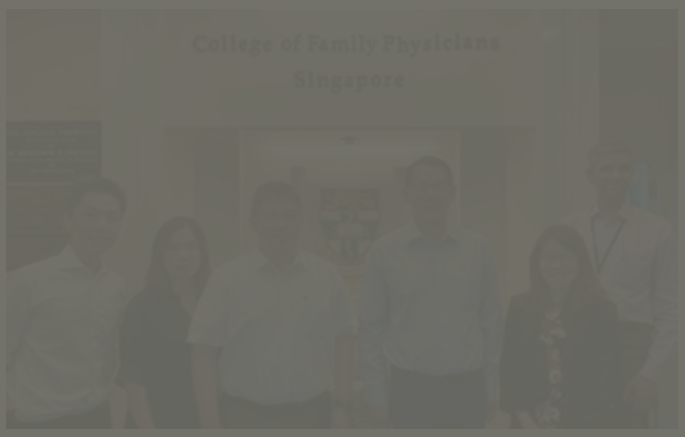
(continued from Page 3: Invitation to MOH- CFPS Webinar for GPs on Covid-19)



the ground. So do keep the questions and concerns coming in and MOH will try to answer as quickly as possible.

- The deadline for daily data entry for FSS has been pushed back to 12pm instead of 9am the next working day.
- Familiarise yourself with how the subsidy scheme works because the information is widely available to the public and there have been queries from some members of the public as to why they had to pay more than what was communicated in the media.
- Testing for COVID-19 is free because of its current public health importance.
- Point of care testing may become available in future.

5| *Need for Continued Vigilance*

- The classic case for COVID-19 infection includes: Acute Respiratory Infection, pneumonia. Based on existing cases, typical symptoms for COVID-19 infection are predominantly respiratory infection symptoms, and may be accompanied by clinical signs of pneumonia.
- There can be concurrent medical conditions coexisting. We need to have a high index of suspicion because there are potential pitfalls.

6| *Continuing Medical Education (CME)*

- No decision yet on whether to waive the need for CME as it is still early in the year.
- SMC is aware of concerns about not having enough educational opportunities for CME points.
- CFPS has been successfully organising remotely delivered lectures for GDFM and is planning more Webinars for Skills Courses.
- Singapore Family Physician journal also has relevant articles and MCQs.

DMS expressed his thanks to all GPs and will work with us to make sure that care for patients is not compromised.

CM

Informed Consent

by Adj Asst Prof Tan Tze Lee, President, 27th Council, College of Family Physicians Singapore

In January 2019, the case of Dr Lim Lian Arn and his fine of $100,000.00 by the Singapore Medical Council's (SMC's) Disciplinary Tribunal (DT) made the news, and hit the medical community like a medicolegal tsunami. It caused quite the uproar amongst both the profession and the public, and the fine was thought by many to be inordinately high for what appeared to be a minor transgression. Some doctors, we had heard, were so perturbed by this that they stopped offering the service altogether. Others increased their charges to factor in the medicolegal risks. Together with the Singapore Medical Association, College conducted a survey to study if a "disciplinary decision can affect practice behaviour."[1] The survey results revealed that there were fewer private sector doctors were offering H&L injections after the DT decision, and the median price band had gone from less than $100.00 to $100.00 to $200.00, representing a 100% increase in costs. In the appeal to the court of three judges, the decision of the disciplinary tribunal was overturned. In the words of the esteemed court of three judges, this had "been an ill-judged prosecution, an unwise decision to plead guilty and an unfounded conviction. In short, there has been a miscarriage of justice, with dire consequences for the medical practitioner concerned."[2]

The Ministry of Health recognised very early on that there was a urgent need to relook at the process of informed consent and the SMC disciplinary process, and convened a "Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process" in March 2019.[3]

The workgroup had 2 objectives, to undertake a comprehensive review and make appropriate recommendations on:

1. the taking of informed consent by doctors
2. the Singapore Medical Council's (SMC) disciplinary process.

After over 30 townhall meetings, conferring with over 1000 doctors from various sectors, as well as countless emails from our members, we were able to reach out to the length and breadth of our profession, be it the private or public sectors, primary, secondary or tertiary care. The feedback back to us came in fast and furious, and these were collected and collated over nine months. Thankfully we had a smooth and timely delivery of the report in December 2019.

It was recognised that "patient safety, interest and welfare … are of foremost consideration", and that "any changes to informed consent practices must continue to nurture a doctor-patient relationship… based on trust, and allow patients to meaningfully participate in the decision-making process."

1. http://www.smj.org.sg/sites/default/files/OA-2019-101-epub.pdf
2. https://www.supremecourt.gov.sg/docs/default-source/module-document/judgement/delivered-judgment---singapore-medical-council-v-dr-lim-lian-arn-2019-sghc-172-(240719)-pdf.pdf

The workgroup also considered that "self-regulation should remain the best way forward for both the patient and the medical profession." Though doctors in the past had almost exclusive knowledge and insight into various conditions, the advent of increased access to medical information has led to the lay public being better informed. However the "voluminous information" available today needs to be contextualized and interpreted by medical professionals. It added that for self-regulation to be effective, the self-regulatory proves is sustainable only if "members of the profession participate actively to ensure its smooth functioning". In order for the various proposed reforms to work, we need to have competent and dedicated doctors to come forward and serve in various capacities, be it on the SMC Council, Complaints Committees (CC), Disciplinary Tribunals (DT) or as expert witnesses.

The workgroup, in deliberating how the SMC disciplinary process can be reshaped, also "embraced the tenet that discipline is the first virtue of a profession", in both "conduct and in deed". Doctors must be worthy of the trust that the public gives to us. We had to consider both sides of the argument. On the one hand, we felt that patients "should not be made to confront unduly onerous rules and requirements in order to exercise their right to make a complaint and request an investigation". On the other hand, such allegations "which can affect the personal and professional lives of doctors, cannot be make carelessly, unthinkingly or without basis". The recommendations aspired to strike a balance and aims for the disciplinary process to be "independent, expeditious, consistent, fair and proportionate, and outcome orientated".

There were calls for the SMC to charge a fee for making complaints, to discourage frivolous and vexatious complaints, which are a real problem for the SMC and a drain on limited resources. The workgroup, to balance the paramount consideration of patient safety, professional discipline and the need to uphold public confidence in the medical profession, deliberated that charging a fee would be an institutional barrier to making a complaint. The balance is to "empower the SMC to order the complainant to pay costs if, after due consideration and investigation, the complaint is found to be frivolous or vexatious, or to have persisted in the complaint despite being aware of contrary facts".

Informed Consent

The Modified Montgomery (MM) test is a patient centric approach to determining a doctor's duty to advise his patient. It signaled to doctors that they would have to change the way they had been taking informed consent. As it required a more customised approach to consent taking, this new standard was somewhat challenging to practitioners.

There was uncertainty about what constituted relevant and material information from the patient's perspective. Many

(continued on the next page)

(continued from Page 5: Informed Consent)

pointed out that the risks might become material after the fact. Giving all the information to the patient was a way to mitigate against such uncertainty, even though information dumping might not be useful for the patient or the doctor.

Doctors were genuinely concerned about the process of taking informed consent that they could be confident of fulfilling the required standard of care. What considerations would they need to take into account to assess what is material from that particular patient's point of view? In a busy clinic setting with limited allocated time, practitioners face difficulties coming up with effective yet defensible work processes that can be reliably consistent in providing material information for their patients. Short consultation times, language barriers and the patients' age all work to impede the level of understanding.

During the townhalls and engagement sessions, some doctors shared that they had already begun to adopt defensive practices. Such defensive practices can result in compromising patient welfare and safety. There have been examples of patients being provided with voluminous information of all risks and alternatives. Such practices may overwhelm and confuse patients and do not necessarily afford doctors better legal protection. Patients provided with such a lot of overwhelmingly detailed information in most instances would not retain this information very well, so how would they be better prepared for the possibility of adverse outcomes? Merely dumping information on patients without ensuring their understanding is not only unhelpful, but is counterproductive. Merely dumping information on patients without ensuring their understanding is not only unhelpful, but can prove to be counterproductive.

Although patients generally want and value their doctors' guidance, some doctors have become more reluctant to guide the patients' decision making. This was borne out in engagements with patient support groups and members of the public who indicated they generally appreciated strong guidance from their doctors. Others have forgone offering certain treatments entirely, for fear of incurring the risk of complaints, and referring them on to specialists instead. Result: increased costs and less efficiency.

The recommendations of the workgroup seek to address these issues.

For the informed consent process, there were essentially 3 recommendations:

1 Provide a clear legal standard for medical professionals' duty to advise which is one that is patient-centric but ultimately based on the opinion of a responsible body of doctors.

The standard will be patient-centric, but ultimately based on the opinion of a responsible body of doctors. The test mandates that the responsible body of doctors must consider whether information that is relevant and material to the patient in the circumstances to allow that patient to make informed treatment decisions, was provided. Under this test, doctors would not be permitted to simply dictate what information patients should receive, without any regard to the individual patient's need for information, but would need to have regard to patient autonomy and choice in order to satisfy the standard of care. This would mean giving patients an opportunity to ask questions and have their specific concerns addressed.

There might be situations where a doctor may, after assessing the information to be relevant and material, decide to withhold that information, in order to prevent harm to the patient. The standard of care in such instances would also be determined by the practice and opinion of a body of peers.

In essence it is patient centricity, with materiality assessed by peers.

2 Revise the SMC's Ethical Code and Ethical Guidelines 2016 (ECEG) provisions on informed consent down to basic irreducible principles, with helpful illustrations to guide doctors on how these principles apply.

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The workgroup received feedback of confusion and a lack of understanding of the purpose of the ECEG. The ECEG expressedly states that it only provides a framework to guide a doctor's professional judgment. However the guidelines were often phrased prescriptively, and could be misconstrued as suggesting that ideal standards of conduct become the base obligatory standard for ethical practice. The perception was that the profession was now being held to "expert" standards, as opposed to usual safe practice standards.

There is therefore a great need to crystallize the section on informed consent into core irreducible principles. The key elements of informed consent (medical condition, viable options, benefits, possible significant complications and risks) would continue to be reflected, with the addition of a risk-differentiated approach for cases involving minor intervention. Annex B sets out the recommended formulation of the proposed standard.

3 Develop nationally agreed specialty-specific guidelines to deal with standard commonplace procedures in each specialty.

The Academy of Medicine, Singapore, College of Family Physicians, Singapore and public healthcare institutions will develop appropriate specialty-specific guidelines to deal with standard commonplace treatments and procedures in each specialty. These guidelines should provide practical guidance to doctors on how they are to comply with their core irreducible duties by illustrating practices that should be adopted in common situations. The procedure specific information will be updated from time to time by the professional bodies in conjunction with advances in medical practice and knowledge.

The intention is not for the guidelines to be prescriptive, but to serve as a source of reference or as a baseline. The contextual circumstance of each treatment must be considered in every case.

In summary, these recommendations aim to restore the doctor-patient relationship, promote patients' interests and reverse the trend of defensive medical practice. And by doing so quell the disquiet our profession finds itself.

1. http://www.smj.org.sg/sites/default/files/OA-2019-101-epub.pdf
2. https://www.supremecourt.gov.sg/docs/default-source/module-document/judgement/delivered-judgment---singapore-medical-council-v-dr-lim-lian-arn-2019-sghc-172-(240719)-pdf.pdf
3. https://www.moh.gov.sg/news-highlights/details/moh-appoints-members-of-workgroup-to-review-the-taking-of-informed-consent-and-smc-disciplinary-process
4. https://www.moh.gov.sg/docs/librariesprovider5/default-document-library/wg-report.pdf

Annex A – Legal Test for the provision of Medical Advice

This is a patient-centric test based on peer professional opinion, which has regard to patient autonomy and choice and takes into account what is material to the patient.

(1) A healthcare professional shall be regarded as having discharged his duty of care in the provision of medical advice to his patient if the medical advice he has provided is supported by a respectable body of medical opinion as competent professional practice in the circumstances ("peer professional opinion").

(2) For the purpose of paragraph 1, the respectable body of medical opinion must consider whether the healthcare professional gave[1] to the patient relevant and material information that a patient in those circumstances would reasonably require in order to make informed treatment decision(s), and information that the healthcare professional knows[2] would be relevant and material to the patient.

(3) However, peer professional opinion cannot be relied on for the purpose of paragraph 1 if the court determines that the opinion is illogical.

(4) The fact that there are differing peer professional opinions by a significant number of respected practitioners

in the field concerning a matter does not in itself mean that the peer professional opinion being relied on for the purpose of paragraph 1 should be disregarded as evidence of a respectable body of medical opinion.

[1] Or arranged to give.
[2] Or ought to have known.

Annex B – Draft ECEG on informed consent

(1) Patient autonomy is a fundamental principle in medical ethics and must be respected.[3] You must respect a patient's right to refuse tests, treatments or procedures.[4]

(2) It is a doctor's responsibility to ensure that a patient under his care is adequately informed about his medical condition and options for treatment (including non-treatment) so that the patient is able to participate meaningfully in decisions about his treatment.[5] In taking consent, the information provided to the patient should include the purpose of tests, treatments or procedures to be performed on them, as well as the benefits, limitations, risks and alternatives available to them.[6] Considerations should also be given as to whether the treatment involves minor or major interventions and the levels of risk, the clinical setting and the context of the consultation, and should be relevant and material to a reasonable patient situated in the particular patient's position.

(3) A doctor should either take consent personally or if it is taken for the doctor by a team member, the doctor or the doctor's department should, through education, training and supervision of team members, ensure that the consent taken on the doctor's behalf meets with these guidelines. It is the principal doctor's responsibility to be reasonably satisfied that this has been done.

(4) In any case, you must ensure adequate documentation of the consent taking process where this involves more complex or invasive modalities with higher risks. Other team members may provide information such as education materials to augment the patient's understanding.

(5) In an emergency or therapeutic situation, a doctor may proceed with treatment without consent when the patient is not capable of giving consent and where the doctor deems that the patient may suffer significant harm or be exposed to inordinate risk unless the treatment is done immediately.

[3] Taken from Section C5 of ECEG 2016.
[4] Taken from C6(13) of ECEG 2016.
[5] Taken from Para 4.2.2 of ECEG 2002. Added the reference to "non-treatment".
[6] Taken from C6(3) of ECEG 2016.

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The Journey Towards MMed(FM)

The College Mirror is delighted to have recent graduands of the MMed(FM) College Programme share their personal journeys and valuable insight into the challenges faced during the course of the 16-month programme. We wish them the best for their endeavours, and hope they continue to inspire!

Dr Ong King Jane

My Exam Journey

I am a Resident Physician in Palliative Care in Changi General Hospital.

I started out petrified as I have been practising palliative care at a restructured hospital for a long time, was the oldest candidate in my batch, and knew no one in the College programme. However my batch was a friendly one and I quickly made friends. The tutors guided us throughout and were passionate about teaching, hence my knowledge increased exponentially. Subsequently I formed a study group with Drs Cynthia Tan and Lim Baoying, and we grew closer as we met frequently to spar with one another. Despite the intense stress, our study group kept our sense of humour and enjoyed ourselves.

Clockwise from top: Dr Cynthia Tan, Dr Ong King Jane and Dr Lim Baoying – the Simei-Changi General Hospital study group at the Family Medicine Convocation Ceremony

What I Have Learnt

1. Resilience and perseverance because this is a gruelling and highly compressed programme that requires one to step up to take the Clinical Exam after 16 months of intensive training.

2. Breadth and some depth of medicine because Family

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