Professional Misconduct, Patient-Doctor Dispute Resolution and the Medical Council

A Looming Crisis of Confidence, More Than Just a Storm in a Tea Cup

By Dr T Thirumoorthy, Executive Director, SMA Centre For Medical Ethics & Professionalism

Recent newspaper reports have put the medical profession in the spotlight, but not for the right reasons. The patients, public and medical professionals are all disturbed by this turn of events. At such poignant episodes, it is appropriate to stop, reflect and craft inclusive and meaningful changes. Patients, the public and medical professionals are waiting for a responsible and reasonable line of action to restore trust and confidence in the profession and system. In the erosion of trust, what is perceived is often considered as reality. Let us take a closer look at the recent chain of events as reported in the *Straits Times* (ST).

The chain of events

23 September 2012

"Judges' scathing comments put spotlight on SMC processes" – a front page article in the *Sunday Times* by Salma Khalik:

The Government Parliamentary Committee (GPC) for Health has urged the Ministry of Health (MOH) and the Singapore Medical Council (SMC) to relook the council's processes, in the light of scathing comments from the Court of Appeal.

Dr Lam Pin Min, chairman of the GPC for Health told the Sunday Times: "MOH and SMC really need to relook and audit the SMC's processes, to ensure that it lives up to its professional and ethical accountability to the medical community and the public."

(…)

Dr Lam added: "This judgement also raises a few queries into other similar cases where the penalties imposed by SMC may be of the same magnitude and line of reasoning but, for some reason, the doctors may not have appealed."

23 September 2012

"SMC taken to task over aesthetic doc's case" – a Top of the News report on page 10 of the *Sunday Times*, by Salma Khalik:

The Court of Appeal has taken the Singapore Medical Council (SMC) to task for poorly managing a disciplinary hearing – the second time it has done so in three years.

28 September 2012

"Audit SMC processes for patients' complaints" – a Forum letter on ST page A34, by Lee Ip San:

The SMC took seven months to reach an outcome for my 2009 complaint, and 14 months for last year's complaint.

An audit on SMC's patient complaint process is long overdue and necessary, if we are to continue to promote Singapore as a leading medical tourism destination.

28 September 2012

"Still waiting for reply after 17 months" – a Forum letter on ST page A34 by Padmini Kesavapany:

But why has it taken the Singapore Medical Council so long to investigate and respond to a complaint that I had raised in March last year?

In its letter of acknowledgement dated April 13 last year, I was informed it would take six to nine months or longer for the matter to be investigated. Sadly, after 17 months, I am still waiting for a response.

29 September 2012

"Dad with dementia goes missing from hospital" – a Forum letter on ST page A45, by Agnes Ang

29 September 2012

"Hospital explains how patient managed to leave" – a Forum letter on ST page A45, by A/Prof Thomas Lew, Chairman, Medical Board, Tan Tock Seng Hospital:

We apologise for Ms Agnes Ang's experience at our hospital.

4 October 2012

"Court tells SMC to relook case against aesthetic doctor – unusual move after court threw out similar case against another doctor" – a Top of the News article on ST page A2, by Salma Khalik:

In an unprecedented move, the Court of Appeal has asked the Singapore Medical Council (SMC) to relook a case before the court, in the light of a judgment given last month in a similar case.

(…)

He (an MOH spokesman) added that the ministry's interest lay in protecting the safety and health of the public and ensuring that all doctors and registered healthcare practitioners maintain high professional standards at all times.

7 October 2012
"Patients come first" – an editorial on page 46 of the *Sunday Times*:

Specialisation can result in professionals focusing only on specific aspects of care and, as a result, the whole person may be neglected. This is when at least one doctor in the team has to take the lead in personal interaction so that the patient understands the big picture and likely outcomes.

7 October 2012
"Disciplining doctors needs legal oversight" – an article on page 46 of the *Sunday Times*, by Andy Ho:

The issue of disciplining doctors has come to public attention recently. In particular, the process doctors undergo when they face disciplinary action has drawn sharp criticism from the courts.

8 October 2012
SMC apologies for delay, promises to do better – a Forum letter on ST page A21, by Tan Fay-Ann, Assistant Manager, Corporate Communications and Administration, SMC:

We recognise the need for the expeditious completion of investigations into complaints against doctors.
(…)
Nonetheless, this does not detract the SMC from discharging its public responsibilities, and we continue to look into improving processes.

17 October 2012
"Medical council to review its disciplinary processes" – a Top of The News article on ST page A2, by Salma Khalik:

The SMC is to set up a committee to review the way it tackles disciplinary cases in the wake of criticism from the High Court.
It has also applied to set aside its guilty verdict against aesthetic doctor Georgia Lee.

23 October 2012
"2nd aesthetic doctor cleared of misconduct" – a Top of The News article on ST page A3, by Salma Khalik:

In an unprecedented move last week, SMC issued a statement to say it had appealed to the court to set aside its guilty verdict against Dr Lee.

The major impact of this flurry of reported events is not just the erosion of trust and the dissatisfaction of the patients and public on the SMC complaints process, but also the erosion of confidence of the doctors in the SMC disciplinary mechanisms.

The three threads

Three other major threads have surfaced from these events, namely:

1. Patients would like a more effective system in dealing with complaints against doctors;
2. Doctors would like to have an efficient, competent and fair system of complaint hearings against doctors; and
3. MOH and SMC would like to protect the health and safety of the public, and ensure that medical practitioners are competent, fit to practise Medicine and uphold the high standards of medical practice in Singapore.

The expectations and objectives of all three parties involved are congruent and complementary. There is neither conflict nor diversity in purpose, all of which would promote medical beneficence, trust and confidence in the system.

Patients and public need an effective response to their complaints against doctors

In healthcare systems marked by uncertainties and complexities, adverse events, unanticipated outcomes and unmet expectations are common.[1] When adverse or unexpected medical events and outcomes occur, patients and their families will want respectful, empathetic and clear explanations.[2] When such explanations are not forthcoming, they will write to newspapers, raise a complaint or make a claim. It is quite clear from international studies[3, 4] that the main reasons for patients to make a claim or complaint after adverse events in hospitals are:

1. When satisfactory information and an explanation are not forthcoming.
2. When apologies or expressions of empathy are not communicated, and there is only a cold exchange of letters with no face to face discussion.
3. When no one takes responsibility for the events, giving an impression of lack of or an evasion of accountability.
4. When the patient and family are unsupported when dealing with the patient's injury, causing a perception of abandonment.
5. When there is no early and reasonable discussion of compensation when clearly indicated.

There are significant evidence that medical negligence and professional misconduct are minor contributions to the majority of adverse events and outcomes.[5] The commonest predisposing factors for claims and complaints are poor doctor-patient relationships and unmet patient expectations.

Open, sincere, timely and effective communication is essential to preserve the doctor-patient relationship, and prevent adverse events from escalating into claims and complaints. Dispute resolution has to be as close to the point of care as possible. Hospitals and clinics must be equipped with adequate structures and competent processes to recognise early, respond effectively and resolve harmoniously.

Support for patients in difficulties

Hospitals should develop emotional support and grieving teams to help families, after serious adverse outcomes and deaths. Resources must be made available and financial considerations resolved.

Early intervention

Hospitals and healthcare clusters would benefit in developing offices of medical ombudsmen who can help to deal effectively with complaints from both patients and other healthcare professionals. Hospitals, the medical profession and medical indemnity organisations working together should invest in programmes of early recognition and intervention with open disclosure, acknowledgement of patients' needs and provision of supportive benefits after an unexpected or adverse medical event.[6, 7] Restorative or early facilitative mediation to ensure all stakeholders' interests are addressed and relationships restored. In addition to hospitals, individual doctors and professional bodies can be effective in this area. SMC, in its review, could develop a pre-action protocol to enable restorative mediation, even before the Complaints Committee level.

Doctors need and deserve a transparent, effective, efficient and fair disciplinary system

Unlike medical negligence, when a doctor is found guilty of professional misconduct, the emotional, reputational and financial costs are greater. He could have his license suspended or even removed, such that he cannot return to work to either care for his patients or earn a living.

Perils of defensive Medicine

When doctors do not have confidence in the system of accountability and a fair trial process, they would resort to defensive Medicine. Defensive Medicine would mean additional investigations and treatment, increasing cost and risk to patients. Defensive Medicine would mean defensive communication. The good doctor-patient relationship based on respect, empathy and sincerity would fly out of the window. Defensive Medicine means both patients and public would not achieve the beneficence of medical care, and doctors feel besieged and burnt out. A real lose-lose situation.

All doctors must understand the rules and process by which a charge of professional misconduct is framed. They must know how to respond to such charges of professional misconduct and defend themselves effectively.

Skills in sitting in judgement of colleagues

Sitting in judgement of our colleagues in coming to a verdict of professional misconduct needs significant skills, wisdom, moral courage and experience. It also requires knowledge in professional ethics, skills in reasoned analysis and judgement of misconduct. The responsibility of such a duty includes competency in basic legal jurisprudence, rules of procedure, admitting evidence, sentencing, and principles of natural justice and fair play. Healthcare professionals must be schooled, trained and skilled when called to sit in judgement of their colleagues, and be able to carry out their duty competently without fear or favour. Such doctors should know the limits of their competence, and be prepared to consult other doctors and seek appropriate legal counsel.

Role of expert witness

Healthcare professionals called to be expert witnesses in complaint hearings and disciplinary tribunals in professional misconduct have a professional duty to gain competence to provide objective, relevant, logical and comprehensive expert reports, which include clinical and ethical judgements. Competent (effective and efficient), timely and a fair system of complaint hearings and disciplinary trials in professional misconduct promotes trust in the system of professional accountability. Trust and confidence of our patients and the public in the healthcare profession and healthcare system is essential for a sustainable, stable and effective system for the benefit of patients and society.

The SMC must provide leadership role in protecting patient safety and ensure doctors are professionally competent

The SMC has two main functions. The first function is the maintenance of a registry of doctors, ensuring that only those sufficiently qualified are admitted. It has a role in auditing and inspecting training systems of doctors in both medical schools and at the postgraduate levels.

SMC's second function is to protect patient and public safety by ensuring that those doctors, who have been given the licence to practice, continue to maintain clinical competence and performance. The doctors on the registry have a duty to conduct their professional work in a manner so as to fulfill the goals of Medicine, and promote trust and confidence in the profession and system. Finally, SMC also promotes the behaviour of doctors, outside their work, which enhances the dignity of the profession and its reputation. Proactive comprehensive strategies, with all stakeholders on board, would have a significant impact compared to a reactive action of only disciplining errant doctors.

Separation of disciplinary function

There is merit in separating the registration and the disciplinary functions. The disciplinary function is better served by an independent body not entangled in conflict of interest with the overall regulator, MOH. MOH has been a major complainant to the SMC. The Minister appoints the President and the majority of members of SMC, and the Director of Medical Services is the registrar of the SMC. In addition, under the present system, the SMC receives complaints, appoints the Complaints Committee and Disciplinary Tribunal (both of which feature SMC members), appoints the prosecuting counsel and receives fines paid by doctors found guilty of professional misconduct. If a doctor is acquitted, SMC has to bear its own legal fees. Of the 25 disciplinary inquiries in 2011, there was only one acquittal. Two were overturned by the High Court appeal process.[8] In effect, the SMC is the investigator, prosecutor, judge and jury in the disciplinary process.

In the past, the UK's General Medical Council (GMC) recruited and trained panelists to sit on the GMC's Fitness to Practise panels. There were significant concerns raised about GMC's adjudication processes, as GMC also prosecutes doctors. The resulting conflict of interest exposed the need for a new independent adjudication service. GMC has transferred its adjudication responsibilities to a new independent tribunal service to be known as the Medical Practitioners Tribunal Service (MPTS). MPTS is funded by GMC but is accountable directly to Parliament, to which they will report on an annual basis, and will also report to the GMC Council twice a year.[9]

Leadership role in guiding and promoting professionalism

To protect patient safety and ensure professional competence, SMC could take a leadership role in developing Good Medical Practice guidelines (like GMC's) and other forms of advisories to promote education and enable doctors to achieve competence in the domains of professionalism, interpersonal and communication skills. Ethical guidelines in the past have been used as statutory codes to draw up charges. Ethical guidelines are sources for reference and are not prescriptive. They are meant to educate and guide but not to dictate clinical practice.

Punishment without remediation does not promote patient safety

In dealing with the issues of professional competence and misconduct, SMC, together with all stakeholders, could develop a comprehensive strategy consisting of the development of explicit performance standards of behaviour and competence; educating and enabling doctors in achieving the competencies; regular assessment of competencies and performance; and the remediation of doctors with knowledge and skill deficits.[10]

There is an opportunity for a paradigm shift from a name, blame, shame and fine system to one of communication, reconciliation, mediation, education and remediation. Patient safety is not served if after punishment, remediation in knowledge and skills deficits does not take place. The paradigm shift needed is from one of managing complaints by purely legally based adversarial, punitive disciplinary action, to a focus of proactively promoting professionalism, quality improvement, error prevention and building a community of lifelong learners.

The efforts for this paradigm shift may appear massive but it is in such courageous efforts that would enable a sustainable system to achieve the threefold aims of effective resolution of patient complaints, a fair and transparent system of disciplinary process for doctors, and promoting safety of patients and of professional competence. SMA

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