Singapore Medical Council

Annual Report 2017

About Us

The **SINGAPORE MEDICAL COUNCIL (SMC)**, a statutory board under the Ministry of Health, maintains the Register of Medical Practitioners in Singapore, administers the compulsory continuing medical education programme and also governs and regulates the professional conduct and ethics of registered medical practitioners.

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President's Foreword

I am pleased to present the Annual Report of the Singapore Medical Council (SMC) for 2017. The Council introduced changes to the Registration and Supervisory Framework, and continued with regular reviews of our processes in addition to overseeing registration, administration of continuing medical education and regulation of registered medical practitioners in Singapore. Patient safety continues to be the Council's utmost priority. I hope that this report provides a useful overview of the Council's work as it carries out its functions to fulfil its objective of protecting the health and safety of the public under the Medical Registration Act (MRA).

Medical and Specialist Registration

The total number of registered medical practitioners grew from 13,478 in 2016 to 13,944 in 2017. There were 764 medical practitioners who registered with SMC for the first time. There were also 339 specialists added to the specialist register. By the end of 2017, the total number of specialists grew to 5,338.

The number of foreign-trained Singapore Citizens and Permanent Residents who returned to Singapore to practise as medical practitioners increased from 197 in 2016 to 236 in 2017.

Practising Certificate Renewal and Continuing Medical Education

In 2017, 8,441 fully and conditionally registered medical practitioners renewed their practising certificates (PCs). The Council also processed a total of 48,280 accreditation applications and credit claims for Continuing Medical Education (CME) activities.

Physician's Pledge Affirmation Ceremony

A total of 701 medical practitioners affirmed the SMC Physician's Pledge at two ceremonies held on 25 February 2017 and 30 September 2017. Professor Thomas Coffman, Dean of Duke-NUS Medical School, was our Guest-of-Honour for the February Pledge while Mr Chee Hong Tat, Senior Minister of State for Health, was our Guest-of-Honour for the September Pledge. The doctors were reminded of their responsibilities to patients and the importance of upholding high professional and ethical standards.

Disciplinary Processes

The number of complaints against medical practitioners dropped from 182 in 2016 to 159 in 2017, a decrease of 12.6%. In 2017, the Disciplinary Tribunals and Health Committees concluded 12 inquiries, including 2 disciplinary proceedings which were discontinued.

Changes to SMC Registration and Supervisory Framework

As part of the regular reviews to maintain high standards of practice by medical practitioners and to ensure patient safety, the Council revised the application criteria for Full, Conditional and Temporary Registration, and the Supervisory Framework for conditionally and temporarily registered doctors. The changes have been implemented since December 2017.

In Appreciation

On behalf of the Council, I would like to thank all members and colleagues who had contributed to our various SMC Committees, as well as the Secretariat staff, for their hard work, dedication and unstinting support throughout the year. Together, we will continue to uphold patient safety and maintain public confidence in the medical profession.

Professor Tan Ser Kiat

President

Singapore Medical Council

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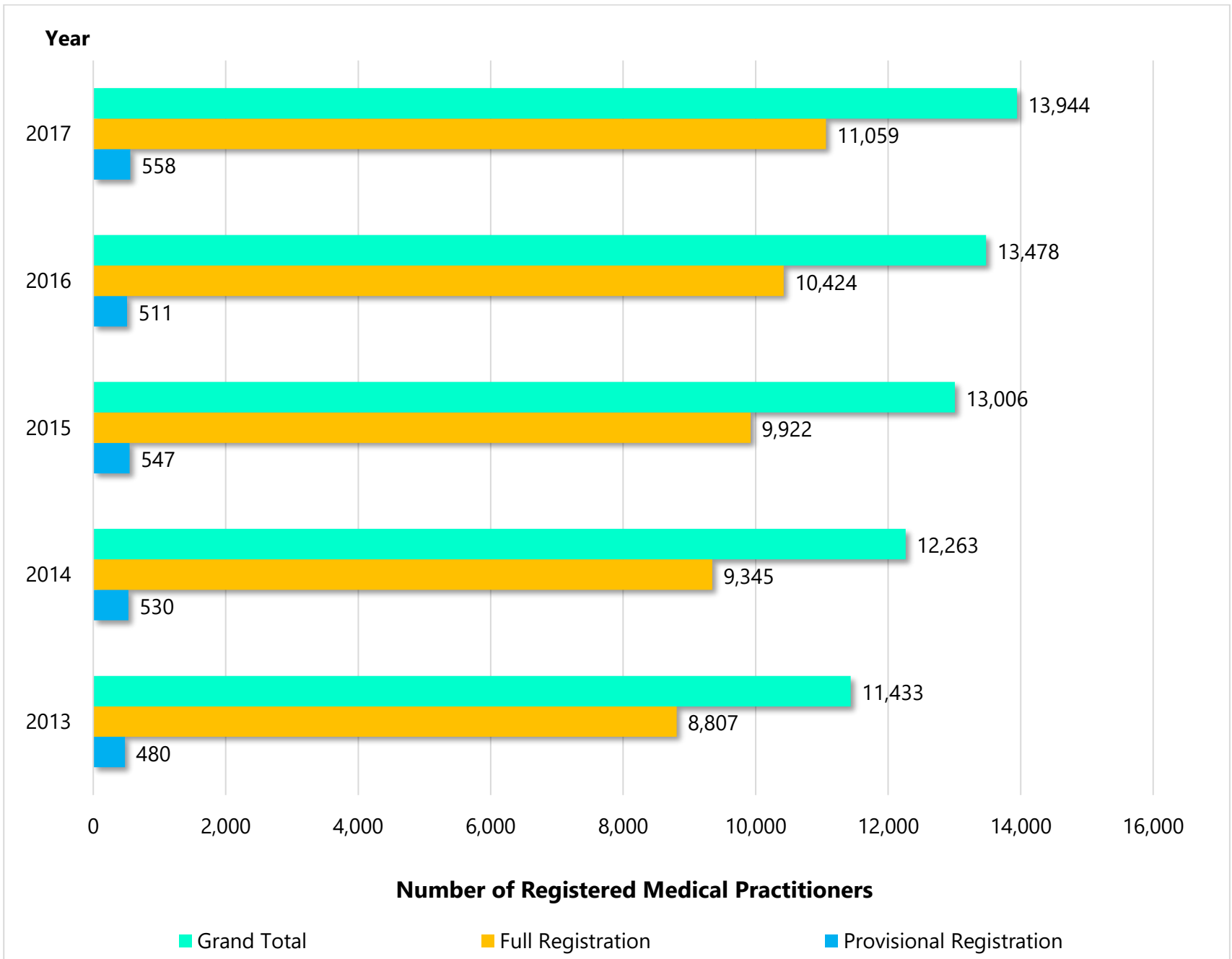
Medical Registration

Number of Registered Medical Practitioners in 2017

As at 31 December 2017, the number of medical practitioners who had full, conditional and temporary[1] registration in Singapore was 13,386. This provides a medical practitioner-to-population ratio of 1:419[2]. There were a total of 13,944[3] registered medical practitioners holding valid practising certificates in Singapore as at 31 December 2017 with the inclusion of 558 medical practitioners on provisional registration.

Figure 1 provides a snapshot of the total number of medical practitioners holding full and provisional registration, from 2013 to 2017.

Figure 1: Number of Medical Practitioners on Full and Provisional Registration, and Total Number of Registered Medical Practitioners (Years 2013 to 2017)



Note: Conditional & Temporary registration types are not charted in this figure.

[1] Refers to temporary registration (service) only.
[2] This is based on a total population size of 5,612,300 (correct as at September 2017) (source: Department of Statistics Singapore).
[3] This number includes all medical practitioners on full, conditional, provisional and temporary registration (service) with valid practising certificates.

Table 1 shows the total number of medical practitioners who were holding valid practising certificates as at 31 December 2017, by category of registration and employment sectors.

Table 1: Total Number of Medical Practitioners with Valid Practising Certificates as at 31 December 2017 – by Category of Registration and Employment Sector

Registration Type	Public Sector	Private Sector	Total
Full Registration	6,517	4,542	11,059
Conditional Registration	2,022	138	2,160
Provisional Registration	558	-	558
Temporary Registration*	154	13^	167
Total	**9,251**	**4,693**	**13,944**

* Refers to Temporary Registration (Service) only.
^ They work in healthcare institutions run by Voluntary Welfare Organisations (VWOs).

Table 1-1 shows the breakdown of the total number of medical practitioners by residential status and place of training[4] in the public and private sectors. Table 1-2 shows the breakdown of total number of medical practitioners by employment sector and specialist status. Table 1-3 shows the breakdown of total number of medical practitioners (non-specialists) by employment sector and family physician status.

Table 1-1: Number of Medical Practitioners by Residential Status (Singapore Citizens [SC], Permanent Residents [PR] & Non-Residents [NR]), Place of Training[4] (Local-Trained [LT] & Foreign-Trained [FT]) and Employment Sector

Registration Type	Public Sector						Public Sector Total	Private Sector						Private Sector Total	Total
	SC		PR		NR			SC		PR		NR			
	LT	FT	LT	FT	LT	FT		LT	FT	LT	FT	LT	FT		
Full Registration	4,147	817	247	902	76	328	6,517	3,045	804	175	416	8	94	4,542	**11,059**
Conditional Registration	9	500	2	491	-	1,020	2,022	-	16	-	44	-	78	138	**2,160**
Provisional Registration	334	186	13	2	14	9	558	-	-	-	-	-	-	-	**558**
Temporary Registration*	-	3	-	15	1	135	154	-	-	-	1	-	12	13^	**167**
Total	**4,490**	**1,506**	**262**	**1,410**	**91**	**1,492**	**9,251**	**3,045**	**820**	**175**	**461**	**8**	**184**	**4,693**	**13,944**

* Refers to Temporary Registration (Service) only.
^ They work in healthcare institutions run by VWOs.

[4] Based on primary medical qualification.

Table 1-2: Number of Medical Practitioners by Employment Sector and Specialist Status

Registration Type	Non-Specialist		Non-Specialist Total	Specialist		Specialist Total	Total
	Public	Private		Public	Private		
Full Registration	3,124	2,770	5,894	3,393	1,772	5,165[#]	**11,059**
Conditional Registration	1,855	132	1,987	167	6	173	**2,160**
Provisional Registration	558	-	558	-	-	-	**558**
Temporary Registration*	154	13^	167	-	-	-	**167**
Total	**5,691**	**2,915**	**8,606 (61.7%)**	**3,560**	**1,778**	**5,338 (38.3%)**	**13,944 (100%)**

* Refers to Temporary Registration (Service) only.
^ They work in healthcare institutions run by VWOs.
[#] 26 specialists were also registered family physicians. Amongst them, 8 were in the public sector and 18 were in the private sector.

Table 1-3: Number of Medical Practitioners (Non-Specialists) by Employment Sector and Family Physician Status

Registration Type	Non-Family Physician		Non-Family Physician Total	Family Physician		Family Physician Total	Total
	Public	Private		Public	Private		
Full Registration	2,725	1,377	4,102	399	1,393	1,792	**5,894**
Conditional Registration	1,847	129	1,976	8	3	11	**1,987**
Provisional Registration	558	-	558	-	-	-	**558**
Temporary Registration*	154	13^	167	-	-	-	**167**
Total	**5,284**	**1,519**	**6,803**	**407**	**1,396**	**1,803**	**8,606**

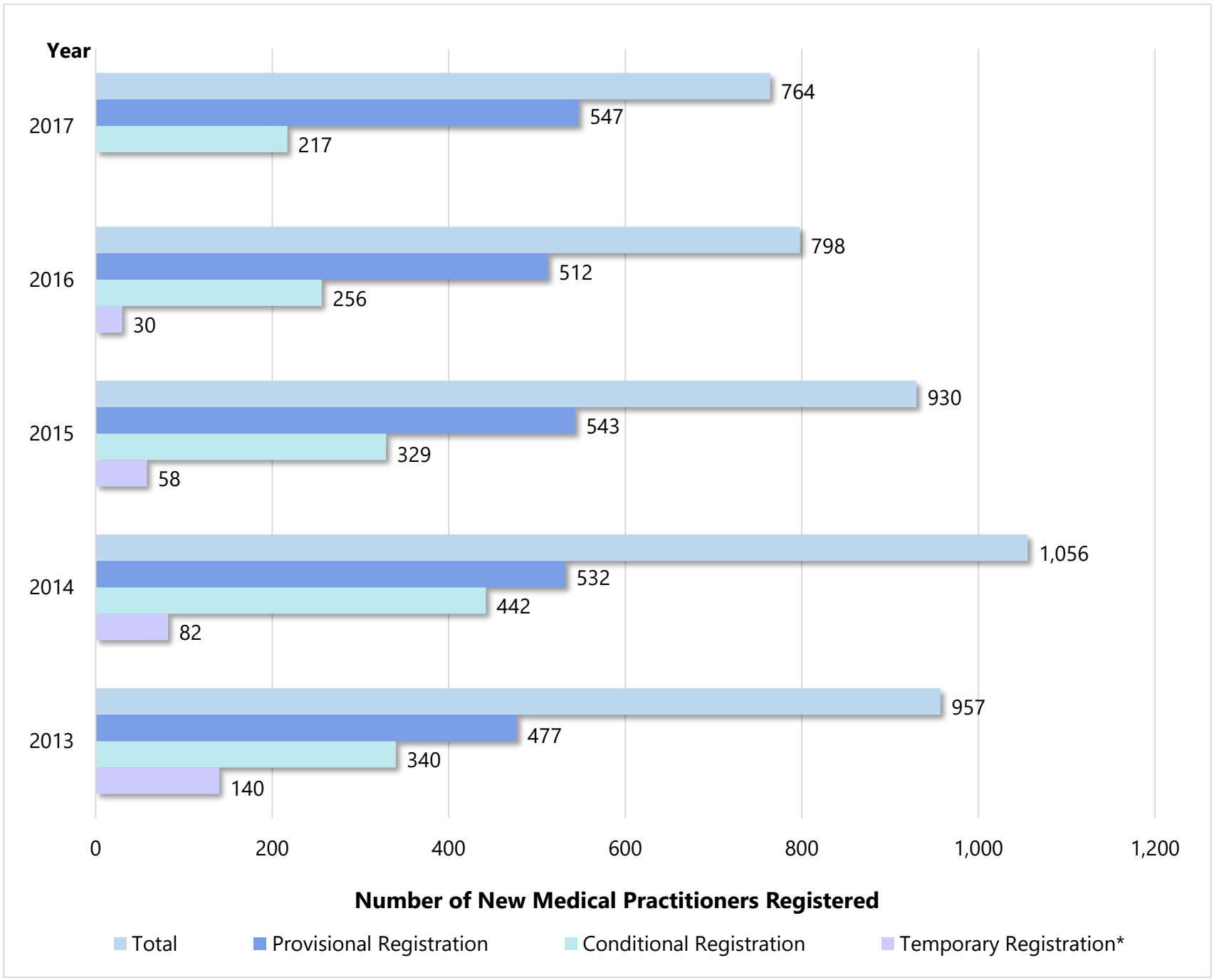
* Refers to Temporary Registration (Service) only.
^ They work in healthcare institutions run by VWOs.

New Medical Registrations in 2017

In 2017, the SMC processed 2,363 applications for registration. 1,036 of these applications were for new registrations and the remaining 1,327 applications were for other purposes, such as for change of employer and conversion to different categories of registration.

Figure 2 shows the number of new registrations by category of registration between 2013 and 2017.

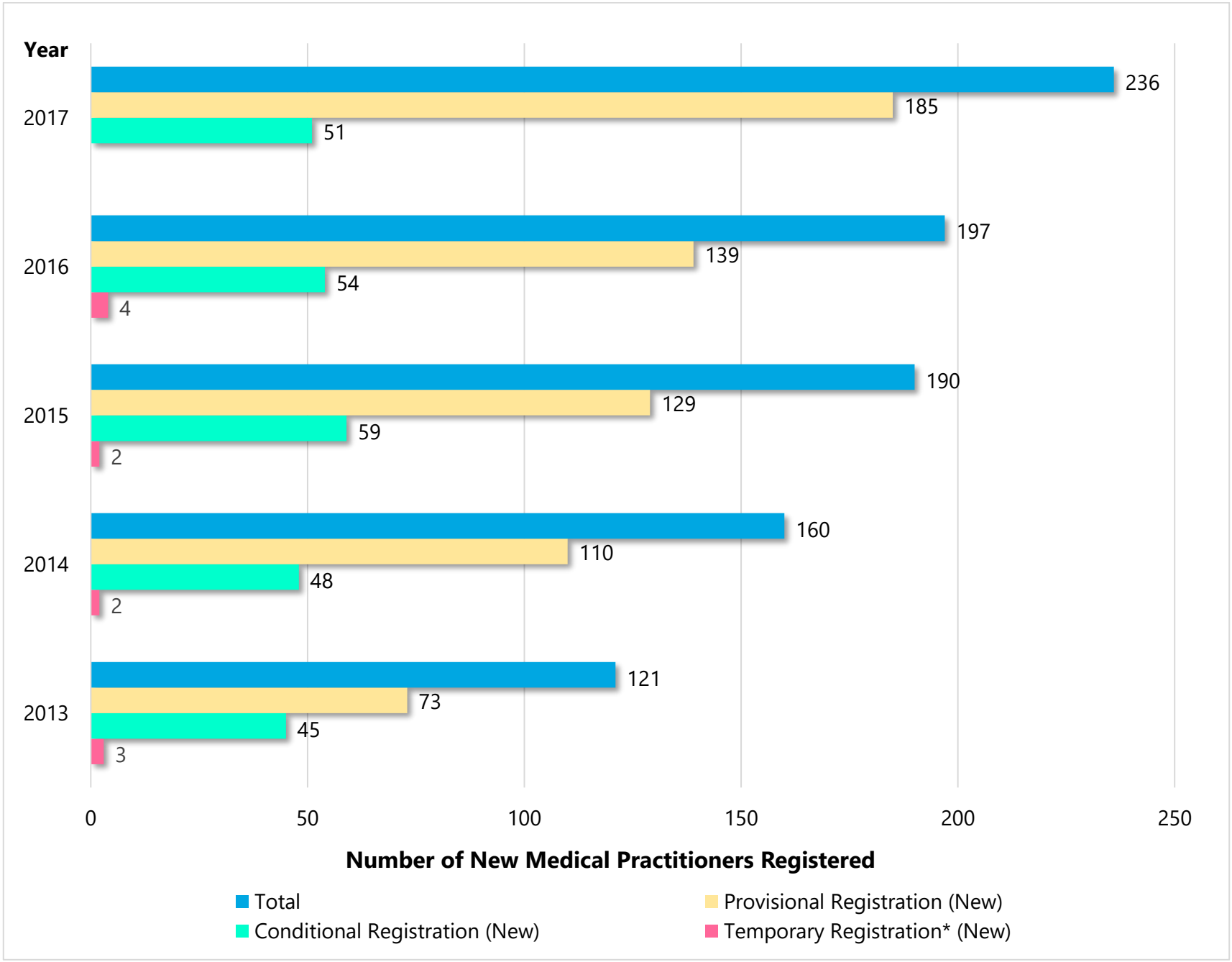
Figure 2: New Registrations by Category of Registration (Years 2013 to 2017)



*Refers to Temporary Registration (Service) only.

Figure 2-1 shows the trend of foreign-trained Singapore Citizens (SCs) and Permanent Residents (PRs) who have returned to Singapore to practise.

Figure 2-1: New Registrations by Category of Registration (Foreign-Trained SCs & PRs only) (Years 2013 to 2017)



*Refers to Temporary Registration (Service) only.

Provisional Registration

Of the 547 new medical practitioners granted provisional registration in 2017, 304 were medical graduates from the Yong Loo Lin School of Medicine, National University of Singapore; 52 were Duke-NUS Medical School graduates; and 191 were graduates from foreign universities who were granted medical registration to undergo housemanship training in the public hospitals for one year.

Conditional Registration

In 2017, 217 foreign-trained medical practitioners were registered directly into conditional registration and of these, 196 were non-specialists (90%) and 21 were specialists (10%). Out of the 217 medical practitioners, 41 were Singapore Citizens (19%).

Temporary Registration

Among the 184 new medical practitioners registered under temporary registration in 2017, 163 were foreign-trained medical practitioners accepted for postgraduate training/research in Singapore, and they comprised 146 Clinical Fellows, 15 Clinical Observers and two Clinical

Research Fellows. The remaining 21 were visiting experts who were invited by the hospitals and medical organisations to provide short-term training and consultancy.

Specialists Register

There were 5,338[5] specialists on the Register of Specialists as at 31 December 2017. They represented 38% of the 13,944 medical practitioners registered in Singapore. The number of new specialists registered during the year was 339. The number of specialists had increased by 5.8% from 2016. The breakdown of new specialist registrations by place of training[6] and employment sector in 2017 is shown in Table 2.

Table 2: New Specialist Registrations in 2017

Place of Training[6]	Public Sector			Public Sector Total	Private Sector			Private Sector Total	Total
	SC	PR	NR		SC	PR	NR		
Local Trained	237	58	11	306	3	3	-	6	**312**
Foreign Trained	3	2	21	26	-	-	1	1	**27**
Total	**240**	**60**	**32**	**332**	**3**	**3**	**1**	**7**	**339**

Out of the 5,338[7] specialists on the Register of Specialists, 476 had been registered in two or more specialties including sub-specialties. As at 31 December 2017, the number of specialists registered in the 10 sub-specialties were 449. Data on registrations in these sub-specialties can be found in Table 3.

In addition, Table 4 shows the total number of specialists in each specialty including medical practitioners who are specialists in more than one specialty or sub-specialty as at 31 December of each year, from 2013 to 2017. Previously, if a specialist has multiple specialties registered (e.g. respiratory medicine and intensive care medicine), only his first specialty (respiratory medicine) was included.

Over the past five years, the specialties with the largest increase in numbers were Internal Medicine, Anaesthesiology and Diagnostic Radiology. In terms of percentage, Internal Medicine, Renal Medicine and Hand Surgery saw the biggest percentage growth in the number of specialists registered. For Internal Medicine this increased number was in large part due to the Specialists Accreditation Board (SAB) allowing dual accreditation for existing registered specialists with recognised qualifications, training and current practice in Internal Medicine along with their existing specialty.

[5] This number includes all medical practitioners on full and conditional registration.
[6] Based on specialty training.
[7] This number includes all medical practitioners on full and conditional registration.

Table 3: Number of Specialists by Specialties as at 31 December 2017

Registered Specialty [35]	Public Sector		Private Sector		Total
	Number	%	Number	%	
Anaesthesiology	320	66.4%	162	33.6%	482
Cardiology	145	63.9%	82 (1)	36.1%	227 (1)
Cardiothoracic Surgery	36	69.2%	16	30.8%	52
Dermatology	73	55.7%	58	44.3%	131
Diagnostic Radiology	264 (1)	74.2%	92	25.8%	356 (1)
Emergency Medicine	162	93.6%	11	6.4%	173
Endocrinology	94 (3)	76.4%	29 (1)	23.6%	123 (4)
Gastroenterology	91	65%	49 (2)	35%	140 (2)
General Surgery	224	61.2%	142	38.8%	366
Geriatric Medicine	86 (5)	89.6%	10	10.4%	96 (5)
Haematology	58	80.6%	14 (1)	19.4%	72 (1)
Hand Surgery	31	73.8%	11 (1)	26.2%	42 (1)
Infectious Diseases	64 (3)	86.5%	10	13.5%	74 (3)
Internal Medicine	117 (73)	76.0%	37 (10)	24.0%	154 (83)
Medical Oncology	79	65.3%	42 (1)	34.7%	121 (1)
Neurology	78	79.6%	20	20.4%	98
Neurosurgery	30	65.2%	16	34.8%	46
Nuclear Medicine	18 (2)	64.3%	10	35.7%	28 (2)
Obstetrics & Gynaecology	98	30.1%	228	69.9%	326
Occupational Medicine	22	53.7%	19	46.3%	41
Ophthalmology	169	64.5%	93	35.5%	262
Orthopaedic Surgery	138 (1)	58.7%	97	41.3%	235 (1)
Otorhinolaryngology	73	54.5%	61	45.5%	134
Paediatric Medicine	221	57.4%	164	42.6%	385
Paediatric Surgery	19	76.0%	6	24.0%	25
Pathology	145	82.4%	31	17.6%	176
Plastic Surgery	36	52.2%	33	47.8%	69
Psychiatry	177	73.8%	63	26.3%	240
Public Health	75 (1)	63.0%	44	37.0%	119 (1)
Radiation Oncology	47	81.0%	11	19.0%	58
Rehabilitation Medicine	35 (1)	87.5%	5	12.5%	40 (1)
Renal Medicine	87	81.3%	20	18.7%	107
Respiratory Medicine	101 (1)	77.7%	29 (1)	22.3%	130 (2)
Rheumatology	48 (4)	82.8%	10 (1)	17.2%	58 (5)
Urology	57	60.6%	37	39.4%	94
Sub Total	**3,518 (94)†**	**66.6%**	**1,762 (19)**	**33.4%**	**5,280 (113)†**
Registered Sub-Specialty [10]					
Aviation Medicine	4 (12)	57.1%	3 (9)	42.9%	7 (21)
Intensive Care Medicine	4 (137)	100.0%	(80)	0.0%	4 (217)
Neonatology	2 (35)	100.0%	(26)	0.0%	2 (61)
Paediatric Cardiology	(4)	0.0%	(7)	0.0%	(11)
Paediatric Gastroenterology	(8)	0.0%	(2)	0.0%	(10)
Paediatric Haematology & Oncology	(12)	0.0%	(2)	0.0%	(14)
Paediatric Intensive Care	(10)	0.0%	(3)	0.0%	(13)
Paediatric Nephrology	(9)	0.0%	(1)	0.0%	(10)
Palliative Medicine	21 (24)	75.0%	7 (5)	25.0%	28 (29)
Sports Medicine	11 (3)	64.7%	6 (7)	35.3%	17 (10)
Sub Total	**42 (252)ϕ**	**72.4%**	**16 (139)ϕ**	**27.6%**	**58 (391)**
Total	**3,560 (321)^**	**66.7%**	**1,778 (155)^**	**33.3%**	**5,338 (476)^**

Note: This table includes all medical practitioners on full and conditional registration.

† One specialist has three registered specialties.

ϕ Five specialists have one registered specialty and two registered sub-specialties.

^ 28 specialists have two registered specialties and one registered sub-specialty.

( ): Figures in parenthesis refer to the number of medical practitioners who had registered that specialty/sub-specialty as their second specialty. For example, there were 18 specialists in the public sector with Nuclear Medicine as their first specialty and another two specialists in the public sector with Nuclear Medicine as their second specialty.

Table 4: Total Number of Specialists in each Specialty including Medical Practitioners who are Specialists in more than one Specialty or Sub-Specialty as at 31 December of each year, from 2013 to 2017

						Comparison between 2013 and 2017	
Registered Specialty [35]	**2013**	**2014**	**2015**	**2016**	**2017**	**Increase**	**%**
Internal Medicine	102	178	204	221	237	135	132.4%
Renal Medicine	71	81	89	100	107	36	50.7%
Hand Surgery	29	29	32	40	43	14	48.3%
Emergency Medicine	118	127	142	156	173	55	46.6%
Infectious Diseases	53	64	67	71	77	24	45.3%
Nuclear Medicine	21	23	27	28	30	9	42.9%
Diagnostic Radiology	258	286	320	340	357	99	38.4%
Haematology	53	60	63	65	73	20	37.7%
General Surgery	268	292	316	333	366	98	36.6%
Respiratory Medicine	97	107	114	125	132	35	36.1%
Gastroenterology	105	114	122	135	142	37	35.2%
Endocrinology	94	108	112	122	127	33	35.1%
Geriatric Medicine	75	81	86	93	101	26	34.7%
Rehabilitation Medicine	31	37	40	40	41	10	32.3%
Radiation Oncology	44	51	52	53	58	14	31.8%
Paediatric Surgery	19	20	22	24	25	6	31.6%
Otorhinolaryngology	102	106	115	125	134	32	31.4%
Dermatology	100	109	119	122	131	31	31.0%
Anaesthesiology	375	412	432	464	482	107	28.5%
Pathology	137	146	163	172	176	39	28.5%
Ophthalmology	204	213	226	247	262	58	28.4%
Medical Oncology	95	99	106	115	122	27	28.4%
Psychiatry	187	207	217	228	240	53	28.3%
Orthopaedic Surgery	184	201	215	218	236	52	28.3%
Neurology	77	86	89	92	98	21	27.3%
Plastic Surgery	55	58	65	67	69	14	25.5%
Cardiology	182	202	213	215	228	46	25.3%
Urology	76	81	84	87	94	18	23.7%
Rheumatology	51	55	59	58	63	12	23.5%
Cardiothoracic Surgery	43	46	49	51	52	9	20.9%
Paediatric Medicine	322	347	356	368	385	63	19.6%
Neurosurgery	39	41	44	45	46	7	17.9%
Public Health	104	107	116	119	120	16	15.4%
Occupational Medicine	37	39	40	40	41	4	10.8%
Obstetrics & Gynaecology	304	311	316	317	326	22	7.2%
Registered Sub-Specialty [10]							
Palliative Medicine	41	47	54	57	57	16	39.0%
Intensive Care Medicine	169	183	199	206	221	52	30.8%
Sports Medicine	23	25	26	27	27	4	17.4%
Neonatology	54	59	61	63	63	9	16.7%
Aviation Medicine	-	28	28	28	28	-	-
Paediatric Cardiology	-	-	-	-	11	-	-
Paediatric Gastroenterology	-	-	-	-	10	-	-
Paediatric Haematology & Oncology	-	-	-	-	14	-	-
Paediatric Intensive Care	-	-	-	-	13	-	-
Paediatric Nephrology	-	-	-	-	10	-	-

Table 5 shows the breakdown of specialists by residential status in public and private sectors. It is observed that about 67% of all specialists were practising in the public sector while 33% of them were in private practice.

Table 5: Number of Specialists by Residential Status and Employment Sector

Registration Type	Public Sector			Public Sector Total	Private Sector			Private Sector Total	Total
	SC	PR	NR		SC	PR	NR		
Full Registration	2,382	768	243	3,393	1,456	273	43	1,772	**5,165**
Conditional Registration	12	49	106	167	-	3	3	6	**173**
Total	**2,394**	**817**	**349**	**3,560**	**1,456**	**276**	**46**	**1,778**	**5,338**

Family Physicians Register

Registered medical practitioners were considered for entry into the Family Physicians Register through the degree/diploma route. Table 6A shows the breakdown of registered family physicians by the routes of entry and categorised by employment sector.

Table 6A: Registered Family Physicians by Route of Entry and Employment Sector as at 31 December 2017

Routes of Entry	Public Sector	Private Sector	Total
Degree / Diploma Route	371	689	**1,060**
Practice Route^	44	725	**769**
Total	**415**	**1,414**	**1,829**

^Entry into the Register of Family Physicians through the practice route was closed with effect from 31 December 2013.

Table 6B shows the breakdown of registered family physicians by employment sector as at 31 December of each year, from 2013 to 2017.

Table 6B: Registered Family Physicians by Employment Sector by Year as at 31 December of each year, from 2013 to 2017

						Comparison between 2013 and 2017	
Employment Sector	**2013**	**2014**	**2015**	**2016**	**2017**	**Increase**	**%**
Public Sector	297	298	336	377	415	118	39.7%
Private Sector	1,109	1,281	1,323	1,350	1,414	305	27.5%

Continuing Medical Education

Number of Processed Applications and Credit Claims for 2017

In 2017, the SMC processed a total of 48,280 accreditation applications and credit claims from Categories 1A, 1B, 2, 3A and 3B. Table 7 shows the breakdown of Continuing Medical Education activities by categories.

Table 7: Total Number of Processed Applications and Credit Claims by Categories

Category	Approved	Reject / Withdrawn	Total
1A	1,506	34	**1,540**
1B	3,297	163	**3,460**
1C	2,356	501	**2,857**
2	906	251	**1,157**
3A	13,112	1013	**14,125**
3B	24,421	720	**25,141**
Total	**45,598**	**2,682**	**48,280**

Cat 1A: Pre-approved established programmes such as grand ward rounds and teaching / tutorial sessions.
Cat 1B: Locally held events such as scientific meetings, conferences, seminars and workshops.
Cat 1C: Overseas events such as scientific meetings, conferences, seminars and workshops.
Cat 2: Publication / editorial work / presentation of original paper or poster.
Cat 3A: Self-study from refereed journals, audio-visual media and online education programmes.
Cat 3B: Distance learning through interactive structured CME programme with verifiable self-assessment.

Renewal of Practising Certificate

In 2017, 8,441 (98.5%) of the 8,568 fully and conditionally registered medical practitioners renewed their practising certificates (PCs). There were 127 (1.5%) medical practitioners who did not renew their PCs due to various reasons. The breakdown of the reasons for non-renewal by the type of medical registration is summarised in the table below.

Table 8: Reasons for Non-Renewal of Practising Certificates by Category of Registration

Reasons for Non-Renewal of Practising Certificate	Total	%
Retired and not renewing PC	22	**17%**
Residing / working overseas	58	**46%**
Did not meet the requirements to renew PC	10	**8%**
No response from doctor	3	**2%**
Others (e.g. stopped practising medicine, health issues)	34	**27%**
Total	**127**	**100%**

Changes in the Criteria for Full, Conditional and Temporary Registration

The SMC regularly reviews the criteria for Full Registration (F-Reg), Conditional Registration (C-Reg) and Temporary Registration (T-Reg) to protect the health and safety of the public by ensuring that (a) registered medical practitioners are competent and fit to practise medicine; (b) uphold standards of practice within the medical profession; and (c) maintain public confidence in the medical profession[8]. The SMC reviewed the registration criteria for F-Reg, C-Reg and T-Reg; and key changes from the review have been implemented since December 2017.

FULL REGISTRATION

New conditionally registered doctors who obtain C-Reg by virtue of a postgraduate qualification registrable with the SMC may be considered for F-Reg if their performance is consistently satisfactory, and they are accredited as a Specialist in a core specialty by the Specialists Accreditation Board (SAB) or a Family Physician by the Family Physicians Accreditation Board (FPAB). To qualify for F-Reg, the doctor must fulfil supervised practice as a Specialist or a Family Physician with consistently satisfactory performance as stipulated.

CONDITIONAL REGISTRATION

C-Reg allows an international medical graduate to work in an SMC-approved healthcare institution, under the supervision of a fully registered medical practitioner. The list of registrable postgraduate qualifications was reviewed, and the revised list was also renamed as the "List of Medical Qualifications Eligible for Consideration for Conditional Registration".

From January 2018, C-Reg doctors were not allowed to provide aesthetic service. C-Reg doctors providing general health screening service should not have this service exceed 20% of their clinical caseload.

TEMPORARY REGISTRATION

The Staff Registrar Scheme (SRS) diplomas will no longer be recognised for conditional registration. Existing temporarily registered doctors who have enrolled and commenced in one of the 28 SMC-approved diploma programmes by 30 June 2018, and completed the programme and conferred the SRS diploma at the latest by 30 June 2021, may however be considered for C-Reg under the old rules if their overall professional competence and clinical performance are considered satisfactory by the Council.

Please refer to SMC's website at www.smc.gov.sg for full details of the changes.

[8] MRA S2A - Object of Act
2A. The object of this Act is to protect the health and safety of the public by providing for mechanisms to — (a) ensure that registered medical practitioners are competent and fit to practise medicine; (b) uphold standards of practice within the medical profession; and (c) maintain public confidence in the medical profession.

Supervisory Framework for Conditionally and Temporarily Registered Doctors

To ensure that patient safety is safeguarded, the SMC has a Supervisory Framework to monitor the performance of foreign-trained doctors working in Singapore who are on Conditional or Temporary registration. This Framework ensures direct supervision of all foreign-trained doctors by senior doctors during the period of supervised practice in Singapore.

To be an SMC-approved supervisor, one must be a fully registered doctor in Singapore who is of an appropriate seniority and in full-time practice in the same department or place of practice as the supervisee. The supervisor to supervisee ratio is defined by the intensity of supervision as summarised in the table below:

Supervision Level	**Intensity**	**Supervisor-supervisee ratio**
Level 1 (L1)	50% of the cases audited for the first 3 months. If performance is satisfactory, 10% of cases audited after the 3rd month. Three to six monthly assessment.	1:2
Level 2 (L2)	10% of the cases seen by the supervisee must be audited. Six monthly assessment.	1:6
Level 3 (L3)	Ready to work independently. Annual assessment.	Excluded*

* There is no limit to the number of L3 supervisees that a supervisor can supervise.

It is important that Level 1 supervision be done properly to enable the doctor to get off to a good start on his supervised practice, and to progress to Level 2 and subsequently to Level 3 supervision if the performance is consistently satisfactory.

Assessments of the doctor by the SMC-approved supervisor is called the Assessment Report or AR, whereas feedback from peers or colleagues of the doctor (i.e. other raters) in the same practice place are referred to as the Multi-Rater report or MR. These AR and MR reports on the doctor are confidential. Hospital incident reports, hospital inquiries, disciplinary reports as well complaints or feedback from patients are also part of the assessment and should be submitted in the ARs to give an all-round assessment of the performance and professionalism of the doctor. Submission of ARs are required at regular intervals and additional MR reports may be requested if necessary.

The assessment criteria in the ARs include ethical behaviour in the clinical setting, history taking, physical examination, procedural skills, overall patient care, medical knowledge, inter-personal and communication skills, professionalism and overall clinical competence. The MR report has a scale of ratings and comments on the doctor's communication with

patients and peers, written communication, his/her qualities of collaboration and teamwork, professionalism and commitment, management and leadership, acceptance of responsibility, ability to work under stress as well as his/her consultation and his/her technical expertise.

Unsatisfactory performance can be reported from various channels of feedback structured into the reports. Doctors whose medical competence are not up to par, or whose interactions and communication with patients and fellow medical practitioners and other healthcare professionals are consistently poor, or who exhibit poor professional work behaviour may receive Letters of Advice from SMC. If his/her performance does not improve significantly from SMC's view, this may be followed by a Notification of Review and Notification of Removal from the register.

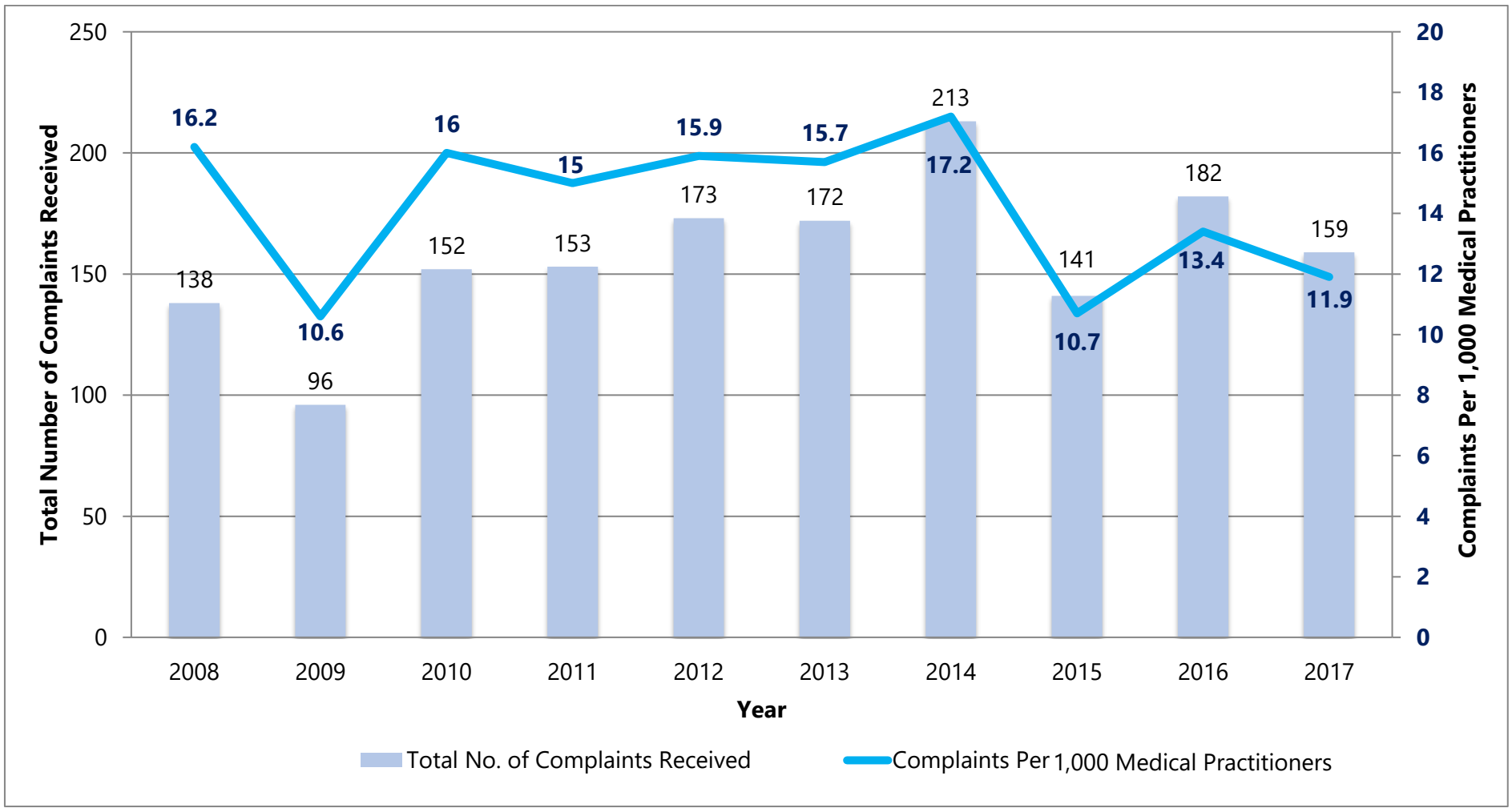
On 15 June 2017, SMC provided a summary of the Responsibilities of a Supervisor under the SMC's Supervisory Framework to remind the SMC-approved supervisors on their roles and responsibilities. The supervisee must work under the direct on-site supervision of an SMC-approved supervisor and there must be sufficient contact time between the supervisor and supervisee as it would be inappropriate to rely solely on feedback from other doctors or staff.

On 18 December 2017, SMC reviewed its criteria for supervision and categorised the eligibility criteria of supervisors by Hospitals and Specialty Centres, General Practices (Polyclinics, GP clinics) and Step-down Care (VWOs, Community Hospitals, Hospices). Generally, the supervisor should be of equivalent or of a higher designation than the supervisee. Where the supervisee is a specialist, the supervisor must be of higher seniority. SMC may also consider other criteria when assessing the suitability of the supervisor.

Complaints Lodged with the Medical Council

In 2017, the Medical Council received 159 complaints against 204 medical practitioners.

Figure 3: Complaints Received by Singapore Medical Council 2008-2017



In total, the Complaints Committees completed inquiries into 125 complaints in 2017 – 68 complaints were dismissed, 12 medical practitioners were issued letters of warning, 23 medical practitioners were issued letters of advice, and 14 medical practitioners were referred to a Disciplinary Tribunal (DT) for a formal inquiry (excluding three directly referred to DTs following their convictions in Court). Two complaints were successfully mediated and six complaints were withdrawn.

More details of the complaints received by the Medical Council are set out in Table 9.

Table 9: Categories for complaints processed in 2017

Category of Allegation[9]	Complaints carried over from 2012	Complaints carried over from 2013	Complaints carried over from 2014	Complaints carried over from 2015	Complaints carried over from 2016	Complaints received in 2017	OUTCOME BY CC							Directly Referred to a DT	Directly Referred to a HC
							No Formal Inquiry					Referred to a DT	Adjourned to 2018		
							Withdrawn	Dismissed	Mediation	Letter of Advice	Letter of Warning				
a) Breach of Advertising Guidelines*	-	-	-	-	-	3	-	-	-	-	-	-	3	-	-
b) Breach of Guidelines on Aesthetic Practice*	-	-	-	-	-	2	-	-	-	-	-	-	2	-	-
c) Breach of Medical Confidentiality*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
d) Delay in Treatment	-	-	-	-	-	1	-	1	-	-	-	-	-	-	-
e) Excessive / Inappropriate Prescription of Drugs	1	-	-	-	-	4	-	-	-	-	-	1	4	-	-
f) False / Inappropriate Certification	1	-	-	-	-	6	-	-	1	-	-	1	5	-	-
g) Misdiagnosis	-	-	1	-	4	14	1	1	1	2	-	-	14	-	-
h) No / Inappropriate / Inadequate Informed Consent	-	-	1	-	-	5	-	1	-	-	-	-	5	-	-
i) Non-evidence based Practices / Practices Not Generally Accepted by the Profession*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
j) Outrage of Modesty / Sexual Relationship with Patient / Other Sexual Offences	-	-	-	-	1	4	-	-	-	-	1	-	4	-	-
k) Overcharging / Improper Charging	-	-	-	-	-	8	-	-	-	-	-	-	8	-	-
l) Professional Negligence / Incompetence	-	2	4	18	154	54	5	42	-	14	4	4	163	-	-
m) Providing False or Misleading Information / False Declaration	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-

* New complaint categories which were added this year to enable better analysis of the complaints.

Table 9: Categories for complaints processed in 2017 (continued)

Category of Allegation[9]	Complaints carried over from 2012	Complaints carried over from 2013	Complaints carried over from 2014	Complaints carried over from 2015	Complaints carried over from 2016	Complaints received in 2017	OUTCOME BY CC								
							No Formal Inquiry					Referred to a DT	Adjourned to 2018	Directly Referred to a DT	Directly Referred to a HC
							Withdrawn	Dismissed	Mediation	Letter of Advice	Letter of Warning				
n) Refusal to Provide Emergency Attention While on Duty	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
o) Rudeness / Attitude / Communication Issues	-	1	-	2	5	29	-	6	-	2	-	-	29	-	-
p) Unnecessary / Inappropriate Treatment	-	-	5	4	8	19		4	1	1	2	3	26	-	-
q) Use of Non-SMC Approved Display of Titles or Designations*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
r) Other Breaches of SMC ECEG	-	1	1	25	5	-	-	11	-	4	5	4	8	-	-
s) Other Complaints	1	-	1	-	-	6	-	1	-	-	-	1	6	-	-
t) Conviction in Court	-	-	-	-	-	4	-	-	-	-	-	-	1	3	-
Total (406 cases)	3	4	13	49	178	159	6	68	2	23	12	14	278	3	-
Percentage (%)	-	-	-	-	-	-	1.5	16.7	0.5	5.7	3.0	3.4	68.5	0.7	-

* New complaint categories which were added this year to enable better analysis of the complaints.

[9] Complaints may involve allegations of more than one category. For the purpose of SMC's annual report, the complaints are categorised by the main allegation.

Formal Inquiries

A total of 12 disciplinary inquiries[10] were concluded by the Disciplinary Tribunals (DTs) and Health Committees (HCs) in 2017. Five appeals against the decisions of the DTs (which were heard by the Court of Three Judges [C3J] and concluded in 2017), are included in this section.

Table 10 summarises the 12 inquiries and the appeals as mentioned above.

Table 10: DT, HC inquiries and C3J appeals concluded in 2017

Nature of Complaints	Appeals concluded by C3J in 2017	Inquiries concluded by DT and HC in 2017	Outcome of Inquiries						Appealed to C3J and Outcome Pending
			Disciplinary Proceedings Discontinued	Restricted Practice / Conditional Registration	Censure and Fine	Censure and Suspension	Censure, Fine and Suspension	Removed from Register	
A) Professional Negligence / Incompetence	5	5	1	-	2	-	-	-	2
B) Excessive / Inappropriate Prescription of Drugs	-	2	-	-	-	-	2	-	-
C) Fitness to Practice	-	2	-	1	-	-	-	1	-
D) Misdiagnosis	-	1	-	-	-	1	-	-	-
E) Over / Unnecessary / Inappropriate Treatment	-	1	1	-	-	-	-	-	-
F) Other Complaints	-	1	-	-	-	1	-	-	-
Total	**5**	**12**	**2**	**1**	**2**	**2**	**2**	**1**	**2**
Percentage (%)	**-**	**100**	**16.7**	**8.3**	**16.7**	**16.7**	**16.7**	**8.3**	**16.7**

[10] Out of the 12 cases concluded, two inquiries were discontinued, and two were pending appeal before the Court of Three Judges (C3J) in 2017. One case was discontinued following the HC's findings that the doctor's fitness to practise was impaired by reason of his medical condition, and the HC's recommendation to have his name removed from the Register and of Medical Practitioners was accepted by the SMC; another case was discontinued following written representations from the doctor.

Summaries of the completed disciplinary inquiries and appeals concluded in 2017 are provided below. The detailed Grounds of Decision[11] for these disciplinary inquiries can be found on the SMC's website.

(A) Professional Negligence / Incompetence

Case 1 | Dr FML

Dr FML pleaded guilty to one charge for failing to provide medical services of the quality that was reasonable to expect of him under section 53(1)(*e*) of the MRA in that he failed to (a) ensure that the information regarding the patient's abnormal Carcino-Embryonic Antigen (**CEA**) test result was accurately communicated to the patient; (b) arrange for a review with the patient to discuss and provide appropriate medical counselling in respect of his abnormal CEA test result; and (c) arrange appropriate and timely investigations for the patient in respect of his abnormal CEA test result.

The DT ordered that Dr FML pay a penalty of $10,000, be censured and give a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct. He was also ordered to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

Case 2 | Dr SKS

Dr SKS pleaded guilty to one charge for failing to refer the patient to a specialist for management of the patient's medical condition in a timely manner. Another charge for failing to exercise due care in the management of the patient by failing to carry out an adequate history-taking was taken into consideration for the purposes of sentencing.

The DT ordered that Dr SKS pay a penalty of $30,000, be censured, give a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct. He was also ordered to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

(B) Excessive / Inappropriate Prescription of Drugs

Case 3 | Dr CYMV

Dr CYMV pleaded guilty to three charges of professional misconduct under section 53(1)(*d*) of the MRA for inappropriate prescriptions of benzodiazepines to the patient; failure to maintain sufficient details in the patient's medical records; and failure to refer the patient to a psychiatrist and/or appropriate specialist for management of the patient's medical issues in a timely manner.

[11] The Grounds of Decision of a DT wherein the DT's decision was set aside by the C3J was not published.

The DT ordered that Dr CYMV be suspended for four (4) months, pay a penalty of $12,000, be censured and give a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct. He was also ordered to pay the costs and expenses of and incidental to the proceedings, including the costs of the solicitors to the SMC.

Case 4 | Dr SHC

Dr SHC pleaded guilty to three charges of professional misconduct under section 53(1)(*d*) of the MRA for failing to (a) provide adequate clinical assessment and evaluation of the patient in breach of Guideline 4.1.1.1 of the 2002 edition of the SMC Ethical Code and Ethical Guidelines (**2002 ECEG**); (b) prescribe medications on clear medical grounds and in reasonable quantities in breach of Guideline 4.1.3 of the 2002 ECEG; and (c) maintain clear and accurate medical records of the patient in breach of Guideline 4.1.2 of the 2002 ECEG. The DT was of the view that Dr SHC being a consultant psychiatrist ought to be held to a higher standard as compared to the other doctors who practised as general practitioners, and noted Dr SHC's seniority and standing as a registered specialist in psychiatry and as a senior doctor in medical practice since 1979. The DT also took the view that Dr SHC's misconduct warranted a stiffer sentence to deter like-minded doctors from blatantly disregarding their patients' interest and well-being.

The DT ordered that Dr SHC be suspended for six (6) months, pay a penalty of $15,000, be censured and give a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct. He was also ordered to pay the costs and expenses of and incidental to the proceedings, including the costs of the solicitors to the SMC.

(C) Fitness to Practise

Case 5 | Dr A

This HC inquiry arose out of correspondences from a psychiatrist who referred to the SMC information touching on the physical and/or mental fitness of Dr A to practise as a medical practitioner. The matter was referred to the HC for consideration on whether Dr A's fitness to practise was impaired by reason of his medical condition. Having considered the matter, the HC concluded that the fitness of Dr A to practise as a registered medical practitioner was impaired by reason of his mental condition. Having regard to all the circumstances, the HC was of the view that Dr A should be allowed to return to clinical practice with patient contact under close supervision.

The HC ordered that Dr A's name be removed from Part I of the Register and that he be registered as a medical practitioner with conditional registration in Part II of the Register of Medical Practitioners for a period of 36 months.

Case 6 | Dr B

This inquiry arose out of information obtained by a DT inquiring into the conduct of Dr B which referred the matter to the HC for consideration on whether Dr B's fitness to practise was impaired by reason of his physical and/or mental condition. Having considered the matter, the HC concluded that Dr B's fitness to practise was so impaired by reason of his mental condition (i.e. Dementia) and recommended for his name to be removed from the Register of Medical Practitioners. The SMC after considering the HC's recommendation, removed Dr B's name from the Register of Medical Practitioners. The HC did not make any order as to costs.

(D) Misdiagnosis

Case 7 | Dr SS

Dr SS claimed trial to two charges of serious negligence amounting to professional misconduct under section 53(1)(*d*) of the MRA for failing to (a) provide adequate clinical evaluation under Guideline 4.1.1.1 of the 2002 ECEG when he failed to conduct an optical coherence tomography and/or further examination before diagnosing the patient with a mild cataract and posterior vitreous detachment in his right eye; and (b) provide the patient with competent and appropriate care under Guideline 4.1.1.5 of the 2002 ECEG when he arranged for the patient to return six weeks later for his next clinical review and allowed the patient to continue driving instead of putting him on medical leave during these six weeks.

The DT convicted Dr SS of both charges and ordered that he be suspended for three (3) months, be censured and give a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct. He was also ordered to pay the costs and expenses of and incidental to the proceedings, including the costs of the solicitors to the SMC.

(E) Other Complaints

Case 8 | Dr CHKC

Dr CHKC pleaded guilty to four charges of professional misconduct under section 53(1)(*d*) of the MRA for failure to (a) obtain informed consent in that he did not adequately inform the patient that there were no acceptable published clinical studies or data on the safety of Aqualift Dermal Filler (**ADF**) procedure and/or the Aqualift Hydrophilic gel (**AHG**) before performing the ADF procedure by injecting AHG into the patient's breasts; (b) treat the patient according to generally accepted methods as the filler was not a generally accepted material for breast augmentation and procedure was not performed in the context of a formal and approved clinical trial; (c) keep sufficient medical records of the ADF procedures performed on the patient; and (d) exercise due care in the management of the patient's right breast mastitis in that he had inappropriately prescribed to the patient several classes of antibiotics without obtaining information on the infectious organisms and did not

perform the incision and drainage procedures appropriately and/or thoroughly. Another charge of failing to obtain the informed consent of the patient prior to Dr CHKC's performance of the second ADF Procedure on the patient was taken into consideration for the purposes of sentencing.

The DT noted the following aggravating factors: (a) Dr CHKC had committed several serious acts of professional misconduct; (b) he had not acted in the patient's welfare and interests; and (c) he had caused the patient to suffer prolonged pain and inconvenience by his failure to exercise due care and competence in the management of her right breast mastitis. Given the gravity of Dr CHKC's breaches, DT was of the view that the appropriate penalty should be a term of suspension rather than a fine. The DT ordered that Dr CHKC be suspended for six (6) months, be censured and give a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct. He was also ordered to pay the costs and expenses of and incidental to the proceedings, including the costs of the solicitors to the SMC.

C3J Appeal Case 1 | Dr Yong Thiam Look Peter

DT Inquiry

Dr Yong was practising as a general practitioner with AcuMed Medical Group of Clinics (**Clinic**) at the material time. The DT proceedings arose out of a complaint by one of Dr Yong's patients to SMC in relation to the medical care and/or treatment provided by Dr Yong in respect of the patient's trigger finger surgery.

Dr Yong was charged with two counts of professional misconduct, under section 53(1)(*d*) of the MRA, in that he had (a) performed a trigger finger release surgery (**Procedure**) at the clinic on the left middle finger of the patient without having obtained his informed consent; and (b) that he had failed to keep clear and accurate medical records in respect of the treatment of and performance of the Procedure on the patient; and one count of failing to provide professional services of the quality which was reasonable to expect of him under section 53(1)(*e*) of the MRA, for failing to provide appropriate care to the patient by performing the Procedure at the consultation table of the clinic, when such a procedure should properly have been undertaken in a procedure room or operating theatre.

Dr Yong pleaded guilty to the three charges and was suspended from practice for a period of six (6) months; fined $10,000, censured, ordered to give a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct, and pay the costs and expenses of and incidental to the proceedings, including the costs of the solicitors to the SMC.

Appeal

Dr Yong appealed against the DT's decision on the grounds that the six (6) months' suspension ordered by the DT was *manifestly excessive*. On 16 January 2017, the C3J

dismissed Dr Yong's appeal and upheld the decision of the DT as it was satisfied that the sentence ordered by the DT was not *manifestly excessive*. In dismissing Dr Yong's appeal, the C3J noted, amongst other things, that Dr Yong's violations were serious and that given Dr Yong's antecedents, there was a need for both general and specific deterrence. The C3J also awarded costs of the appeal to the SMC.

C3J Appeal Case 2 | Dr Chia Foong Lin

DT Inquiry

Dr Chia was a paediatrician and was practising at Chia Baby and Child Clinic at the material time. The proceedings arose from a complaint lodged by the mother of a one-year-old child (the **Patient**) to the SMC against Dr Chia for failing to diagnose and treat the Patient for Kawasaki Disease (**KD**). As a result of the late diagnosis of KD, the Patient was exposed to the possibility of developing severe cardiac complications.

Dr Chia faced one charge of professional misconduct under section 53(1)(*d*) of the MRA for failing to adequately evaluate and provide due care to the Patient (the **Charge**). The Patient had presented with signs of KD but Dr Chia had failed to diagnose and treat the Patient in a timely and competent manner.

Having considered all the evidence adduced in the Inquiry, the DT was satisfied that Dr Chia's management of the Patient amounted to such serious negligence that it objectively portrayed an abuse of privileges which accompany registration as medical practitioner. Accordingly, the DT convicted Dr Chia of the Charge.

In deciding on the appropriate sentence to impose, the DT took into account several mitigating factors highlighted by the Counsel for Dr Chia. The DT also considered other important factors of sentencing, such as the nature of the disease entity in question, the potential harm and the potentially life-threatening illness afflicting the Patient, and all the facts and circumstances of the case. The DT concluded that an order of suspension would be warranted in Dr Chia's case in order to maintain the highest professional standards expected of medical professionals and to uphold the trust of the public in the medical profession.

The DT ordered that Dr Chia be suspended from medical practice for a period of three (3) months, be censured, to give a written undertaking to the SMC that she would not engage in the conduct complained of and any similar conduct, and to pay the cost and expenses of and incidental to the proceedings, including the costs of the solicitors to the SMC.

Appeal

Dr Chia appealed against the DT's decision in respect of both her conviction and sentence on the Charge. On 27 June 2017, the C3J dismissed Dr Chia's appeal. The C3J held that the DT's finding in relation to the applicable standard of care and Dr Chia's breach thereof was

not unsafe, unreasonable, or contrary to the evidence, and saw no basis to disagree with the DT's finding that Dr Chia's conduct amounted to professional misconduct on the basis of gross negligence. The C3J was also of the view that the penalty imposed by the DT was within the acceptable range as established by precedents relied upon by both parties. In particular, the C3J disagreed with Dr Chia that a suspension would be more suitable only where there was a conviction on more than one charge of misconduct.

C3J Appeal Case 3 | Dr Ang Peng Tiam

DT Inquiry

Dr Ang was a medical oncologist. At the material time, he was the Medical Director at the Parkway Cancer Centre. The Inquiry arose out of a joint complaint (the **Complaint**) to the SMC, made by the children of Dr Ang's patient (the **Patient**). The Complaint pertained to representations that Dr Ang had made to the Patient at a consultation (the **Consultation**), as well as his treatment of the Patient. The Patient passed away subsequently.

The four charges of professional misconduct under section 53(1)(*d*) of the MRA were preferred against Dr Ang were set out as follows:

(a) Dr Ang made a false representation to the Patient, who was suffering from lung cancer, that there was a "*70% chance*" of the disease responding to treatment and achieving control with chemotherapy and/or targeted therapy (the **Statement**) (the **First Charge**);

(b) Dr Ang failed to offer to the Patient, who was suffering from cT3 N0 M0 (stage IIB) lung cancer, the treatment option of surgery (the **Second Charge**);

(c) Dr Ang recommended to and carried out on the Patient an inappropriate treatment, namely, alternate-day dosing of Iressa (250mg) in combination with chemotherapy using gemcitabine and cisplatin (the **Third Charge**); and

(d) Dr Ang recommended to and carried out on the Patient treatment with Tarceva after treatment with Iressa had failed, when Dr Ang knew or ought to have known that it was not, given the circumstances, a generally accepted method of treatment by the medical profession (the **Fourth Charge**).

Dr Ang contested all four charges. At the conclusion of the DT inquiry, the DT found Dr Ang to be guilty of the First Charge and Second Charge. The Third Charge and Fourth Charge against Dr Ang were dismissed.

As part of the sentencing considerations, the DT was of the view that Dr Ang's breaches of the 2002 ECEG were serious offences which merit severe penalty, and a clear message should be sent to the medical profession that strict and due observance of the ECEG is required of all medical practitioners. An adequate sanction is intended to deter similar misconduct and to uphold the trust and respect of the society for the medical profession.

However, the DT also took into account the long delay in these proceedings. The DT was of the view that this delay had caused tremendous suffering to Dr Ang. As such, the DT was not minded to impose any period of suspension on him. Accordingly, the DT ordered that Dr Ang be fined a sum of $25,000, be censured, give a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct in the future, and pay 60% of the costs and expenses of and incidental to the proceedings, including the costs of the solicitors to the SMC.

Appeal

Dr Ang appealed against the DT's decision in respect of his conviction on the First Charge and Second Charge. The SMC appealed only in respect of the sentence. On 27 June 2017, the C3J upheld Dr Ang's convictions on the First Charge and Second Charge and allowed the SMC's appeal and substituted the DT's sentence of a global fine of $25,000 with a total term of suspension of eight months in respect of the two charges. The C3J upheld the following orders made by the DT, namely, that Dr Ang be censured and that he give a written undertaking to the SMC that he would not engage in the conduct complained of or similar conduct in the future.

C3J Appeal Case 4 | Dr Lam Kwok Tai Leslie

DT Inquiry

Dr Lam was a cardiologist and was practising at the Cardiac Centre Pte Ltd (the **Clinic**) at the material time. The Inquiry arose from a complaint made by Dr Lam's patient (the **Patient**) to the SMC, that Dr Lam had advised and persuaded him to undergo a Conventional Angiogram and a Percutaneous Coronary Intervention (**PCI**) procedure which Dr Lam carried out, without due clinical evaluation.

Dr Lam claimed trial to the following three charges:

a) Failure to provide adequate medical care to the patient, in that he advised and persuaded the patient to undergo a Conventional Angiogram and a PCI without due clinical evaluation (**First Charge**);

b) Failure to use proper skill and care in performing the PCI and stenting procedure on the patient and thereby exposed the patient to potential serious medical consequences (**Second Charge**); and

c) Failure to ensure that the patient was adequately informed about his medical condition and options for treatment so that he was able to participate in decisions about his treatment (**Third Charge**).

The First Charge and Third Charge were brought under section 53(1)(*d*) of the MRA while the Second Charge was brought under section 53(1)(*e*) of the MRA.

At the conclusion of the Inquiry, the DT dismissed the First Charge and the Second Charge against Dr Lam and found him guilty of the Third Charge.

In deciding on the appropriate sentence to impose, the DT considered SMC's submissions on sentence on the Third Charge as well as the mitigation by Dr Lam. The DT ordered that Dr Lam be suspended for a period of three (3) months, be censured, give a written undertaking to the SMC that he would not engage in the conduct complained of and any similar conduct and pay one-third of the cost and expenses of and incidental to the proceedings, including the cost of the solicitors to the SMC.

Appeal

Dr Lam subsequently filed an appeal against the DT's decision in respect of both his conviction and sentence. On 20 October 2017, the C3J set aside Dr Lam's conviction on the Third Charge and the DT's orders on the sentence and the costs of the inquiry.

The C3J took issues with how the Third Charge was framed by the SMC in the Notice of Inquiry, i.e. that it was framed in ambiguous terms because at plain reading, there was at least two possible interpretations of the SMC's case on this charge – that Dr Lam's misconduct lay in: (a) informing the Patient of some, but not all, of the PCI benefits, risks, complications and alternatives; or (b) informing the Patient of none of these matters. In addition, the particulars laid out in the Third Charge did not give Dr Lam a sufficiently clear idea of the precise allegations that he had to meet.

In its judgment, the C3J sets out that sentencing could be recalibrated now with the current MRA (with fines up to $100,000) such that fines at the higher end of the enhanced range should be imposed where offences are not so serious as to deserve the statutory minimum of three months' suspension, but too serious to be punished merely giving a censure or ordering an undertaking

The C3J also sets out some considerations in relation to sentencing errant doctors for professional misconduct in the form of failure to obtain informed consent. A DT faced with such a case should consider the following non-exhaustive list of factors in sentencing:

(a) The materiality of the information that was not explained to the patient, namely, whether there is evidence that the patient would have taken a different course of action had such information been conveyed;

(b) The extent to which the patient's autonomy to make an informed decision on his own treatment was undermined as a result of the doctor's failure to convey or explain the necessary information; and

(c) The possibility of harm and, where applicable, the materiality of the harm which resulted from the doctor's failure to explain the necessary information.

C3J Appeal Case 5 | Dr Jen Shek Wei

DT Inquiry

Dr Jen was a registered Gynaecologist & Obstetrician and was practising at Women's Clinic of Singapore at the material time. The DT proceedings arose from a complaint to the SMC by one of Dr Jen's patients. The complaint pertained to Dr Jen's removal of the patient's left ovary during a surgery he had performed on the patient after she had consulted him regarding a pelvic mass (**Mass**) found on a Magnetic Resonance Imaging scan performed on her by another doctor.

Dr Jen claimed trial to the following two charges of professional misconduct preferred against him pursuant to section 53(1)(*d*) of the MRA:

(a) that he had advised the patient to undergo surgery to remove the Mass without carrying out further evaluation and investigation of the patient's condition when such further assessment was indicated, and that his aforesaid conduct amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner (**First Charge**); and

(b) that he had performed a left oophorectomy (i.e. the removal of the left ovary) on the patient (**Procedure**) without obtaining the required informed consent from the patient for the Procedure (**Second Charge**), in breach of the 2002 ECEG, and that his aforesaid conduct constituted an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.

The DT found Dr Jen guilty of both the First Charge and the Second Charge.

In considering the appropriate sentence for Dr Jen, the DT took into account, *inter alia*, the following factors:

(a) Dr Jen saw the patient and within 24 hours had persuaded her to undergo the Procedure, without fulfilling his duty of informing her of the treatment option of conservative management and obtaining informed consent from her;

(b) The Procedure which Dr Jen performed, i.e. removing the patient's left ovary and fallopian tube, was a grossly inappropriate treatment for the patient, especially when he knew that the patient did not want any part of her womb area to be removed because of her fertility concerns. This showed an indifference to the Patient's welfare and best interests;

(c) Dr Jen did not evaluate the patient using acceptable guidelines to determine whether the Mass was likely benign or had a high degree of malignancy before advising surgery and this demonstrated he did not have his patient's best interests at heart; and

(d) Dr Jen did not show any remorse over the removal of the patient's left ovary and fallopian tube for a benign condition, and had even callously suggested that he had improved her fertility.

Having regard to all the facts and circumstances of the case, a significant period of suspension would be appropriate in order to adequately address Dr Jen's offending conduct. The DT ordered that Dr Jen be suspended from medical practice for a period of eight (8) months, fined $10,000, censured, give a written undertaking to the SMC that he would not engage in the conduct complained of and any similar conduct; and pay the cost and expenses of and incidental to the proceedings, including the costs of the solicitors to the SMC.

Appeal

Dr Jen appealed against the DT's decision on both charges, in respect of both his conviction and sentence. On 14 November 2017, the C3J dismissed Dr Jen's appeal in its entirety.

As regards Dr Jen's appeal on sentence, the C3J noted the following: -

(a) There was a lack of care in the way Dr Jen addressed the patient's condition when he assessed the Mass to be malignant without applying any malignancy guidelines and that he had failed to make known to the patient that he had removed her ovary. The C3J was of the view that such conduct called for a sufficiently deterrent sentence.

(b) There was a lack of remorse on Dr Jen's part, especially in relation to the Second Charge, when he sought to disclaim responsibility for ensuring that the patient understood the nature of the Procedure.

(c) While the C3J accepted that Dr Jen's sentence ought to reflect the delay in the prosecution of the case, the C3J saw no reason to disturb the DT's sentence given that the term of suspension imposed by the DT was on the low side, and that a suspension of 16 months was justified in this case. Even if that term of suspension was halved on account of the delay in prosecution, the suspension would remain at eight months. The C3J also saw no reason for disturbing the fine and written undertaking ordered by the DT.

Financial Statements

SINGAPORE MEDICAL COUNCIL

AUDITED FINANCIAL STATEMENTS
FOR THE FINANCIAL YEAR ENDED
31 MARCH 2018

SINGAPORE MEDICAL COUNCIL
(Constituted under the Medical Registration Act, Cap 174)

FINANCIAL STATEMENTS
For the financial year ended 31 March 2018

CONTENTS **PAGE**

SINGAPORE MEDICAL COUNCIL
(Constituted under the Medical Registration Act, Cap 174)

STATEMENT BY THE COUNCIL'S MANAGEMENT
For the financial year ended 31 March 2018

In our opinion:

(a) the accompanying financial statements of the Singapore Medical Council (the "Council") are properly drawn up in accordance with the provision of the Medical Registration Act, Cap 174 (the "Act") and Statutory Board Financial Reporting Standards ("SB-FRS") so as to give a true and fair view of the financial position of the Council as at 31 March 2018 and of the financial performance, changes in accumulated fund and cash flows of the Council for the financial year then ended on that date;

(b) at the date of this statement, there are reasonable grounds to believe that the Council will be able to pay its debts as and when they fall due; and

(c) nothing came to our notice that caused us to believe that the receipts, expenditure, and investment of monies and the acquisition and disposal of assets by the Council during the financial year have not been in accordance with the provisions of the Act.

The Council's management has, on the date of this statement, authorised these financial statements for issue.

On behalf of the Council,

.....
Prof. Tan Ser Kiat
President

.....
A/Prof. Pang Weng Sun
Chairman, Finance Committee

Singapore

5 June 2018

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INDEPENDENT AUDITOR'S REPORT
TO THE MEMBERS OF SINGAPORE MEDICAL COUNCIL
(Constituted under the Medical Registration Act, Cap 174)
For the financial year ended 31 March 2018

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of Singapore Medical Council (the "Council"), which comprise the statement of financial position as at 31 March 2018, and the statement of comprehensive income, statement of changes in accumulated fund and statement of cash flows for the year then ended, and notes to the financial statement, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements are properly drawn up in accordance with the provision of the Medical Registration Act, Cap. 174 (the "Act") and Statutory Board Financial Reporting Standards ("SB-FRS") so as to present fairly, in all material respects, the state of affairs of the Council as at 31 March 2018 and the results, changes in equity and cash flows of the Council for the year ended on that date.

Basis for Opinion

We conducted our audit in accordance with Singapore Standards on Auditing (SSAs). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the Council in accordance with the Accounting and Corporate Regulatory Authority (ACRA) Code of Professional Conduct and Ethics for Public Accountants and Accounting Entities (ACRA Code) together with the ethical requirements that are relevant to our audit of the financial statements in Singapore, and we have fulfilled our other ethical responsibilities in accordance with these requirements and the ACRA Code. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Other Information

Management is responsible for the other information. The other information comprises the Statement by the Council's Management but does not include the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the provisions of the Act and Statutory Board Financial Reporting Standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the Council's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless there is intention to wind up the Council or for the Council to cease operations.

Those charged with governance are responsible for overseeing the Council's financial reporting process.

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INDEPENDENT AUDITOR'S REPORT
TO THE MEMBERS OF SINGAPORE MEDICAL COUNCIL
(Constituted under the Medical Registration Act, Cap 174)
For the financial year ended 31 March 2018

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with SSAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with SSAs, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Council's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Council's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Council to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

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INDEPENDENT AUDITOR'S REPORT
TO THE MEMBERS OF SINGAPORE MEDICAL COUNCIL
(Constituted under the Medical Registration Act, Cap 174)
For the financial year ended 31 March 2018

Report on Other Legal and Regulatory Requirements

Opinion

In our opinion:

(a) the receipts, expenditure, investment of moneys and acquisition and disposal of assets by the Council during the year are, in all material respects, in accordance with the provisions of the Act; and

(b) proper accounting and other records have been kept, including records of all assets of the Council whether purchased, donated or otherwise.

Basis for Opinion

We conducted our audit in accordance with SSAs. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Compliance Audit section of our report. We are independent of the Council in accordance with the ACRA Code together with the ethical requirements that are relevant to our audit of the financial statements in Singapore, and we have fulfilled our other ethical responsibilities in accordance with these requirements and the ACRA Code. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on management's compliance.

Responsibilities of Management for Compliance with Legal and Regulatory Requirements

Management is responsible for ensuring that the receipts, expenditure, investment of moneys and the acquisition and disposal of assets, are in accordance with the provisions of the Act. This responsibility includes implementing accounting and internal controls as management determines as necessary to enable compliance with the provisions of the Act.

Auditor's Responsibilities for the Compliance Audit

Our responsibility is to express an opinion on management's compliance based on our audit of the financial statements. We planned and performed the compliance audit to obtain reasonable assurance about whether the receipts, expenditure, and investment of moneys and the acquisition and disposal of assets, are in accordance with the provisions of the Act.

Our compliance audit includes obtaining an understanding of the internal control relevant to the receipts, expenditure, investment of moneys and the acquisition and disposal of assets; and assessing the risks of material misstatement of the financial statement from non-compliance, if any, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Because of the inherent limitations in any accounting and internal control system, non-compliances may nevertheless occur but not detected.

PAUL HOOI & COMPANY
Public Accountants and
Chartered Accountants
Singapore

5 June 2018

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SINGAPORE MEDICAL COUNCIL
(Constituted under the Medical Registration Act, Cap 174)

STATEMENT OF FINANCIAL POSITION
As at 31 March 2018

	Note	2018 S$	2017 S$
ASSETS			
Non-current assets			
Plant and equipment	4	80,848	144,197
		80,848	144,197
Current assets			
Other receivables	5	2,875,772	1,742,511
Cash and bank balances	6	5,144,132	6,224,184
Fixed deposits with financial institutions	7	6,183,930	6,114,296
		14,203,834	14,080,991
Total assets		14,284,682	14,225,188
EQUITY AND LIABILITIES			
Non-current liabilities			
Fees received in advance	9	2,427,767	1,211,269
		2,427,767	1,211,269
Current liabilities			
Other payables and accruals	10	1,780,339	2,373,084
Fees received in advance	9	4,949,997	4,422,246
Grants received in advance	8	12,414	30,238
Provisions for contributions to consolidated fund	23	-	516,587
		6,742,750	7,342,155
Total liabilities		9,170,517	8,553,424
Equity			
Accumulated fund		5,114,165	5,671,764
Total equity		5,114,165	5,671,764
Total equity and liabilities		14,284,682	14,225,188

The accompanying notes form an integral part of these financial statements.

SINGAPORE MEDICAL COUNCIL
(Constituted under the Medical Registration Act, Cap 174)

STATEMENT OF COMPREHENSIVE INCOME
For the financial year ended 31 March 2018

	Note	2018 S$	2017 S$
Income			
Application fees	11	759,255	787,970
Registration fees	12	145,280	144,000
Practising certificates	13	5,734,181	5,520,482
		6,638,716	6,452,452
Other Income			
Other fees	14	92,240	81,240
Finance income	15	72,097	32,215
Administrative income	16	22,715	8,928
Reimbursement from professional boards	17	874,289	810,183
		1,061,341	932,566
Total Income		7,700,057	7,385,018
Less: Expenditure			
Operating expenses	18	810,169	1,350,446
Administrative expenses	20	7,899,792	7,464,205
Other expenses	22	64,282	42,594
Total Expenditure		8,774,243	8,857,245
Deficit before grants and contribution to consolidated fund		(1,074,186)	(1,472,227)
Deficit for the year before statutory contribution to consolidated fund		(1,074,186)	(1,472,227)
Statutory contribution to consolidated fund	23	516,587	-
Net deficit for the year, representing total comprehensive loss for the year		(557,599)	(1,472,227)

The accompanying notes form an integral part of these financial statements.

SINGAPORE MEDICAL COUNCIL
(Constituted under the Medical Registration Act, Cap 174)

STATEMENT OF CHANGES IN ACCUMULATED FUND
For the financial year ended 31 March 2018

	Accumulated Fund
	S$
Balance at 1 April 2016	7,143,991
Total comprehensive loss for the financial year	(1,472,227)
Balance at 31 March 2017	5,671,764
Total comprehensive loss for the financial year	(557,599)
Balance at 31 March 2018	5,114,165

The accompanying notes form an integral part of these financial statements.

SINGAPORE MEDICAL COUNCIL
(Constituted under the Medical Registration Act, Cap 174)

STATEMENT OF CASH FLOWS
For the financial year ended 31 March 2018

	Note	2018 S$	2017 S$
Cash flows from operating activities			
Deficit before contribution to consolidated fund		(1,074,186)	(1,472,227)
Adjustments for:			
Depreciation of plant and equipment	4	67,560	93,501
Loss on disposal of plant and equipment		-	3,303
Finance income	15	(72,097)	(32,215)
Over provision for contribution to consolidated fund	23	516,587	-
Deficit before working capital changes		(562,136)	(1,407,638)
Changes in working capital:			
Other receivables		(1,133,261)	2,299,621
Other payables and accruals		617,093	(4,852,887)
Net cash flows used in operating activities		(1,078,304)	(3,960,904)
Cash flows from investing activities			
Purchases of plant and equipment	4	(4,211)	(40,508)
Interest received		72,097	32,215
Increase in fixed deposit with original maturities over 3 months		(69,634)	(3,029,522)
Net cash flows used in investing activities		(1,748)	(3,037,815)
Net decrease in cash and bank balances		(1,080,052)	(6,998,719)
Cash and bank balances at the beginning of financial year		6,224,184	13,222,903
Cash and bank balances at the end of financial year	6	5,144,132	6,224,184

The accompanying notes form an integral part of these financial statements.

1. GENERAL INFORMATION

Singapore Medical Council (the "Council") was constituted under The Medical Registration Act, Cap. 174 (the "Act"). Its principal place of business is located at 16 College Road, #01-01 College of Medicine Building, Singapore 169854.

The principal activities of the Council are to regulate and promote the interests of medical practitioners.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

2.1 Basis of Preparation

The financial statements of the Council have been prepared in accordance with the provision of the Act and Statutory Board Financial Reporting Standards ("SB-FRS"). SB-FRS includes Statutory Board Financial Reporting Standards, Interpretations of SB-FRS and SB-FRS Guidance Notes as promulgated by the Accountant-General. The financial statements have been prepared on the historical cost basis except for certain financial asset and liabilities as disclosed in the accounting policies below.

The financial statements are presented in Singapore Dollars (S$) which is the Council's functional and presentational currency and all values are rounded to the nearest one dollar.

2.2 Adoption of new and revised standards

The accounting policies adopted are consistent with those of the previous financial year except in the current financial year, the Council has adopted all the new and revised standards which are relevant to the Council and are effective for annual financial periods beginning on or after 1 April 2017. The adoption of these standards did not have any material effect on the financial statements.

At the date of authorization of these financial statements, the following new/revised SB-FRS, INT SB-FRS and amendments to SB-FRS that are relevant to the company were issued but not effective:

Description:	Effective for annual periods beginning on or after
SB-FRS 109 Financial Instruments	1 January 2018
SB-FRS 116 Leases	1 January 2019

Except for SB-FRS 109, and SB-FRS 116, the Council's management expect that the adoptions of the other standards above will have no material impact on the financial statements in the period of initial application. The council's management are in the process of assessing the possible impact of implementing SB-FRS 109 and SB-FRS 116 and do not plan to early adopt these SB-FRS.

The nature of the impending changes in accounting policy on adoption of SB-FRS 109 and SB-FRS 116 are described below:

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Cont'd)

2.2 Adoption of new and revised standards (cont'd)

SB-FRS 109 ***Financial Instruments***

SB-FRS 109 was issued in December 2014 to replace SB-FRS 39 Financial Instruments: Recognition and Measurement and introduced new requirements for (i) the classification and measurement of financial assets and financial liabilities (ii) general hedge accounting (iii) impairment requirements for financial assets.

Key requirements of SB-FRS 109:

- All recognised financial assets that are within the scope of SB-FRS 39 are now required to be subsequently measured at amortised cost or fair value through profit or loss (FVTPL).

- With some exceptions, financial liabilities are generally subsequently measured at amortised cost. With regard to the measurement of financial liabilities designated as at FVTPL, SB-FRS 109 requires that the amount of change in fair value of such financial liability that is attributable to changes in the credit risk be presented in other comprehensive income, unless the recognition of the effects of changes in the liability's credit risk in other comprehensive income would create or enlarge an accounting mismatch to profit or loss. Changes in fair value attributable to the financial liability's credit risk are not subsequently reclassified to profit or loss.

SB-FRS 116 ***Leases***

SB-FRS 116 was issued in June 2017 and will supersede SB-FRS 17 *Leases* and its associated interpretative guidance.

- The Standard provides a comprehensive model for the identification of lease arrangements and their treatment in the financial statements of both lessees and lessors. The identification of leases, distinguishing between leases and service contracts, are determined on the basis of whether there is an identified asset controlled by the customer.

- Significant changes to lessee accounting are introduced, with the distinction between operating and finance leases removed and assets and liabilities recognised in respect of all leases (subject to limited exceptions for short-term leases and leases of low value assets). The Standard maintains substantially the lessor accounting approach under the predecessor SB-FRS 17.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Cont'd)

2.3 Currency transactions

Functional and presentation currency

Items included in the financial statement of the Council are measured using the currency that best reflects the economic substance of the underlying events and circumstances relevant to that entity ("the functional currency"). The financial statements are presented in Singapore Dollars, which is the functional currency of the Council.

2.4 Plant and Equipment

Measurement

All items of plant and equipment are initially recorded at cost. The cost of an item of plant and equipment is recognised as an asset if, and only if, it is probably that future economic benefits associated with the item will flow to the Council and the cost of the item can be measured reliably.

Plant and equipment are stated at cost less accumulated depreciation and impairment loss, if any.

Depreciation

Depreciation is charged so as to write off the cost of assets over their estimated useful lives, using the straight-line method, on the following bases:

Computer systems and software	3 years
Office equipment	3 years
Furniture and fittings	8 years

Fully depreciated assets still in use are retained in the financial statements. The estimated useful lives, residual values and depreciation methods are reviewed at the end of each reporting period, with effect of any changes in estimate accounted for on a prospective basis.

Disposal

An item of plant and equipment is derecognised upon disposal or when no future economic benefits are expected from its use or disposal.

The gain or loss arising on the disposal or retirement of plant and equipment is determined as the difference between the sales proceeds and the carrying amount of the asset and is recognised in Statement of Comprehensive Income.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Cont'd)

2.5 Financial Assets

Classification

Loan and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are presented as current assets, except for those expected to be realised later than 12 months after the balance sheet date which are presented as non-current assets. Loan and receivables are presented as "other receivables" (Note 5), "cash and bank balances" (Note 6) and "fixed deposits with financial institutions" (Note 7) on the balance sheet.

Recognition and derecognition

Regular way purchases and sales of financial assets are recognised on trade date - the date on which the Council commits to purchase or sell the asset.

Financial assets are derecognised when the rights to receive cash flows from the financial assets have expired or have been transferred and the Council has transferred substantially all risk and rewards of ownership. On disposal of a financial asset, the difference between the carrying amount and the sales proceeds is recognised in profit and loss. Any amount previously recognised in other comprehensive income relating to that asset is reclassified to profit and loss.

Initial measurement

Financial assets are initially recognised at fair value plus transaction costs except for financial assets at fair value through profit or loss, which are recognised at fair value. Transaction costs for financial assets at fair value through profit or loss are recognised immediately as expenses.

Subsequent measurement

Loans and receivables are subsequently carried at amortised cost using the effective interest method.

Impairment

Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy and default or significant delay in payments are objective evidence that these financial assets are impaired.

The carrying amount of these assets is reduced through the use of an impairment allowance account which is calculated as the difference between the carrying amount and the present value of estimated future cash flows, discounted at the original effective interest rate. When the asset becomes uncollectible, it is written off against the allowance account. Subsequent recoveries of amounts previously written off are recognised against the same line item in profit or loss.

The impairment allowance is reduced through profit or loss in a subsequent period when the amount of impairment loss decreases and the related decrease can be objectively measured. The carrying amount of the asset previously impaired is increased to the extent that the new carrying amount does not exceed the amortised cost had no impairment been recognised in prior periods.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Cont'd)

2.6 Cash and bank balances

Cash and bank balances comprise cash held with banks that are readily convertible to known amounts of cash and which are subject to an insignificant risk of change in value.

Cash and bank balances carried in the balance sheet are classified and accounted for as loans and receivables under SB-FRS 39.

2.7 Financial liabilities

Financial liabilities include other payables and accrued operating expenses. Financial liabilities are recognised on the balance sheet when, and only when, the Council becomes a party to the contractual provisions of the financial instrument. Financial liabilities are initially recognised at fair value of consideration received less directly attributable transaction costs and subsequently measured at amortised cost using the effective interest rate method. Gains and losses are recognised in the income and expenditure statement when the liabilities are derecognised as well as through the amortisation process. The liabilities are derecognised when the obligation under the liability is discharged or cancelled or expired.

2.8 Other payables and accruals

Other payables and accruals represent liabilities for goods and services provided to the Council prior to the end of financial year which are unpaid. They are classified as current liabilities if payment is due within one year or less (or in the normal operating cycle of the business, if longer). If not, they are presented as non-current liabilities.

Other payables and accruals are initially recognized at fair value, and subsequently carried at amortised cost using the effective interest method.

2.9 Provision

Provisions are recognized when the Council has a present legal or constructive obligation as a result of past events, it is probable that an outflow of resources will be required to settle the obligation, and a reliable estimate of the amount can be made.

2.10 Fair value estimation of financial assets and liabilities

The carrying amounts of current financial assets and liabilities carried at amortised cost approximate their fair values.

2.11 Tax

The Council is a tax-exempted institution under the provisions of the Income Tax Act (Chapter 134, 2004 Revised Edition).

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Cont'd)

2.12 Government grants

Government grants are recognised at their fair value where there is reasonable assurance that the Council will comply with the conditions attached to them and the grants will be received.

Government grants are recognised as income over the periods necessary to match them with the related costs which they are intended to reimburse, on a systematic basis. Government grants that are receivable as reimbursements for expenses already incurred are recognised in profit or loss in the period in which they become receivables.

Grants are recognised only when there is reasonable assurance that the Council would comply with the conditions attaching to those grants, and the grants would be received.

2.13 Leases

When the Council is lessee of an operating lease

Where the Council has the use of assets under operating leases, payments made under the leases are recognised in the statement of comprehensive income on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of comprehensive income as an integral part of the total lease payments made. Leased assets under operating leases are not recognised in the Council's statement of financial position.

2.14 Revenue recognition

Revenue is measured at the fair value of the consideration received or receivable.

Revenue is recognized to the extent that it is probable that the economic benefits will flow to the Council and the revenue can be reliably measured.

(i) Practising fees

Practising fees are recognised when due.

(ii) Interest income from fixed deposits

Interest income from fixed deposits is recognised on a time-proportion basis, using the effective interest method. Other income are recognised upon receipt.

2.15 Employee compensation

Defined contribution plans

Obligations for contributions to defined contribution pension plans are recognised as an expenses in the statement of comprehensive income as incurred.

Short-term benefits

Short-term employee benefit obligations are measured on an undiscounted basis and are expensed as the related service is provided. A liability is recognised for the amount expected to be paid if the Council has a present, legal or constructive obligation to pay this amount as a result of past service provided by the employee, and the obligation can be estimated reliably.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Cont'd)

2.16 Related parties

A related party is defined as follows:

(a) A person or a close member of that person's family is related to the Council if that person:
   i. has control or joint control over the Council;
   ii. has significant influence over the Council; or
   iii. is a member of the key management personnel of the Council or of a parent of the Council.

(b) An entity which is related to a Council if any of the following conditions applies:
   i. The entity and the Council are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
   ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
   iii. Both entities are joint ventures of the same third party
   iv. One entity is a joint venture of a third entity and the other entity is an associate of the third party.
   v. The entity is a post-employment benefit plan for the benefit of employees of either the Council or an entity to the Council. If the Council is itself such a plan, the sponsoring employers are also related to the Council.
   vi. The entity is controlled or jointly controlled by a person identified in (a).
   vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).

2.17 Contingencies

A contingent liability or asset is a possible obligation or asset that arises from the past events and whose existence will be confirmed only by the occurrence or non-occurrence of uncertain future event(s) not wholly within the control of the Council.

There are no contingent assets or liabilities as at 31 March 2018 which require disclosure in the financial statement (2017: Nil).

3. SIGNIFICANT ACCOUNTING JUDGEMENTS AND ESTIMATES

Estimates, assumptions concerning the future and judgements are made in the preparation of the financial statements. They affect the application of the Council's accounting policies, reported amounts of assets, liabilities, income and expenses, and disclosures made. They are assessed on an ongoing basis and are based on experience and relevant factors, including expectations of future events that are believed to be reasonable under the circumstances.

3.1 Key Sources of estimation uncertainty

The key assumptions concerning the future and other key sources of estimation uncertainty at the balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Depreciation of plant and equipment

The costs of plant and equipment are depreciated on a straight-line basis over their estimated useful lives. The Council's management estimates of the useful lives of these plant and equipment are disclosed in Note 2.4. Changes in the expected usage and technological developments could impact the economic useful lives and the residual values of these assets. Therefore, future depreciation charges could be revised. The carrying amount of plant and equipment and the depreciation charge for the year are disclosed in Note 4 to the financial statements.

3.2 Critical judgements made in applying accounting policies

In the process of applying the Council's accounting policies, management has made certain judgements, apart from those involving estimations, which have significant effects on the amounts recognised in the financial statements.

Allowance for bad and doubtful receivables

The impairment policy for bad and doubtful debts of the Council is based on the evaluation of collectability and ageing analysis of the accounts receivables and on management's judgement. At the balance sheet date, the receivables from disciplinary proceedings, net of allowance, amounted to S$230,349 (2017: S$204,598). A considerable amount of judgement is required in assessing the ultimate realisation of these receivables, including the current credit worthiness and the past collection history of disciplined practitioners. If the financial condition of these disciplined practitioners were to deteriorate, resulting in an impairment of their ability to make payment, additional allowance will be required.

Impairment of non-financial assets

The carrying amounts of the Council's non-financial assets subject to impairment are reviewed at each balance sheet date to determine whether there is any indication of impairment. If such indication exists, the asset's recoverable amount is estimated based on the higher of the value in use and the asset's net selling price. Estimating the value in use requires the Council to make an estimate of the expected future cash flows from the continuing use of the assets and also to choose a suitable discount rate in order to calculate the present value of those cash flows.

4. PLANT AND EQUIPMENT

	Computer systems and software S$	Office equipment S$	Furniture and fittings S$	Total S$
Cost				
At 01.04.2016	148,197	89,686	835,305	1,073,188
Additions	9,149	-	31,359	40,508
Disposals	-	-	(15,099)	(15,099)
At 31.03.2017	157,346	89,686	851,565	1,098,597
Additions	4,211	-	-	4,211
Disposals	(1,740)	(2,518)	-	(4,258)
At 31.03.2018	159,817	87,168	851,565	1,098,550
Accumulated Depreciation				
At 01.04.2016	146,992	88,428	637,275	872,695
Depreciation charge for the year	2,499	656	90,346	93,501
Disposals	-	-	(11,796)	(11,796)
At 31.03.2017	149,491	89,084	715,825	954,400
Depreciation charge for the year	4,920	602	62,038	67,560
Disposals	(1,740)	(2,518)	-	(4,258)
At 31.03.2018	152,671	87,168	777,863	1,017,702
Net Book Value				
At 31.03.2018	7,146	-	73,702	80,848
At 31.03.2017	7,855	602	135,740	144,197

5. OTHER RECEIVABLES

	2018 S$	2017 S$
Receivables from disciplinary proceedings	230,349	204,598
Manpower receivables from secondment	3,076	397,035
Shared services receivables	-	4,452
Interest receivables	8,479	6,015
Sundry receivables	2,505,685	1,025,486
Deposits	67,472	80,972
Prepayments	60,711	23,953
	2,875,772	1,742,511

Other receivables are unsecured and non-interest bearing.

6. CASH AND BANK BALANCES

	2018 S$	2017 S$
Cash at bank	5,144,132	6,224,184

7. FIXED DEPOSITS WITH FINANCIAL INSTITUTIONS

All fixed deposits mature over 6 to 12 months (2017: 6 to 12 months) and bear interest at rates ranging from 0.68% to 1.29% (2017: 0.68% to 1.29%) per annum.

8. GRANTS RECEIVED IN ADVANCE

	2018 S$	2017 S$
Beginning of the financial year	30,238	795,362
Received during the year	2,054,918	1,700,000
Paid during the year	(1,280,758)	(1,740,888)
Transferred to statement of comprehensive income	(791,984)	(724,236)
End of the financial year	12,414	30,238

9. FEES RECEIVED IN ADVANCE

	2018 S$	2017 S$
Practising certificate fee received		
- due within 12 months	4,949,997	4,422,246
- due after 12 months	2,427,767	1,211,269
	7,377,764	5,633,515

10. OTHER PAYABLES AND ACCRUALS

	2018 S$	2017 S$
Other payables	543,537	544,550
Accruals	1,236,802	1,828,534
	1,780,339	2,373,084

Other payables are unsecured, non-interest bearing and are normally settled within 30 days or on demand.

11. APPLICATION FEES

	2018 S$	2017 S$
Amendment to the Register of Specialists and Family Physicians	(100)	100
Conditional registration	164,400	236,700
Family Physicians registration (Any other case)	19,000	22,200
Family Physicians registration (Foreign)	3,500	2,200
Full registration	185,250	157,750
Provisional registration	86,805	88,020
Specialist registration	225,000	183,000
Temporary registration	75,400	98,000
	759,255	787,970

12. REGISTRATION FEES

	2018 S$	2017 S$
Additional qualification	36,700	37,400
Appeal for medical registration	1,300	1,400
Certificate of good standing	51,920	51,120
Certified true copy of document/certificate	2,160	1,200
Duplicate of certificate	24,800	17,280
Exam fee	7,000	4,500
Renewal of temporary registration	17,400	27,100
Restoration to any other register	4,000	4,000
	145,280	144,000

13. PRACTISING CERTIFICATES

	2018 S$	2017 S$
Practising certificate for 1 year	290,910	278,462
Practising certificate for 2 years	5,298,715	5,073,092
Practising certificate (Lower fee) for 1 year	1,890	2,298
Practising certificate (Lower fee) for 2 years	54,322	48,711
Temporary practising certificate for less than 6 months	7,379	8,040
Temporary practising certificate for 6 months to 1 year	77,039	96,849
Temporary practising certificate for 18 months to 24 months	3,926	13,030
	5,734,181	5,520,482

14. OTHER FEES

	2018 S$	2017 S$
Fine for not voting	84,000	76,500
Late application fee for renewal of practising certificate	8,240	4,740
	92,240	81,240

15. FINANCE INCOME

	2018 S$	2017 S$
Fixed deposit interest income	72,097	32,215

16. ADMINISTRATIVE INCOME

	2018 S$	2017 S$
File transfer	5,990	2,247
Income from registered mail	16,650	6,550
Recycling materials	75	131
	22,715	8,928

17. REIMBURSEMENT FROM PROFESSIONAL BOARDS

	2018 S$	2017 S$
Income from MOH - Dental Specialist Accreditation Board	106,511	38,143
Income from MOH - Family Physicians Accreditation Board	293,532	274,712
Income from MOH - Pharmacy Specialist Accreditation Board	103,627	71,181
Income from MOH - Specialists Accreditation Board	288,314	316,408
Shared service income	82,305	109,739
	874,289	810,183

Under the exercise to amalgamate the administration of the Professional Boards driven by the Ministry of Health (MOH), the Council rendered shared services including Human Resource, General Administration, Information Technology and Finance for other Professional Boards. From January 2018, the finance and payroll functions of the Professional Boards has been transferred to a centralised finance and payroll division under the Ministry of Health. As a whole, the harmonisation of shared services seeks to derive economies of scale and efficiency of common functions across the Boards.

The income from MOH was reimbursement of expenses paid on behalf of the Boards for shared services rendered under the amalgamation exercise.

For shared service income, it was derived from shared service rendered to other Professional Boards.

18. OPERATING EXPENSES

	2018 S$	2017 S$
Committee expenses	1,751	17,755
Expert witness fee (recovered)/incurred for disciplinary proceedings	(243,138)	51,731
Honorarium	111,318	111,350
Insurance expenses	1,603	-
Legal expenses for disciplinary (net) (Note 19)	882,227	1,080,616
Mediation expenses	1,926	1,284
Physician pledge ceremony	35,874	37,856
Publication and printing	14,300	7,466
Transcript	4,308	42,388
	810,169	1,350,446

19. LEGAL EXPENSES FOR DISCIPLINARY (NET)

	2018 S$	2017 S$
Legal proceeding cost recovered	(713,554)	(898,240)
Legal expenses for disciplinary incurred	1,595,781	1,978,856
	882,227	1,080,616

20. ADMINISTRATIVE EXPENSES

Administrative expenses include the following significant items:

	2018 S$	2017 S$
Computer operations and maintenance	771,960	756,385
Shared service cost [1]	149,263	-
Depreciation of plant and equipment (Note 4)	67,560	93,501
Employee compensation (Note 21)	6,248,922	5,883,941
Rental	425,637	413,015
Office maintenance	24,279	29,647
Utilities	29,314	26,349

[1] For periods beginning January 2018, the finance and payroll functions of Singapore Medical Council has been transferred to a centralised finance and payroll division for selected statutory boards under the Ministry of Health.

21. EMPLOYEE COMPENSATION

	2018 S$	2017 S$
Wages and salaries	5,360,912	5,028,209
Employer's contribution to Central Provident Fund	796,981	764,026
Other short-term benefits	91,029	91,706
	6,248,922	5,883,941

22. OTHER EXPENSES

	2018 S$	2017 S$
Entertainment	2,092	2,533
Refreshments	6,873	6,115
Overseas travelling expenses	28,678	5,732
Miscellaneous expenses	26,639	28,214
	64,282	42,594

23. CONTRIBUTIONS TO CONSOLIDATED FUND

Under Section 13(1)(e) and the First Schedule of the Singapore Income Tax Act (Chapter 134), the income of the Council is exempt from income tax.

In lieu of income tax, the Council is required to make contribution to the Government Consolidated Fund if it generates accounting surpluses in accordance with the Statutory Corporations (Contributions to Consolidated Fund) Act (Chapter 319A).

As decided by Ministry of Finance, the applicable rate for contribution for the current financial year is 17% (2017: 17%). The Council is not required to contribute to the Consolidated Fund given the net deficit for current financial year. This deficit will be carried forward to offset against future years' operating surpluses.

	2018 S$	2017 S$
Balance as at beginning of the financial year	516,587	516,587
Current year provision	-	-
Over provision from prior year	(516,587)	-
Balance as at end of the financial year	-	516,587

At the end of the financial year, the Council has accumulated deficits carried forward as follows:

	2018 S$	2017 S$
Balance as at beginning of the financial year	5,573,012	4,100,785
Deficit for the financial year	1,074,186	1,472,227
Balance as at end of the financial year	6,647,198	5,573,012

Benefits in relation to the accumulated deficits were not recognised due to the unpredictability of future surplus streams.

24. RESERVES MANAGEMENT

The reserves management objective of the Council is to safeguard the Council's ability to continue as a going concern.

The management monitors its cash flows, availability of funds and overall liquidity position to ensure the Council is able to fulfil its continuing obligations.

The Council is not subject to externally imposed reserve requirements.

There were no changes to the Council's approach to reserves management during the year.

25. RELATED PARTY TRANSACTIONS

The Council is a statutory board incorporated under Ministry of Health. As a statutory board, all government ministries and departments, other statutory boards and Organs of State are deemed related parties of the Council.

In addition to the information disclosed elsewhere in the financial statements, the following transactions took place between the Council and related parties at term agreed between the parties.

	2018 S$	2017 S$
Ministries and Statutory Boards		
Grants received from government	-	-
Sales (Non-trade)	874,289	810,183
Amount due from (Non-trade)	1,804,767	1,203,559
Public Healthcare Institutions		
Amount due to (Non-trade)	447,427	365,427

26. OPERATING LEASE COMMITMENTS

The Council leases office space and office equipment from non-related parties under non-cancellable operating leases.

These leases have tenure of 1 to 3 years, varying terms and renewal options.

The lease terms do not contain restrictions on the Council's activities concerning further leasing.

As at the balance sheet date, future minimum lease payments under non-cancellable operating leases where the Council is the lessee are as follows:

	2018 S$	2017 S$
Operating lease payments due		
- within 1 year	381,708	293,779
- after 1 year but not later than 5 years	537,220	296,880
	918,928	590,659

The above operating lease commitments are based on known rental rates as at the date of this report and do not include any revision in rates which may be determined by the lessor.

27. FINANCIAL RISK MANAGEMENT OBJECTIVES AND POLICIES

The Council is exposed to minimal financial risks arising from its operations and the use of financial instruments. The key financial risks are credit risk, liquidity risk and interest rate risk. The Council's management reviews and agrees on policies for managing each of these risks and they are summarised below:

Credit risk

Credit risk is the potential risk of financial loss resulting from the failure of customers or other counterparties to settle their financial and contractual obligations to the Council as and when they fall due.

The Council's main financial assets consist of cash and cash equivalents and short to medium term fixed deposits. Cash and cash equivalents and fixed deposits are placed with financial institutions which are regulated.

At the reporting date, there was no significant concentration of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset in the statement of financial position.

(i) Financial assets that are neither past due nor impaired

Bank deposits that are neither past due nor impaired are mainly deposits with banks with high credit-ratings assigned by international credit-rating agencies. Other receivables that are neither past due nor impaired are substantially companies with a good collection track record with the Council.

(ii) Financial assets that are past due and/or impaired

There are no financial assets that are past due and/or impaired except for trade receivables.

The carrying amount of receivables that are individually determined to be impaired as at the balance sheet date is S$ nil (2017: S$ nil).

There are no financial assets that are past due as at the balance sheet date.

Interest rate risk

The Council does not have any interest-bearing financial liabilities. Its only exposure to changes in interest rates relates to interest-earning bank deposits. The management monitors movements in interest rates to ensure deposits are placed with financial institutions offering optimal rates of return.

The interest rates and terms of maturity of financial assets of the Council are disclosed in Note 7 to the financial statements.

27. FINANCIAL RISK MANAGEMENT OBJECTIVES AND POLICIES (Cont'd)

Liquidity risk

Liquidity risk is the risk that the Council will encounter difficulty in meeting financial obligations due to shortage of funds.

The management exercises prudence in managing its operating cash flows and aims at maintaining a high level of liquidity at all times.

All financial liabilities of the Council are repayable on demand or mature within one year.

The Council receives government operating grants to fund any deficit incurred for the year.

28. FAIR VALUE OF FINANCIAL ASSETS AND LIABILITIES

The carrying amounts of cash and cash equivalents, receivables and payables approximate their respective fair values due to the relatively short-term maturity of these financial statements.

Categories of financial instruments

The following table sets out the financial instruments as at the end of the reporting period:

	2018 S$	2017 S$
Financial Assets		
Cash and bank balances	5,144,132	6,224,184
Fixed deposits	6,183,930	6,114,296
Receivables and deposits	2,815,061	1,718,558
	14,143,123	14,057,038
Financial Liabilities at Amortised cost		
Other payables and accruals	1,780,339	2,373,084

29. AUTHORISATION OF FINANCIAL STATEMENTS

The financial statements of the Singapore Medical Council for the year ended 31 March 2018 were authorised for issue by the Council on 5 June 2018.

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