SMC Disciplinary Processes: Time for a Redesign? (Part 3)

By Dr Bertha Woon

This is the third and final instalment of a three-part series. The first instalment, titled "SMC Disciplinary Processes: Time for a Redesign? (Part 1)", was published in the February 2013 issue of SMA News (http://goo.gl/Ip2gx). The second instalment, titled "SMC Disciplinary Proceedings and Sentencing: Some Thoughts Regarding the Current Process (Part 2)", can be found in the March 2013 issue of SMA News (http://goo.gl/9n5uX).

Ever since Part 2 of my article was published in *SMA News*, the SMA Council and our legal counsels have put together a 14-page paper to the Singapore Medical Council (SMC) incorporating the Council and members' feedback to date on the issue of SMC disciplinary processes (see page 11). As such, I will not belabour the points that we have already raised therein.

7. Proposed ameliorations to the current framework – taking a leaf from medical councils in related jurisdictions

Streamlining the cases that SMC receives: ensuring that SMC is not a complaints agency

To cut down the SMC workload, it must be made clear to the public that SMC handles serious matters. We could, for example, use the framework of the Australian Medical Association (AMA) that has two categories of notifications:

i. Mandatory notifications

These are issues where there is a risk of harm to a patient due to significant departure from standards, risk of substantial harm because of impairment of the medical practitioner, practicing while intoxicated by alcohol or drugs or sexual misconduct connected to medical practice.

ii. Voluntary notifications

These are issues such as departure from standards of conduct and/or knowledge, skills or judgement; unsuitability to be registered; contravention of national law; contravention of condition of registration or undertaking or fraudulent registration.

Regardless of the category of notification, the notifications are handled the same way and the AMA Board (the equivalent of our SMC Council) can take "immediate action" for the most serious cases. Persons who notify are protected from legal liability for making notifications. AMA takes effort to be consistent and transparent in how serious matters are managed and ensuring remedies are the right ones. There is active management of doctors' health and permanent publication of sanctions.

Appointing the Legal Officer for SMC and the scope of the Legal Officer's duties and the standard of proof

i. Comparing the situation in Hong Kong

Both Hong Kong and Singapore used to be British colonies. It is interesting that although a statutory declaration (SD) from a public officer; the President of the Hong Kong Medical Association; the Dean of the Faculty of Medicine at either the University of Hong Kong or the Chinese University of Hong Kong; or Presidents of the Hong Kong Academy of Medicine and any of its Colleges is not required, nevertheless, at a disciplinary inquiry, the complainant acts as the witness of the Secretary for Justice. Further, in Hong Kong, the Secretary for Justice appoints the Legal Officer who presides over the case with the Hong Kong Medical Council (HKMC). The appointed Legal Officer retires together with HKMC and helps in the deliberations and drafting of the judgement, but does not participate in the discussion and decision.

Contrast this with Singapore's position, where the complainant can be anonymous and not have to be witness to the allegations, or where legal counsel for SMC is from the private sector, where potential conflicts of interest come into question. It may be advisable in future to have legal counsel for SMC to be appointed by our Minister for Law.

ii. Standard of proof

In Hong Kong, the standard of proof is the civil standard, which is proof on a preponderance of probability. Misconduct in a professional respect is that which falls

short of the standards expected among registered medical practitioners. In this regard, it may be that an officer at SMC is empowered to convene a Complaints Committee (CC) or Disciplinary Tribunal (DT), which include members of the particular specialty for which the doctor under investigation is from. At present, it is not always the case that this is so, resulting in some doctors being judged by practitioners who have little practical experience in that specialty.

Closing potential loopholes

Right now, SMC has no provisions for dealing with non-medical persons who employ doctors. Such non-medical persons may be the ones that indirectly cause doctors to fall foul of SMC codes. Also, there are no provisions regarding medical students or persons who are not registered medical practitioners. These serious issues should be looked into and a position stated clearly.

Mediation as an option

The option of mediation should be used in the CC process under the Medical Registration Act (MRA), Cap 174, Section 42(4)(b)(ii) and 49(1)(h) in the first instance, and also at other points of the investigative process, such as where a tort has been committed.

The SMA Council has already provided feedback regarding Section 43(1), where we believe that mediation should not be used when the complainant is a government officer or statutory body.

My proposal is to train SMC members to identify where the option of mediation, as provided in statute, can be more frequently used in the first instance to resolve issues in a non-adversarial way.

The Singapore Mediation Centre (SMC2) is well set up and has already established a mediation structure and process[1] that follows a timetable. The mediation process whittles down the issues to what is important to each party after the initial exchange of documents, frames these issues in a neutral way and sets out a mutually agreed agenda prior to the meeting between the parties. At the confidential meeting with both parties, further solutions can be developed and modified to suit their interests better.

If agreement to settle is reached, the mediator drafts an agreement[2] on the agreed points, stating that the agreement is full and final, thus obviating future litigation. Since mediation has not been attempted at SMC CCs and DTs much, whether mediation clauses are enforceable has not been tested rigorously. If there is no or partial agreement, the mediator can report to SMC that an attempt has been made to resolve the dispute but failed. Parties can then carry on with the fallback position in the current system.

I am in no way suggesting that mediation restricts the scope of regulatory bodies, criminal proceedings or fatal accident inquiries. If the mediation attempt fails, then the process can continue as at present. Trained mediators are, of course, a must, and confidentiality needs to be maintained.

Advantages of mediation include potential cost savings (which would have to be validated in a prospective study) and confidentiality for all parties concerned (which would help a doctor's rehabilitation post-inquiry, since mediation outcomes are not published).

Jurisdictions whose medical councils utilise the mediation process already as part of their disciplinary process

i. New Zealand

New Zealand's Professional Conduct Committee (PCC) functions like our CC. If the PCC "determines the complaint should be the subject of conciliation, it must appoint an independent conciliator to help those concerned to resolve the complaint by agreement. If the complaint has not been successfully resolved by agreement, the PCC must promptly decide whether it should lay a charge against the doctor before the DT, or whether to make any recommendations to the Medical Council about the doctor; or whether no further steps should be taken in relation to the complaint".[3]

The New Zealand PCC has to be read in the context of the no-fault government-funded system, called the Accident Compensation Corporation that New Zealand has had since 1974, which essentially barred medical malpractice litigation. This system ensures financial support for personal injury victims.

ii. Scotland

In 2002, when the Scottish Executive was reviewing the National Health Service complaints procedure in Scotland, the Royal Society of Edinburgh recommended, "mediation should be considered as an integral option in the process of resolving non-medical negligence disputes". The Royal Society further recommended that "the Health Service should take steps to enable and encourage a greater and more effective use of conciliation within the complaints procedures, with a view of avoiding the need for any further alternative dispute resolution, including mediation".[4]

Addressing the interests of the parties rather than assigning blame

The mediation process gives the parties the opportunity to air their grievances and express their emotions to the neutral third party trained mediator(s) so that the disputed issues can be "systematically isolated … so as to develop options, consider alternatives and reach a consensual agreement that will accommodate their needs", as defined by Jay Folberg and Alison Taylor.[5] The neutral mediator can elicit issues that each party may not disclose to the other.

By concentrating on interests and issues rather than fault-finding and assignment of blame, it is arguable that both the complainant's and the defendant doctor's interests are better served. The benefits of mediation are multiplied in cases where the dispute is multipartite.

Building in an audit loop to refine the system along the way

As in all systems implementation, it is important to "close the loop" and evaluate the efficacy of the change and modify it as and when necessary. The question is who should be in the position to audit the SMC CCs and DTs? Would it be the Ministry of Health (MOH), doctors with the requisite abilities, or third parties?

8. Conclusion

Most common law countries agree that mediation is a possible means to achieve better outcomes in medical complaints procedures. There is no one-size-fits-all scheme. To be most effective, mediation should happen at the earliest stage of a dispute, once both parties are sufficiently prepared, and can also be effective and used at all stages prior to resolution. Mediation will not become a practical option, or be used as a resolution process more regularly, simply by advocating its merits and the potential it offers. For that to happen, issues of culture, education, funding and process need to be addressed. This state of affairs is what SMC is experiencing today. Trained mediators should be effectively deployed. SMC2 has not been utilised to its full potential. All this time, complainants' satisfaction rates are not high and doctors who have been complained against also have limited avenues to voice their frustrations.

I thus humbly suggest redesigning the system in the SMC CCs and DTs to increase the likelihood that mediation is used in the CC and DT processes. For mediation to be seen as neutral and without a whiff of conflict of interest, it would be best if the mediators are trained people who are seen to be independent from SMC and/or MOH. I further propose to educate all doctors, all CC and DT members, as well as the public that mediation is an option to resolve complaints to SMC and should be used.

Once the complaints and disciplinary process is redesigned, hopefully the attendant emotional duress for all parties involved, high financial costs and waste of precious time and resources for the people involved in investigating the complaints will decrease and there would be more **public confidence** in the SMC processes. SMA

References

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