Submission of Feedback by SMA to SMC Review Committee

Recently, SMA submitted feedback to the Singapore Medical Council (SMC) Review Committee, which SMC had appointed to look into disciplinary proceedings involving doctors. SMA's letter and feedback are reproduced below.

5 April 2013

Members of the Review Committee
c/o Dr Lau Hong Choon
Singapore Medical Council

Dear Members of the Review Committee,

Request for Feedback on Complaints and Disciplinary Processes under the Current Medical Registration Act and Regulations

We refer to your letter to the Singapore Medical Association dated 18 March 2013, our letter to you dated 20 March 2013 and your subsequent email reply dated 2 April 2013.

We are grateful that the Committee has invested, and will be investing, valuable time in undertaking a comprehensive and careful review. As such, attached herewith is the feedback and recommendations from the 53rd SMA Council. Should we receive additional feedback from SMA members later on, we will forward them to the Review Committee in due course. The 54th SMA Council will be happy to meet up in person with the Review Committee to discuss the recommendations and feedback herein if invited.

We would like to suggest that the recommendations and findings of the Review Committee be made public as soon as practicable.

Yours sincerely,
Dr Tammy Chan
Honorary Secretary
53rd SMA Council

Feedback to SMC Review Committee

1. Composition of Review Committee

As the Review Committee has to achieve a very important set of aims that will have a lasting effect on the medical profession, it is important that the medical profession and the public know who the members of the Committee are. We thus reiterate the necessity of making the identities of the Committee's Chairperson and members known in the interests of accountability. This also reassures the medical profession and the public of no conflicts of interests on the part of any of the members of the Review Committee. It is important that all who make submissions are clearly informed of the Review Committee's Terms of Reference. The final report and recommendations should also be made public in order to restore trust and confidence in SMC's disciplinary system.

2. Composition of SMC

The composition of SMC should include representation from various medical professional bodies such as the Singapore Medical Association, Academy of Medicine Singapore and College of Family Physicians Singapore. This will provide a multifaceted representation. The current law [Medical Registration Act (MRA), Chapter 174, Section 4], provides for the inclusion of two registered medical practitioners from each prescribed medical school in Singapore. However, SMC should have a more diverse input. We recommend that the three medical schools and the three abovementioned professional bodies be allocated one seat each for their selected representatives to be appointed to the SMC Council. This is to enable greater diversity and range of views from different segments of the profession, while maintaining the overall number of SMC Council members.

It is also important to expound on the remit of appointed members of the SMC. There has to be a clear distinction between whether their interests should align with those of the organisations they represent, or with the interests of society. SMC should also clarify to the members elected by the medical profession on their duty and obligations to those who had elected them.

3. Financial Statements of the SMC

The accounts of the SMC, in particular the costs of administration and costs of engaging counsel, should be made public annually.

4. Medical Registration Act (Chapter 174)

a. Minimal Sentences [Section 53(2)(b)]

As mentioned in the High Court judgement of Eu Kong Weng v Singapore Medical Council [2011] SGHC 68, there are situations whereby a three-month suspension is excessive.[1] The Disciplinary Tribunal (DT) should be given leeway to give shorter suspensions without the provision of the minimal suspension period.[2]

b. Role of Investigators [Section 60(A)]

The introduction of investigators into the SMC complaints process is perceived by some to be a duplication of the existing investigation arm within the Ministry of Health (MOH), which should be sufficiently comprehensive and adequate. This is a perception which SMC and MOH could address.

Nevertheless, the role of SMC's investigators needs to be clarified and made known to all stakeholders. The powers of these investigators are, in a sense, even greater than that of the police. These investigators do not need a search warrant to seize anything from a clinic or hospital. However, before investigators are allowed to do so, we propose that affected doctors be informed of the nature of the complaint that has resulted in the investigation. We also note anecdotal information that patient confidentiality may not be preserved in the process, and that the time and method in which raids are conducted unnecessarily disrupts clinic work and patients' needs. We have been told that in some cases, investigators have been calling patients for feedback on doctors' performances, causing significant distress to patients and mistrust in the healthcare system. The Complaints Committee (CC) should provide clear instructions regarding what materials are necessary and the appropriate investigational methods in the investigation of received complaints. It is possible that inappropriate or inadequate instructions and unnecessary referrals to investigators have resulted in protracted and unnecessary delays in the complaints process.

Investigators should also have formal training and suitable qualification, so as to ensure their adequacy in fulfilling their role. Protocols and practices, such as identification upon arrival on-site, liaison with the doctor involved in the investigation, and request for only the necessary documents, could be indicated in a Code of Conduct for investigators. This is to professionalise their role and educate doctors on what they can expect during an investigation.

c. Mediation (Section 43)

We propose that SMC be given the power to bring parties to mediation only when the complainant is a

private individual. When the complainant is a government officer or a statutory body, SMC should not be given this right to make an order for mediation as stated in Section 43(1).

We also recommend that SMC officers highlight mediation as an alternative, effective way of resolving disputes to complainants at the time of statutory declaration of the complaint, especially in cases of miscommunication and where complainants and their families are still grieving after an adverse medical event. The CC should also be empowered to offer early recommendation of mediation as an option prior to or during the inquiry, especially in complaints that are likely due to miscommunication. It is clear from medical literature that patients' complaints are most commonly due to lapses in communication, and that empathy and a sincere apology often help to resolve disputes. It is thus recommended that SMC have a list of qualified persons able to provide such mediation services.

d. Number of Secretaries (Section 10)

The MRA provides for "an executive secretary". Yet in recent times, there were two. The MRA should be clear if it provides for only one executive secretary or more.

e. Avoiding dual roles in related organisations that can result in potential conflicts of interest

To avoid conflicts of interest, the Registrar and Executive Secretary should not hold other regulatory functions in MOH, especially when MOH is a major complainant to the SMC. Independence of key members and key administrative staff of the SMC would go a long way in restoring the confidence of patients, the public and the medical profession in SMC's disciplinary system.

5. Registrar, Complaints Committee and Disciplinary Tribunal

We are of the view that the current problem with delays possibly stems from too many layers of administration and case management. These should be conflated and streamlined. We recommend that complaints and disciplinary processes be handled by a key person. We thus suggest the consideration of a Registrar of the CC and DT, and vesting in him/her the requisite powers to manage and improve these processes. The Registrar can also play a more active supporting role in the management of complaints, monitoring of investigations, pre-inquiry conferences (PICs) and case management. We have included our understanding of the current processes in Appendix A (see page 17), and we recommend the appointment of a Registrar for the following roles:

a. While the Chairman of the Complaints Panel can appoint who to sit on a CC, the Registrar can be empowered to fix meetings for all CCs to sit in a stipulated timeframe, so that the three persons constituting the Committee will free their schedules in advance for those designated days.

b. This will minimise coordination difficulties and result in a more productive use of SMC's limited resources. If the CC needs to discuss, provision can be made for them to engage in discussion via email and phone or video conference, as opposed to physical meetings at SMC. This means that the Registrar can simply allot cases to CCs after ascertaining that there is no potential conflict of interest, thus facilitate the process of discussion and inquiry. This should expedite CC sittings.

c. The Registrar can also monitor investigation timelines to enable SMC investigators to complete their investigations without stagnation of cases. Differentiated case management can be introduced, like in the courts, with straightforward complaints to be completed within X weeks, and complex ones within X months. The Registrar can be empowered to ask the investigators for status updates of their investigations, and identify any reason for delay and make this known to the CC, which will then be able to give directions on what can be done to expedite the process.

d. When a case proceeds with formal inquiry, the Medical Registration Regulations 2010, Section 29 provides for the Chairman of DT and Legal Assessor to preside in PICs. Unfortunately, this could result in a lack of consistency (as each has his/her own style) and unnecessary delays due to possible lack of training and experience. The Registrar should be involved in the PIC by sitting with the Chairman of DT and Legal Assessor so as to improve administrative efficiency and consistency. The Chairman of DT will still be the one to give the necessary directions at the PICs, but the Registrar can assist with a centrally-managed diary where he/she will be able to estimate the number of days likely to be required for a particular inquiry, and whether a case is likely to proceed in the direction of a plea of guilt, thus optimising the number of days of use of the SMC Tribunal Room.

e. Likewise, the Registrar can assist the respective Chairmen of DTs with a differentiated case management system for managing inquiries. For example, simple cases are to have expedited tracks, complex ones to have tightly monitored timeframes, and avoidance of part-heards and last minute vacation of trial dates wherever possible.

6. The Complaints Process

a. A limitation period for complaints is appropriate and satisfies the laws of natural justice. SMA proposes a time bar of six years for making complaints. Special court orders

can be made available for important cases that exceed the limitation period, when necessary, eg, paediatric cases. The limitation period of six years is also consistent with the same time bar used for the legal profession.

b. MOH complaints to SMC should be filed by a named government officer for accountability to the complaint filed.

7. Training for Persons Sitting On DTs

a. There must be proper training for doctors sitting in SMC, the CCs, Health Committees, Interim Orders Committees, or the DTs. This training should minimally include:

i. Basic concepts of legal procedure and reasoning;
ii. Understanding the laws of natural justice and rule of law;
iii. Ethical analysis and justification;
iv. Usage of past decisions to ensure consistency; and
v. Writing Grounds of Decision.

This training will ensure that committee members are able to exercise their own judgement instead of relying on the legally trained DT Chairperson (if any) or on the Legal Assessor, bearing in mind that the rationale behind the SMC is to enable a doctor to be judged by his peers.

b. The rationale for having legally trained persons on DTs should be made clear. In a letter dated 13 July 2009 from the Director of Medical Services to the medical profession, it was stated that requiring a legally trained chairperson to chair a DT is to address high profile cases and avoid potential conflicts in the medical community. We would like to know (and the medical profession should also know) whether the rationale for this has changed in any way.

8. SMC Legal Counsel and Drafting of Charges

a. The role of legal counsel needs to be clarified. Is the main role of the legal counsel to uncover the truth [similar to a Deputy Public Prosecutor (DPP)], or to win the case for SMC (similar to a lawyer-client relationship)? We propose that the chief role of SMC's legal counsel should be akin to that of a DPP – to uncover the truth.

b. We strongly propose that SMC engage the services of Government Legal Service Officers instead of legal counsel from private law firms. Additional positions in the Legal Service arising from the needs of SMC can be funded by SMC funds with no financial detriment to the Legal Service budget. SMC should minimally consider requesting for the secondment of Legal Service Officers who are serving as DPPs in the Attorney General's Chambers (AGC) (preferably with at least ten years of undertaking prosecution work), to be entrusted to scrutinise charges and statements of facts prepared by panel law firms undertaking prosecution for SMC, to ensure consistency and legal correctness in the drafting of charges. Alternatively and preferably, we could learn from Medical Council of Hong Kong (MCHK) where government legal officers act as counsel. We believe this is beneficial for the following additional reasons:

i. Using a pool of Legal Service Officers from the AGC will help build up domain knowledge in the medico-legal arena over time, and enable consistency and improve quality of charges drafted and carried through, as compared to the engagement of different lawyers across different firms.
ii. SMC's experience with private lawyers drafting charges has not been entirely satisfactory. In one case, it was described as "legally embarrassing".[3] Legal Service Officers, being more familiar with the criminal justice process than litigation lawyers from private practices, are likely to be better trained and experienced. A veteran Legal Service Officer with an experienced prosecution background can centrally and positively shape the way charges and statements of facts are framed, as compared to SMC's current process, which varies with the varying styles of each individual legal counsel.
iii. Currently, the lawyers crafting the charges following the conclusion of the CC inquiry and before the commencement of the DT inquiry operate in a vacuum. This lack of transparency is disconcerting. Having Legal Service Officers (who are public servants) draft charges together with the Chairman of the CC, who is medically trained, will more appropriately highlight medical professionalism and ethical issues. Complaints received should be subjected to ethical analysis and transformed to charges that suit the quasi-legal nature of the proceedings. This will improve public and professional confidence in this part of the disciplinary process, and will improve the quality of drafted charges and save costs.
iv. Using the legal service will also remove private legal counsels' possible consideration of financial incentives, which could present a possible moral hazard to the disciplinary process.
v. Using the legal service will in all likelihood help to control the costs of running SMC.

c. We call on SMC to publish the legal costs incurred for disciplinary cases, including a breakdown of the average cost per case, tabulated for cases in which the registered medical practitioner was not found guilty, and for cases in which he/she was found guilty. This must be made available to defence lawyers, medical indemnity organisations and

others with a legitimate interest. This transparency will help to alleviate fears that the SMC's legal costs are inconsistent across the outcomes.

d. Legal fees should be determined on an objective basis and not dependent on whether a case is won or lost. There must not be a moral hazard for lawyers acting on behalf of SMC, nor should there be financial incentives, whether real or perceived, for lawyers to "win" a case. Rising legal costs will inevitably lead to increased healthcare costs for patients.

e. Clear guidelines and scale on legal costs and fees could be stipulated by SMC and made transparent to involved parties, so as to reduce unnecessary quibble over such matters before the High Court. This will also help cap costs at a consistent, reasonable and affordable level for all parties involved.

f. MCHK requires each party to bear its own costs regardless of the outcome. There is much wisdom in this.

9. The Disciplinary Process

a. If there is a trained lawyer or retired judge sitting on the DT, then we should do away with the need for a legal assessor.

b. In view of the backlog of cases, we encourage SMC to devote more logistical and manpower resources to speed up the process. SMC could also consider adequately and fully reimbursing the time and effort spent by the CC and DT members in the preparation and carrying out of the proceedings.

c. We note the interval between determination by the CC and commencement of the DT to be inconsistent, and possibly too long. We propose a maximum period of three months between the date of the CC's order to the submission of charges to the DT, and another maximum of six months to the start of the first hearing.

d. We recommend that all Grounds of Decisions (including cases in which the doctor was found not guilty) be published. Sensitive information can be anonymised if necessary. This provides educational value for doctors by highlighting what would be (and what would not be) considered professional misconduct. This transparency will also improve public confidence in SMC's disciplinary system.

e. We recommend that precedents and hearing documents should be made available for defence lawyers to be able to appropriately advise doctors who are facing charges.

f. We note several court cases[4] that highlight instances in which the doctor facing a complaint was wrongfully asked to pay full legal costs when he/she was not found guilty of all charges. This indicates an insufficient understanding of the abovementioned principles during the complaints and disciplinary process.

g. We propose that the medical experts selected to present their expert opinions during CC and DT proceedings should be adequately trained and free from any conflicts of interest. The DT should not withhold questioning of medical experts when the expert's report and testimony are found wanting. Being the party most medically experienced in and knowledgeable of this process, this onus thus rests on the DT and not solely on the prosecution or defence lawyers. SMA, in partnership with Medical Protection Society (MPS) UK, has been conducting relevant training for medical expert witnesses (MPS-SMA Medical Experts Training Course), which we recommend that current and future medical expert witnesses attend.

h. The DT should be empowered to raise questions to enable greater understanding of the case, which SMC's lawyers have to prove beyond reasonable doubt. A practitioner prosecuted in DT proceedings is only required to respond to the charge. If the charge against a practitioner is for professional misconduct, the DT should focus on what the alleged actual conduct of the practitioner is, with reference to the care of his/her patients, or otherwise. A key lesson from recent DT decisions that were overturned by the High Court is that the DT should first and foremost seek to clearly understand SMC's case (based on the charge), so that as evidence unfolds during the trial, the DT will not digress from the crux of the charge.

10. Ethical Code and Ethical Guidelines

a. The SMC Ethical Code and Ethical Guidelines needs to be clarified. We understand that the Guidelines are, as the name implies, guidelines. A guideline is not a legal tool of "strict liability" (such as traffic violations) whereby any deviation is tantamount to professional misconduct. Knowing that no two patients' illnesses or interests are identical, it is therefore not unusual to have variations in the provision of healthcare. Such variations should not be misconstrued as intentional deviation from good professional standards articulated in the ethical guidelines. Not all non-adherences to clinical and ethical guidelines automatically qualify as professional misconduct. Some do not warrant a ruling of professional misconduct. Simple negligence, errors of judgement, and single lapses in judgement should not equate to professional misconduct.

b. Indeed, in the introduction of the Ethical Code and Ethical Guidelines (page 1), it is stated that "persistent failure" or "serious disregard" of the Guidelines "may

lead to disciplinary proceedings". Serious neglect of professional responsibilities and wilful abuse of a registered medical practitioner's privileges encapsulate and underline the concept of professional misconduct. Therefore, not every violation constitutes professional misconduct that is deserving of sanctions from SMC. The gravity of the act before being deemed to constitute professional conduct should be clearly enunciated.

c. We note an article in *SMA News*, December 2011[5] where Dr T Thirumoorthy expounded on the definition of professional misconduct following recent legal cases at that time.

11. Appeals Process (to Minister)

a. There have been several cases whereby complainants have appealed to the Minister for Health for cases to be reopened when the CC or DT has ruled in the doctor's favour. This process is currently opaque. We note that Section 49(10)-(13) and Section 55(1)-(12) explain the appeal processes for CCs and DTs respectively. However, how does the Minister consider rejection of the appeal or sending the case to a DT? What are the criteria for such a decision? How does the Review Committee (under Section 55) decide whether to direct SMC to file an appeal to the High Court, or not? We would like to suggest that SMC makes known how these processes are run, reveals who have been consulted, and ensures that clear grounds of decisions are provided and made known to all stakeholders.

b. It is believed by some that the number of successful appeals to the Minister has significantly increased in recent years. If this is true, then this actually (unintentionally) undermines the role of the CC. Thus, an important question remains in light of this: who are the people who recommend the merits of such appeals to the Minister?

c. The current Minister (as also stated during a luncheon at MOH with the SMA Council) has said that in future, he would publicly give written reasons for the merits in reopening a case. We welcome this and hope that this can be enshrined in the law.

12. Training and Equipping the Profession

a. In addition to the point raised at paragraph 7 above, the SMC should take a proactive role in the education of doctors with regard to the definition and concept of good professional practices, including what constitutes professional misconduct.

b. SMA has taken the initiative to develop several training courses in the area of medical ethics, health law and professionalism, and welcomes the participation of doctors sitting in the various SMC committees. We have noted that some of the members who participate in such committees have already taken the initiative to attend some of such courses that were conducted in previous years. We believe that more should be encouraged to do so in order to be adequately trained so as to be able to sit in judgement of their fellow professionals.

13. Certificate of Good Standing

Currently, doctors who have been convicted by SMC are unable to receive a Certificate of Good Standing (CGS) from SMC, which is often required when he wishes to practise overseas. We believe that this is unnecessarily harsh. We propose that for first-time offenders, a CGS can still be issued three years after disciplinary action, if the order is only a fine or a suspension of six months or less. For repeat offenders, or in cases where a person has been suspended for more than six months, SMC's current position on the issuance of CGS can remain.

We are also given to understand that doctors who have a pending complaint will also be unable to receive a CGS. This could unnecessarily impact the training of the doctor, eg, a doctor going for overseas Healthcare Manpower Development Plan attachments where a CGS is needed for medical registration in a foreign country. This is especially pertinent in view of the current situation where a CC or DT's decision could take a few months or more. There ought to be a mechanism to facilitate the provision of a CGS for pending complaint cases, as the principle should be a presumption of innocence until guilt is found by due process.

14. Remediation and Rehabilitation

A doctor found guilty of professional misconduct may lack, or have a deficiency, in knowledge, skills and personal attributes. In such situations, the interest in public and patient safety necessitates giving these doctors an opportunity to remedy their professional deficiencies before they return to practice.

Similarly, in a prolonged disciplinary process, even when the professional is vindicated, the physical and emotional stress incurred is serious and needs proper closure. It is clear that when a doctor's reputation is publicly challenged, even his/her family members undergo emotional trauma. After such a negative event, it is not uncommon for doctors to experience maladaptation, suffer burnout and become disillusioned. It is important for future patients, the public and fellow professionals that such doctors be supported and given avenues for proper closure, in order to resume their professional roles.

Appendix A

Current Processes of CCs and DTs

The process as we currently understand is:

a. A complaint is lodged. The Secretariat of SMC refers it to the Chairman of the Complaints Panel.
b. The Chairman of the Complaints Panel has to decide on three persons from the Panel to form a CC.
c. The Secretariat of SMC will then notify these three persons and arrange a date/time for them to meet. Being doctors and other professionals, it can be hard to coordinate the meeting date/time.
d. When the CC meets, if they feel that a complaint requires investigation, they will direct an SMC investigator to carry out the investigation.
e. The SMC investigator then writes to the doctor concerned for explanation. The doctor may ask for an extension of time.
f. After the SMC investigator receives the doctor's explanation, he/she has to put up a report with a recommendation for the CC's consideration.
g. The CC will then have to meet again, which entails coordination of the date/time of availability of three members.
h. The CC makes a decision, which is posted to the relevant parties. This will often take several months, and in some cases more than one year, from the time of submitting explanation to a CC decision.
i. If a formal inquiry is directed, the legal counsel of SMC will work on the charge. This entails another period of waiting. We understand that the CC will typically write to inform the doctor of their decision and it will be several months, or in some cases, more than a year, before the Notice of Inquiry is served.
j. SMC will then appoint a DT comprising another three persons.
k. Notice of Inquiry with the charge will then be sent to the doctor in question. If an expert's report is required, the process is lengthened to await the report, which is usually enclosed with the Notice of Inquiry.
l. The respondent doctor may ask for more time to prepare his defence after seeing the charge, although about two months' notice would have been given to the doctor.
m. In between, a pre-inquiry conference may be held and presided over by the Chairman of the DT and legal person (in place of the legal assessor under the amended MRA) to look into narrowing issues and determining trial days required. The problem is that unless either of these persons has adequate and relevant training or experience in framing issues and approximating trial days, the exercise may not lead to more efficient hearings during the Inquiry.
n. Consequently, trial days given may be too few, which require part-heards (ie, adjournment of the hearings), thus further prolonging the case. This is because a part-heard signifies the need to synchronise the availability of multiple parties, including the DT (three persons), legal assessor (if one is required under the amended MRA), counsel for both sides, respondent doctor, and witnesses. Part-heards also increase costs for all parties due to the need to refresh evidence and prepare again for the next tranche of hearing.
o. In view of the time constraint, some DTs may then rush to finish within insufficient trial days to avoid part-heards. This rushing of parties to finish within the days allocated, means sitting beyond 8 pm. This is not conducive for a fair hearing when witnesses are on the stand for long hours, and when the counsel and all parties are exhausted/hungry after six hours or more of intense legal battle. All these can be avoided if greater emphasis is placed on the pre-inquiry stages to correctly assess the time necessary for the proceedings. SMA

Notes

1. *Eu Kong Weng v Singapore Medical Council [2011] SGHC 68: "We agree that a suspension is called for, and if we had the discretion, we would have imposed a shorter period of suspension. However, the law does not allow us to do that as the 3-month suspension is the minimum mandated by s 45(2)(b) of the Act."*
2. *Tin KS, Kang YX. Specified minimum suspension term for doctors and other healthcare professionals: a time to rethink, review and revoke? Singapore Med J 2012; 53(11):706-11. Available at http://www.sma.org.sg/UploadedImg/files/SMJ/5311/5311co1.pdf. Accessed 5 April 2013.*
3. *Low Chai Ling v Singapore Medical Council [2012] SGHC 191.*
4. *Lim Teng Ee Joyce v Singapore Medical Council [2005] 3 SLR(R) 709: "The notion of a completely subjective or unfettered discretion was contrary to the rule of law. It would be inconsistent with principle, and contrary to the notion of fairness, for the DC to punish a registered medical practitioner (RMP) with the costs of the SMC if he was exonerated from the charge preferred against him. The function of a disciplinary process was to determine wrongdoing and to punish a person, be he an employee or a member of a profession or association, for having committed the wrong. There was no justification for punishing a person with having to pay costs if he was acquitted of the charge." See also Shorvon Simon v Singapore Medical Council [2006] 1 SLR 182.*
5. *Thirumoorthy T. Professional Misconduct – Reflections on the Proceedings of the Recent SMA Seminar. SMA News 2011; 43(12): 17-9. Available at http://news.sma.org.sg/4312/Commentary.pdf. Accessed 5 April 2013.*