

DOCTORS' FEES:

What Has Changed after the Susan Lim Case?

By Dr Tan Chi Chiu



A watershed case

The Court of Appeal's verdict in *Lim Mey Lee Susan v Singapore Medical Council (SMC)*, delivered on 28 June this year, led to much discussion in the public domain. Numerous press commentaries and letters argued for and against the concept of an "ethical limit" to doctors' charges, but most agreed that some soul-searching by the profession is due, in light of this case. The public would, of course, like to see lower healthcare bills. The profession, however, may be left in a quandary as to how to define "ethical limits" in real-life practice situations. A detailed study of the written judgement is edifying, and I will attempt to make sense of it here for the purpose of practical application.

The first principle confirmed by the court is that the practice of Medicine, as with other noble professions, must first uphold the honour, honesty and integrity of the profession:

Overcharging would constitute an abuse of trust and confidence placed by a patient in his or her doctor and this would (in turn) constitute conduct that is dishonourable to the doctor as a person as well as in his or her profession, ie, it would constitute professional misconduct.¹

The law confirms that the ethical responsibility to charge fair and reasonable fees is intrinsic to the profession and overrides contractual obligations and market forces. The court added that:

Although there is no provision in the ECEG (SMC's Ethical Code and Ethical Guidelines) which refers precisely to an ethical obligation to charge a fair and reasonable fee for services rendered, the ECEG nevertheless contains relevant provisions which on their terms, support the existence of such an obligation.¹

Therefore, the first practical implication is that: even if patients enter into contracts to pay certain fees, doctors may still be liable to charges of professional misconduct if the fees are too extreme.

So how much is too much? Although the court declared that ethical limits are objective, it did not propose any formula to compute such limits. Instead, it affirmed the SMC Disciplinary Committee's (DC) view that there are objective criteria that can be drawn from all the circumstances of the case, including:

*(a) the nature and complexity of the services rendered, (b) the time spent in rendering the services, (c) specific demands made by patients, (d) any special relationship of trust and confidence between the medical practitioner and the patient, (e) the medical practitioner's professional standing and seniority, (f) the fees generally invoiced by comparable services by other medical practitioners of similar skill and standing, (g) the opportunity costs of rendering the services in question, and (h) the circumstances of urgency under which the services were rendered.*²

All of this, while sounding objective, still yields enormous variations in fees. However, it is helpful to have the criteria stated in clear terms to help doctors set the range of their fees. My belief is that, sans such elucidation, doctors have always intuitively known that these are the factors on which to base their fees, and therefore not much change in real terms is needed. The court also affirmed the DC's view that:

*We do not, however, accept that the affluence of the patient is an objective criterion which can legitimately be taken into account in setting or assessing what is a fair and reasonable fee. It is ethically legitimate, and indeed something to be encouraged, for a doctor to charge an indigent patient a fee which is less than a fair or reasonable fee, or even to waive a fee, simply because the patient is indigent. It is not ethically legitimate for a doctor to charge a rich patient more than a fair and reasonable fee simply because that patient is rich.*²

But the fact is that the "Robin Hood" principle is firmly in operation in both the public and private sectors, and the cross subsidies that occur allow poorer patients access to necessary medical care. There is means testing in public healthcare, which de facto means having more well-off patients pay a greater share of the cost of care. Although the total cost may be the same, the effect of means testing on wealthier patients is that they are simply being asked to pay more. Richer patients also routinely pay more through the A class wards or private services of public hospitals, where further surcharges of 100% or more beyond the "rack rate" are common – representing genuinely higher charges simply because they can afford this. In the private

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sector, wealthier patients may sometimes pay fees at a somewhat higher point within a range which must yet be “fair and reasonable”.

Patient autonomy is also obliquely addressed in the case verdict. The doctor-patient relationship has evolved from one of paternalism, to a more equal partnership in which patients have the right to decide for themselves what treatment to accept, having obtained the relevant information. It then seems inconsistent (and somewhat unfair to doctors) that when it comes to fees, it is down to only doctors to determine what is right fees to charge, but patients have little responsibility to decide for themselves what they are willing to pay. In the context of demonstrating “the viability of arriving at fair and reasonable fees for medical services through improved pricing transparency”,¹ the court referred extensively to the Competition Commission of Singapore's (CCS) Statement of Decision – in *Re Singapore Medical Association – Guidelines on Fees* [2010] SGCCS 6, which stated, inter alia, that increasing public transparency, viz displaying charges in clinics, publishing hospital bill sizes on the Ministry of Health website (with encouragement for private hospitals to do the same), and requiring medical bills to be itemised, are “effective, unrestricted and unbiased ways to deal with the issues of information asymmetry, overcharging and optimal consumption of healthcare services”.¹

Hence, although the concept of caveat emptor has limited application in medical practice due to relative information asymmetry and the vulnerability of patients when they are seriously ill, it is not entirely irrelevant. Patients who have information on bill sizes might, through making educated choices of their service providers, play a bigger role in determining the acceptable market prices of medical services. On doctors' part, such information as is available would be seen to be informal, incomplete, or are aggregates or averages of total bill sizes in which doctors' fees are buried and for which wide ranges may still apply. At best, these sources provide a sense of what orders of magnitude are in play, rather than clear guidance as to what precise fees to charge. Hopefully in future, better data than what is currently available may be published.

Defining “overcharging”

What then is “overcharging”? The court stated that, in reviewing charges, doctors’ peers would have the ability to “opine on the possible range of fees which would be considered fair and reasonable in a particular set of circumstances”.¹ This produces a dilemma. Is an opinion on whether charges are reasonable only possible in retrospect? How should doctors prospectively decide on fees? Given the guidance described above on how to “objectively” determine fees, the only practical way is for doctors to decide their fees based on all these factors, as best as they can, and then put themselves in the shoes of potential peers who might one day have to assess their fees for reasonableness. Most doctors in their heart of hearts would know when the fees they are contemplating grossly exceed any possible reasonable range. This might still leave the scary possibility that they may have inadvertently overreached and thus get into trouble. However, there is much in the court’s judgement to reassure doctors that this is unlikely, if the determination of fees is done in good faith.

It seems that doctors’ fees may be deemed excessive if peers providing similar services in similar circumstances when reviewing the fees come to a firm and definite conclusion that they are in excess of what is reasonable in the circumstances. But is every incident of overcharging representative of professional misconduct? It would seem not. Quoting a precedent case involving a lawyer who overcharged, the court said:



“Typically, I don’t accept magic beans for payment.”

Obviously not every case of overcharging will constitute grossly improper conduct. Inevitably there will be some diversity of opinion as to what would or would not be correct in each case, and where a line ought to be drawn ... the extent to which a client is overcharged is a very strong factor.¹

So while overcharging is frowned upon, it does not automatically become professional misconduct, unless it is to an extreme extent. The court further emphasised that:

(T)he ethical rule that a doctor must charge a fair and reasonable fee for his or her services is not only one that is rooted in logic, common sense, justice and fairness, but is also one that will not be enforced unreasonably. As the DC itself pertinently observed ... “Given the very serious consequence of having been found by one’s peers to have breached this obligation [to charge a fair and reasonable fee for services rendered] and to have committed professional misconduct by having done so, it is no doubt the case that one’s peers will be slow to find a breach or to find professional misconduct in marginal cases.”¹

This is absolutely crucial because the bar is set quite high for a finding of professional misconduct in respect of fees. There are two hurdles. Firstly, a panel of peers would have to decide that a fee is indeed in excess of an already very wide range of fair and reasonable fees. Secondly, the same array of peers would have to decide that a fee already deemed excessive crosses a further threshold into egregious and unconscionable overcharging and professional misconduct. When would such a threshold be breached? The court’s judgement is generously endowed with numerous words and phrases, some or all of which would describe fees that are so high that it would amount to professional misconduct. While none of the qualifiers is measurable, reasonable persons would understand the threshold described.

I aggregate and summarise all the relevant qualifiers contained in various parts of the written judgement as follows: (a) represent intentional, deliberate departures from the standards observed or approved by the profession, (b) far in excess of, grossly disproportionate and bearing no relation to the services rendered in the circumstances, (c) undeniably unjustifiable, (d) excessive in the extreme, (e) far beyond any possible reasonable range of charges for the services provided, (f) overcharging of astonishing proportions, (g) show a systematic pattern of overcharging, (h) clearly opportunistic and taking advantage of patients’ ignorance or vulnerabilities, (i) indiscriminate, inconsistent, haphazard and arbitrary in the pattern of charges, (j) opaque in construction so as not to be able to ascertain what the charges are for, (k) represent unjustifiable multiple charges for overlapping services or time periods, and (l) represent excessive inflation of charges made by third parties, without disclosure and/or false representation that the invoiced fees are due entirely to third parties.¹

This is a breathtaking list of criteria! It should be obvious that it would take almost an extraordinary effort of deliberate, almost predatory, overcharging to fulfil some or all of these descriptors. It is therefore most unlikely that any doctor would inadvertently or innocently stumble into the territory of egregious overcharging. It is also my view that Complaints Committees have been, and will continue to be, slow to send any but the most obvious cases to the Disciplinary Tribunals, and the latter have been, and will continue to be slow to find professional misconduct in all but the most extraordinary cases.

So how should doctors decide where an ethical limit is? Well, it is neither a place nor a point on a continuous range of fees where one could draw a line and state categorically that anything falling beyond the line is immediately a case of professional misconduct. Indeed, such a point should never be specified, as that could in effect bring about a de facto cartel which is against the public interest, since doctors would feel unfettered to charge right up to that limit. It would set fees higher than a formal Guideline on Fees, which previously gave ballpark ranges, but no ethical maximum.

The ethical limit is more akin to a "tolerance limit". Imagine yourself and some friends (all reasonable people) at home having a quiet drink. There is loud music coming from a party next door. It gets progressively louder, disturbing you more and more. At some point, you concur unanimously that the noise is "excessive" and you might possibly go next door to tell them. Despite this, it gets worse. You do not need to know the precise volume in measurable decibels at which your patience snaps, you experience outrage and you pick up the phone to call the police. For a community of doctors, the ethical limit is probably something like that.

I would like to add here what I think is a helpful quote from the late US Supreme Court Justice Potter Stewart. He uttered what must be one of the most famous phrases in the entire history of the Supreme Court, when he delivered judgement in *Jacobellis v Ohio* 378 US 184 [1964]: "I shall not today attempt further to define ... (hard-core pornography); and perhaps I could never succeed in intelligibly doing so. But **I know it when I see it** ... (emphasis mine)".³ This is arguably very applicable to deciding whether doctors' fees appear so "obscene" that they represent professional misconduct.

Conclusion

To summarise, because we are a profession, there is indeed an intrinsic ethical limit to doctors' charges that trumps contractual obligations and market forces. It is possible to form an opinion on what constitutes an acceptable, reasonable and fair range of fees for particular services under specific circumstances. This range will, however, necessarily be very wide, and it will not be possible to pin down a limit beyond which it becomes an ethical breach. But it is evident that the threshold for professional

misconduct in respect of fees is high and very unlikely to be breached inadvertently or innocently. The ethical limit is in fact a limit of tolerance by reasonable members of the profession and the community when looking at high fees. Peer opinion will determine whether a fee is excessive, and if so, whether it crosses a further threshold into the realm of professional misconduct. It is reassuring that the ethical limit will neither be assessed nor enforced unreasonably.

Following the Susan Lim case, the public expects doctors to be more circumspect in making charges, although the vast majority of doctors have always intuitively known how to set reasonable fees. Specific improvements could include: doctors being more aware of the factors upon which they may determine fees; paying more attention to SMC's ECEG; giving heed to data in the public domain to provide further guidance; testing their own fees by taking the viewpoint of reasonable peers who might potentially opine on their fees; and ensuring greater self-restraint among the few with a propensity to charge very high fees, knowing that serious exploitation of patients can and will be checked. Although CCS has declared it illegal to publish fee guidelines, it has no objections to publishing data on fees that are actually charged. Thus it would be helpful to have medical services from both public and private sectors publish more of their charges, at the median, 25th and 75th percentiles, as well as provide finer granularity and greater transparency in the data, such as clearly separating doctors' charges from other components of fees charged.

Despite all the angst generated by the Susan Lim case, ultimately this case is very much an outlier. Doctors have always been aware of the perils of overcharging and have (mostly) done the right thing, way before this landmark case picked the issue apart so comprehensively and brought it to a sharp focus. **SMA**

References

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