

SINGAPORE MEDICAL COUNCIL

2016 EDITION OF THE SMC ETHICAL CODE AND ETHICAL GUIDELINES AND HANDBOOK ON MEDICAL ETHICS

EXPLANATORY NOTES – PRINCIPLES OF REVISED ECEG

This information sheet provides key explanatory notes to doctors on the following areas:

- (a) The review process and principles on which the **2016 edition of the SMC ECEG** (2016 ECEG) is built;
- (b) The rationale for having two publications, i.e. the 2016 ECEG and a new **SMC Handbook on Medical Ethics** (2016 HME), understanding the “must” and “should” statements in these publications and the relevant documents to be referred to for standards to be met for disciplinary matters; and
- (c) The comments on specific topics of concerns to doctors such as practise of defensive medicine, doctors treating themselves and those close to them, gifts or hospitality, industry sponsorship, and managed care companies and third party administrators.

PROCESS OF REVIEW

2. A Working Committee to review the ECEG was appointed by SMC in September 2010 comprising Council members and other senior doctors and an ethicist with considerable experience in medical ethics. Over a six-year period, the Working Committee met more than 30 times. The review process involved:

- (a) Thorough research into the medical ethical code publications of many overseas medical bodies that have well developed ethical frameworks to provide essential reference points;
- (b) Inviting and receiving initial inputs and suggestions from the medical profession, including public and private healthcare institutions, medical professional bodies and individuals;
- (c) Drafting a revised ECEG for consultations with the medical profession;
- (d) Legal review including checking for consistency with Singapore law;
- (e) Holding three focus group discussions on the draft ECEG and dialogues with representatives from various sectors of the medical community and laypersons from the SMC Complaints Panel in 2011;
- (f) Refining the draft ECEG in response to the focus group’s input;
- (g) Presentation of the draft ECEG for Council’s inputs before proceeding to profession-wide consultation exercises;
- (h) First profession-wide consultation exercise in 2014;
- (i) Deliberation by the Working Committee on the feedback and re-writing of the draft;

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- (j) Presentation of draft ECEG to Council for approval to proceed to further profession-wide consultation;
- (k) Second profession-wide consultation exercise in 2015;
- (l) Deliberation by the Working Committee on the feedback and finalisation of the draft ECEG and HME to be presented to Council;
- (m) Deliberation by Council on the draft ECEG and HME; and
- (n) Final approval by Council for the 2016 ECEG and HME.

Challenges faced in revising the ECEG

3. For something as fundamental and important, the ECEG had to be written with two main considerations in mind:

- (a) The ECEG must be broadly in line with the ethical standards applicable in other developed jurisdictions. The ECEG should neither allow significantly lower standards, nor unreasonably demand much higher standards than the equivalent codes and guidelines of reference countries such as UK, Australia, New Zealand, USA, Canada, Ireland, South Africa, Hong Kong, and Malaysia. Singapore as an international medical centre must have world-class standards of medical ethics; and
- (b) The ECEG derives its authority from the consensus of the medical profession that it is right for our community. A great diversity of views amongst medical professionals, institutions and professional bodies, many strongly held, was only to be expected. The challenge was to find a path that adequately protects patients while being fair to our doctors.

4. The Working Committee undertook the process of studying in detail each and every piece of feedback and input that was received over the years. The final profession-wide consultation exercise in 2015 yielded no major fundamental objections to any of the individual guidelines, which meant that overall, the revisions to the guidelines undertaken after the last round had rendered them generally acceptable.

Principles on which the 2016 ECEG is built

5. The 2016 ECEG is to set out, as far as possible, the roadmap for arriving at acceptable ethical conduct in any given situation, governed primarily by the following principles:

- (a) Relevance to modern medical practice;
- (b) Adapting to the complexities and variations of medical practice;
- (c) Protecting patients' best interests while being fair to doctors;
- (d) Maintaining the values important to society and to the medical profession;
- (e) Regulating behaviour rather than imposing blanket prohibitions; and
- (f) Upholding the principle of professional self-regulation.

6. Extensive reference has been taken from well written ethical guidelines of many overseas countries. The 2016 ECEG is not more stringent or legalistic than these countries (as mentioned above). In fact, extra care has been taken to phrase guidelines to be fair and just to our doctors (e.g. to justify variations in many more areas than

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allowed in these other jurisdictions, owing to our local medical culture). The way it is written is consistent with many ethical codes and guidelines of other jurisdictions.

2016 ECEG AND HME

7. After the second profession-wide consultation exercise in 2015, SMC agreed with the Working Committee that the ECEG will only contain the actual ethical code and guidelines and none of the elaborations, explanations and advice on best practices (i.e. the “should” statements). Therefore, all the additional material has been moved to a separate publication called the SMC Handbook on Medical Ethics. This clear separation should further assuage remaining worries that the information could be mistaken as the actual ethical guidelines, yet leave it still relatively accessible to those who desire to know more about medical ethics.

8. The 2016 ECEG is the primary document on which doctors’ behaviour will be judged. Should there be any apparent discrepancies between the 2016 ECEG and what is written in the HME, the ECEG will take precedence. For the avoidance of doubt, failure to abide by all the best practices discussed in the HME does not automatically mean that doctors are in breach of the ECEG.

“Must” and “should” statements

9. The 2016 ECEG contains guidance that generally ought to be met in the majority of situations. The phrase “you must” is extensively used to indicate that the ethical guideline is an overriding duty and the principles stated must be upheld unless circumstances prevent it. The phrase “you must” does not mean that implementation is mandatory regardless of any circumstances.

10. The HME contains two types of material:

- (a) The first is designed to help doctors understand the rationale behind the ethical guidelines in the 2016 ECEG, to expound on what they mean and how they may be applied. These explanations and elaborations are not part of the ECEG as such and should there be any apparent inconsistency between the ECEG and the material in the HME, the ECEG will prevail; and
- (b) The other kind of material is a discourse on the various ways in which doctors could improve practice in an effort to meet the ethical standards required. The phrase “you should” is extensively used and indicate advice on a variety of best practices. The phrase “you should” is also used where the principles may not apply in a significant proportion of situations, where there are factors outside doctors’ control that affect your response. For the avoidance of doubt, failure to abide by all the “best” practices indicated by the phrase “you should” does not automatically render doctors in breach of the 2016 ECEG.

11. In both publications, the phrase “you may” provides elaboration on situations in which it is permissible for doctors to take particular courses of action that would still fulfil their obligations under the 2016 ECEG.

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Document referred to for standards to be met

12. The 2016 ECEG is the primary document that disciplinary processes will refer to, yet it does not stand on its own. Firstly, it is not a substitute for legislation (the Medical Registration Act (MRA), the Medical Registration Regulations and other applicable statutes and regulations) or case law. If there is a conflict between the 2016 ECEG and the law, the law takes precedence.

13. Secondly, the 2016 ECEG provides basic guidelines. In specific situations, the 2016 ECEG has to be read in conjunction with current directives and guidelines issued by the Ministry of Health which the ECEG also alludes to as obligatory for doctors to comply with.

Peer review

14. The application of the 2016 ECEG will vary according to individual circumstances but the principles should not be compromised. The assessment of the appropriateness of a doctor's professional conduct vis-à-vis the 2106 ECEG is largely a matter of peer review. Peer review is the basis of every part of SMC's disciplinary processes and is also applicable in civil or criminal courts.

15. The principle of peer review requires the appropriateness of a doctor's 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.

16. Peers would take into account the precise circumstances in which a doctor found himself to determine the range of acceptable responses consistent with the ethical guidelines in question. Peers would have to decide whether the approach of a particular doctor lies so far outside an acceptable range of options in a particular situation, that he or she may have breached the 2016 ECEG.

SMC-registered doctors but practising overseas

17. The 2016 ECEG is intended first and foremost to guide SMC-registered doctors practising in Singapore. However, as cross-border medicine becomes more prevalent certain aspects, such as telemedicine conducted in Singapore for overseas patients, may become subject to the 2016 ECEG, in addition to the laws and rules that apply in the overseas jurisdiction.

18. It is sometimes asked why misconduct overseas should attract SMC's attention at all since the events did not occur in Singapore. Indeed, it is the responsibility of the overseas jurisdiction to deal with doctors who breach the local rules.

19. However, doctors who are registered with SMC carry the reputation of Singapore doctors. Should their behaviour overseas bring the reputation of Singapore doctors into disrepute, and SMC receives complaints or information about the doctors' conduct while overseas, SMC could also take disciplinary actions against the doctors.

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COMMENTS ON SPECIFIC TOPICS

Defensive medicine and a rise in healthcare costs

20. There was feedback received on whether the 2016 ECEG will lead to doctors not treating patients according to their best interests by practising defensive medicine.

21. “Defensive Medicine” can be defined as “*The practice of ordering medical tests, procedures, or consultations of doubtful clinical value in order to protect the prescribing physician from malpractice suits.*” No doubt medical ethics requires doctors to treat patients appropriately, but what this actually entails is based on clinical management guidelines. Just as ethical guidelines are not sacrosanct, doctors should use clinical guidelines in context and not blindly. It is illogical to equate abiding by ethical guidelines to practising defensive medicine and increasing healthcare costs. It should be to the contrary, since ethical handling of patients should lead to reduced complaints and litigation and thus lower insurance and indemnity costs.

Complementary and alternative medicine

(Guideline B9 on “Complementary and alternative medicine”)

22. There was feedback on why the 2016 ECEG could not accept and respect the qualifications and professional registration status of doctors trained in any modality of complementary and alternative medicine (CAM).

23. SMC is not obliged to allow doctors to practise any CAM they wish as it has a duty to ensure that patients’ best interests are protected under conventional medicine standards. Doctors are free to learn and practice CAM modalities that are approved by SMC. This is on the basis of sufficient evidence of safety and efficacy. Other CAM modalities that do not have sufficient evidence may not be practised or offered by SMC registered doctors. If doctors wish to practise non-SMC approved CAM modalities, they can cease their conventional practice, de-register from SMC and pursue careers as CAM practitioners under different regulatory frameworks that may exist.

Application of ECEG to doctors in policy-making, management or administrative positions

(Guideline B1, point 8 on “Decisions about providing services”)

24. With regard to why the 2016 ECEG apply to doctors in policy making, management or administrative positions, the SMC and the Working Committee note that the principle is that even though such doctors do not have direct patient care responsibilities, they have general ethical responsibilities towards their colleagues and their patients because of the impact their policies or decisions may have on patient management.

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Doctors treating themselves and those close to them (Guideline B1, point 5 on “Decisions about providing services”)

25. This was a difficult area to resolve as the principle remains that even with consent, patients who are close to doctors still have the right to care that is objective, professional and unaffected by emotional interference.

26. Yet this is clearly something our medical profession would like to retain. In order to sustain the ethical principles inherent in such treatment of patients close to doctors, yet allowing some leeway, the guideline says that doctors may provide care to themselves and those close to them when it is for routine continued care for stable conditions, minor conditions, or in an urgent/emergency situation when no other suitable doctor is available in a timely manner. If doctors choose to provide significant care such as major surgery to those close to them, they must ensure that their objectivity, judgment and professionalism in medical decision-making are not compromised to patients’ detriment due to the emotional proximity.

27. In other reference jurisdictions, the ethical code and guidelines totally prohibit doctors from treating themselves, their relatives or those close to them. While there are reservations about this practice, it is acknowledged that in our local cultural context, treatment of self and those close to doctors has become a norm. The SMC and Working Committee therefore seek in the 2016 ECEG to afford such patients adequate protection of their best interests.

Medical certificates and “light duties” for patients (Guideline B4 on “Medical certificates”)

28. It is difficult to escape the professional responsibility to ensure that the appropriate type of “light duty” is truly available before certifying patients fit for this. Leaving it to employers to decide is insufficient and risky to patients. The lightest duty available may exceed what patients ought to perform without aggravating their conditions. It is not right to expect employers to have the medical knowledge to calibrate what duties are given to their employees who are given “light duty” medical certificates. Employers, in general, are not even entitled to know patients’ diagnoses, unless patients share it or give consent for disclosure.

29. It is however accepted that a detailed conversation with the patients themselves about what “light duties” are available to them might also serve the purpose. There is no need to contact the employer to check, unless the information cannot be obtained through the patients themselves.

Gifts or hospitality from medical companies (Guideline H2 on “Gifts from patients” and Guideline I1 on “Relationships with the medical industry”)

30. There is some difficulty in evaluating various gifts or types of hospitality. The SMC and Working Committee decided to base the guideline on the “reasonable observer” principle, which means how an objective and reasonable person seeing the

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gifts or hospitality would regard them, and whether they would infer that you have become beholden to the companies by those gifts or hospitality.

31. For example, it is unlikely that an objective observer would view a note pad or a pen with the company name on it as causing conflict of interest, but the same observer might deem the gift of a car, or first class travel to a resort destination where the programme is mostly sports or entertainment, to be unacceptable.

Industry sponsorship of educational or research events (Guideline I1 on “Relationships with the medical industry”)

32. In relation to why industry sponsorship of educational or research events are still allowed, while there is the risk of undue influence of industry on doctors’ professional decisions, the SMC remains consistent in not passing judgments on this aspect of business relationships, in favour of specifying the ethical approach doctors are obliged to take in such engagements.

33. SMC’s position remains that doctors acknowledging such relationships and regulating the response to them is better than attempting a ban which would be unhelpful to medical education and research, and in any case a ban is likely to be unsuccessful and would drive the practices underground.

Managed care companies and third party administrators (Guideline B1, point 7 on “Decisions about providing services” and Guideline H3, points 5-7 on “Financial conflicts of interest”)

34. The role of SMC under the MRA is to regulate the doctors’ professional standards and behaviour and to protect the interests of patients. The regulation of managed care companies and third party administrators (TPAs) does not come under the ambit of SMC.

35. With reference to the guidelines enunciated in the 2016 ECEG, the approach and SMC’s stand on this matter are as follows:

- (a) Doctors who participate in managed care or TPA contracts must not allow any financial constraints or pressures inherent in such schemes to influence the objectivity of their clinical judgment in managing patients, such that the required standard of care is not provided. Should doctors be challenged as to whether they provided appropriate care, it is not a defence that the contracts they have entered into did not allow them to provide the necessary standard of care. Patients should not get differential treatments just because they are from companies which are involved in such contracts with doctors;
- (b) Paying of fees is in and of itself not necessarily disallowed, provided in general, the sums reflect the actual work of the managed care companies or TPAs in handling and processing patients and that such fees must not be based primarily on the services doctors provide or the fees they collect from patients. SMC would deem unethical the sharing or splitting of fees with a referring doctor, merely for the privilege of being referred a patient, with no commensurate work done justifying such fees. Both doctors would then have behaved unethically. If a doctor splits fees with a third party who is not

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a doctor and has done nothing commensurate with the payment, the doctor would be deemed to have behaved unethically;

- (c) Doctors must not pay fees that are so high as to constitute “fee splitting” or “fee sharing”, or which impact their ability to provide the required level of care. Therefore, doctors need to give due consideration to any contract before signing; and
- (d) If doctors pass such fees onto patients, doctors ought to be transparent about this with their patients and disclose this to them.

36. Therefore, SMC is of the view that patients’ best interests are compromised when:

- (a) Patients are sent to doctors inappropriate to their needs, due to the doctors agreeing to pay fees to managed care companies or TPAs;
- (b) Doctors under-treat patients due to financial pressures;
- (c) Doctors over-treat patients to make higher revenues to cover the fees they must pay; and
- (d) Doctors grossly over-charge patients in order to redeem high business costs due to such fees.

CONTACT US

37. If doctors have any queries or require any further clarifications, please email us at SMC@spb.gov.sg

38. Thank you.

SMC Working Committee for the review of ECEG
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