intention to do so and your reasons for doing so. You should not inform them if you believe that doing so would cause harm to the minors involved, or if it would undermine the very purpose of your reporting. Your obligation to maintain medical confidentiality is waived when you lodge such a report in good faith.

C9. Caring for patients with diminished mental capacity

You need to treat patients with diminished mental capacity with respect and recognise their rights, values and preferences.

Caring for patients with diminished mental capacity also comes with additional responsibilities. Patients with diminished mental capacity are still autonomous individuals with rights and wishes to be respected. When dealing with patients who appear to have difficulty in or to be slow in understanding you, you are obliged, to the extent of what is possible, to effectively communicate matters on medical diagnoses and treatment with them. You then need to determine their capacity for understanding and their ability to make decisions about their treatment.

You are obliged to assess patients' residual or fluctuating mental capacity and cognitive function to determine whether they can understand and retain information sufficiently to participate in decision making.

You should not assume a lack of decision making capacity based on age, disability, appearance, medical condition, behaviour, beliefs, apparent inability to communicate or the fact that they make a decision that you disagree with. Neither should you assume that a patient with fluctuating cognitive function can never understand enough for self-determination. When in doubt, you should refer patients for assessment of mental capacity.

Until you have determined the level of mental capacity of patients to understand and make decisions about their own care, they remain autonomous and have the right of confidentiality. You need to avoid being too quick to involve other parties unless patients have given their permission for disclosure of their medical information.

If patients do not have sufficient cognitive function, you may consider the views of family, carers or those with legal authority to represent them to help ascertain their best interests, but in the end, it is your responsibility to act in patients' best interests.

If you have established that patients are of insufficient mental capacity to understand and make decisions about their medical care, you should recognise the role of family members, carers or legal guardians in discussing medical diagnoses and management plans and involve them appropriately in the decision making process. This includes working with legally appointed persons with the requisite authority to make decisions for these patients.

However, it is ultimately your responsibility to ensure that patients are managed in their best interests, as much as you can ascertain within your ability.

You need to be aware of the vulnerability of patients with diminished mental capacity to abuse, neglect or self-harm and if you have reasonable grounds for suspicions you need to either offer assistance or report it to the relevant authorities.

Patients with diminished mental capacity may be more vulnerable and their best interests are your highest priority. You need to safeguard their health and well-being by being alert to any possibility that they are subject to abuse, or neglect by any party or are at risk of harming themselves. It is well known that the elderly, particular those with diminished mental capacity, are often subject to abuse of various kinds. Examples include starving them until they are unwell and then admitting them to hospital so that the family can have time off from caring for them, neglecting their medical needs or even exacerbating their medical conditions to hasten death so as to gain inheritance or asking doctors to certify mental incapacity so that family members can legally take control of their finances. Physical abuse of the elderly is also well-known and you should be alert to evidence of this. Those who are depressed due to neglect or loneliness may also be more liable to self-harm or to attempt suicide.

C10. Visual or audio recordings of patients

You may wish to make recordings (which include photographs, sound and video recordings) of patients for the purposes of documentation in the patients' medical record, teaching, research and publications in journals or demonstrating techniques. Sometimes, patients do not mind being identified in the recordings, but sometimes, they would prefer to remain anonymous and you have to respect their wishes.

In general, there is no issue with routine recordings of various kinds, such as ECGs, medical imaging, videos of surgeries or endoscopic procedures. In most instances, patients cannot be identified through these recordings except through biodata on the records. Formal consent is not necessary for such recordings. However, some recordings are more sensitive such as those that show facial or other features that could lead to identification of patients and images of intimate parts of the anatomy that patients may feel embarrassed to have recorded, or to have such images stored somewhere.

Ethical handling of patient recordings means:

(a) You need to ensure that patients' privacy, dignity, confidentiality and autonomy are not compromised in recordings.

In general you should:

- Let patients know of your intention to make recordings, obtain their agreement and be sensitive to any expressions of reluctance or discomfort.
- Not pressurise patients to agree to recordings.
- Not give patients the impression that their care might be compromised if they do not agree to recordings (unless their care is indeed compromised by their refusal to allow recording integral to their management).
- Check that patients are comfortable with the presence of recording crews, if any. If patients are uncomfortable, the recording may have to be reconsidered.

- Record as little as is necessary for the purposes intended and be careful not to inadvertently capture sensitive parts of the anatomy if this is not necessary.
- Stop recording at any point when patients demonstrate or indicate discomfort, or if the recording appears to have an adverse effect on the consultation or treatment.

(b) You need to have patients' consent for visual or audio recordings except where these are an integral part of clinical assessment or treatment. You also need to recognise that patients have the right to view or listen to the recordings if they wish. If they decide to modify or withdraw their consent, they have the right to do so, including to have the recordings erased.

You ought to obtain and document consent from patients for recordings that are not generally regarded as integral to the management of the patients. The consent should include information about the purposes of the recording if it goes beyond legitimate clinical record keeping.

Examples of recordings that are part of clinical assessment include those for aesthetic treatments, recording movement disorders or studying patients' gait. Audio recordings may be used, for example, in documenting speech disorders and monitoring therapy. Such recordings are integral and special consent is generally unnecessary even if patients can be easily identified from the recordings. However, if intimate parts of the body are to be recorded, even if it is integral to management, such as for breast enhancement or plastic surgery to genitalia, it is good practice to obtain specific consent to record in order to avoid possible misunderstanding and future problems.

If you make recordings that are an integral part of patient management which therefore do not require specific consent, and you subsequently wish to use the recordings for any other purpose including medical education, research or in the public domain for any purpose, you ought to obtain the patient's consent in advance.

Even if you do obtain formal consent for recordings, you have to bear in mind that such consent does not allow you to use the recordings for any purpose you choose.

- (c) If you wish to use audio or visual patient recordings of patients for legitimate purposes that advance healthcare for the community, such as medical education and research, if there is any risk that patients can be identified, you must obtain specific consent. However, if you wish to use such recordings for these purposes without specific consent, you must take every reasonable measure to remove all identifiable characteristics and ensure that patient confidentiality and privacy will not be breached.**

It is good practice to obtain patients' consent for use of their audio or visual recordings even in medical education and research. This is strongly recommended especially if patients are easily identifiable in the recordings. However, recognising that it is sometimes impractical to do so, such as if a patient has become uncontactable, considerations of the overriding benefits of medical education and research would allow your use of the recordings without specific consent, provided you do your very best to preserve patient confidentiality and privacy in doing so. You can achieve this by removing or obscuring all identifiable features, such as by blurring out faces, only showing limited parts of limbs with no identifying features, changing the sound frequency of the voice, etc. The aim is to reduce the risk of using such audio and visual recordings to the same low level as anonymised chest or abdominal x-rays, ultrasound images, videos of endoscopic or surgical procedures, blood test results, etc. that have traditionally been used without specific consent.

Despite attempts at anonymisation for use in professional publications or lectures, there may be details included in the recording that may inadvertently lead to the disclosure or revelation of patients' identities, so considerable caution should be exercised.

- (d) You must obtain specific consent if you wish to use audio or visual recordings of patients anywhere in the public domain (such as advertising, public lectures or any kind of media output). On top of the need to obtain specific consent for such use, unless patients further consent to be identifiable, you must ensure that patients' confidentiality and privacy will not be breached.**

Medical education and research would expose patients' recordings to only a limited audience for justifiable purposes, although you still need to do everything possible to protect patients' confidentiality and privacy. However, if the recordings are put in the public domain, then the risk of loss of confidentiality and privacy is much higher. Hence, specific consent needs to be taken for use of patients' recordings anywhere in the public domain.

- (e) You need to, within your ability, ensure that the storage or transmission of patients' recordings is secure and that no unauthorised persons have access to it. Such recordings deserve the same level of confidentiality protection as medical records.**

It may be that recordings that are not an integral part of patient management are not stored together with the patients' medical records in a safe and secure manner. Some recordings may be stored on computers, external hard drives, or even in the cloud. If you have not stored the recordings together with the medical records, you need to ensure that where you do store them, they are as secure and safe from unauthorised access as your medical records.

- (f) If patients are minors, or have diminished mental capacity, you need to, where possible, obtain their consent for recordings. If this is not possible, then you may obtain consent from parents, guardians or those with the legal authority to decide for them.**

The principles involved in obtaining consent for recordings from minors and those with diminished mental capacity are fundamentally the same as those for clinical management of these patients. But given that making recordings per se is very unlikely to be necessary to ensure patients' best interests and to prevent harm to them, you should not proceed if you cannot obtain consent at all from any relevant party.

- (g) You are not to make surreptitious recordings (without patient knowledge or consent) unless there are special circumstances and it is in patients' best interests.**

In special circumstances, surreptitious recordings intended for disclosure may need to be made in the interests of patients without patient consent. A typical example is to detect laxative abuse by an in-patient through surveillance. In such exceptional situations, you should obtain additional professional opinions to justify surreptitious recording and notify institutional authorities to obtain their support of such actions.

It is not legitimate to make surreptitious recordings of your consultations or treatments with patients merely to protect yourself from possible complaints of any kind.

With patients being more educated, more sophisticated and perhaps more demanding, there seems to be an upward trend in complaints and litigation against doctors. Some of you may consider making video recordings of all your consultations so that you have evidence to defend yourselves against complaints. If patients consent to such recordings, it is allowable. However, such a culture of defensiveness will likely damage the mutual trust that underpins patient-doctor relationships. Hence, it is strongly recommended that such measures not be taken as routine. Instead, you should strengthen the patient-doctor relationship and improve trust between you and your patients by good communications and overall high level of professionalism.

It is wholly inappropriate to make surreptitious recordings of patients using hidden recording devices as this is deceptive and would damage the relationship of trust much more than if it were done with patient consent.

Nowadays with the availability of audio visual recording devices as pocket size machines or in the form of smartphones, it is very easy for anyone to record a consultation with their doctor. Of course, it is common courtesy for patients or their accompanying persons to ask for their doctors' agreement to be recorded.

Sometimes, patients or persons accompanying them may ask to record your consultations. You may accede to this according to your judgment of the situation. For instance if you believe that this is for the purpose of reviewing information you are presenting after they go home, for the purpose of informing other family members or making decisions about their management, you could allow the recording. If you think there is some ulterior motive, you may decline to allow the recording. On the other hand, if you suspect that you are being surreptitiously recorded, this is simply unacceptable and you have the right to refuse this.

You are not obliged to proceed with consultations or management if patients or accompanying persons insist on making recordings and you have made the decision not to allow it, or you have detected attempts to make surreptitious recordings. Under such circumstances, a relationship of trust would be difficult to forge and could undermine the professional relationship to the extent that it would be difficult to manage the patients. You should explain why you do not wish to be recorded and enter into a dialogue to try to come to a mutual understanding. If that fails, you may decline to see the patients and if they request, you may offer to recommend other doctors.

If you use security cameras in your premises and are in control of the systems, you need to ensure that they are not placed where patients' privacy and dignity will be compromised. The cameras must be obvious and not hidden and you are obliged to ensure that access to recordings is limited to authorised persons for legitimate purposes and they keep the recordings confidential.

The use of closed circuit television or webcam surveillance for security purposes is becoming increasingly commonplace. Where such systems are used, you cannot place the security cameras in places where patients' privacy and dignity may be compromised, such as in the toilet or over your examination couch or any area where patients may be partially or totally undressed. If you use security cameras for routine surveillance, the cameras need to be obvious and not hidden, in which case no specific consent need be taken from patients. Security cameras are nowadays almost ubiquitous and most people would expect them to be present and can see them if they merely look around. Where the surveillance systems are monitored by security personnel or linked to external security agencies such that external parties are able to view the images, you need to ensure that access is limited to authorised persons for legitimate purposes only and that they keep the recordings confidential.

C11. Third parties in attendance

You have to ensure that patients are comfortable with the presence of third parties during your care of patients and that such presence would not disrupt patient care.

Many different persons may be present when you are with patients. Patients themselves often attend with spouses, family members or friends and these are also third parties in attendance.

You should not assume that relatives or friends of patients have automatic rights to attend a consultation or treatment session or to know any confidential medical information about the patients. Sometimes, the relationships between the patients and the third parties are complicated and the patients may not want these parties to be involved. If a third party is associated with patients, you may allow that party to attend provided:

- (a) The patients specifically request or allow it.
- (b) There is no evidence that the patients are under any coercion or undue pressure by the third parties to allow them to attend.
- (c) You do not believe that the presence of the third party would interfere with the consultation or treatment, or be disruptive to the patient-doctor relationship.

A third party may be related to you or your practice. Such persons include (but are not limited to):

- (a) Those who are part of the healthcare team, such as:
 - Clinic assistants.
 - Nurses.
 - Pharmacists.
 - Other ancillary healthcare professionals.
- (b) Those who are not integral to the healthcare team, such as:
 - Observers present for legitimate reasons, such as SMC appointed auditors.
 - Students or junior doctors who are present to learn.
 - Research fellows or assistants.
 - Photographers, videographers or other persons documenting the interaction.

Patients generally accept the presence of persons who are an integral part of the healthcare team. All others are not part of their care and patients have the right to accept or reject their presence.

For such third parties, you should consider the following principles:

- (a) The presence of the third party need to be justifiable and you should be able to explain their presence if patients ask.
- (b) Patients should be under no pressure to accept the presence of these persons and should not be under the impression that their medical care might be compromised by their refusal to admit them.
- (c) If patients express any discomfort or reluctance to have third parties present, you should reconsider their presence. Chaperones are a special category of third parties in attendance and as discussed elsewhere, there are circumstances in which they ought to be present.
- (d) If the patients allow the third parties to be present, they should not distract you or the patients or interfere with the consultation or treatment. Medical students, official observers or junior doctors may legitimately participate in care provided the patients consent for them to do so.
- (e) Patients should not be embarrassed by having the third parties present, especially if intimate questions are asked, confidential information is exchanged or intimate physical examinations are being conducted.

C12. Relationships with patients and those close to them

C12.1 - Personal relationships

You are obliged to display a standard of behaviour towards your patients and those close to them that warrants their trust and respect.

A patient-doctor relationship is an unequal one where there is a power imbalance due to the asymmetry of information and influence between the parties, usually in the doctor's favour. Patients are in a vulnerable position and may be unduly influenced by you, hold you in high regard or develop an emotional attachment to you. The same applies to the people who are close to patients.

You need to avoid personal relationships that are sexual, romantic or emotionally intimate with patients who are still under your care.

A sexual, romantic or emotionally intimate relationship with current patients breaches the integrity of the patient-doctor relationship and constitutes taking advantage of vulnerable patients. A sexual or emotionally intimate relationship, even if consensual, may impair your judgment as well as that of the patients, and compromise your patients' care or cause psychological harm to them. Such relationships are therefore strictly disallowed.

You need to avoid such relationships with ex-patients when they are still vulnerable to your influence.

Even former patients are subject to possible emotional vulnerability with respect to a relationship with their previous doctors. While it is not strictly forbidden for you to have such relationships with former patients, the circumstances in which such relationships are forged and the nature of the relationships will determine whether such relationships are acceptable or not. When you consider establishing personal relationships with former patients, it is advisable for you to be reasonably certain that you no longer have undue influence over your patients. An elapsed period of time following the termination of a professional relationship may be helpful, although the length of this time would be extremely variable, depending on the circumstances.

In general, you should not embark on romantic or sexual relationships with former patients under the following circumstances:

- (a) Where the patient-doctor relationship involved psychotherapy, counselling or emotional support.
- (b) Patients whose judgments were impaired and continue to be impaired.
- (c) Patients who had demonstrated strong emotional dependence on you.
- (d) Patients who were victims of sexual abuse.
- (e) When the patients are influenced through your prior knowledge of them.

You are not to prematurely discharge patients with the express purpose of entering into romantic or sexual relationships.

This would be a breach of your professional responsibilities to the patients and leave them still vulnerable to your influence immediately after discharge. Taking advantage of patients or former patients for your personal gratification or to further your personal interests is not permitted.

You are not to use your patient-doctor relationships as the means of entering into exploitative associations with patients and those close to them.

Persons close to patients would include the immediate members of patients' families or carers. However, patients may also be very close to distant relatives or friends and you should be sensitive to this. If you interfere in any way with such relationships, you could disrupt the patients' lives and damage the relationship of trust between you and your patients.

Sexual or intimate relationships between you and family members of patients may also be unethical if you entered into them by relying on any knowledge acquired by you, or on influence or power wielded by you as a result of being the patients' doctor.

C12.2 - Social media and internet presence

You ought not to breach professional boundaries by initiating social media relationships with patients.

Engaging in social relationships with your patients through the use of social media platforms can blur the professional boundary between you and your patients. Although superficial and casual interaction on social networking sites may appear innocuous, you should be aware that the power imbalance between you and your patients may influence your patients' decision to enter into online relationships with you. You are not to initiate social media relationships with your patients because patients may be put in a position where they feel pressurised or obliged to engage you.

If you accept social media relationships with your patients who initiate them, you need to take care not to compromise your patient-doctor relationship by sharing anything that would breach patient confidentiality or privacy, or through inappropriate words or behaviour towards patients.

Whereas it is inappropriate for you to invite patients to be friends with you on social media, if patients of their own accord initiate social media contact, you may engage although it is strongly recommended that you do not do so. If you do enter into personal social media relationships with patients who invite you, perhaps in order not to give offence, or simply out of politeness, you have to prevent any compromise to your professional relationships by the inappropriate sharing of personal information which might breach patient confidentiality or privacy. You ought not to discuss patients' confidential medical matters online as others may have access to the information. Social media is not an appropriate medium for medical consultations or for patients to discuss with you any medical matter. In any case, your behaviour should be of the highest standard as the relationship of respect and trust could be seriously damaged through inappropriate words or behaviour towards the patients.

If you are active in social media or develop a strong internet presence, you need to be careful that any exposure of your personal life and actions does not diminish your professional standing or the trust and confidence that patients have in you, or bring the profession as a whole into disrepute.

While it is not possible to list the entire range of possible inappropriate behaviour on social media, examples include:

- Appearing intoxicated by alcohol or drugs.
- Engaging in lewd or inappropriate behaviour.
- Breaking rules or the law.
- Speaking or writing in an indiscreet, bigoted, rude, obscene or profane manner.
- Posting indecent images.
- Posting personal or derogatory comments about patients or colleagues.

C12.3 - Financial relationships with patients and family members

You ought not to allow any business or financial relationships with patients, their families or those close to your patients to jeopardise the patient-doctor relationship.

You should be cautious about forging or entering into close business or financial relationships with your patients and their known family members as these have the potential to adversely affect the patient-doctor relationship. Such relationships include:

- (a) Business partnerships.
- (b) Co-ownership of companies or assets.
- (c) Company directorships.
- (d) Executor or beneficiary of wills.
- (e) Trusteeships.

While not strictly disallowed, you need to be careful not to allow such relationships to affect or interfere with the patient-doctor relationship. If business or financial considerations take priority, there is a risk that patients' best interests may be compromised.

Persons with whom you have existing business relationships may become your patients. This is not a problem as long as you are able to maintain your objectivity and professionalism towards these patients. However, if you sense that you are not able to make objective decisions or are subject to unreasonable expectations due to the influence of your existing business relationships, you should consider transferring the care of these patients to other doctors.

C12.4 - Abuse of trust

You are obliged not to abuse or exploit in any way the trust and confidence that patients, their families or those close to patients place in you for your personal gain or gratification.

If you become a friend of the patient or the patient's family and enjoy the trust and confidence of family members, you need to ensure that your standard of behaviour towards your patients and those close to them continues to warrant their trust and respect. You need to avoid giving them the impression that you are trying to gain materially or obtain other benefits for yourself through them. While friendships are natural and are a positive outcome of good patient-doctor relationships, you should be continually aware of your status as their doctor and do nothing to bring yourself or the profession as a whole into disrepute.

You should also guard against the risk of losing objectivity in your clinical judgment, when you are called upon to exercise it, if you become too friendly with patients and their relatives or friends.

C13. Dealing with adverse outcomes and medical errors

You need to handle adverse outcomes in a professionally accountable way. You need to openly and honestly inform patients of the outcome and possible consequences in a timely manner, ameliorate harm, report the outcomes as appropriate and not allow any complaint or investigation to prejudice your further care of the patients.

Patients may in the course of the practice of medicine suffer an adverse outcome. Sometimes this may be due to a medical error. When something goes wrong during your care of patients, you have a responsibility to put things right as quickly as possible.

The appropriate approach to adverse outcomes includes:

- (a) Immediately taking steps to ameliorate any harm to the patients.
- (b) Telling the patients about the adverse outcome as soon as possible.
- (c) Reporting the adverse outcome to institutional authorities as appropriate.
- (d) Being honest with the patients about the causes and possible consequences.
- (e) Refraining from apportioning blame in advance of a formal inquiry.
- (f) Cooperating with an investigation, complaints procedure or inquiry if they are convened.
- (g) Not allowing any investigation, complaint or inquiry to prejudice your further care of the patients.
- (h) Taking steps to understand the wider implications, if any, of the outcome and if possible addressing any root causes or deficiencies so as to prevent recurrences of the event.

In addition, you should:

- (a) Show empathy and compassion in dealing with the patients' disappointment or distress.
- (b) Without necessarily admitting fault or liability, express regret for the outcome.
- (c) Not withhold information in an effort to protect your own interests.
- (d) Do your best to rebuild the relationship of trust with your patients and offer continuity of care.

If trust in you is lost due to an adverse outcome and it is the patients' wish, you may terminate the professional relationship. However, you are obliged to offer continuing care until the patients have been properly handed over to other doctors with the transfer of all the necessary information about the patients.

C14. Termination of a patient-doctor relationship

If a professional relationship is so seriously compromised and rendered so ineffective that you feel incapable of continuing care, you need to explain this to patients before terminating the relationship. You need to then facilitate a smooth handover of care to other doctors ensuring sufficient support until the care has been properly taken over.

There could be circumstances which do not allow for the continuation of your professional relationship with your patient. Examples are serious conflict in personalities, loss of confidence and trust, deception or abuse by patients, insistence on treatments that you consider are not in their best interests, refusal of essential treatment by the patient or any other reason that renders you personally unable to continue your management of the patients. In such instances, you are allowed to terminate the relationship.

When you are terminating a patient-doctor relationship, you have to:

- (a) Make clear to the patients that you are terminating the relationship and give reasons why you are doing so. The patients should be left with no residual expectations of future medical care from you. You should document your reasons for terminating care in the medical records.
- (b) Offer a referral to other appropriate doctors who can take over the care of the patients.
- (c) Ensure a smooth handing over of care by providing the new doctors with the necessary medical information and continuing to provide essential care if patients wish so, until a handing over takes place. If patients prefer to find their own replacement doctors and you do not know who the replacement doctors are, you need to facilitate the transition of care by giving the medical information directly to the patients.

A professional relationship may be terminated by a third party payer, for example, when you are removed from its panel of doctors or a contract is ended. In such cases:

- (a) You may offer to continue managing the patient outside of the original third party payer's contract, but make clear to the patient the new financial arrangements and charges.
- (b) If patients or their new doctors request it, you should provide them with the necessary medical information to facilitate continuing care.
- (c) If the third party payer requests a report (often with the payment of fees), patients have to give their consent for disclosure of medical information.

Where patient-doctor relationships are terminated by patients, you should not withhold medical information from the patients or other doctors whom the patients subsequently consult if you receive a request for such information.

If you are retiring or withdrawing from practice or reducing your patient list, you need to ensure the continued care of patients whom you wish to discharge from your care.

You are obliged to ensure that patients who need continued care are not suddenly left without access to care. Hence, if you are retiring or reducing your patient list, you need to inform patients in advance of your plans and have transfer arrangements in place. To ensure good continued care, you can offer to transfer your medical records (or provide medical reports) after obtaining patients' consent to do so.

D - RELATIONSHIPS WITH COLLEAGUES

Maintaining good collegial relationships with colleagues is important. This section looks at some of the aspects that you should consider in order to maintain good relationships with your colleagues. These include:

1. Collegiality
2. Respect for other doctors' patients
3. Comments about colleagues
4. Colleagues' performance, medical fitness to practise and professional conduct
5. Colleagues under supervision
6. Students in a healthcare setting
7. Professional behaviour in the healthcare team

D1. Collegiality

You are obliged to regard all fellow professionals as colleagues, treat them with dignity and fairness, accord them respect, and readily share relevant information about patients where this is in patients' best interests.

You ought to manage and nurture colleagues under your supervision with professionalism and care.

You are not to discriminate against colleagues on the basis of age, race, ethnicity, culture, lifestyle, disability, gender, sexual preference, marital status, religion, politics, beliefs, socio-economic status or any other characteristic.

Collegiality maintains a healthy and positive healthcare environment that patients can develop trust in. Mutual respect and support among doctors also creates an environment that strengthens the patient-doctor relationship and enhances patient care.

Observing positive conduct in your relationships with colleagues is part of professionalism. However, it is equally relevant to patient care, since failing to uphold these standards would diminish the standard of care patients receive. In addition, if you refrain from referring your patients to the doctors most beneficial to them out of unfair discrimination of these doctors, you would not be acting in patients' best interests.

D2. Respect for other doctors' patients

Professional courtesy requires that you not take over, attempt to take over or interfere with the management of patients who are under the active management or follow-up treatment of other doctors unless you have the knowledge and consent of these other doctors.

The only exceptions are when you are:

- (a) Taking over, or making adjustment of care within or between teams in a particular system of care.
- (b) Taking over the care of patients who have sought a second opinion from you and chosen to receive further care from you.
- (c) In an emergency or urgent situation where patients need care that would save life, or you have to prevent severe deterioration of illness or to alleviate pain.

Similarly, it would be wrong to persuade or induce patients to abandon their doctors or change doctors by denigrating their current doctors.

Only if you have objective evidence for believing that patients' best interests would be damaged should you even consider suggesting to them that they might be better off seeing you or someone else. Even so you should couch your advice in as neutral and objective terms as possible so as not to give the impression that you are gratuitously criticising your colleagues. This kind of decorum is required of you as a professional as explained below.

If you are seeing the patients of other doctors, you should ensure that you acquire sufficient medical information to provide appropriate continued care. If the patients consent, and if necessary, you should contact the original doctors to acquire all relevant information. If patients do not want the original doctors to be informed, then you as the second doctor should proceed with whatever medical information is available from the patients. As you may need to perform or even repeat tests, you should explain to the patients why it is necessary to do so.

D3. Comments about colleagues

There needs to be mutual respect among doctors. Professional relationships require you to refrain from making gratuitous, malicious or unsustainable comments, expressly or by implication that could undermine patients' trust in your colleagues and reduce the patients and public's regard and respect for them.

You would be interfering with patients' autonomy if they are subject to unfair, denigrating comments about other doctors that would confuse them in their healthcare decision making. In addition, a culture of sniping, back-biting and running one another down would distress and confuse patients who are merely seeking the best care possible. They would not know who to trust any more.

If you have issues with other doctors, you should decide whether the issues are serious enough to bring them to the attention of the doctors or, if necessary, to the relevant authorities.

You are obliged to refrain from undermining public confidence in the profession through making unsustainable and broad comments against unnamed individuals or groups of doctors in the public domain.

This can be in the form of comments made in conventional media such as letters to the press, through blogs or social media platforms or during talks or lectures. You are obliged not to issue broadsides against your colleagues as that would unfairly undermine public confidence in the profession in general.

If you are sincerely attempting to improve medical practice in the community, you should take concrete actions to redress the problems you see in other doctors or practices through institutional channels, SMC or MOH. By making only broad statements, you are not providing specific information that the relevant authorities would find useful or can act upon.

D4. Colleagues' performance, medical fitness to practise and professional conduct

You are obliged to first consider the welfare of patients when deciding whether to act on concerns about your colleagues' performance, fitness to practise or professional conduct.

If you have a reasonable belief that your colleagues have issues over their performance or medical fitness to practise but the issues are not severe enough to cause harm to patients, you should consider approaching the colleagues. Likewise, if you have a reasonable belief that your colleagues are engaging in professional misconduct but not to the extent that patients are at immediate risk, you should consider approaching the colleagues to express your concerns. This is in the hope that your colleagues take corrective actions to address the issues and thus prevent harm to patients.

If you have a reasonable belief that your colleagues have such serious issues that patients have been harmed or are at imminent risk of harm, you are obliged to report them to the relevant authorities.

For instance, you have to report them to the relevant authorities if:

- (a) Your colleagues do not voluntarily address their issues.
- (b) You have a reasonable belief that your colleagues are so impaired in performance or fitness to practise that it is clearly unsafe for them to continue managing patients.
- (c) Your colleagues are engaged in such serious professional misconduct that it is imperative that they are stopped forthwith to prevent harm to further patients.

You also ought to consider reporting your colleagues, if they:

- (a) Practise medicine under the influence of drugs or alcohol.
- (b) Practise medicine in a manner that is a flagrant departure from accepted standards of professional practice or competence.
- (c) Suffer from diminished mental or physical capacity to the extent that care of their patients is compromised.
- (d) Engage in sexual misconduct with patients.

You may report colleagues in these ways:

- (a) If there are established reporting procedures in your place of work to deal with such colleagues, follow them. If you deem the response unsatisfactory, escalate your report to the SMC or MOH.
- (b) If you have no established reporting procedures where you work, report the colleagues to the SMC or MOH, providing the relevant information for their review and necessary action.

D5. Colleagues under supervision

Teaching and supervising colleagues (usually juniors) is an integral part of a doctor's calling. When you train, appraise and assess doctors, you carry a great responsibility not only towards the doctors under your supervision, but also for patients under the care of these doctors presently and in the future.

If you are a doctor in a teaching and supervisory capacity, you are obliged to display the necessary attitudes, knowledge, skills and practices of a competent teacher. If you cannot fulfil the requirements to do a good job of training other doctors, you need to inform the relevant institutions so that they may provide help for you to meet these requirements.

Teaching is a key professional responsibility. In some instances where you are appointed to teach, it can sometimes be difficult to do it as well as you would like to. Sometimes these are issues related to your personal aptitude for teaching or you may face time constraints or overwhelming work commitments. It is highly recommended that you should not decline or withdraw from your teaching and supervising responsibilities but instead try to meet these responsibilities by improving your teaching ability. You should ask your institution for training to be a good educator or to rearrange your work obligations so that you can provide training competently, diligently and responsibly.

You should ensure that only those with the appropriate knowledge, skills and attitudes conduct the teaching and training that you are responsible for. If you are in charge of training, you should also monitor the performance of the doctors under you who are conducting teaching and supervision, and do what you can to help them improve.

You are obliged not to abuse your position in your supervisory relationships with your colleagues for any personal gain or gratification. In particular, you need to avoid entering into emotionally intimate or sexual relationships with your supervisees while they are under your charge.

You need to recognise that because of your asymmetrical relationships, colleagues whom you supervise are vulnerable to your influence and may agree to enter into inappropriate relationships with you out of fear of adverse reports, or in order to ingratiate themselves to you for better reports. You should similarly refuse advances by those you supervise for you to engage in such relationships.

However, unlike patients, there is little residual risk that after the supervisory relationship is over that your colleagues will remain vulnerable to your influence. Hence there is no prohibition of such relationships after the supervisory relationship is completed.

Bearing in mind the safety of patients, present and future, your formal appraisals of colleagues' conduct, performance, safety and competence in practice need to be fair, honest, justifiable and accurate. You ought to draw on feedback from other colleagues when necessary to give a more accurate report.

When colleagues you train or supervise prove themselves unfit to have patients entrusted to them, you may not want to jeopardise their future careers and, in marginal cases, you could give them the benefit of the doubt. However, in such cases, kindness and generosity of heart are misplaced. If those you train or supervise persistently demonstrate a lack of competency, or poor professional behaviour, you are obliged not to turn a blind eye. The same standards apply to references provided to prospective employers.

D6. Students in a healthcare setting

If you teach students in a healthcare setting, you need to ensure that you can do so competently, diligently and responsibly. If you cannot meet these standards, you have to inform the relevant institutions so that you can receive help to meet the required standards.

Doctors who teach or supervise students have the responsibility to teach them well, instil correct professional attitudes and create learning opportunities for them to improve their future clinical practice.

You are obliged to treat students with due respect as junior colleagues, explain to them and to patients their role in the clinical team and supervise them properly.

The role of students in the clinical care team and the relationship between patients and students need to be explained and clearly understood by both students and patients. You should ensure that patients neither mistake students as an integral or indispensable part of the care team, nor as mere interested observers to whom little consideration need be given. You should encourage patients to accept students in their learning role but if patients object to the students' presence, or their attending to them, you need to respect patients' wishes.

Teaching students is such an important responsibility that you ought to ensure that you can do so competently, diligently and responsibly. If you are appointed to teach students but find that you cannot meet these standards, you need to inform the relevant institutions so that you can receive help to meet the required standards, such as through training or rearranging your work commitments so that you can do better.

Since teaching of students is an important aspect of professionalism, you should try your best not to decline or withdraw from responsibilities for teaching students, but strive to meet these responsibilities.

You have a responsibility not to enter into personal relationships with students that are sexual, romantic or emotionally intimate as well as avoid using your teaching relationship as a means of entering into exploitative associations with the students and those close to them.

Because of the huge asymmetry of relationship between you and your students, they are extremely vulnerable to your influence as you have a say in the progression of their future careers as healthcare professionals. You need to treat students with utmost propriety and maintain an appropriate professional distance for as long as you are teaching them or have some say in their educational outcome, such as being an examiner in their final year, even if you have not directly taught them up to then.

If you believe a student is so impaired as to be a risk to the public as a student or ultimately as a healthcare professional, you are obliged to inform the relevant institutions.

If you are an educator of students in a healthcare setting, you have a responsibility not to turn a blind eye to students who ought not to be exposed to patients either as a student or in the future as a practising healthcare professional in the community. Kindness and generosity are misplaced when there is a risk of harm to the public. You have to notify the relevant institutions if you reasonably believe that a student has an impairment in personality, attitude, competency or professional behaviour that may place the public at significant risk of harm in the course of the student undertaking clinical training or in the future when that student graduates as a healthcare professional.

D7. Professional behaviour in the healthcare team

As a professional, you need to endeavour to be a good role model and exemplify positive behaviour within your team.

You are obliged as a medical professional to set a good example for colleagues and juniors. The importance of teamwork is recognised by the medical profession. Although every person possesses different behavioural characteristics and there will be wide variations in how well team members get along with one another, there are nonetheless some styles of interaction with fellow doctors, other healthcare professionals, patients, family members or others, that are considered disruptive and, if chronic and repetitive, would interfere with patient care by interfering with the effective functioning of teams you lead or are part of. Such behaviour could significantly jeopardise or affect patient care, or pose risks of physical or psychological harm to patients or colleagues. Single or intermittent impulse control problems that are out of proportion to the circumstances could also be disruptive to team function.

You are obliged not to manifest behaviour that significantly interferes with or jeopardises patient care or poses risks of harm to colleagues or patients.

Behaviours that you should avoid include (but are not restricted to):

- (a) Bullying, intimidation or harassment.
- (b) Sexual harassment.
- (c) Discriminatory or bigoted remarks.
- (d) Excessively hurtful, rude or inappropriate comments.
- (e) Malicious criticism or extreme sarcasm.
- (f) Abusive or offensive language.
- (g) Persistent lateness or tardiness in carrying out duties.
- (h) Throwing instruments or other objects.
- (i) Threats of any kind against any person.
- (j) Lack of cooperation with team members.
- (k) Abuse of power.

Such behaviour is inappropriate and can, in some circumstances, result in a hostile work environment and may result in the patients' best interests being undermined, or pose a risk of harm to colleagues.

E - MAINTAINING HEALTH AND FITNESS TO PRACTISE

It is important for doctors to be physically and mentally capable of giving appropriate care to patients. This section discusses the risks to patients if you are impaired and, looks at issues on how to handle your own health and fitness to practise, provided insight is preserved.

If you know that you are physically or mentally impaired to practise in some way, you are obliged to ensure that your impairment does not cause harm or distress to patients.

You ought to maintain your own health and well-being so that you are able to give of your best to patients under your care. You are not immune from the stresses and pressures of life and work, or the medical (including psychiatric) conditions that afflict the rest of the community. In fact, some studies show that doctors are more prone to dependence on alcohol or drugs, liver cirrhosis, accidents, or psychological disorders, including depression and tendency to suicide. For a variety of reasons, doctors are also known to be less willing to be patients of other doctors and may end up undiagnosed, poorly treated or untreated for their needs.

You are at the frontline of maintaining a community's health and fitness and you should set a good example. You should be aware that if you are physically or mentally impaired, you may cause harm or distress to patients by:

- (a) Making impaired judgments.
- (b) Having impaired senses that affect clinical performance.
- (c) Having impaired cognitive or procedural skills.
- (d) Exhibiting inappropriate behaviour towards patients.
- (e) Exposing patients to infectious diseases, examples such as Hepatitis B, HIV.
- (f) Acting in a way which may affect patient safety.

You should especially guard against alcohol, drug or substance abuse.

You should get immunised against commonly serious communicable diseases where vaccines are available.

If you know that you are impaired in your ability to practise, you are obliged to:

- (a) Seek medical or professional intervention and treatment so that your condition can be reviewed, monitored and assessed.**
- (b) Notify the SMC of your condition, together with a report by your treating doctor.**

Clearly these requirements are inapplicable where you are not aware of your problem, such as if you are suffering from dementia. It is then down to your colleagues to take steps to prevent you from doing harm to patients.

If the colleagues who are your patients are physically or mentally impaired to such an extent that patients have been harmed or are at immediate risk of harm, your initial approach ought to be to counsel them to self-report, failing which you are obliged to report them to the relevant authorities even without their consent.

If you are treating colleagues as patients, you may have a dilemma with regard to medical confidentiality, as well as with regard to collegiality. In such a situation, where your intention is to prevent harm to patients, your obligation to patient confidentiality is waived. Any considerations of kindness and generosity towards your colleagues are also misplaced if patient safety is at stake.

F - PROBITY

The community needs to have trust in the integrity of the medical profession. While there are many areas in which you have to express your integrity, this section discusses the following areas where your good standing is important:

1. Disclosure of personal information and cooperation in inquiries
2. Doctors as expert witnesses

F1. Disclosure of personal information and cooperation in inquiries

Probity means being honest and trustworthy and acting with integrity in your conduct to justify the public's trust in you and in the profession as a whole. You are obliged not to conduct yourself in a way that brings disrepute to the medical profession.

You need to inform, without delay, the SMC and any organisation for which you work, if anywhere in the world:

- (a) You have been found guilty of a criminal offence (this excludes offences that have been settled by the payment of composition fines in lieu of prosecution, such as traffic offences).
- (b) Another professional body has made a finding against you in disciplinary proceedings or proceedings regarding your fitness to practise.
- (c) You have been suspended from practice or have had conditions or restrictions imposed on your practice by any medical registration authority.
- (d) You have resigned or been dismissed from employment or practice for disciplinary, ethical, professional or competence issues.

One may question why it is necessary to disclose the above if a penalty has been paid or a sentence served. Someone so convicted could be said to have paid their dues to society and should be allowed to move on without discrimination. However, not to make such disclosures would adversely affect the autonomy of authorities under whom you work or the autonomy of your employers. They would want to know the facts and circumstances so as to determine whether you ought to be given full freedom to practise or they should take whatever measures deemed necessary to protect patients or the profession from potential harm. While in many cases there may be no further problems, to assume so without the chance to give due consideration is not to act in the public and patients' best interests.

You are obliged to cooperate fully with formal inquiries into your practice or other doctors' practices. You have to participate in such inquiries honestly, truthfully, openly, fairly and objectively.

If you are either the subject of any institutional or statutory inquiry, you are required to disclose any information relevant to such inquiries to anyone entitled to ask for it. You have to avoid withholding the truth in an effort to defend yourself.

F2. Doctors as expert witnesses

You are obliged to ensure that you are competent, objective and impartial when giving your opinion as an expert witness to a court or inquiry.

If you disclose confidential information about patients, you need to ensure that you do so only to the extent that it is relevant to the case. You have to avoid disclosing more than is necessary as a means to embarrass or otherwise pressurise any party involved.

You need to ensure that you have sufficient information to give your expert opinion, and if not, you have to qualify your opinion.

You may be asked to be an expert witness. This is an important professional duty. Your duty is to the inquiry or court and not to the party who is instructing or paying you. As an expert witness, you:

- (a) Should make clear the limit of your experience and competence before giving evidence.
- (b) Should not by any act or omission allow the court or inquiry to be misled as to your credentials or experience.
- (c) Should disclose any potential conflicts of interest.
- (d) May disclose confidential information on the patient that you received as a result of such engagement though you ought to refrain from divulging more information than what is necessary in the context of the case. This is especially so in relation to information that might embarrass or pressurise any party involved.
- (e) Should restrict yourself only to those areas where you have sufficient knowledge and experience when providing evidence or opinion.
- (f) Should make it clear if you are asked for an opinion on an area outside your knowledge and experience. You should decline to give an opinion, unless the court orders you to do so in which case you need to make clear to the court the limitations of your opinion.
- (g) Should base your opinion on the facts available. If there is a range of possible interpretations, you should state this range and explain how you arrived at your own opinion or if the opinion is qualified.
- (h) Should ask for further information, such as that derived from the physical examination that you are unable to conduct, or else be reasonably confident that the availability of such information is unlikely to make a difference to your opinion.
- (i) Render your opinion in an objective, impartial, accurate and non-misleading manner.

G - ADVERTISING

The information you provide in medical advertising about you and your services needs to be consistent with the noble image and dignity of the medical profession. This section looks at the following principles on advertising:

1. General principles
2. Standards required of advertising information
3. Platforms for advertising
4. Talks, interviews and written articles
5. Doctors associated with healthcare organisations
6. Professional announcements
7. Advertising overseas

G1. General principles

You are obliged not to advertise in a manner that misleads patients, undermines trust, demeans the profession, or exploit patients' vulnerabilities, fears or lack of knowledge.

Both members of the profession and the public require information about doctors to whom they can refer patients or from whom they may seek consultation. Patients seeking such information are entitled to protection from misleading or deceptive information. While provision of information about your services is legitimate, it is not appropriate to advertise in a way that exploits patients' vulnerabilities, fears or lack of knowledge such that they are persuaded beyond reason to seek healthcare services that they may not need.

Examples of such advertising are those that:

- (a) Persuade members of the public who are quite comfortable with the way they look that they somehow fall short of some aesthetic ideal and therefore need treatments that could redress their shortcomings.
- (b) Exploit the public's fear of dying of heart attack, stroke or cancer, alarm them unnecessarily or persuade them to present themselves for health checks that are actually inappropriate for their current age and circumstances.

You may validly provide information about your services to both colleagues and members of the public. Medical advertising has to conform to all parts of the ECEG as well as the publicity guidelines as set out in the Private Hospitals and Medical Clinics (Publicity) Regulations.

G2. Standards required of advertising information

Information in medical advertising has to meet the following standards:

- (a) Factual.
- (b) Accurate.
- (c) Verifiable.
- (d) Not misleading.
- (e) Not unduly persuasive.
- (f) No extravagant claims.
- (g) Not sensational.
- (h) Not enticing or alluring.
- (i) No financial inducements.
- (j) Not laudatory.
- (k) Not comparative.
- (l) Not disparaging.

G2.1 - Factual, accurate, verifiable and not misleading

Advertising has to be truthful and verifiable. You may provide neutrally toned and objective information about your SMC-registered qualifications, experience, areas of practice and your expertise in procedures. You have to avoid including information that could mislead the public as to your credentials.

In general, you may provide information about your qualifications, areas of practice, practice arrangements and contact details.

To make rational decisions about whether to seek healthcare from you, patients depend on objective and neutrally presented information about your experience, medical qualifications, and ability to provide treatments or services. This is an aspect of patient autonomy that needs to be protected. Any information that is presented in such a way as to seek to influence patients' minds unduly and therefore interferes with patient autonomy is not allowed.

It is not allowable to advertise in such a way as to create, encourage or promote an unreasonable expectation of benefit versus risk from medical treatment, such as by false, incomplete or biased information, underplaying or failing to disclose risks or making unsubstantiated claims of benefit.

When advertising, you may state your SMC-approved qualifications and indicate your area of practice according to SMC's Registers. These are the only qualifications allowed as your titles. You may, however, list memberships, affiliations, associations or other information below your titles if they accurately indicate your level of experience or expertise. You are not allowed to advertise information which may mislead the public as to your SMC-registered area or areas of practice or your level of experience or expertise.

If you use the title Professor or any variant of it, you should only put the title before your name if you are currently duly appointed by an SMC-accredited university in Singapore. If you are appointed Professor or any variant of it by any other university or in any other part of the world, you may indicate this below your titles as part of other information.

The terms Consultant and Senior Consultant or any variations are meaningless outside of public health institutions or large organisations that employ you where it allows the public and patients to distinguish rank and seniority among large numbers of doctor employees. In private practice, such terms should generally not be used in your formal designation. Some doctors calling themselves Senior Consultants are clearly more junior than other doctors in the same specialty, thus misleading the public as to the relative seniority of the doctors. It is, however, fair to indicate the most senior organisational rank you achieved prior to entering private practice as information below your titles or in your resume.

Images of you are legitimate information for patients, assuming that patients care about how their doctors look. Therefore, your images are allowed, provided they are a reasonably accurate portrayal of your true appearance and have not been touched up or modified.

Similarly, images showing you at work, if used, should accurately reflect the context of your work without embellishments. Obviously, patient confidentiality needs to be preserved when using such images.

G2.2 - Not unduly persuasive, no extravagant claims, not sensational, not enticing or alluring and no financial inducements

Making unrestrained or superlative claims regarding your practice, quality of services or expected outcomes are not allowed.

You are not allowed to use “before” and “after”, or even only “after” images or information for medical advertising in the public domain as anecdotal cases create unjustified expectations of the results of treatment, which may vary from patient to patient.

In respect of persuasiveness and extravagant claims, use of “before” and “after” or only “after” images is of particular concern. Whereas such use may be legitimate in the context of education, in advertising the public is entitled not to be misled into thinking that such images are representative of the overall outcomes of your practice. In advertising, such images or information are not placed in context and when seen in isolation have great potential to mislead. Even if a disclaimer is added, there remains a strong effect of solicitation or encouragement for the use of medical services. Therefore you may not use such images in advertising to the public.

In addition, illustrations, graphics and animation, while legitimately helpful in explaining things, have the potential to exaggerate, since they are fictitious. If these are used, you need to be careful not to present exaggerated claims of quality or outcomes.

Factual information which is published in peer-reviewed journals may be presented with references.

You are not allowed to advertise in a manner that seeks to excessively persuade patients beyond logic and reason (“unduly persuasive”) through arousing intense curiosity or interest about a medical service or stimulating strong emotional reactions that would impair patients’ rational decision making about whether they should pursue medical services.

Patients’ autonomy requires that they make decisions on healthcare based on facts and not through undue influence on patients’ minds. You should avoid using exaggerated, spectacular or vivid information and images. You should avoid use of phrases of the kind exemplified by: “do not delay”, “be safe not sorry”, “achieve the look you want” or “looking better and feeling more confident”.

The public is entitled to be protected from experiencing ill-founded fear or insecurity over their health or longevity. You are not allowed to play on the public’s sense of self-esteem, generate overly critical perceptions or dissatisfaction with self, body image, or physical attractiveness.

It is legitimate to present factual information about risks of common medical problems to the public. For example, the community risk of colon cancer is high enough to alert the public of the risk and to recommend some kind of screening from the age of 50, provided there is no family history. However, you need to be disciplined in not presenting the information in a sensational manner that exaggerates the possible risks and places the public in fear of their lives. Neither should you strive to induce dissatisfaction about their appearances which they were likely to be contented with prior to seeing your advertisement.

It is also not appropriate for you to advertise using elements involving leisure activities, glitz, glamour, style, famous locations, association with celebrities and the entertainment or fashion world.

Commercial advertising uses these tactics often as the public are likely to be persuaded by celebrities endorsing products and services. While this may be fine elsewhere, it is wholly inappropriate in veracity, and to the dignity of the profession to have medical information presented in association with glamour, celebrities or fashion.

You are not allowed to offer financial inducements such as free or discounted examinations or treatments (outside of legitimate non-commercial health promotion activities). You are not to lure patients through time-limited special offers, tie-ups with unrelated commercial entities (such as credit card companies), or offering gifts or other material incentives to persuade them to take up your services.

In this regard, there are sometimes tie-ups that promise special rates or discounts for consultations or procedures if payment is given through particular credit cards or membership cards. Sometimes vouchers for special deals are given away as promotional materials. Financial inducements include the use of “time-limited offers” which influences potential patients to make decisions under the pressure of time and the imperative of saving money rather than about their healthcare needs.

You are not to use medical services and products as prizes or gifts in any context in your medical advertising, as the use of these is unrelated and irrelevant to the recipient’s medical needs.

The principle in operation here is that the public ought to only make decisions on medical services based on objective information about health and health risks which are relevant to them. Any advertising that is anchored on irrelevant prizes or gifts is therefore inappropriate and to be avoided. For example, it is unacceptable to offer health screening packages, aesthetic procedures or other medical services as lucky draw gifts as they would bear no relevance to the recipient’s real medical needs.

G2.3 - Not laudatory

Subjective praise and compliments about you or your services have no place in medical advertising. Testimonials are subjective and are not allowed to be used in advertising on any media where you have any control over the content about yourself. Equally, you are not to ask or induce your patients or anyone to write positive testimonials about you in any media.

Patient testimonials, even if genuine, are disallowed because any number of testimonials cannot present the whole picture of your practice accurately or truthfully, and because these may not be representative of the collective views of your patients. Testimonials by famous persons or celebrities would in addition be deemed sensational.

Testimonials or their equivalent are disallowed in websites, social networking media and blogs that you maintain or which content you have control over. If you manage such media, you have to ensure that testimonials or their equivalent do not appear in these platforms, even through hyperlinks.

Where you have no control over the media or the content about yourself, it is possible that gratuitous laudatory comments are spontaneously written about you in blogs, doctor review websites or other social media. However, it is unacceptable for you to specifically ask or induce your patients to write positive testimonials about you.

G2.4 - Not comparative or disparaging

You are not allowed to disparage other doctors or their practices or make comparisons between you and your practice, and others' practices. It is inappropriate to give the impression that you and your practice are superior in any way compared to other doctors who provide similar services.

Advertising should not speak of other doctors and their practices in a slighting or disrespectful way, belittling their capabilities and results or seeking to reduce the esteem of other doctors in the eyes of potential patients. Even apparently innocuous statements such as "painless procedure" may give the impression that other doctors who provide the same services are likely to cause pain. And it would not be factual as the perception of pain is subjective and painlessness can never be guaranteed.

G3. Platforms for advertising

The advertising modalities you use have to be consistent with the honour and dignity of the medical profession. Advertising ought not to be ostentatious, offensive, undignified or in bad taste, as this would damage the reputation of the medical profession.

There are numerous ways in which you can advertise your services. Regardless of what medium you use, the content needs to abide by the standards of the ECEG.

The public needs to be protected from medical advertising that is intrusive and aggressive. While the content of your advertising is more important than the medium you choose, some methods may be unacceptable if they detract from the dignity of the profession or are intrusive or aggressive. These include unsolicited visits, active distribution of advertising materials to the public, such as unsolicited emails, individually addressed messages, viral distribution of advertising information through social media, faxed advertising or telemarketing and public canvassing for patients by you or your proxies.

Medical advertising should not be “in your face” as this demeans the profession. Blatant advertising may be the norm in the commercial world but not in medical practice. Some examples of questionable advertising include Facebook profiles that are broadcast to everyone with a request to “like” it. The Personal Data Protection Act enjoins doctors not to misuse contact information of members of the public for unsolicited advertising. You are required to keep within the law in this respect.

If you contribute charitably, your name and the name of your practice may be acknowledged in carefully phrased terms that would not constitute advertising of your medical services or bring disrepute to the profession.

You may have sponsored, donated towards, participated in or rendered services for charitable endeavours or have given grants or endowments for educational or charitable purposes. You are allowed to have your name and practice name appear in the lists of sponsors, donors or participants for the purpose of acknowledging such contributions. However, the information ought not to go beyond your name, designation and place of practice and it cannot include details about your services and how to access them or why you or your services might be of interest to potential patients and why you might be a preferred provider.

G4. Talks, interviews and written articles

When participating at public platforms, you ought to give only objective medical information. Any unsolicited information about you or your practice needs to conform strictly to the standards required of medical advertising.

You may and should serve the medical profession and the community by participating in public education activities, giving talks and interviews, or writing educational articles in public media.

However, such activities can also serve as platforms for you to advertise yourself and your practice. For that reason, you should provide only objective medical information and not unsolicited information about you or your practice that does not abide by the required standards. This includes information given in the context of education for doctors or the public, in talks, broadcasts, seminars, webinars or articles.

When you are featured in the media, you ought to ensure that the statements you make and the information you provide abide by the standards required of medical advertising. Where you have the opportunity to do so, you have to ensure, to the best of your ability, that the output is consistent with these standards.

Articles written by journalists in popular media are a particular problem as sensationalism is common. Materials that you provide for articles in which you are featured may be deemed advertising, and so needs to also conform to the standards stated above. You should be careful to restrict your material content to the medical topic at hand. You should not encroach into the area of encouraging the public to seek consultation or treatment from you or the organisation you are associated with.

You should do your best to ensure that media reports based on interviews with you are primarily for public education and not for advertising your services. You are responsible for the public statements that you provide. While you cannot ensure that journalists do not breach the required standards in how they write about you or quote you, the information you supply on which journalists base their writing needs to be of a high standard. It is also common practice for journalists to check quotations for accuracy with the interviewee and you should, whenever possible, ask for this opportunity to ensure that you are not misunderstood.

If despite providing only objective and neutral toned information that abides by the standards required of advertising, it comes to your attention that the article is written in breach of the standards, you should, as a matter of good practice make a complaint to the publisher or editor about this and document what you write to them.

If you use case studies, images (for example, photographs, videos, graphics, animation), devices, models or other props to illustrate or explain medical procedures or treatments or their outcomes, you are obliged to ensure that it is for educational purposes and not used gratuitously. Their use ought not to exaggerate the quality of your services or to mislead the public into thinking that you are making a claim or guarantee of your expected results.

Case studies, images (for example, photographs, videos, graphics, animation), devices, models or other props used to illustrate or explain medical procedures or treatments or their outcomes can legitimately be used in educational talks organised by professional bodies, healthcare institutions, or professional communication media (such as medical journals) where the intended audience is not the public but healthcare professionals who are knowledgeable and less likely to misinterpret what they mean. Even so, you need to put your material in the correct context, explain the limits of interpretation and what range of results may be expected, so that the audience does not mistakenly ascribe greater skills or better results on your part than is the case.

Such materials ought to be used much more judiciously in the public domain for legitimate public education purposes as they could be deemed to be laudatory. The public does not have the knowledge to have a perspective on what they see and hear, so it is even more important that you inform them that such images are not a claim or guarantee of results of particular treatments you provide since results will vary between patients.

Where you write articles or columns or participate in broadcasts which offer advice in response to public queries on particular subjects, the guidelines on good clinical practice and the establishment of a proper patient-doctor relationship apply.

If you or your organisation paid for the right of publication or broadcast in any media, or entered into an arrangement where paid advertising is a condition of publication or broadcast or you have paid for what appears to be impartial information originating from a third party, you are obliged to disclose prominently to your audience that these are your advertisements.

There are instances when you have to pay for an ostensibly objective article or interview to be published or uploaded. Alternatively, you or your organisation may have to pay for the right of publication or broadcast in any media, or enter into an arrangement whereby paid advertising is a prerequisite for accompanying journalistic articles, or you have paid for what appears to be impartial information originating from a third party such as a blog or documentary you sponsor. Such paid platforms are deemed to be pure advertising and not legitimate public education and you have to make this explicitly clear in a prominent way in the medium you use.

The public attend your talks primarily for their personal education and you should not assume that they also want details of you and your practice. Often, sufficient basic information about you as a speaker is already made available in programmes or flyers about the event. After public talks, if members of the public approach you for further information about you and your services, such information may then be provided and the information needs to conform to the standards required of advertising.

G5. Doctors associated with healthcare organisations

You are responsible for ensuring that any information put out by a healthcare organisation that you have material relationships with abides by the standards of medical advertising.

If you have material financial, or significant professional, governance or management relationships with healthcare organisations, you are responsible for the organisations' standard of information released about you, your practice or your organisation's services, unless you can show that the company had either not consulted you, or had proceeded in acting against your instructions or advice on this matter.

Even if you have no direct control over the organisation's events, publications or other media output, you ought to acquaint yourself with its nature and content to check that what is said about you is acceptable.

If you discover that it is not, you should as a matter of good practice, make a complaint to the responsible party and document what you write to them.

If you provide information for the organisation's media output, you need to ensure that the information you provide is factual and conforms to the standards required of medical advertising.

Where you participate in writing medical articles, events or other media content disseminated on the healthcare organisations' information platforms, any information you provide about yourself and your services or your organisation's services needs to conform to the standards required of advertising.

G6. Professional announcements

You may notify patients, other doctors and other persons or parties with whom you have a professional or personal connection of any commencement or cessation of a practice or any new practice arrangement or venue.

However, such notifications have to abide by the standards required for the platforms and content of advertising. This means that the content of your announcement needs to be consistent with the ethical requirements of advertising and you cannot make your announcements through means such as unsolicited visits, active distribution of notifications to the public, unsolicited emails, viral distribution over social media, faxed notices or telemarketing and public canvassing for patients by yourself or your proxies.

G7. Advertising overseas

Any medical advertising done overseas by you, your practice or the healthcare organisation of which you have material relationships must conform to the standards as specified in the ECEG as well as the standards of the overseas jurisdiction.

As a Singapore-registered doctor, you bear the reputation of, and your behaviour overseas reflects on, the entire community of SMC-registered doctors. Hence, you may not take the attitude that SMC's ethical requirements do not apply to what you do overseas, or that if you breach the overseas requirements, SMC would not take an interest. Your advertising overseas would include talks, seminars, articles and media reports about you and your services that are primarily directed at the overseas market, even if they may be secondarily accessed in Singapore (for example, discoverable through Google search). Your behaviour in such activity overseas would be scrutinised by the medical community and regulatory authorities in these overseas jurisdictions. If offence is caused, or you have breached the local standards, if such information is provided to SMC, you may be put through SMC's disciplinary processes.

If you, your practice or the healthcare organisation of which you have a material financial, or significant professional, governance or management relationship advertises overseas, you have to abide by standards required by SMC as well as any ethical or regulatory requirements relating to medical advertising in the overseas jurisdiction.

Where there is any disparity in the requirements for medical advertising between those specified by SMC and those of the overseas jurisdiction, the higher or stricter standard would prevail.

H - FINANCES IN MEDICAL PRACTICE

As the public generally perceives the medical profession as a noble one, your profit motives need to be subservient to treating patients in their best interests.

In this section, we look at the principles of handling financial matters in medical practice which include:

- 1. Fees for services**
- 2. Gifts from patients**
- 3. Financial conflicts of interest**

H1. Fees for services

H1.1 - General

This section is more relevant to doctors who have the ability to set fees.

If you have material financial interest, or significant professional, governance or management responsibility for an organisation that sets fees from which you directly benefit, it is your responsibility to ensure that the fees abide by ethical standards.

There are many instances where doctors do not have the responsibility of setting their own professional fees or fees for other services they offer. This is true for the majority of cases in the public healthcare institutions. Clearly, if you have no responsibility for setting the fees charged and no ability to control this, you could not be in breach of the ethical requirements.

However, if you work in the private sector, or even in the private or paying class sector of public healthcare institutions, you may have the ability to set your professional fees as well as the prices of services you offer patients. Hence, you need to ensure that your fees abide by ethical standards.

You are obliged to uphold the noble character of the profession by levying fair and reasonable fees for your services. The range of fees you set has to be transparent and made known to patients in advance of providing services.

Overcharging can erode the sanctity of trust and confidence that the community has in doctors and bring the profession into disrepute. What constitutes “fair and reasonable” depends not only on the relevant facts, but also on the views of your peers.

The legal concept of “caveat emptor” or “buyer beware” where it is the purchasers’ responsibility to be satisfied of the quality of the goods and services they are getting for the price they are paying is of limited application in a patient-doctor relationship. Firstly, there is considerable knowledge asymmetry and secondly, medical urgency may compromise patients’ opportunity to study the market. That said, you are entitled to be properly remunerated for your services.

You have to be honest and open with your patients about your fees. In this regard, do bear in mind the following:

- (a) If you are responsible for setting your own fees, you ought to advise patients of all fees and charges, or their estimates, prior to consultation or obtaining their consent to investigations and treatment.
- (b) You are not allowed to exploit your patients’ vulnerabilities or their lack of medical knowledge when charging for treatment or services.
- (c) You should not, for the purpose of earning a higher fee, put undue pressure on patients to receive treatment from you in the paying class of your institution, or your private practice outside of your institution, when they can be reasonably managed by you in the subsidised classes.

H1.2 - Appropriate fees

Your ethical obligation to charge fair and reasonable fees for services rendered operates over and above contractual and market forces and is not superseded by any agreement between you and your patient.

Your ethical responsibility to charge fair and reasonable fees that goes over and above contractual and market forces means that even if patients acquiesce to your charges (thus forming a contract), you are not absolved from the responsibility of charging reasonable fees. This principle has been affirmed by the courts in Singapore. In business terms, a contract is binding and it might be argued that should patients agree to a level of fees presented to them, they have no reason for complaint. However, this is not in the spirit of professionalism.

If you are contracted to a third party payer that sets fees which you deem less than fair and reasonable, then provided your contract allows this, it would not be unethical per se if you bill your patient for the difference unless you set such a high level of fees that your peers would not accept it as fair and reasonable. What would be the real problem is if you do not provide the required standard of care due to the remuneration being too low (and balance-billing is not allowed) for you to do so in a financially sustainable basis. As discussed elsewhere, under such circumstances you should reconsider participating in such schemes.

You should consider the following non-exhaustive factors that are often significant considerations in deciding whether a fee that is charged is fair:

- (a) The nature and complexity of the services rendered, including the degree of risk and responsibility which the care entails.
- (b) The time spent in rendering the services.
- (c) Specific demands made by patients.
- (d) Your special training, skills and expertise.
- (e) Your professional standing and seniority.
- (f) The opportunity and operating costs of rendering the services.
- (g) The circumstances of urgency under which your services are rendered.

In addition, you should take into account available sources of information which are helpful to you in determining your fees. Such sources include data on fees published by the MOH on their website or data from institutional sources. Whereas such sources are sometimes informal and incomplete, are aggregates or averages for which wide ranges may apply, these sources should nonetheless help you to determine the reasonableness and fairness of your fees.

The affluence of a patient should not be taken into account in setting or assessing what is a fair and reasonable range of fees. It is ethically legitimate and indeed something to be encouraged for you to charge a poor patient a reduced fee which is less than a fair or reasonable range of fees, or even to waive the fee bearing in mind the patient's impecuniosity. The converse, however, does not apply, i.e. you should not charge a rich patient beyond what would otherwise fall within a fair and reasonable range of fees simply because that patient is affluent.

H1.3 - Overcharging

You are obliged not to charge fees of a level that would bring the profession into disrepute. Therefore, you need to exercise due consideration when setting your fees for services.

There being a wide range of fees that are charged by doctors or institutions for services, it is not possible to specify upper limits of fees which doctors may charge for any service beyond which the concept of overcharging might apply. It is not a "cliff effect" in which a dollar above a specified threshold would tip a doctor over into the realm of "overcharging". Having a threshold would also not be in the best interests of patients, since doctors might be tempted to always charge at the upper end of the threshold regardless of the circumstances in which care is rendered, thus causing an inflation of healthcare costs.

The reasonableness of fees charged in a particular case is a matter for peer review by members of the medical profession of good repute and competency.

Your fees may be deemed excessive if your peers, providing similar services in similar circumstances, when reviewing your fees come to a firm and definite conclusion that your fees are beyond a range deemed appropriate for the circumstances. However, as there will invariably be some diversity of opinion as to what would or would not be correct in each case and where a line ought to be drawn, your peers will be slow to find a breach or to find professional misconduct in marginal cases.

The point at which a high fee crosses the threshold into egregious and unconscionable overcharging and professional misconduct is where the same peers agree that it is so grossly unreasonable and unjustifiable that it is sufficient to bring disrepute to the profession. Unreasonable or unjustifiable fees tend to have some or all of the following characteristics:

- (a) Intentional, deliberate departures from the standards observed or approved by the profession.
- (b) Grossly disproportionate fees to the services rendered in the circumstances.
- (c) Systematic pattern of egregious overcharging of patients.
- (d) Opportunistic charging and taking advantage of patients' ignorance or vulnerabilities.
- (e) Indiscriminate, inconsistent and arbitrary charging.
- (f) Lack of particulars in bills such that patients are not able to ascertain what the charges are for.
- (g) Multiple charges for overlapping services or time periods.
- (h) Inflation of charges levied by third parties, typically doctors whom you refer patients to, without disclosure and/or false representation that invoiced fees are due entirely to third parties.

You must only charge fees for services rendered directly either by you or those directly under your supervision.

For the avoidance of doubt, you may collect fees on behalf of other doctors who have assisted you in your overall care of your patients but you cannot take additional fees for yourself if you have not materially provided any part of the services of the other doctors. If you have materially assisted the other doctors in providing the services, then you may legitimately charge a fee commensurate with the level of your participation. Examples would be being assistant surgeon to a colleague that you have referred your patient to, or assisting in the endoscopic insertion of a gastrostomy tube.

Taking a fee for yourself alongside that for the other doctors without contributing a commensurate portion of care in collaboration with these doctors is inappropriate. You would refer a patient to a colleague to provide a part of their care as it is in their best interests and not because you will profit from it.

H1.4 - Non-payment for services

If a patient is unable or unwilling to pay for services, you may refuse to provide further treatment and may terminate the relationship. If you do so, you are still obliged to do it in a professional way as discussed elsewhere.

H2. Gifts from patients

You ought not to solicit any personal gifts, favours or other forms of gratuitous rewards from patients under your care.

In the natural course of a patient-doctor relationship, patients may well be grateful to you and your institution for the good care they have received. To express this gratitude, some patients may offer gifts or other considerations.

Although you ought not to ask for them, you may accept grants or bequests from patients made for the benefit of legitimate medical research, education or charitable causes but only on behalf of relevant organisations and never to yourself.

However, patients ought not to be pressurised to make such grants or be led to believe that their care may be compromised if they do not offer or make such grants and bequests.

Equally, preferential treatment in return for such grants or bequests is inappropriate and unacceptable.

When such offers of gifts or bequests are made by patients, you should not compromise your professional relationship by dealing with these offers in a clinical setting. You should arrange to have such offers discussed and managed through official channels.

You ought to refuse the kind of gifts or other gratuitous rewards that reasonable observers would deem extravagant and likely to set up a sense of obligation on your part and expectation on the part of the patients for preferential treatment. Such gifts would violate the objectivity of the professional relationship.

Patients may offer gifts to you as gestures of appreciation. You may accept such gifts within the patient-doctor relationship, as long as the gifts are occasional, well intentioned and of modest value.

It would be difficult, if not impossible, to itemise the kinds of gifts that are allowed and those that are not. Most reasonable persons would not deem as excessive an offering of food such as a basket of fruits or confectionary whereas most reasonable persons would regard a gift such as a car as extravagant and excessive. While it is not difficult to discern a gift so extravagant that you should not accept it, you should in general err on the conservative side in accepting gifts. If your organisation has policies with regard to gifts, you should abide by them.

H3. Financial conflicts of interest

You are obliged to always place patients' best interests above your personal interests and any business or financial considerations.

Patients trust their doctors to act in their best interests in giving advice and offering treatment to them. When you have financial interests that compete with your duty of care to them, this sets up a conflict of interest. Conflicts of interest per se are not the issue. It is only when you act out of conflicts of interest for your own benefit that you have failed in your duty.

You are obliged not to let business or financial considerations influence the objectivity of your clinical judgment in your management of patients.

One way of dealing with conflicts of interest would be to always disclose these to your patients where relevant. Disclosure alerts your patients to your conflicts and supports their autonomy by giving them information to help them decide whether to accept your advice or recommendations. You also set up an atmosphere which encourages yourself to remain objective.

Disclosure, however, is not a perfect solution. Your disclosure may well mislead patients into believing that your recommendations are indeed objective, when they remain tainted by considerations of your self-interest. Hence, while you ought to disclose conflicts of interest, ultimately it is your recommendations and decisions that need to be honest and objective.

Disclosure would generally be unnecessary for conventional instances where profit may potentially be gained through the practice of medicine, for example, the fact that a doctor may obtain a reasonable profit from the sale of medication and devices prescribed.

You are obliged to avoid exerting undue influence upon your patients to enter into transactions in which you or anyone close to you have a material interest.

Whether the level of "interest" is sufficient to trigger disclosure is a matter of whether real conflict of interest exists as well as perception of such conflict when the situation is viewed by reasonable persons. The term "material interest" is a commonly understood phrase which means interests that could give rise to a conflict of interest or perception of this if it were known to reasonable persons.

H3.1 - Doctors in the business of medicine

You need to ensure the objectivity of your clinical judgment in your management of patients when you have conflicts of interest directly related to their care.

You are obliged to disclose your material interests, or those of anyone close to you, in organisations, companies or services to which you refer your patients. If patients request an alternative provider, you are obliged to facilitate this.

Trust between patients and you may be damaged if your professional judgment is, or is seen to be, influenced by financial considerations. Hence, you should be careful:

- (a) Not to let financial considerations occasioned by your own practice, investments or financial arrangements influence the objectivity of your clinical judgment in the treatment of your patients.
- (b) Not to over-utilise any medical test or treatment because of your financial investment in them, financial benefit from them or financial relationship with any company.
- (c) Not to allow any financial arrangement that commits you to give a revenue or profit guarantee to a third party to influence how you manage patients. You should avoid such arrangements as a matter of good practice as the pressures on you to meet your financial obligations would be great.

If you or anyone close to you have material interests in organisations, companies or services to which you intend to refer patients for admission, treatment, investigation, or for the purchase of any drugs, medicine, device or service in the course of treatment, you have to always disclose these interests to the patients when making your recommendations. Although it may be rare for this to happen, if patients ask for alternative professionals, you are obliged to give them the necessary information and facilitate this and to effect a smooth handover of care.

H3.2 - Payment for referrals

You are obliged not to participate in “fee splitting” or “fee sharing” by offering gratuitous payments, gifts or other rewards for patients referred to you from any source.

The referral sources to whom you may not provide kickbacks include any doctor or other healthcare professional, concierge service or agent, internet-based referral service or any other source. The principle is that doctors ought to receive referrals based on their expertise and reputation rather than because they have paid for the referrals, which damages the objectivity of the process of patient referral and thus undermines patient autonomy.

Similarly, you may not ask for or receive fee kickbacks, payments or any other compensation in kind for referring patients to other doctors, medical service professionals or healthcare facilities.

The principle is that you ought to refer patients for services because these are in the patients' best interests, not because you are materially rewarded to make such referrals in the form of inducements to make these referrals outside of patients' best interests.

When participating in legitimate managed health or insurance systems, you ought not to allow constraints or financial pressures to adversely affect the objectivity of your clinical judgment in managing your patients such that you fail to provide the required standard of care.

If you participate in managed health or insurance reimbursement systems, there may be constraints inherent in such participation systems. If such schemes are so onerous that you are forced to compromise the standard of care provided to your patients in order to maintain financial viability, you should reconsider your participation.

You are obliged to ensure that if you pay fees to managed care or insurance companies or patient referral services, these fees reflect their actual work in handling and processing the patients and that such fees are not based primarily on the services you provide or the fees you collect from patients. You ought not to pay fees that are so high as to constitute "fee splitting" or "fee sharing" or which render you unable to provide the required standard of care.

There may be fees that you are charged by managed care companies, third party administrators, insurance companies or patient referral services that you engage. These fees ought to be proportionate to the actual work done by these companies in handling and processing such patients. It follows therefore, that such fees ought to be based on the work of the third party and not on the services that you provide or the fees you collect. Any fee that is too high in quantum could be deemed "fee splitting" or "fee sharing". While it is difficult to specify the limits of such fees, the level of fees cannot be so oppressive that you are unable to provide the required standard of care. If you pass such fees onto patients, you ought to be transparent about this with your patients and disclose this to them. You should itemise such fees in their invoices.

I - DOCTORS IN BUSINESS RELATIONSHIPS

In medical practice, there are many links between doctors and pharmaceutical or medical device companies. In addition, doctors may also be involved in companies for non-medical products and services.

This section discusses how to ethically handle:

- 1. Relationships with the medical industry**
- 2. Relationships with non-medical companies**

I1. Relationships with the medical industry

You need to handle with care relationships with companies in the medical industry.

There have been very direct, mutually beneficial relationships between doctors and pharmaceutical, medical equipment or device companies, with companies often sponsoring doctors on educational events or for research projects. However, such relationships can render doctors susceptible to biases in their prescribing and dispensing of medicines and their choice of equipment and devices to offer patients.

Patient autonomy, patients' trust in you and the patient-doctor relationship may all potentially be jeopardised if there is a perception that you have a conflict of interest and are recommending investigations or treatment based on your relationships with companies, rather than on medical indications, the most appropriate modalities available and patients' best interests.

You need to be careful not to allow your relationship with any company to influence or appear to influence:

- (a) The pattern of prescription and dispensing of medicines.
- (b) The choice of medical equipment, devices or procedures.
- (c) The sources of education and information you choose that determine your clinical practice and with which you educate your patients.
- (d) The objectivity and integrity of your research and publications. Conflicts of interest need to be declared to review committees and there ought to be no publication bias.
- (e) The content of any contribution you make to medical education for colleagues or the public.

11.1 - The role of the medical industry in education and research

It is acknowledged that by sponsoring local and overseas educational events and availing doctors of opportunities to develop professionally for the benefit of patients, industry has played an important part in medical education and research. Without industry sponsorship, junior doctors and those without the means to finance themselves would be disadvantaged to the detriment of the profession and the public.

Therefore, industry support is likely to be necessary for the foreseeable future. Some degree of influence by companies on doctors' behaviour is inevitable. But if this is well managed, it is a better alternative to the prohibition of sponsorships which could damage educational or research prospects and industry funding of conferences. Prohibition may also encourage covert or "under the table" relationships between doctors and industry that will be difficult to regulate or manage. This would be more insidious and potentially more damaging to the reputation of the profession.

If you accept sponsorships for legitimate educational events, you need to act ethically and not show, or appear to show favouritism to the companies that provide such sponsorships.

You should seek to minimise any influence of sponsorship on your behaviour.

As far as possible, industry sponsorship should be objectively disbursed and managed by institutions and professional bodies.

11.2 - Legitimate educational or research events

A legitimate educational or research event is one which is:

- (a) Primarily dedicated, by time and effort, to scientific or educational activities.
- (b) Devoid of excessive extraneous activities such as extravagant meals and entertainment or unrelated side travel.

11.3 - Invited expert at legitimate educational events

Any financial reimbursement or honoraria that you receive for your role as an expert participant in educational events must be fair, reasonable and commensurate with your time and expertise provided.

Your role at educational events may include speaking, presenting, demonstrating or participating in research, for which you may receive financial reimbursement and honoraria. You ought to avoid any invitation for any entertainment other than those which are part of the official programme.

Should there be direct financial support from companies for your participation in such events, you need to disclose any support you receive from them to your audience.

This principle should also cover your writing as an expert, including if you report on research sponsored by a company.

You need to ensure that your participation in sponsored medical events, publications or websites does not appear to endorse the company products or services of the sponsor, or to persuade patients or members of the public to use its products or services.

The ways in which you could ensure this include being fair and objective in choosing data that you present, avoiding repetitive references to a particular branded product when other drugs in the same class are equivalent and avoiding remarks that could be misconstrued as persuading your audience to choose a particular named product or service beyond objective evidence.

11.4 - Ethical obligations of receiving sponsorships for attending legitimate educational events as a delegate

While participating in educational events whether locally or overseas, you may accept support from any company only to the extent that is necessary to facilitate your attendance, with reasonable logistic support such as travel, accommodation and meals.

There would be considerable variations in the support you receive. What appears to be relevant or extravagant to some may not be so to others. For example, some travel provisions are only for economy class flights, while others provide business class. Sometimes this depends on the duration of the flight, which might seem reasonable.

It is moot whether first class flights are ever appropriate or necessary for the purpose of attending educational events in reasonable comfort as opposed to a hardship experience. The standard of accommodation would vary greatly as well, although it might be questionable whether luxury suites or palatial trappings are appropriate. Similarly, one cannot have hard and fast rules about the quality of meals provided although the provision of hugely extravagant meals would likely raise eyebrows.

You should therefore avoid hugely expensive meals such as Michelin three-star meals, entertainment that is outside of those associated with official opening ceremonies or official dinners, or any other kinds of leisure activity in place of educational content. You should avoid the kinds of events that promise a talk or two before getting onto the golf links or ski fields as major components of the programme.

In general, the standard and cost of all these provisions should be appropriate to the dignity and decorum of educational events. They should also reflect what you might be able to afford or be prepared to pay on your own accord if there were no sponsorship. In the end, it would be down to the opinion of reasonable peers to decide whether provisions are within an acceptable range. Also relevant are the opinions of objective external observers who may see how you are treated, whether it gives the impression that you are receiving blatant inducements to be biased in the companies' favour.

You should also be judicious and not accept sponsorship of a level or frequency that could lead a reasonable person to believe that you would be biased in favour of the sponsoring companies.

In summary, when accepting sponsorships for legitimate educational events, the following general principles would apply:

- (a) The programmes you are sponsored for are primarily for education or research, and not be focused on extravagant meals, entertainment or any other kind of leisure activity.**
- (b) The sponsorship needs to be directed towards facilitating your attendance of the programmes including reasonable logistic support.**
- (c) The greatest proportion of your time ought to be spent attending the formal content of the programmes rather than unrelated activities.**
- (d) You have to personally pay for the costs of unrelated activities including any extension of your stay before or after the period of the formal programme.**
- (e) The sponsorship can only be for your own participation and not for any accompanying persons who are not participants, unless there is insignificant or no additional cost (for example, sharing a hotel room at no extra charge). You have to personally pay for meals and other costs incurred by persons accompanying you.**

11.5 - Advisers, directors and consultants to medical companies

If you are formally appointed by a company to be an adviser, director or consultant or to hold similar positions, you need to be careful to ensure that your appointment does not appear in any way to endorse any of the company's products or services, or to appear to persuade other doctors, patients or members of the public to use the products or services.

You may be fairly and reasonably remunerated for your time and expertise provided to the companies if such remuneration is not excessive when compared with other similar remuneration for doctors' time and expertise, such as being expert witness or giving a lecture.

If you are asked to attend meetings of any kind as part of your work for the companies, for which you receive financial support for travel and accommodation on top of remuneration, these meetings have to be specifically for the internal work of the companies. This internal work has to be directly related to your expertise and specific contributions. In the course of such attendance, you should not accept any hospitality that is wholly unrelated to the work.

11.6 - Gifts and hospitality

It is not acceptable for you to ask for gifts under any circumstances or accept extravagant gifts, hospitality or other inducements from companies that could be seen by reasonable observers as potentially affecting your judgment in making decisions about patient care.

Gifts, hospitality or other inducements that may be provided by companies may affect or be seen to affect your judgment in making decisions about patient management. However, you may receive small, insubstantial gifts which will not be regarded as inducements by reasonable observers. Examples include stationery items or meals as part of educational events. Educational materials and items of medical utility, if of modest value, are also allowed if they improve patient care.

12. Relationships with non-medical companies

12.1 - Appropriateness of relationship

You are not allowed to carry on a trade or business, or participate in any relationship with any company that could bring your practice and the profession into disrepute.

12.2 - Association with non-medical companies or non-medical products or services

If you are associated with non-medical companies, you are not to use your professional status to promote the products or services of the companies. You are not to mislead the public into believing that such products or services are effective on medical grounds.

You may be associated in an official capacity with non-medical products or services or with non-medical companies. Your position may be shown on the company's stationery, literature or website, but you need to be careful not to include any reference that draws attention to your professional qualifications or services that are unrelated to the non-medical products or services. You are not prohibited from conducting non-medical businesses or being associated with such businesses, but your involvement in such businesses needs to be clearly separated from your medical practice and your medical qualifications. This is so that the public is not misled into believing that the non-medical products or services are medically beneficial or being endorsed by you as a doctor.

If you are involved in public talks or other advertising platforms focusing on non-medical products or the products and services of non-medical companies, you may not promote your practice and you are obliged to declare that you are speaking in a non-professional capacity.

When presenting any information to the public on non-medical products and services, apart from being careful not to use your professional credentials to promote them, you need to be careful not to mix advertising of these products or services with advertising of your professional practice as they are not relevant to each other and the same platform ought not be used for promoting both. Doing so would confuse the public. Any reference to your involvement in the companies should not mention your professional qualifications or services and this also applies to the companies' websites or other platforms on which they advertise.

12.3 - Doctors and "health spas"

You are not to associate yourself with "health spas" or other parties that do not provide legitimate medical or medical support services in a way that can mislead the public into believing that such services are medically endorsed.

There is an increasing trend of doctors participating in establishments that purportedly enhance health and well-being, which are sometimes called "health spas". Typically, such businesses provide a spectrum of "therapies" ranging from traditional spa services to those said to specifically improve health, prevent disease or increase well-being. Often, these establishments also offer some varieties of CAM.

Associating yourself with such establishments can mislead the public into believing that any of the services provided which are not part of conventional medicine are endorsed by you as a doctor or the medical profession as a whole.

You may own, have a stake in or be a director of a "health spa" or be involved in managing such establishments as a business but you are not allowed to personally participate in or endorse the services offered in your professional capacity.

12.4 - Association with non-medical persons

In your professional capacity, you are not allowed to associate yourself with or support the services provided by persons or organisations that do not provide legitimate medical or medical support services in a way which could mislead the public into believing that any of the services are medically endorsed.

Non-exhaustive examples of such services include beautician, non SMC-approved CAM, anti-ageing and colonic cleansing services.

12.5 - Association with promotion of foods, vitamins, tonics, health and nutrition supplements, health, weight loss or fitness programmes

You may promote food, vitamins, tonics, health and nutritional supplements, health, weight loss or fitness programmes provided that whatever you say, write or broadcast in this connection is supported by scientific evidence or is generally accepted by the medical profession.

You may be asked to promote foods, vitamins, tonics, health and nutrition supplements, health, weight loss or fitness programmes, many of which carry extravagant claims of enhancing performance, general health or bodily functions or preventing specific diseases. As there is a huge overlap between such substances that provide proven health benefit and those that have scanty or no evidence, you need to be very careful how you refer to them. For example, probiotics have some proven benefits that you could mention, but not other purported benefits that do not have evidence supporting them.

You are not allowed to give personal testimonials of you and your family's use of such products or services.

This would be an abuse of your position as a doctor to unduly influence public perception of the validity of any of these products or services, as such claims of benefits to yourself or your family may be anecdotal reports which, even if honestly made, remain unconfirmed by reputable literature.



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