

# The 2016 Edition of The SMC Ethical Code and Ethical Guidelines

The 64-page 2016 edition of the Singapore Medical Council's (SMC) Ethical Code and Ethical Guidelines (2016 ECEG) was published on 13 September 2016 and will come into force on 1 January 2017. The 2016 ECEG is much longer than the existing 2002 edition (2002 ECEG) which has only 26 pages. Not only does the 2016 ECEG contain many new provisions, but significant changes have also been made to existing provisions in the 2002 ECEG.

The 2016 ECEG is also accompanied by a newly introduced 154-page SMC Handbook on Medical Ethics (2016 HME) which has no equivalent under the 2002 ECEG. The 2016 ECEG contains actual ethical codes and guidelines with "you must" statements that must be complied with unless circumstances prevent them from being upheld. In contrast, the 2016 HME contains elaborations, explanations and advice on best practices; the failure to abide by any of the "you should" statements in the 2016 HME does not automatically render doctors in breach of the 2016 ECEG.

As the 2016 ECEG and 2016 HME contain so much more material than the 2002 ECEG, it is imperative that doctors read and become familiar with them. There are many new provisions that doctors must be aware of and have to ensure they do

not breach. Ignorance of the contents of the 2016 ECEG and 2016 HME would not be valid defence in any disciplinary proceeding.

As it is not possible to summarise all the new and different provisions in one article, I will highlight four areas and some questions which would hopefully spur doctors to read the 2016 ECEG and 2016 HME cover to cover.

## **DISCIPLINARY ACTION AGAINST TEAM LEADERS FOR JUNIOR DOCTORS' NEGLIGENCE**

Clause A5 of the 2016 ECEG concerns doctors working in teams – a new area that was not covered under the 2002 ECEG. In particular, Clause A5(3) of the 2016 ECEG states: "If you are a team leader, you must ensure that the overall performance of the team meets the required standard care for the patients, including, if necessary, arranging for the redeployment or substitution of team members who are unable to perform to the required standard."

Could a senior doctor in charge of a team of junior doctors be disciplined if a junior team doctor was negligent, and if the senior doctor knew that the junior doctor was not up to

the required standard but did not have the junior doctor redeployed or substituted? What if the senior doctor tried to have the junior doctor redeployed or substituted but his request was refused by the hospital?

## **OBLIGATIONS IN AESTHETIC PRACTICE**

While the 2002 ECEG does not have provisions dealing with aesthetic practice, the 2016 ECEG imposes many onerous obligations on doctors in this area.

For example, Clause B10(4) of the 2016 ECEG states: "...you must advise patients of side effects and adverse outcomes beyond those that are more common. For the purpose of obtaining consent, you must disclose risks that are lower than those required to be disclosed in conventional medicine." How much more information must a doctor engaging in aesthetic practice give to a patient?

Clause B10(7) of the 2016 ECEG further states: "You must not offer to or perform aesthetic procedures on minors or persons with diminished mental capacity, unless you have independent professional assessments indicating that these procedures are indeed in these patients' best interests." What would qualify as independent professional assessments?



## CONSENT OF MINORS

The 2002 ECEG simply states that if the patient is a minor, the parent or guardian must be given adequate information about the patient's medical condition and the options for treatment for the purpose of his or her consent on behalf of a patient. Clause C6 of the 2016 ECEG contains many more provisions concerning the taking of consent of minors.

For example, Clause C6(14) of the 2016 ECEG states: "Despite it being standard practice that consent for minors is taken from parents or legal guardians, you must give consideration to the opinions of minors who are able to understand and decide for themselves." How should a doctor proceed if there is a difference in opinion between the parents and a minor?

Clause C6(17) of the 2016 ECEG states: "If parents or legal guardians object to tests, treatments or procedures that you deem necessary despite your best explanations, you must act in the best interests of the minors and not of the parents. You may then have to take steps (such as going through independent advocates or the courts) in order to prevent harm to the minors." What steps must a doctor take to be considered acting in the best interests of a minor?

## THIRD PARTY ADMINISTRATORS

The 2002 ECEG does not have provisions dealing with third party administrators (TPAs), but Clause 4.6.2(c) states that: "A doctor shall refrain from fee sharing or obtaining commissions from referral of patients."

Clause H3(7) of the 2016 ECEG provides that: "You may pay managed care companies, [TPAs], insurance entities or patient referral service fees that reflect their actual work in handling and processing the patients. Such fees must not be based primarily on the services you provide or the fees you collect and you must not pay fees that are so high as to constitute 'fee splitting' or 'fee sharing' or which render you unable to provide the required standard of care. In addition, if you pass on such fees to patients, you must disclose this to your patients." What happens if a doctor has an existing contract with a TPA before 1 January 2017 that provides for "fee-sharing"? Must the doctor take steps to terminate the contract?

## CONCLUSION

Apart from the above clauses that I have highlighted, the 2016 ECEG and 2016 HME contain many new and

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different clauses compared to the 2002 ECEG. Time will tell the effect of the 2016 ECEG and 2016 HME on disciplinary proceedings against doctors. Meanwhile, it would be prudent for all doctors to set aside some time to familiarise themselves with the 2016 ECEG and 2016 HME. ◆