REPLY TO "THE DILEMMA OF MEDICAL LEAVE"

Text by Dr Natarajan Rajaraman

In "The Dilemma of Medical Leave" published in the August 2016 issue of *SMA News* (https://goo.gl/PGXg64), Dr Alex Wong discusses conflicting pressures that doctors face in deciding the duration of medical certificates (MCs) for work-related injuries. He highlights the recent suspension of a medical practitioner in connection to this,[1] and argues that the dilemma ought to be thought of not as rooted in medical ethics, but in our healthcare system.

Dr Wong's contention raises several questions. I would like to pursue three of them:

1. What are the healthcare system roots of this dilemma?
2. What are possible healthcare system/policy solutions?
3. And in the meantime, what can doctors do in everyday practice?

Healthcare system roots of this dilemma

The dilemma is multifactorial, but has two principal contributors: the presence of strong incentives for employers to ensure that MCs for work-related injuries do not exceed three days, and our healthcare financing model that allows employers undue influence on doctors' MC-issuance decisions.

Employers' incentives to influence MC

According to the Workplace Safety and Health (Incident Reporting) Regulations, injuries that result in MCs exceeding three days are reportable by employers.[2] This triggers mechanisms to improve workplace safety but also imposes multiple costs: the risk of Stop Work Orders, adverse lost-time injury records, investigations by the Ministry of Manpower (MOM), penalties, etc. It is unclear which incentive created by the reporting regime is the greater: to *prevent* work-related injuries, or to *circumvent reporting* them.

The three-day cut-off is intriguing. Singapore's benchmark appears in line with international practice, "…defining accidents leading to an absence from work of more than three days… provides a good balance between comprehensive and significant data on the one hand and a feasible use of resource for reporting and processing time on the other."[3] However, our novel category of "light duty" does not count towards the reporting criteria; furnishing a creative means to elude reporting, even when an injury does not permit a return to routine work within three days. This may partly explain Singapore's reported rate of work-related injuries being impressively below par among countries with similar rates of work-related deaths.

Healthcare financing model allowing employers undue influence on doctors

2007 to 2010 saw the withdrawal of subsidies for foreign workers in public healthcare institutions[4,5] and the introduction of mandatory employer-purchased medical insurance.[6] The net effect is that medical practitioners now compete in the open market to provide care and are naturally responsive to the payer's (ie, the employer's) interests.

Notwithstanding exhortations from the Singapore Medical Council (SMC), that employers do in fact influence doctors' issuance of MC has been frequently reported[7] and has not escaped the notice of relevant authorities.[8]

Possible healthcare system/policy solutions

Modify work-related accident reporting criteria

The practice of issuing "light duty" in lieu of MCs for work-related injuries is a glaring loophole. Counting as reportable any form of medically prescribed excuse from routine work (eg, MC, light duty, excuse from specific activities) for more than three days would both preserve the desired balance between data and resource management, and accord with international practice. An alternative would be reporting all injuries that meet specified criteria for severity (eg, all work-related injuries that result in fractures or chargeable operative procedures).

Such amendments should not be difficult; MOM had previously closed a similar reporting loophole in 2014.[9]

Calibrate penalties on employers for reported workplace accidents

The aviation and healthcare industries have long advocated a "no blame" culture, intended to prioritise transparency and attention to safety over desire to conceal lapses. Singapore's highest-risk industries, such as construction and shipbuilding, may benefit from optimising this balance (eg, by moderating penalties on employers for reported workplace accidents).

Change the payer

Singapore mandates employer-purchased medical insurance

for foreign workers. This places in employers' hands not just the responsibility to underwrite medical care, but also the power to influence or obstruct it. Local non-governmental organisations regularly decry cases of delay or denial of care, and even instances of forced repatriation of injured workers,[10] to shirk these obligations. Shifting the insurance purchaser/payer role away from employers and on to workers, either individually or by group (eg, by country of origin, industry, place of residence), would decouple the unhealthy alignment between the financial interest of employers as payers and medical practitioners.

What doctors can do in everyday practice

Here I offer only two suggestions and invite my clinical colleagues to contribute others.

Develop MC guidelines

The medico-legal gravity of MCs eclipses the scant guidance currently available to medical practitioners for issuing them. The 2016 edition of the SMC's Ethical Code and Ethical Guidelines[11] and ad-hoc circulars on the topic supplies necessary principles but insufficiently detailed direction for clinical decision-making in the consultation room.

This gap could be filled by clinicians articulating publicly available MC guidelines, with duration ranges for typical injuries (eg, "distal radius fracture: seven to 14 days or until specialist clinic appointment"). Carefully selected ranges would provide a firm reference point from which doctors can resist undue pressure from employers, without interfering with routine care or physician autonomy.

Become familiar with policy surrounding migrant workers

Migrant workers now comprise a fifth of Singapore's population. Understanding the relevant policy landscape would enable doctors to more ably serve their medical needs and more wisely negotiate inevitable ethical ambiguities.

Conclusion

I affirm Dr Alex Wong's core argument: the dilemma of medical leave is not purely an issue of medical ethics, but the logical outcome of our work-related injury reporting and healthcare financing architecture. Any system which relentlessly pits medical practitioners' financial interests against their ethical obligations will not consistently prevail in favour of the latter. I invite the medical community to call for the necessary policy modifications and to develop creative practice solutions. ◆

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