PROPOSED AMENDMENTS TO MRA

In response to the invitation to comment on the proposed amendments to the Medical Registration Act by the Ministry of Health (MOH), SMA submitted the following points from SMA Council members. Subsequently, MOH replied on 21 July and SMA responded on 3 August. These documents are reproduced below.

SECTION 1: COMMENTS

Accountability and transparency

1 The stated purpose in proposing the change is to promote greater accountability and transparency.

The SMA believes that

a) Transparency could be promoted far more effectively by any number of means. Transparency and accountability are not enhanced just by having a legally trained person chair a DT. A chairman does not just contribute to accountability and transparency but directs and influences the proceedings.
b) Transparency is best served by having more laypeople observe the proceedings and if necessary, these laypersons can include not just lawyers, but other representatives from the community (e.g., religious and community leaders).
c) We can have a full-voting layperson on the DT instead of a non-voting layperson. Again, this person can be from other representatives from the community (a lawyer or a community leader etc). Being a full-voting member is still different from being the Chairman of a DT.
d) Transparency and accountability could also be served by explaining to concerned parties the rationale for their decisions or even letting complainants have access to the recordings of the SMC proceedings.

Cases involving high profile or senior medical practitioner

2 The main scenario given for requiring a legally trained chairperson to chair a DT is to address those cases involving high profile cases and avoid potential conflicts in the medical community.

The SMA believes this is troubling at best, and possibly alarming at worst. It suggests that past and current SMC members (of which the majority is appointed by the government) were or are unable to handle cases involving high profile doctors. The SMC, being a body vested with statutory powers should and must treat all doctors equally and fairly with the same ethical standards and processes. If the medical profession or SMC has to outsource the disciplinary process to a legally trained chairman just because the doctor is a high profile figure, it would suggest that the SMC has two standards or two modes of operation – one for high-profile doctors and one for low-profile doctors.

3 Perhaps MOH can ensure that SMC members do not refrain from chairing DTs just because the doctor concerned is known to them professionally. They should only be allowed to exempt themselves when the doctor concerned has a close personal relationship with them, e.g. relatives, practice partners, former classmates within the same clinical group, family friends etc. Given the fact that there is diverse representation in SMC, there cannot be a doctor who is a close relative, friend or practice partner etc, of all 19 SMC members at the same time.

4 On the other hand, it would be interesting how other professions handle disciplinary cases involving high profile or senior members of the profession in Singapore. Do they similarly involve legally trained persons? It would be very pertinent to know how the Law Society handles cases involve high-profile and senior lawyers. Do they outsource the chairing of their DTs to persons outside of the legal profession?

Assessing the weight of the evidence

5 Weighing the evidence presented before the DT is indeed one of the most important tasks and responsibilities of not just the chairman but all members of the DT. It is paradoxical to note that

a. while it is claimed that if both medical practitioners vote unanimously on the case, the outcome is not changed no matter how the legally trained or medically trained chairperson works,
b. having a legally trained chairperson who can better weigh the evidence will be material to the outcome of the proceedings.

6 It is important to note that as stated, the High Court has criticised some disciplinary committees for their handling of cases and their limited understanding of fundamental legal principles. What has MOH and SMC done in the past to address the problem besides now coming up with the option of outsourcing the chairing of the DT to a legally trained person? It is far more important to ensure that all SMC members, after they have been elected or appointed to be on SMC, are properly trained in ethics, points of law and to weigh evidence given in proceedings, just as all ASTs now have to be trained in ethics. Does MOH or SMC offer any kind of such relevant training to the SMC members?

7 The dangers of having a lawyer playing doctor in weighing evidence has already been described by the previous CJ Yong in Gunapathy vs Khoo. Indeed, we concur that weighing evidence of a medical (and often complex) nature requires proper medical training. Even if a legally trained person can better weigh the evidence as claimed, he need not be the chairperson; being a full-voting member would suffice. (To recap, in Gunapathy vs Khoo, the High Court Judge weighed the evidence and decided a brain tumour existed. This was subsequently overturned by the Court of Appeal.)

Conduct that does not relate to the practice of medicine such as false of laudatory advertising

8 Currently inappropriate advertising is already being dealt with under laws such as the Private Hospitals and Medical Clinics (PHMC) Act and the Medicines Act. If a doctor can be successfully prosecuted under these laws, then the SMC should in practice not find it too difficult to be found guilty of professional misconduct. If the SMC finds it difficult to interpret the SMC Code on matters pertaining to advertising for those rare instances where inappropriate advertising falls outside the provisions of the statutes, then it is perhaps more pertinent to consider revising the SMC Ethical Code to make the SMC's stand on advertising more explicit, so as to directly address these issues.

Multiple charges for one doctor

9 The complexity of a case does not increase if the charges are the same as in the example given (inappropriate prescribing to many patients over a period of time). The case may become more laborious and repetitive, which is different from complexity. Complexity only increases if there are different charges (and not just many of the same) against one doctor.

Law, legal technicalities and ethics

10 It is stated that "the Council need not appoint a lawyer/judge as Chairperson if it is deemed that the case is essentially about medical ethics." This statement is perplexing. If the case is not essentially about medical ethics, then why is SMC handling the case at all? SMC cases mainly fall under the following four broad categories, all of which are the bread and butter of medical ethics

a) Neglect of professional duties and responsibilities
b) Abuse of professional privileges
c) Conduct derogatory to the reputation of the profession
d) Inappropriate advertising, canvassing and related offences

11 The last two categories are still part and parcel of medical ethics and not conduct in general. Indeed, all four categories are covered in the SMC Ethical Code and Ethical Guidelines.

The practice of DTs in other countries

12 It was stated that the practice for allowing legal professionals in DTs is not new and is already the case in UK, NZ, selected states of Canada, Australia and USA. Many of these examples also have much higher medico-legal costs than Singapore. For example, the medical professional indemnity insurance subscriptions for Australia, USA and UK are many times that of Singapore's. Should we ape their systems blindly, the end-result may also be a more litigious environment and high medico-legal costs which ultimately have to be borne by the public.

SECTION 2: QUESTIONS

1 Have MOH and SMC explored other alternatives to providing the option to appoint legally trained persons as Chairmen of DTs? Such alternatives include

a) In the light of the criticisms from the High Court, has SMC in the past or

presently embarked on any efforts to train SMC members in fundamental ethical and legal principles to address the stated shortcomings?

b) Must the legally trained person be the chairman? Can he not just be a member of a DT? What is the justification for the legally trained person to be the chairman and not just a member of a DT?

c) Should the SMC handle cases that do not mainly pertain to medical ethics? Should there be a provision in the MRA Bill to allow SMC to refer cases to the Courts?

d) Can other less radical steps be taken to improve accountability and transparency? Examples of these include submitting SMC proceedings for audit (since they are already recorded), or having laypersons who are not only legally trained. Community and religious leaders can be full-voting members on the DT as well. SMC proceedings can also be made available to the complainant.

e) For the disciplinary cases involving "general conduct" – can MOH and SMC not consider revising the SMC Ethical Code to be more explicit such that the profession is better guided by what is permissible and not? Examples include the Code of Professional Conduct issued by the MCHK (Medical Council of HK) and the MMC's (Malaysia Medical Council) Guideline on Dissemination of Medical Information by the Medical Professions. More explicit guidelines for the profession should be attempted before we jump straight to the conclusion that having a legally trained chairman will solve the problems SMC faces.

f) Instead of appointing legally trained chairpersons to address the (as claimed) increasingly legalistic nature of SMC proceedings, what other measures have MOH and SMC considered to make proceedings less legalistic than they are now?

g) Does the SMC have clear guidelines that describe under what situations a SMC member can excuse himself from a case brought before SMC? The guidelines and criteria should exclude relationships of professional acquaintance. (Please refer to Section 1, Para 3 for elaboration.)

2 The claim that cases involving high profile and senior medical practitioners should be handled by legally trained chairpersons and not in the usual way that DT operates suggests that SMC has two modes of operations for doctors of differing profile or seniority. This is a grave position to take. To illustrate with a hypothetical example – a first-year medical officer and a prominent professor of surgery commits the same ethical offence – both have sexual relations with their patients. The medical officer appears before a DT chaired by a doctor while the professor (just because he is prominent or senior) appears before a DT chaired by a legally trained person. We would like to ask if such a practice would be in line with the principles of natural justice.

3 On the issue of grounds for appointing a legally trained chairman on a case-by-case basis, we would like to seek clarification from DMS - in the event the Bill is passed and a lawyer can chair certain cases - would the SMC explain in writing to the doctor being investigated in the DT, the grounds for which SMC has deemed that a case requires a legally trained chairman and would the doctor being investigated be able to appeal against such given grounds?

4 The statement that appointing a legally trained chairman to address the situation whereby a doctor is known to all SMC members needs clarification. This is because even if the chairman was legally trained, at least one of the other two members on the DT has to be a SMC member. Can SMC explain how this problem of getting quorum for the DT will be addressed by having a legally trained chairman?

5 No other profession outsources the chairing of a DT to a legally trained person. Indeed, it is noteworthy that the legal profession has removed the requirement for a layperson on its DT as recently as last year. Can the DMS explain why it considers the medical profession to be different? As a point of interest, would this practice be extended to other professionals under MOH's purview – such as dentists, pharmacists, TCM practitioners, contact lens practitioners and nurses?

6 We would like to ask DMS if the results of the current exercise would be published. In particular SMA members would be keen to see the following data:

a) The total number of respondents
b) The number or respondents that support the proposed amendment
c) The number of respondents who object to the proposed amendment
d) The number of respondents who think it is good to have DMS meet in person interested members of the profession in forums
e) Other responses

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21 July 2009

Dr Chong Yeh Woei
President, 50th Council
Singapore Medical Association

Dear Yeh Woei

MEDICAL REGISTRATION (AMENDMENT) BILL

I refer to the Singapore Medical Association's request and comments in your letter on 20 July 2009 regarding our circular on the proposed amendment to allow the Singapore Medical Council (SMC) the option to appoint a senior lawyer, legal officer or retired judge as the chair for a disciplinary tribunal.

2. We have already begun to receive replies and comments from the medical community. While the deadline for replies is set on 25 July 2009, late returns will be considered as well. We are interested in all opinions from the medical community and will carefully consider them prior to concluding the exercise at an appropriate time.

3. We have noted SMA's position on this issue arising from the earlier consultation and in our meeting with the key leaders of SMA, AM, and CFPS. Our circular dated 13 July 2009, was specifically sent to individual medical practitioners to obtain their views. Medical practitioners, including members of SMA, need to decide on the matter for themselves.

4. We appreciate SMA's feedback. However, initiatives to forge a collective action would defeat the purpose of our invitation to medical practitioners.

Yours sincerely

PROF K SATKU
DIRECTOR OF MEDICAL SERVICES

Cc Minister for Health
President, Singapore Medical Council
Master, Academy of Medicine, Singapore
President, College of Family Physicians, Singapore

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3 August 2009

Prof K Satku
Director of Medical Services
MINISTRY OF HEALTH

Dear Prof Satku

RE: MEDICAL REGISTRATION (AMENDMENT) BILL

We refer to DMS' letter dated 21 July 2009, which we received on 27 July 2009, and wish to extend our thanks for allowing late returns of comments from doctors.

We agree that doctors should decide on the matter for themselves. Since DMS's letter to the medical profession on 13 July 2009, SMA's position has been to encourage the members to

- Respond to MOH by the original deadline 25 July 2009 as they see fit.
- Ask for more time beyond the original deadline. We are now glad to note that the responses beyond the deadline will be accepted and recognised.
- Seek a face-to-face meeting with DMS to clarify matters.

We note the comment "…initiatives to forge a collective action would defeat the purpose of our invitation to medical practitioners." We have no intention to unfairly skew this consultation being conducted by MOH. We had to alert our membership to the importance of such an issue in view of the looming deadline.

The SMA Council is now studying DMS' clarification dated 13 July 2009. The SMA Council will respond with its position soon after due consideration of the pertinent issues.

Yours sincerely

DR CHONG YEH WOEI
PRESIDENT
SINGAPORE MEDICAL ASSOCIATION

Cc Minister for Health
President, Singapore Medical Council
Master, Academy of Medicine, Singapore
President, College of Family Physicians, Singapore

ENHANCING POST-GRADUATE MEDICAL EDUCATION

SMA recently wrote to the Ministry of Health (MOH) to ask for details regarding the proposed Residency programme which will affect postgraduate training of doctors. Reproduced below is our letter and the reply from MOH.

29 September 2009

Prof Satkunanantham Kandiah
Chairman, Specialists Accreditation Board (SAB) /
Director of Medical Services, Ministry of Health (MOH) /
Registrar, Singapore Medical Council (SMC)

Dear Prof Satku

RESIDENCY PROGRAMME

1 Although we have not received any official communication from the relevant authorities, we have received information and feedback from various sources, including SMA members and medical students on this matter of the proposed residency programme.

2 We understand that the residency programme may be introduced next year in what is understood could well be the most fundamental and comprehensive revamp of our specialist training system in the last 50 years. The future of the medical profession, if not the healthcare system, rests upon a good postgraduate medical training system and therefore is of grave importance to not just some segments of doctors but to the entire medical profession.

3 As a general principle, the SMA Council is of the opinion that a more structured and supervised training system for our specialty trainees, leading to a shorter training period without compromising quality and professional standards, is to be supported.

4 Nonetheless, the feedback we have received has been from informal and unverified sources and as such, we would like to seek clarification from SAB, MOH and SMC on the proposed residency programme so that we can communicate this information to our members.

The Rationale for the Change

5 Education is an investment in the future. Specialty training as such is an investment and like all good investment decisions, there should be expected returns with an eye on the potential down-side of an investment.

6 Our existing specialty training system has served us well. Our specialists are generally well-trained and this is evidenced by the excellent feedback we get about our specialists from reputable overseas institutions when they go for their HMDP fellowships. Nonetheless, the current system has weaknesses and there is certainly room for improvement. We would like to know:

a) What are the weaknesses of the current specialty training system (if any)?
b) How will the proposed residency programme address these weaknesses?
c) Having addressed these weaknesses, does the proposed residency programme make major and fundamental improvements over the current system and if so, what are these improvements?
d) Should the proposed residency programme not yield the expected results, is there an option of returning to the original (i.e. current) specialty training system?
e) To mitigate the risk and to keep options open, is there the possibility of running both systems concurrently (current and the proposed residency programme)?

International Recognition

7 We understand that the proposed residency programme is run along the lines of the programmes by Accreditation Council for Graduate Medical Education (ACGME) of the USA. Indeed, we note that ACGME has advertised for a director of ACGME-International to be based in Singapore. Since Singapore is essentially adopting the ACGME system, we would like to know if our specialty trainees who complete the Singapore residency programmes will be recognised by the American Board for Medical Specialties (ABMS) and the various specialty boards under the AMBS umbrella for certification as specialists in the USA?

8 Currently, we have established conjoint examinations with several Royal Colleges in the United Kingdom. We would like to understand what is to become of the reciprocal recognition currently enjoyed by our local postgraduate examinations and that of the Royal Colleges.

Decision-Making and Selection Process

9 We understand that final year medical students are asked to make a decision as to which residency programmes they would like to apply to before they take their final exams. If this is correct, we are concerned with this development in several areas:

Final Year Medical Students Selecting Residency Programmes

10 There is some merit in a young doctor taking his time to discover where his interests lie. Indeed, this is the advice many doctors have received from their seniors in the past. We are concerned that a final year medical student may not have the professional experience and exposure to adequately make an informed decision in selecting an appropriate residency programme for himself.

11 While we understand that there is a "transition year" for doctors who have not made up their minds as to which residency programmes they want to apply for, there are fears that doctors who delay making a decision are disadvantaged because residency places are limited for each cohort and any delay in applying for a residency programme significantly disadvantages the applicant. We would like to seek clarification if there are measures put in place to ensure that medical students are not unduly pressurised to make such a major professional decision even before they graduate.

12 We have also received feedback that some final year medical students in the Yong Loo Lin School of Medicine have been taken by surprise by the call for them to make a decision to choose a residency programme so early. It appears that the application process of preparing a portfolio and attending interviews are being carried out uncomfortably close to their final MBBS exams and are posing as significant distractions to their exam preparations.

Residency Programmes Selecting Residents

13 It appears therefore that residents can be selected based solely on their academic performance as medical students. In contrast, the current system ensures that a trainee is only selected after evaluation of his performance as a house and/or medical officer. There is sufficient anecdotal evidence to strongly suggest that academic performance as a medical student may not be an entirely reliable predictor for performance as a doctor or a specialist. We would like to understand how the residency selection process will address these concerns.

"Over- and/or Under-Subscription" of Residency Programmes

14 Are there pre-determined quotas for each residency programmes? If there are, how would the residency programme respond to the situation where a programme has more or less applicants than the pre-determined quota?

Supervision and Assessment

15 Given the current specialist manpower shortage in the public health system, do we have enough supervisors to ensure that the residency programme is effectively implemented?

16 How would residents be assessed? Would the current exams e.g. M.Med, MRCP, MRCS, FRCS and so on, be still relevant to the residency programmes?

Other Issues

17 We understand that doctors who have recently graduated are not allowed to apply for the residency programme. If this is correct, as a consequence, the situation will arise whereby graduates of 2010 may well become specialists before their seniors are able to. We would like to clarify if this is true and how will the issues of seniority, equity and parity be addressed?

18 We are also given to understand that residents will have workload caps. If this is true, we would like to seek clarification as to how workload will be distributed between residents and non-residents? (In the transition period, non-residents would also include specialty trainees under the current system.)

19 In addition, with workload caps and possibly a shortened period of training, how do we ensure that residents have enough clinical exposure in their specialty training so that quality is not compromised?

20 Will there be a difference in the remuneration of residents and non-residents of similar seniority? With the residency system, what will become of the position of registrar and the registrar allowance?

21 We would also like to know what is the length (i.e. number of years) and what is the supervisor to resident ratio for each residency programme.

22 We understand not all specialties will roll out residency programmes next year. We would be grateful if we are informed as to which years each specialty would roll out their residency programmes.

23 Many Singaporean male residents have full-time National Service (NS) obligations. Will the residency programmes have provisions for such residents to have their training interrupted by NS?

24 We are given to understand that it has been suggested that all hospitals offering residency programmes have to be accredited by Joint Commission International (JCI), thereby linking ACGME requirements with a JCI accreditation. We would be grateful if you could confirm if this is true. If so, this could well represent a comprehensive "Americanisation" of the public hospital system in Singapore, as there are quite a few quality hospital accreditation schemes that exist in the world in addition to JCI. This is not necessarily a good or bad thing in itself but it would be appreciated if there is more clarity on this such that all stakeholders understand the strategic direction our public hospital system is heading towards.

25 We look forward to your clarification on the abovementioned issues. Thank you.

Yours sincerely,

DR CHONG YEH WOEI
PRESIDENT
SINGAPORE MEDICAL ASSOCIATION

Cc Prof Ong Yong Yau, President, Singapore Medical Council
Prof Fock Kwong Ming, Master, Academy of Medicine Singapore
A/Prof Goh Lee Gan, President, College of Family Physicians Singapore

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5 Oct 2009

Dr Chong Yeh Woei
President
Singapore Medical Association

Dear Dr Chong

RESIDENCY PROGRAMME

I refer to your letter to Prof Satku, Chairman Specialists Accreditation Board (SAB), dated 29 Sep 2009.

MOH and SAB has been in discussions and communicating with various groups of doctors and administrators. A circular for all doctors by the Director of Medical Services was already in the process of being drafted when your letter came. A copy of this circular which will be sent to all doctors is attached.

With regard to the issues and questions in the letter, we would like to invite SMA's Council and others who are interested to the specially arranged dialogue session on Wednesday, 28/10/2009 at 5:30pm at the Auditorium, College of Medicine Building, Ministry of Health. This session is for those who are not currently medical students or doctors from our restructured hospitals.

Colleagues who are working in restructured hospitals and medical students would have their own dialogue sessions in their own hospitals and in NUS, details of which will be announced through their respective institutions.

Thank you.

DR LAU HONG CHOON
SECRETARY, SPECIALISTS ACCREDITATION BOARD
MINISTRY OF HEALTH

Cc Prof Ong Yong Yau, President, Singapore Medical Council
Prof Fock Kwong Ming, Master, Academy of Medicine Singapore
A/Prof Goh Lee Gan, President, College of Family Physicians Singapore