Disciplinary Proceedings in the Medical Profession

Francis Xavier
Disciplinary Proceedings in the Medical Profession
Francis Xavier

Like the legal profession, the ethical and professional standards of the medical profession are to a large extent, self-regulated. In order to retain public confidence in the profession, these standards are exacting and are scrupulously enforced. In this article, Francis Xavier provides an overview of the disciplinary process involved and the applicable standards in the light of the changes that came into effect in April 1998. This article also examines the impact of the duty of patient confidentiality.

The Governing Entities

The disciplinary powers of the profession rests chiefly with the Singapore Medical Council (‘SMC’). The SMC possesses adjudicatory and punitive powers.

In addition to the SMC, the Singapore Medical Association (‘SMA’) and the Ministry of Health (‘MOH’) can and do receive complaints from the public. These, bodies, however, have limited powers of investigation and punishment. Also, the individual hospitals invariably have an internal disciplinary process as well.

The SMC

The SMC was established under the Medical Registration Act (‘MRA’). Its functions include maintaining a register of practitioners and making recommendations on the training and education of medical professionals.

Section 5(f) of the MRA provides that the SMC is ‘to determine and regulate the conduct and ethics of the registered medical practitioners’. In fulfilling its role, the SMC can make regulations ‘regulating the professional practice, etiquette, conduct and discipline of registered medical practitioners’.

The SMA

The SMA was formed in 1959 by the profession itself. It represents the majority of the medical practitioners in Singapore and has its own constitution. Part of the objectives of the SMA is to maintain the honour of the medical profession and to support a higher standard of medical ethics and conduct.

The public perception is that the SMA is the key body regulating the disciplinary process within the profession. Indeed, in recent times, the majority of complaints against doctors are lodged

---

1 This is similar to the powers of the Law Society in its disciplinary proceedings under Section 71 of the Legal Profession Act (Cap 161). However, in the case of the legal profession, the Chief Justice must approve these rules before they come into effect.

© Francis Xavier
Rajah & Tann, Knowledge Management
December 2000
Page 1
with the SMA and not the SMC.  

Contrary to popular perception, the SMA has no investigative or punitive powers. Even where the conduct of the practitioner concerned falls short of expected standards, the SMA is powerless to impose sanctions. The SMA’s power to regulate the conduct of medical practitioners has aptly been described as being only ‘persuasive’.

Invariably, upon receiving a complaint, the SMA plays the role of mediator. Where the complaint cannot be resolved or the complainant remains dissatisfied, the SMA usually recommends that the complainant obtain legal assistance or lodges an official complaint with the SMC (see, for instance, the Ethics Committee Report as contained at p 47 of the ‘Annual Report of the Singapore Medical Association, 1993-1994’).

The MOH

The MOH has no direct disciplinary control over members of the profession. While there is nothing to prevent the MOH from conducting its own investigation into a complaint against a practitioner, in practice, it usually refers such complaints to the SMA or SMC.

The regulatory powers of the MOH lie in its control over hospitals and other medical establishments. These powers are contained in the Private Hospitals and Medical Clinics Act (Cap 248) (‘PHMCA’). With the exception of Alexandra Hospital and the Institute of Mental Health, the PHMCA applies to all hospitals as well as to private clinics, clinical laboratories and healthcare establishments.

Pursuant to the powers set out in the PHMCA, the MOH oversees the licensing, quality and appropriateness of the services provided and the practices and procedures employed.

Alexandra Hospital and the Institute of Mental Health come under the purview of the MOH by virtue of the Government Hospitals Act (‘GHA’).

Broadly speaking, the MOH is concerned with the practice of these establishments as opposed to that of the individual practitioner.

The Hospitals

The hospitals governed by the PHMCA are obliged to set up a quality assurance programme to ‘monitor and evaluate the quality and appropriateness of patient care … and to identify and resolve problems’ (section 30, PHMCA). The inquiry is an internal exercise within the hospital and will be governed by the internal disciplinary practices of the hospitals concerned. There are no

---

2 Between 1994 to 1997, the SMA received a total of 417 complaints as compared with 216 complaints received by the SMC. See Appendices 1 and 2 of Medico-Legal Responsibility in Singapore by Yeo Khee Quan (2000).

3 Medico-Legal Responsibility in Singapore by Yeo Khee Quan (2000) at p. 108.
specific standards or guidelines governing such disciplinary processes, apart from the general law.


There is a need for a standard set of guidelines or minimum standards governing the operation of such quality assurance programmes to be implemented.

It is interesting to note that no similar obligation as set out above is provided for in respect of hospitals governed by the GHA.

**Disciplinary Proceedings by the SMC**

Disciplinary proceedings by the SMC are governed by the MRA and the Medical Registration Regulations (‘MRR’) both of which were amended in April 1998.

The disciplinary proceedings comprise two main stages: a review by the Complaints Committee (‘CC’), which may be followed by a formal inquiry by the Disciplinary Committee (‘DC’).

The primary role of the CC is to inquire into a complaint and determine if the matter should be formally inquired into by the DC. The CC cannot inquire into matters beyond those raised in the complaint.

The CC has fairly wide powers. For example, it can, while conducting its inquiry, require any person ‘to assist’ in the inquiry and any documents or records to be produced. It can even compel a medical practitioner to disclose all information relating to such documents or records (section 40(16) MRA). A person withholds such information or document on pain of imprisonment and/or the imposition of a fine (section 40(17), MRA: maximum fine of S$5,000 and imprisonment for up to 12 months). The patient confidentiality issue in this context is discussed below.

The medical practitioner whose conduct is being investigated has no right to be heard by the CC (section 40(21), MRA).

In the event that the CC decides that no formal inquiry be made but that the practitioner be issued with a letter of advice or warned, the aggrieved practitioner has the right of appeal to the Minister of Health, whose decision shall be final.

---

4 Where the complaint touches on the physical or mental fitness of the practitioner, the CC must order an inquiry to be held by the Health Committee who will determine if the practitioner’s fitness to practise is impaired.


© Francis Xavier
Rajah & Tann, Knowledge Management
December 2000
Page 3
The Grounds for Liability

Prior to the 1998 amendments to the MRA, a practitioner facing a DC would be liable for professional misconduct if he was either:

1. convicted of a heinous offence; or

2. found to have been guilty of infamous conduct in a professional respect (section 23(1) of the now revoked MRA, 1970).

The SMC Ethical Code of 1995 (the ‘Code’) is a publication of the SMC which sets out what the SMC regards as the minimum standards applicable to practitioners in the discharge of their professional duties and responsibilities. The Code defines a ‘heinous offence’ as ‘a conviction in the criminal courts of Singapore of an offence involving moral turpitude affecting a practitioner’s fitness to practise’ (the Code, para 16).

The Code also defines ‘infamous conduct in a professional respect’ as a ‘serious professional misconduct judged according to the rules, written and unwritten, which govern the medical profession’ (the Code, para 18). English judges have construed this phrase to mean acts which ‘would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency’ (Allinson v General Council of Medical Education and Registration [1994] 1 QB 650).

This language was done away with by the 1998 amendments. Under the amended MRA, the substantive grounds on which the DC may find a practitioner liable include the practitioner having:

1. been convicted in Singapore or elsewhere of any offence involving fraud or dishonesty or implying a defect in character which makes him unfit for his profession;

2. been guilty of such improper act or conduct which brings disrepute to his profession; or

3. been guilty of professional misconduct.

The MRA does not offer any assistance as to the meaning of the above phrases. Further, the Code has not been updated by the SMC to reflect the 1998 amendments. The extent to which the old definitions would be applied remains unclear. No doubt, some oblique guidance can be obtained from the conduct of disciplinary proceedings in the legal profession in the cases interpreting section 83 of the Legal Profession Act.

An appeal lies to a court of three judges from an order made by a DC (section 45(12), MRA). In such an appeal, the High Court will accept as final and conclusive any finding of the DC relating

---

6 For some examples of where the High Court did interfere, see David Tan Boon Chee v Medical Council of Singapore [1980] 2 MLJ 116 (where some DC members were absent on some days of the hearing or were apathetically walking in and out of proceedings), Re the Medical Registration Act (Cap 174); re Chuang Wei Ping [1994] 1 SLR 176 (where
to issues of medical ethics or standards of professional conduct unless the court takes the view that such a finding is ‘unsafe, unreasonable or contrary to the evidence’.

Doctor-Patient Confidentiality in the Context of Disciplinary Proceedings before the SMC

A fundamental element of the medical profession is doctor-patient confidentiality. It is enshrined in the Hippocratic oath which requires the doctor to ‘respect the secrets that are confided in [him], even after the patient has died’. That a doctor owes his patient a duty of confidentiality is undoubted in equity (Hunter v Mann [1974] QB 767, W v Wgdell [1990] Ch 359). It is also embodied in the Code which forms the SMC’s guide to a doctor’s proper conduct (the Code, para 20(b)(ii)).

The question therefore is whether a practitioner seeking to defend himself in medical disciplinary proceedings would, as a result of the duty of doctor-patient confidentiality, find himself barred from adducing confidential information as evidence.

As with any other duty of confidentiality, doctor-patient confidentiality is subject to exceptions. Two recognised exceptions or limitations which have established roots in the duty of confidence are where there has been an implied waiver to the right of confidentiality, and the limitation of self-interest. Unfortunately, neither has been tested in the arena of doctor-patient confidentiality.

It is accepted in relation to lawyers that a lawyer may utilise confidential information of his client’s where his client has brought a claim against him. The exception is founded on the basis that by instituting proceedings and putting the lawyer’s conduct in issue, the client implicitly waives his right of confidentiality (Lilicrap v Nalder [1993] 1 WLR 94). The position as regards legal proceedings commenced against a doctor for medical negligence by a patient is the same: in instituting proceedings, the patient puts his health in issue and thereby implicitly consents to the breach of confidentiality (see Hay v University of Alberta Hospital [1991] 2 Med LR 204 and Powers and Harries, Medical Negligence (2nd ed, 1994), p 133). There would seem to be no good reason why the courts should treat disciplinary proceedings any differently.

The position as regards claims or complaints brought by a patient would therefore seem to be relatively clear in equity. However, a complaint against a doctor may be brought by someone else other than the patient. This may arise where the patient has passed away or is no longer mentally competent. Or a third party, such as the MOH, may decide to raise a complaint. In such a case, as it is not the patient that has raised the issue, the exception of implied waiver would not apply. In those instances, however, it is suggested that the exception of self-interest would apply.

The exception of self-interest essentially provides that the duty of confidentiality is limited where the interests of the duty-bound party requires disclosure of the confidential information. The duty was first formulated in banker-client relationships (Tournier v National Provincial and Union Bank of England [1924] 1 KB 461, Sunderland v Barclays Bank Ltd (The Times, 24 November 1938).

reasonable suspicion of bias arose as a DC member was also member of the complainant, MOH), Tan Sek Ho v Singapore Dental Board[1999] 4 SLR 757 (where in the Court’s opinion, the punishment imposed was excessive).
However, the duty was expressed in general terms and it is suggested that the doctor-patient relationship of confidentiality should be treated no differently. Support for this proposition in relation to doctors may be found in the case of *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513, where the Wellington High Court stated in *dicta* that ‘a doctor may reveal confidences and secrets if he is required to defend himself, or others, against accusations of wrongful conduct’.

Oddly enough, the position in equity seems to be contradicted by the Code, as paragraph 29 of the Code provides that:

> …confidential information in respect of patients should not be disclosed, even in situations where the practitioner wishes to rely upon it in his defence in a disciplinary proceeding. If such information is relevant, the patient’s identity must not under any circumstances be disclosed.  

It is trite law that the common law (including equity) can only be changed by the legislature and even then, only in express words. A review of the MRA and the MRR does not reveal any express (or even implied) curtailment of the exception. The Code itself occupies an odd position under the law. It is not a creature of statute in that it has not been passed by the legislature, or even promulgated under any power vested in the SMC by the legislature to create subsidiary legislation. Its impact on established case law may therefore be doubted.

The nub, however, is of course that there has been no decision in respect of doctor-patient confidentiality in the area of disciplinary proceedings in Singapore. The position therefore remains unclear.

It is suggested, however, that there are compelling reasons why a doctor should be able to bring exonerating evidence even if in doing so he would be breaching doctor-patient confidentiality and that the exceptions discussed above in the various cases should prevail:

1. Where a patient has raised a complaint against the doctor, doctor-patient confidentiality should not be in issue as the patient has arguably waived his right to confidentiality. In the face of a waiver or consent (albeit implied), the issue of ethics ceases to be relevant. The only issue left is the extent of the waiver. Arguably, while the facts immediately relevant to the medical case have ceased to be covered by the duty of confidence, other related facts in respect of other medical cases of the patient may not be. Any consideration of protecting the client from an excessive disclosure of medical information may arguably be protected by limiting the extent of the implied waiver.

---

7 Although it is difficult to see how the patient’s identity is to be kept a secret where the complaint relates to a specific case of the doctor’s against a patient.

8 While the SMC does have a power to make regulations regulating the professional practice, etiquette, conduct and discipline of registered medical practitioners under section 58(2)(e), the Code has not been made as a regulation pursuant
2. While there is much to be said for preventing doctors from using confidential information in their possession that may be potentially embarrassing and damaging to the patient, this must be balanced against the doctor’s own rights. As a matter of natural justice and morality, the doctor should be entitled to defend his good name with the evidence available. This must be the case where a third party not covered by a duty of confidentiality selectively utilises evidence supportive of his case, but leaves out evidence detrimental to it.

3. There is nothing intrinsic to medical information that should cause it to be treated on a higher scale from say, legal information provided to a lawyer, or credit information provided to a bank.

4. There is no compelling reason why disciplinary proceedings against a practitioner should be treated any differently from civil proceedings against him.\(^9\)

Under section 13(2) of the PHMCA, any medical information in the possession of the MOH is not to be disclosed except under specified exceptions. Disciplinary proceedings under the MRA constitute one of those exceptions. If the MOH may disclose a patient’s medical information in disciplinary proceedings, it is suggested that a doctor should be entitled to do so as well.

\(^9\) Disciplinary proceedings aside, it may be of interest to note that, the MOH possesses wide powers under the PHMCA. An analysis of the PHMCA reveals that the MOH is virtually unfettered by the rules of doctor-patient confidentiality in its conduct of investigations pursuant to the Act. See for example section 12(2) and (3) of the PHMCA.