SMC Disciplinary Proceedings and Sentencing: Some Thoughts Regarding the Current Process (Part 2)

By Dr Bertha Woon

This is the second instalment of a three-part series. The first instalment, titled "SMC Disciplinary Processes: Time for a Redesign? (Part 1)", can be found in the February 2013 issue of SMA News *(http://goo.gl/lp2gx).*

The following discussion is by no means comprehensive but aims to draw attention to a few aspects of our current system that doctors ought to know, but may not know about.

I will compare Part VII of the Medical Registration Act (MRA), Cap 174, and Part V of the Medical Registration Regulations 2010 (MRR) containing the details surrounding our professional conduct and discipline with that of the Legal Profession (Disciplinary Tribunal) Rules[1] (LPDTR).

3. Investigators

Section 60A(2)(d) of the MRA states that an investigator may, "without warrant enter, inspect and search during regular business hours any premises which are used, or proposed to be used or in respect of which there is reasonable cause to believe are being used by the registered medical practitioner who is under investigation to carry out the practice of medicine". There are seven points under this subsection of the long list of things that the investigator may do.

I believe that the majority of doctors are unaware of, and would be surprised by, this provision. In fact, this manner of investigation is akin to that used under the Criminal Procedure Code 2010. On the other hand, LPDTR utilises the discovery process, as found in Civil Procedure.

One must really question why a criminal investigation process is used for medical disciplinary proceedings whereas the legal profession utilises the Civil Procedure.

4. Evidence Act

Section 51(4) of the MRA states that "a Disciplinary Tribunal (DT) shall not be bound to act in a formal manner and shall not be bound by the provisions of the Evidence Act (EA), Cap 97, or by any other law relating to evidence but may inform itself on any matter in such manner as it thinks fit".

Contrast this with Rule 23 of the LPDTR which states that "the EA shall apply to proceedings before the DT in the same manner as it applies to civil and criminal proceedings".

Is it not interesting that our DT functions in a quasi-judicial manner and yet, does not comply by the EA and treats doctors under investigation using a quasi-criminal investigative process? It must be pointed out that the EA encapsulates the manner in which evidence can be admissible. Perhaps the Review Committee (RC), set up to look into the Singapore Medical Council (SMC) disciplinary process, should consider incorporating Rule 23 of the LPDTR into the MRA. Imagine a DT case going on to the Court of Appeal where the DT evidence was not adduced properly according to the EA in the first instance – would that not wreak havoc on due process and the rule of law?

5. Adversarial system – is it necessarily the best way forward?

As opposed to an adversarial system, an inquisitorial system would allow for parties to essentially work together to enquire and get to the truth, rather than a blame-levying mode where the doctor is already accused.

a. Win-lose

Due to the adversarial nature of the DT process, one party will win and the other will lose, and neither would

be totally satisfied. To quote Edward A Dauer, apart from this system being "inefficient, ineffective, inaccurate and … structurally inconsistent with the fundamentals of quality improvement and future patient safety", "it is, in all, something only a trial lawyer could love".[2]

b. Competence of lawyers, members of the Complaints Panel and DT, and investigating officers

Since the outcome of a DT depends, to some extent, on the quality of the legal representation available and the competence of the Complaints Panel and DT, perhaps the RC can structure a formal system to train Complaints Committee (CC) and DT members in legal procedure, so as to accord uniformity and due process to all doctors who ever come under investigation.

c. Duration of the disciplinary process under the current system

Anecdotally, it appears difficult to impose strict timelines on the process and sometimes, the psychological trauma to doctors from cases that drags on for years, is far greater punishment than what is eventually meted out. A patient and his family who complained about an errant doctor are agonised by the long delay in closure, especially when there has been a serious adverse event. Perhaps the RC can look into ways to enforce stricter timelines to complete the DT process in a just, expeditious and economical manner. Rule 13 of the LPDTR utilises pre-hearing conferences to achieve this end.

d. High costs

There is a high cost to pay in terms of legal costs (which make up the bulk of the costs), costs in time to all the people involved in the CC and DT, and ancillary costs, such as the cost of photocopying transcripts of the proceedings that are necessary for the appeal. These costs are borne in part by fees paid by every single doctor in the country to SMC, and the Medical Protection Society, which indemnifies doctors. As such, the RC ought to look into the accountability of SMC funds. As SMC DT hearings are of public interest in nature, is it appropriate to modulate the legal fees involved? In addition, is there a need for SMC to appoint senior counsels?

Ever since the second limb of Section 39(1) of the MRA allowed public officers to send complaints to SMC without statutory declaration, there have been a number of cases whereby Ministry of Health officers, rather than members of the public, have filed complaints against doctors with SMC. Would a penalty for costs against the complainant where the doctor is not errant, but where the complaint was frivolous or without merit, be in order? This issue arguably occurred in Dr Low Chai Ling and Dr Georgia Lee's respective cases.

The SMC disciplinary process is of public interest and thus cost containment is of public interest. Rising legal costs would in turn raise medical indemnity fees which would find its way to rising medical costs to the public, contributing to rise in healthcare costs to society.

e. Unsatisfactory outcomes that do not address the primary issues of what the complainant wants

The complainant seldom benefits from the disciplinary procedure. As mentioned above, the punishment to the doctor is financial in nature and sometimes punitive, in the form of a warning, a suspension or getting struck off the register. The complainant does not get any damages. In such a situation, both the complainant and the defendant end up in a lose-lose situation because what the complainant needs or wants may include other things,[3, 4] including restoration (more broadly than cash); sanction (accountability for erring providers); communication (disclosure, explanation, apology); and correction (steps taken to assure the error is not repeated).[2, 5]

f. Psychological trauma to both complainant and doctor under investigation

While being advised by the lawyers, a complainant has to relive the events repeatedly. In addition, relatives and friends who may add fuel to fire may affect a complainant's emotional state.

Doctors go through emotional duress and some even become depressed as their professional competence or ethics are questioned. Even if they are ultimately acquitted, many suffer from post-traumatic stress. Another point the RC ought to look into is a framework for rehabilitation of doctors post-DT.

6. Certainty regarding definitions, precedents and sentencing

Up till recently, SMC DT proceedings were not published and hence there was a dearth of information to aid a defendant doctor's lawyer. It is helpful that SMC now publishes summaries of the DT proceedings. Section 93(4) to (6) of the Legal Profession Act (LPA) sets out in detail regarding the publication of DT findings.[6] However, under Rules 42 and 43 of the MRR, the publication of DT inquiries is discretionary.[7] I hope the RC will consider the LPA provisions and import it into the MRR to build up a body of case law with clearly reasoned decisions to clarify SMC's stand regarding the Ethical Code and Ethical Guidelines.

There is also a need for the SMC DT to be clear about the difference between simple negligence and professional misconduct. There have been cases where the two terms appeared to be interchangeably used. This is cause for great concern.

Thirdly, the RC should consider clarifying the

sentencing framework. At present, for example, there is a specified mandatory minimum of three months suspension for certain offences.[8] Is this necessary? Often, a DT sentence by itself is akin to a death knell on a doctor's practice because patients inevitably google a doctor's name prior to seeing him, and will see the conviction. It is time to consider removing this mandatory minimum.[9] SMA

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Dr Bertha Woon, FRCSEd (Gen), FAMS, JD, is a general surgeon in private practice at Gleneagles Medical Centre. She belongs to the first batch of graduates from the Juris Doctor programme at the Singapore Management University School of Law. She is currently doing her practice training contract after completing the Singapore Bar Examinations.