
REPORT ON RECOMMENDATIONS

28 NOVEMBER 2019

**WORKGROUP TO REVIEW THE TAKING
OF INFORMED CONSENT AND SMC
DISCIPLINARY PROCESS**

List of Recommendations

The Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process has made the following recommendations in this report:

I. INFORMED CONSENT	
1	Provide a clear legal standard for medical professionals' duty to advise which is one that is patient-centric but ultimately based on the opinion of a responsible body of doctors.
2	Revise the SMC's ECEG provisions on informed consent down to basic irreducible principles, with helpful illustrations to guide doctors on how these principles apply.
3	Develop nationally agreed specialty-specific guidelines to deal with standard commonplace procedures in each specialty.
II. SMC'S DISCIPLINARY PROCESSES	
<i>Structural improvements</i>	
4.1	Establish an Inquiry Committee to filter out complaints that are frivolous, vexatious, misconceived or lacking in substance early.
4.2	Remove the requirement that the Chairman of a CC must be a Council member.
4.3	Establish a Disciplinary Commission to professionalise and preserve the independence of the DT.
4.4	Improve access to legal resources for the CCs and DTs through the creation of a legal advisory unit and a separate prosecution unit.
<i>Improvements to process and procedure</i>	
5.1	Introduce strict timelines to control the overall length of time a complaint takes to be resolved.
5.2	Provide early notification to the doctor when a complaint has been made.
5.3	Introduce a time-bar against the filing of aged complaints with the SMC.
5.4	Empower the IC or CC to make cost orders against complainants.
5.5	Allow the IC to order investigations once it determines that the complaint is not frivolous, vexatious, misconceived or lacking in substance.
5.6	Allow the CC to refer additional issues during investigations to the SMC, for the SMC to make a fresh complaint.
5.7	Introduce strict criteria for the submission of relevant documents and evidence in relation to complaints.
5.8	Allow the SMC to make the final determination if matters should be referred to the DT and to withdraw charges at any point in the proceedings.
5.9	Using a tribunal-appointed expert as far as possible, to reduce acrimony in proceedings.

5.10	Adopt measures to enhance the consistency of decision-making.
5.11	Expressly legislate that costs can be awarded against the SMC.
5.12	Stipulate clear rules on conflict of interests for experts, and members of the IC, CC, and DTs.
5.13	Provide support for doctors involved in disciplinary proceedings.
<i>Role of mediation in the disciplinary process</i>	
6.1	Empower the SMC to direct the complainant and doctors to participate in mediation upon receiving the complaint.
6.2	Subsidise mediation between the complainant and doctor.
6.3	Strengthen cooperation between the SMC and the Singapore Mediation Centre.
<i>Appeals</i>	
7.1	Remove the right to appeal to the Minister from decisions of the CC and replace it with a request to a Review Committee to review the decision.
7.2	Remove the right for complainants to compel SMC to appeal against a decision of the DT.
<i>Training</i>	
8	Enhance training for IC, CC, and DT members.
III. BACKLOG	
9.1	Devote separate resources to clear backlog.
9.2	Create a parallel system to deal with backlog and fresh cases respectively.
IV. CONTINUING MEDICAL EDUCATION	
10	Introduce compulsory Continuing Medical Education (CME) on medical ethics for all doctors, in particular informed consent and the SMC Ethical Code and Ethical Guidelines, SMC disciplinary processes and pertinent medico-legal cases.

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I. Preamble

1. The Workgroup to Review the Taking of Informed Consent and SMC Disciplinary Process (“Workgroup”) was appointed by the Ministry of Health (“MOH”) on 13 March 2019. It was given a broad mandate, and asked to undertake a comprehensive review of and to make appropriate recommendations on:
 - a. the taking of informed consent by a medical practitioner from a patient; and
 - b. the Singapore Medical Council (“SMC”) disciplinary process.¹
2. The Terms of Reference also required the Workgroup to canvass the views of medical practitioners from a range of diverse practice backgrounds across private and public healthcare settings.
3. The Workgroup made extensive efforts at engaging doctors across all practices, as well as the professional bodies and the public. Since its appointment on 13 March 2019, the Workgroup has conducted more than 30 engagement and townhall sessions. More than 1000 doctors, from a range of diverse practices and seniority, have attended these sessions. The Workgroup also reached out to hospitals from both public and private sectors. Engagements were also organised with young doctors, patient advocacy groups and lawyers involved in medico-legal cases, to fully canvass views.
4. The engagement and townhall sessions were an effective platform for the Workgroup to hear a wide range of views. The feedback and suggestions received were wide-ranging, but a consistent theme was a call for change, not just in relation to the prevailing legal and ethical requirements but also in the manner in which the disciplinary process was being conducted. It was

¹ The composition of the Workgroup and its Terms of Reference are at **Annex A** and **Annex B** respectively.

also clear to the Workgroup that there is an urgent need to restore trust in the system. Faith had not only been eroded in the process, but also in several high profile mis-steps in the manner in which some cases were decided.

5. Starting from a clean canvas, the Workgroup formulated preliminary recommendations from the early recommendations. The Workgroup presented these preliminary recommendations to doctors, medical professional bodies and other groups that represented the public for further testing, feedback and fine-tuning.² The Workgroup sets out its final recommendations in this Report, and also explains the background thinking to the changes being proposed.

(A) Erosion of trust in the system

6. The practice of medicine revolves around trust.
7. A doctor and patient relationship that is built on trust is central to the practice of medicine. The quality of that relationship often has a direct impact on the quality of care and the outcome of that care. Where the relationship is strong, patients are more willing to confide in his or her doctor, enhancing the quality of the diagnosis and proposed treatment plan. This allows the doctor to focus on his or her patient's needs and communicate information about the disease or condition and options for treatment more effectively. This in turn enhances decision-making and outcomes for the patient. To a doctor, the interests of patients are paramount – informed consent is key to this because it is only when patients know and understand the treatment they are receiving that their interests are served.
8. In turn, doctors must also be able to trust the professional disciplinary system to produce fair and consistent outcomes. When the disciplinary system does not effectively and consistently enforce the profession's standards, doctors are faced with uncertainty and unnecessary stress. To

² A summary of the feedback we obtained through these engagement and townhall sessions are at **Annex C** and **Annex D**.

cope with this, doctors may feel pressured to adopt practices that they think will best protect them, even if they end up being less effective in serving the needs of their patients. Over time, this will erode the trust of the patient, not to mention undermine patient safety. Some of these practices include the practice of defensive medicine, which has been proven to have deleterious effects on the healthcare system. Defensive medicine is often practised when a doctor views the patient primarily as a potential plaintiff and not as a patient that he should care for to the best of his knowledge and ability. It is not in the interest of either the doctor or the patient to have the patient-doctor relationship supplanted by a doctor-potential plaintiff relationship.

9. For our healthcare system to function at a high level of effectiveness, this tapestry of trust must be woven tightly.
10. However, it became evident to the Workgroup that these relationships of trust are under serious threat of erosion. High profile cases against doctors that have attracted wide coverage, some of them controversial, seriously dented the profession's confidence in the fair and just enforcement of professional standards. The fact that cases are taking an inordinate amount of time to be dealt with has been a source of frustration not just for doctors but also for complainants. It is untenable, and not at all in the interests of justice for complaints to take an inordinate amount of time to be resolved. Whenever outcomes seem to diverge from well-established practices or long-held views on patient care within the medical community, it has caused doctors to second-guess their own judgment as to how to care for their patients, and feel that they are constantly under threat of incurring medico-legal risk from their patients. The damaging effect that this has on the doctor-patient relationship should not be underestimated.
11. Indeed, the system has been under strain for some time now. What the Court described as "*the medical profession's propensity to protest loudly over the decisions of the disciplinary tribunals and/or courts*"³ has to be understood against this backdrop of a growing disquiet and pessimism

³ *Singapore Medical Council v Dr Soo Shuenn Chiang* [2019] SGHC 250 ("*Soo Shuenn Chiang*") at [68].

within the medical fraternity, that has been brewing for some time. We do not believe Government decisions or policies should be determined by petitions. Notwithstanding that, the several petitions were supported by thousands⁴ probably because those controversial decisions felt like the proverbial straw that broke the camel's back.

12. While this state of affairs was evolving, there was a key medico-legal development. In 2017, the Court of Appeal in landmark decision, *Hii Chii Kok v Ooi Peng Jin London Lucien*⁵ changed the legal test to be applied when determining if a doctor had met the standard of care when giving advice. This new legal test represented a significant shift from the long-established peer-review standard set out in the *Bolam-Bolitho* test. The Court of Appeal was of the view that the *Bolam-Bolitho* test gives insufficient regard to the autonomy of the patient. Instead, the test in *Hii Chii Kok* determines what is considered material and relevant information that needs to be discussed with the patient from the perspective of a reasonable patient in *that particular patient's situation*, at that point in time. The test rightly prioritises patient autonomy and recognises that what may be relevant to one patient may be less important to another. This test is known as the *Modified Montgomery* test ("MM Test"). This test heralded a new era of informed consent taking, where it is no longer regarded to be sufficient for doctors to simply follow prevailing medical practice standards in terms of what risks and treatment complications are typically disclosed to their patients.
13. As a new legal standard for the provision of advice to patients, the MM Test aims to be nuanced and well balanced in promoting patient autonomy. At the same time, it assures doctors that the Court recognises that the duty to advise does not require doctors to disclose all risks to the point of blanketing patients with the minutiae of various treatment options. However, it was perceived by many doctors that the MM Test brings in an element of

⁴ See for example, the petition asking MOH to clarify its stand on the taking of informed consent for minor procedures, which was signed by more than 6,000 people. "Sign the Petition." Change.org, January 24, 2019. <https://www.change.org/p/what-is-the-ministry-of-health-s-stand-on-informed-consent-for-minor-procedures>.

⁵ [2017] 2 SLR 492 ("*Hii Chii Kok*").

variability and hence uncertainty regarding what each patient might want to know. While some doctors understand how the test is to be applied, many have expressed confusion and anxiety about what exactly they are now required to do. Some doctors have even candidly admitted that they now practise defensively just to be sure.⁶ We do not believe that doctors set out to undermine their patients' interests by practising defensively. On the contrary, doctors are often trying their best to figure out how to meet their patients' expectations under the new legal standard. However, they may have simply concluded that in order to anticipate what the patient might want to know, it is best to give copious amounts of information, even if it may end up being unwelcome, or difficult for the patient to retain or process. In this sense, the MM Test has, in its practical application, led to unintended negative outcomes. Patients are not necessarily better informed. On the contrary, we have received feedback that they are now increasingly inundated with information and are none the wiser.

14. One possible reason for the disconnect⁷ could be that patients look to the doctor for the advice, and this remains relevant in our Asian context, at this time. Indeed, the Court of Appeal in *Hii Chii Kok* noted that the nature of the doctor-patient relationship had evolved and that there are shifts in societal attitudes towards the practice of medicine, in deciding that it was incumbent on the Court to reconsider the applicable standard for the giving of advice.⁸ Many doctors shared personal stories and anecdotes to illustrate how their patients prefer to be passive recipients of information, or how advice has the effect of analysis paralysis.⁹ It *may* be the case that many members of our society are still not yet ready to make use of a collaborative relationship with their doctor. It is noteworthy that the jurisdictions that have earlier departed from the *Bolam-Bolitho* test are advanced Western societies with cultures which are more communicative. Also, in *Montgomery*

⁶ In this report, defensive practices refer to practices adopted to avoid legal liability (even if the practices would not in fact achieve this outcome such as information dumping), rather than acting in the patient's best interest.

⁷ Doctors recognised that patient autonomy is a fundamental principle in medical ethics and that MM Test promoted patient autonomy, but many struggled to put the MM Test in practice.

⁸ *Hii Chii Kok* at [119] and [120].

⁹ A surgeon recounted a memorable anecdote where she was asked for a second opinion. The patient had been advised on various treatment options and their attendant risks and did not know what to do with the information. In seeking the second opinion, the patient simply wanted the surgeon to tell her what to do.

and in *Hii Chii Kok*, the patient-plaintiffs were well-resourced, well-educated individuals who would have been comfortable asking questions of their doctors, and assessing the advice given to them. It appeared that the experience of doctors is that this is not necessarily true of most patients in Singapore today.

15. It did not help assuage the concerns that, against this new legal landscape, the SMC undertook a number of prosecutions that raised even more concerns and exacerbated the problem. In a short span of four months, the High Court was faced with two “unfortunate” cases which should never have been referred to the Disciplinary Tribunal (“DT”) in the first place.¹⁰ The outcomes galvanised doctors into expressing their dissatisfaction and loss of confidence in the SMC’s disciplinary process.
16. The decision of the DT in *Singapore Medical Council v Dr Lim Lian Arn*¹¹ raised more than just a few eyebrows for various reasons. In that case, the doctor was fined \$100,000 – the *maximum* fine permissible under the law – for failing to inform a patient about the risks associated with a relatively simple procedure. In the months that followed the DT’s decision, many believed that the SMC expected doctors to advise patients about *all* the risks associated with simple procedures, failing which they would face the prospect of prosecution and conviction. There were questions about how the SMC came to conclude that the doctor’s conduct was considered “professional misconduct” in the first place. The severity and harshness of the sentence also caught the profession by surprise.
17. Decisions such as *Lim Lian Arn* not only muddled the understanding of what informed consent means, but also exposed the inadequacies in the SMC’s disciplinary process, and the competency of the Tribunals which decided the cases. The decision in *Soo Shuenn Chiang* was another example of a harsh and inexplicable outcome. The doctor’s plea of guilt should not have been accepted by the DT (nor indeed by the SMC in that case) because

¹⁰ *Soo Shuenn Chiang* at [44].

¹¹ [2018] SMCDT 9 (“*Lim Lian Arn*”).

there was simply no cogent evidence of wrongdoing by the doctor, least of all professional misconduct. The fine of \$100,000 imposed by the DT in *Lim Lian Arn* was also manifestly excessive. Disciplinary Tribunals must not only be aware of the medical aspects of the case, but must also be familiar with legal concepts such as rules of natural justice and due process, burden of proof, the minimum standard for professional misconduct (which is an issue of mixed fact and law), and proportionate sentencing. We should add that these cases also raise concerns over the SMC's role as the prosecutor – on what basis could the SMC have sought a five-month suspension in *Lim Lian Arn*, even if it believed that there was misconduct in that case.

18. The profession clearly has been harbouring serious doubts about the ability of that process to produce fair outcomes. A serious inadequacy is the lack of training and/or knowledge on the part of those involved in the disciplinary process. Doctors also perceive the disciplinary process to lack transparency. The SMC's appearance of being (or at the very least, appointing) the investigator, prosecutor, and judge(s) in each case has cast doubts about its independence. The competence of individuals who perform these roles has equally been doubted.
19. Some doctors feel that the SMC holds them to unrealistically high standards and prosecutes them for minor breaches. There is also a perception that the private law firms the SMC engages are overly focused on obtaining a conviction. This perception was reinforced by the recent court decisions. These decisions have quite rightly criticised the SMC's prosecution of cases and the untenable positions taken with respect to the charges and proposed penalties.
20. We recognise that the continued confusion about what the law expects of doctors has negative bearings for the practice of medicine in Singapore and for the well-being of our people. When risk and liability are unpredictable, it is not surprising for doctors to adopt defensive practices designed to avoid or manage such risk and potential liability. This leads to inefficiency and

drives up medical costs without necessarily bringing corresponding improvements to patient care.¹²

21. The poor handling of complaints by SMC will also undermine the public's trust of the medical profession over time. If doctors are perceived to be poor at enforcing high professional standards (or worse, unsure of what the standards are), patients will naturally become more skeptical and litigious, creating further factors driving defensive practices, increased costs, and poorer patient care.
22. If these pressing issues are not tackled swiftly and effectively, they will continue to fester and have serious ramifications. Our concerns are not just for the medical profession. Ultimately, what remains of utmost importance are the best interests and welfare of patients, which cannot be well served unless these problems are swiftly tackled and the entire ecosystem is restored to health, nurtured by trust.
23. For these reasons, the Workgroup recommends that the Government take urgent steps to arrest this unravelling of the tapestry of trust, so that we can hopefully rebuild these key relationships and provide the best conditions for our healthcare system to thrive and grow from strength to strength.

(B) Restoring trust and confidence in the system

24. Having interacted with more than a thousand participants, both doctors and non-doctors, the Workgroup has collected a wide range of feedback. In some instances, the suggestions were diametrically opposed.
25. The Workgroup considered it important to lay down a series of fundamental principles and parameters to guide its review, a lodestar to look to as we shaped our recommendations.

¹² See a commentary on how the decision in *Lim Lian Arn* may shape the cost and availability of H&L injections: "About That \$100,000 Fine for An Injection" at <http://hobbitsma.blog/2019/01/25/about-that-100000-fine-for-an-injection>.

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26. Patient safety, interest, and welfare are, and must always be, of foremost consideration. Therefore, any changes to informed consent practices must continue to nurture a doctor-patient relationship that is based on trust, and allow patients to meaningfully participate in the decision-making process. At the same time, it should set a clear and fair standard, one that allows doctors to practice without fear of unwarranted litigation. This is not an easy balance to achieve, and is very much dependent on the cultural and practice context in which the doctor and patient operates.
 27. The nature of medical practice is such that there will always be inherent uncertainty, due to variations in humans and diseases, limitations to our body of medical knowledge, and therapeutic options. The ethical and legal environment should not be confected in a way that adds further uncertainty for either the doctor or the patient, but should instead decrease uncertainty and foster a better patient-doctor relationship.
 28. Second, the Workgroup considers that self-regulation should remain the best way forward for both the patient and the medical profession.
 29. Not all occupations that are regulated are accorded the privilege of self-regulation. The medical profession in Singapore – an esteemed profession entrusted with the duty to heal and save – has always had the privilege of self-regulation. Historically, it has been thought that because the body of knowledge held by members of the medical profession is esoteric and unknown to the average person, it would be difficult for external regulation to be effective. With better educational levels and basic medical knowledge becoming accessible, this premise may be challenged. At the same time, medical science is advancing faster and therapeutic techniques have become more complicated and sophisticated than ever before. Thus, even though access to information has increased, the voluminous information available needs to be interpreted in the context of the quality of the research data and in different clinical settings by medical professionals.
 30. The Workgroup recognises these developments and believes that self-regulation should continue to provide the optimal framework to encourage

medical innovation while maintaining professional standards in order to deliver the best outcomes for patients.

31. Third, in looking at how the SMC disciplinary process can be reshaped, the Workgroup embraced the tenet that discipline is the first virtue of a profession.¹³ A profession must be disciplined both in conduct and in deed.¹⁴ Members of the public repose some of the most important aspects of their lives to doctors. Doctors must be worthy of this trust. Where this trust has been breached, patients must not be made to confront complex or unduly onerous rules and requirements in order to exercise their right to make a complaint and request an investigation. This is critical not only to achieving justice for the particular case, but also in preserving the integrity of the healthcare system, overall. At the same time, it must be made clear that alleging misconduct is an extremely serious matter. These allegations, which can affect the personal and professional lives of doctors, cannot be made carelessly, unthinkingly, or without basis.
32. Through our recommendations, the Workgroup aspires to facilitate a medical disciplinary system that strikes this balance and has the following hallmarks – independent, expeditious, consistent, fair and proportionate, and outcome-oriented.
33. We should add that these factors often do not sit nicely together and may pull in different directions. The Workgroup therefore found that, invariably, our recommendations had to be formulated after striking a balance between competing interests. For example, there was feedback from some quarters that the SMC should charge a fee for making complaints. This was to discourage frivolous and vexatious complaints from being filed, which would free up SMC resources for serious complaints (which, presumably, would not be dissuaded by the fee). Our review showed that the problem of frivolous and vexatious complaints is a real one, and such complaints undoubtedly do take up resources that can be better deployed. However,

¹³ Wee Chong Jin CJ, “The Legal Profession in Singapore – Past, Present and Future” [1980] 2 MLJ lvii at lvii.

¹⁴ Sundaresh Menon CJ, “Medicine and Law: Comparative Perspectives on Professional Conduct and Discipline”, Singapore’s Professional Affairs Lecture (14 March 2018).

bearing in mind the paramount consideration of patient safety, professional discipline, and the need to uphold public confidence in the medical profession, the Workgroup decided that there should not be an institutional barrier to making a complaint, in the form of a fee. The balance could be better struck by allowing complainants to lodge complaints without a fee, but to empower the SMC to order the complainant to pay costs if, after due consideration and investigation, the complaint is found to have been frivolous or vexatious, or to have persisted in the complaint despite being aware of contrary facts or information.

34. Being outcome-oriented means that there cannot be blind adherence to process, whilst forgetting the true objective of the disciplinary system and the need to ensure fair and consistent outcomes. The Workgroup recommends that the SMC Council be more involved in the disciplinary process to make the final decision to refer complaints to DTs. This ensures that there is a formal stage in each case where Council in its collective wisdom can consider each case in its proper perspective. In some cases under the present system, Council could not intervene because the process did not allow it to do so.
35. **The essence and hallmark of self-regulation is in the “self”.** An effective, self-regulatory medical disciplinary system is only sustainable when the members of the profession whom it is supposed to regulate participate actively to ensure its smooth functioning. This is because the process is highly dependent on competent and dedicated doctors coming forward to serve in various capacities – on the SMC Council, on Complaints Committees (“CCs”), and DTs and as expert witnesses in appropriate cases. Otherwise, the proposed reforms to the structure and processes in and of themselves will not bear fruit. The SMC also has a part to play in ensuring that members who participate in the process are appreciated, encouraged, and fairly recognised for their hard work and contributions.
36. We conclude by emphasising that none of the proposed reforms, adopted individually, can operate as a silver bullet. The proposals are to be viewed holistically, with each part working in tandem to keep the gears in the

system moving efficiently and effectively. It is in this spirit that we elaborate on the rationale for and details behind the proposed reforms.

II. Informed Consent

(A) Introduction

37. The MM Test embodies a patient-centric approach to determining a doctor's duty to advise his patient.¹⁵ Even prior to the introduction of this test, many doctors already saw it as part of a doctor's duty (under the *Bolam-Bolitho* test¹⁶) to take into account their patient's circumstances when giving medical advice. Hence, the change in the legal test should logically not have yielded different results in the vast majority of cases. In fact, the adoption of the new test did not result in a finding of liability in *Hii Chii Kok* itself.

(B) Description of challenges

38. However, the decision to depart from *Bolam-Bolitho* and the pronouncement of a new test for the doctor's duty to advise, signaled to doctors that they had to change the way in which they have been taking informed consent. Since it requires a more customised approach to consent-taking, attenuated to the "particular patient", fulfilling this new standard in practice can sometimes be challenging. Even as the profession was adapting to the new legal requirements, the subsequent prosecution in *Lim Lian Arn* and the harsh penalty meted out to the doctor in that case rolled back the progress that had been made. It left confusion and anxiety within the profession in its wake, and cemented the impression amongst some doctors that the MM Test established unrealistically high standards.
39. First, there is uncertainty among doctors regarding what constitutes relevant and material information from the patient's perspective. Many have also pointed out that patients in whom the risk eventually materialise would

¹⁵ Under the MM Test, a doctor must ensure that the patient is aware of the material risks involved in any treatment, with materiality assessed from the *patient's perspective*.

¹⁶ Under the *Bolam-Bolitho* test, the assessment of whether a doctor has met the requisite standard of care in his interaction with a patient is made with reference to the practices and opinions of a responsible body of medical practitioners, although such practices and opinions must be logically defensible. This was the law laid down by the Court of Appeal in *Khoo James and another v Gunapathy d/o Muniandy and another appeal* [2002] 1 SLR(R) 1024.

inevitably claim that risk to be material, after the fact. They fear that patients are now able to blame them for inadequate advice if something should go wrong with the treatment. In reality, the information in question could also be at times relevant/irrelevant and material/immaterial at different points in the treatment journey – but almost certainly at the point when something adverse has occurred. Giving *all* information to the patient, rightly or otherwise, is therefore seen as a way to mitigate against such uncertainty (even if such information dumping is unnecessary and not in the best interests of the patient). The Court of Appeal in *Hii Chi Kok* did warn against this, but doctors nonetheless expressed the view that they would rather provide more information than less.

40. Second, doctors are genuinely unsure of when and how to take informed consent to an extent that they confidently believe would fulfill the standard of care. Doctors are unsure what considerations will be taken into account to determine materiality from the *particular patient's point of view*, especially when they are faced with real challenges on the ground, such as when the patient is seen in a busy clinic setting, when the doctor is seeing a new patient or covering another doctor's clinic, etc. Due regard also needs to be given to prioritising adequate and timely access to care, including ensuring that wait times are well-managed and within acceptable limits. Factors such as language barriers and the patients' age may also impede the patient's level of understanding. As a result, practitioners face difficulties coming up with effective and defensible work processes that can reliably and consistently provide material information to the spectrum of patients they may encounter in their practice, within the limited time allocated for them to attend to each patient.
41. It became clear during the townhalls and engagement sessions that some doctors have begun to adopt defensive practices, partly in response to *Hii Chii Kok* and also the recent Disciplinary Tribunal decisions such as *Lim Lian Arn*. Doctors said so, quite openly, at the townhalls. In the latter DT case, a fine of \$100,000 levied on Dr Lim for failing to take informed consent in one instance when administering an H&L injection was seen as wholly unjustifiable. Doctors could not reconcile the alleged misconduct (if there was one) with a sanction attracting the maximum statutorily permitted fine.

Many doctors admitted that they would probably have taken consent in the same way, and this reinforced the perception that it was the change in the legal test for taking informed consent that has set the bar too high. The key implication of such defensive practices is that patient welfare and safety, which is the fundamental tenet of a robust healthcare system, is being compromised.

42. Some doctors have also started providing patients with voluminous information of all risks and alternatives, which would likely overwhelm and confuse patients. Ironically, such practices do not afford doctors any better legal protection as they can lead to poorer quality advice. More information does not necessarily equate with better advice or better understanding.
43. One gynecologist in private practice shared that she has started to take as long as 30 minutes to explain procedures to patients, without being sure that this would be beneficial to the patients, but simply out of an abundance of caution. However, merely dumping information on patients without actually enhancing their understanding is unlikely to be helpful. In fact, it is counterproductive and undesirable. Ironically, doctors were cautioned against such behaviour in *Hii Chii Kok*. Yet, in the uncertain climate that followed such a landmark change in the legal standard, doctors found themselves falling into such practices because they were conscious that patients may now want more information, and that was what they felt was the best way to meet that demand.
44. Over time, if this continues, and patients are given information (and much more of it) rather than advice, the ability of the patient to make a proper choice will be inhibited. The patient-doctor relationship cannot be built on the doctor doing what he thinks will least result in an adverse litigation outcome. This ultimately erodes patient safety.
45. In addition, some doctors have become more reluctant to guide their patients' decision-making, worrying that they could be accused of paternalism if they did so. This is ironic when it was clear from the feedback which we received that in fact patients generally wanted and valued their doctors' guidance.

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46. Some other doctors have decided not to offer certain treatments altogether. For instance, some general practitioners have started declining such treatment and have instead started to refer patients to whom they would previously have offered H&L injections to specialists instead, because they do not want to run the risk of a similar complaint being made against them. There is also evidence that the prices of H&L injections have risen (in some instances, significantly) since *Lim Lian Arn*.¹⁷ The result is a more inefficient and less cost-effective medical system for patients.
47. Although *Lim Lian Arn* has since been reversed by the Court of Three Judges, this was chiefly on the grounds that the disciplinary threshold of professional misconduct was not met. Uncertainty regarding what the law requires of doctors when taking informed consent, continues to linger. Furthermore, a defensive mindset that has bred within the medical profession can sometimes take a long time to recalibrate.
48. We are thus mindful of the need to maintain a careful balance in our recommendations on how informed consent should be assessed. Patient safety takes precedence, and we have to ensure that the proposals foster that spirit. Medical advice ought to take into account what is material to the patient, and there is broad consensus among doctors that this is key to meeting the standard of care expected of them.

¹⁷ Wong, Surajkumar, Lee and Tan, “A descriptive study of the effect of a disciplinary proceeding decision on medical practitioners’ practice behaviour in the context of providing a hydrocortisone and lignocaine injection”, *Singapore Medical Journal* 2019, 1-18.

(C) Recommendations

Recommendation 1 – Provide a clear legal standard for medical professionals’ duty to advise which is one that is patient-centric, but ultimately based on the opinion of a responsible body of doctors.

49. Bearing in our mind our paramount concern of patient safety and welfare, we recommend a clear legal standard for medical professionals’ duty to advise. The standard will be one that is patient-centric, but ultimately based on the opinion of a responsible body of doctors.
50. The proposed formulation of the test is set out at **Annex E**.
51. The medical advice provided, and the materiality of the information and risks, would ultimately be assessed based on the practice and opinion of a responsible body of doctors. However, we clarify that this approach explicitly requires that a responsible body of doctors must have regard to patient autonomy and choice and consider what is material to the patient when providing medical advice. It would not represent the view of a responsible body of doctors, or meet the threshold test of logic, if it failed to do so.
52. The test mandates that the responsible body of doctors must consider whether information that is relevant and material to the patient in the circumstances to allow that patient to make informed treatment decisions, was provided. The intention is to signal that doctors must give due weight and consideration to this factor in assessing what information to provide to a patient. Under this test, doctors would not be permitted to simply dictate what information patients should receive, without any regard to the individual patient’s need for information. A doctor would need to have regard to patient autonomy and choice in order to satisfy the standard of care. This would mean giving the patient an opportunity to ask questions and have his/her specific concerns addressed. At the same time, the decision-making partnership between doctor and patient envisages that

patients will be forthcoming in sharing their specific concerns with their doctors.

53. The test, in practice, means that a doctor cannot argue that information is irrelevant or immaterial simply because the doctor is of the view that the treatment is in the best interests of the patient (or even if the treatment is the only viable option) and that information about risks would dissuade the patient from seeking that treatment. If a doctor is to have proper regard to patient autonomy, the doctor cannot simply substitute the patient's decision-making with his or her own. In such a situation, the doctor is required to disclose the information, help the patient to assess the risks, and advise the patient to accept the treatment. The choice is ultimately the patient's, and the doctor's duty is to help the patient make an informed choice.
54. It also follows that where a patient has shared a specific concern or raised a specific query, it would ordinarily be unreasonable for the doctor to withhold information even if such information might otherwise be immaterial. A responsible body of medical opinion would also require the doctor to advise the patient of related risks, even if these risks are rare.
55. To be clear, there might be situations where a doctor may, after assessing that the information is relevant and material, decide to withhold that information. These are situations where withholding the information is necessary to prevent harm to the patient, such as cases of medical emergency or therapeutic privilege (the standard of care in relation to such assessments would also be determined by the practice and opinion of a body of peers).
56. The test therefore embraces the patient centricity in the MM Test, but makes it clear that materiality should be assessed by peers. Doctors should not have to practice in fear of their patients turning around to blame them for giving inadequate advice only when something has gone wrong.

Recommendation 2 – Revise the SMC’s ECEG provisions on informed consent down to basic irreducible principles, with helpful illustrations to guide doctors on how these principles apply.

57. This test should be introduced as part of a holistic package of measures to provide clarity and certainty on the standards by which doctors would be assessed. Specifically, the Workgroup recommends the concurrent streamlining of the SMC’s Ethical Code and Ethical Guidelines (“ECEG”) on informed consent into core, irreducible principles, to be accompanied by specialty-specific guidelines to provide more detailed guidance to doctors on how the core principles should be applied in particular contexts.
58. In this regard, the Workgroup has received feedback that there was confusion and a lack of understanding as to the purpose of the ECEG. The ECEG was last revised in 2016 but in our view, these revisions were regressive from the perspective of the ECEG providing guidance on the broad principles of ethics and professional conduct. Through those revisions, the ECEG was transformed into a far more detailed set of guidelines for medical practice. The ECEG expressly stated that it only provides a framework to guide a doctor’s own professional judgment. However, in many instances, the guidelines have been phrased prescriptively. Therefore, the guidelines could be (and often were, by the SMC) misconstrued as suggesting ideal standards of conduct becoming base obligations/ requirements for ethical practice, and not sufficiently accounting for exceptional or extenuating contextual circumstances where deviations could become justified.
59. The Workgroup has received feedback that the ECEG is less of an ethical code and more of a code of conduct prescribing actions which doctors *must* take. With a more comprehensive and detailed set of guidelines and instances, the SMC’s prosecutors have on occasion preferred multiple charges alleging breaches of provisions in the ECEG in each DT inquiry, leading to an unhealthy perception within the profession that the ECEG is akin to a “Penal Code”. The general sentiment amongst the doctors at the

townhalls was that doctors are being held to “expert” standards, as opposed to the usual safe practice standards.

60. Indeed, doctors are not the only ones who misunderstand the effect of the ECEG. In its decision delivered on 24 July 2019, the Court of Three Judges noted that even the doctor’s counsel in that case had wrongly understood the effect of the ECEG.¹⁸ Counsel had proceeded on the basis that a breach of a “basic principle” in the ECEG amounts to professional misconduct. However, only a serious disregard of or persistent failure to meet the standards in the ECEG may rightly lead to disciplinary proceedings.
61. There is a pressing need to stay with the original purpose and intent of the ECEG, by crystallising the section on informed consent into core, irreducible principles. The key elements of informed consent which should be explained to patients (e.g. the medical condition, viable options for treatment, benefits, possible significant complications and risks) should continue to be reflected in the ECEG. The ECEG should also reflect a risk-differentiated approach for cases involving minor intervention and treatment, as opposed to cases where the treatment is complex, invasive or has significant potential for serious adverse events. The draft ECEG section on informed consent is set out at **Annex F**.
62. Apart from the section on informed consent, the current form of the ECEG as a whole does not work to provide effective guidance to doctors on professional standards. The level of detail in the ECEG leaves little room for doctors to exercise professional judgment in accordance with the circumstances of each patient or case. The ECEG should be revised to focus on prescribing the principles to be adhered to in each case, and not prescribing the particular actions that must be taken.

¹⁸ *Singapore Medical Council v Lim Lian Arn* [2019] SGHC 172 (“*Lim Lian Arn HC*”) at [33].

Recommendation 3 – Develop nationally agreed specialty-specific and situational guidelines to deal with standard commonplace procedures in each specialty.

63. In conjunction with the streamlining of the ECEG, we recommend that the professional bodies such as the Academy of Medicine, Singapore (“AMS”) and public healthcare institutions jointly develop appropriate specialty-specific guidelines to deal with standard commonplace treatments and procedures in each specialty. These guidelines should provide practical guidance to doctors on how they are to comply with their core irreducible duties by illustrating practices that should be adopted in common situations.
64. The common interventions and procedures should be studied, and the professional bodies (along with the various AMS specialty chapters) should work out a list of risk criteria, alternative options to be considered and other relevant information germane to that intervention or procedure. Naturally, this procedure-specific information will need to be updated from time to time by the professional bodies with the advance of medical knowledge and practices.
65. The intention is not for the guidelines to be prescriptive or to have the force of law, but to serve as a source of reference or as a baseline. In the appropriate case, if the guidelines are not adhered to, it does not *ipso facto* follow that there is misconduct. Equally, there might well be situations where the patient might require even more than what the baseline guide provides. In short, whilst useful to provide guidance on common situations, the contextual circumstance of each treatment must be considered. Doctors should be allowed to explain their conduct, bearing in mind the context and the patient’s particular circumstances. As the Court emphasised in *Lim Lian Arn*,¹⁹ it is only “*serious disregard of or persistent failure to meet [the standards]...that may lead to disciplinary proceedings*”.

¹⁹ *Lim Lian Arn* HC at [34].

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66. Collectively, the legislative changes, combined with the amendments to the ECEG and practical guidance, reinforced by compulsory medical education on these standards (see general recommendation on education),²⁰ aim to provide clear guidance and certainty to doctors, while concurrently ensuring that patients' interests and autonomy are appropriately protected.
67. This package of measures will restore the doctor-patient relationship and promote patients' interests by reversing the rising trend of defensive practices. It will send a strong signal to the medical profession that so long as they take their patients' concerns into consideration, they can practice with confidence in the manner in which their disclosure of risks and taking of consent would be assessed. Doctors will also be less concerned, for instance, that they may be judged with the benefit of hindsight as to what would have been material to their patients. This will more quickly abate and reverse the trend of defensive practices. In turn, the doctor-patient relationship will be restored, and the patient's best interests protected.

²⁰ See page 66 of this report.

III. SMC Disciplinary Process

(A) Introduction

68. There is an incontrovertible expectation that medicine is practiced in accordance with certain baseline professional standards. Where these professional standards are breached and the lapse entails matters of integrity or connotes serious ineptitude or deviation from acceptable standards, there is clear public interest in holding the doctor accountable. It is also in the medical profession's interest to ensure that the errant conduct is met by an appropriate response, in order to preserve the good image and integrity of the medical profession.
69. Holding doctors to account for misconduct is important for two reasons:
 - a. First, patients entrust themselves to the care of their doctors and can justifiably expect that their doctors will perform their role competently and with integrity.
 - b. Second, unpoliced conduct will strike at the trust that the public reposes in the profession. The SMC plays a pivotal role in exercising oversight over medical practitioners to maintain high standards and to preserve the reputation of the medical profession. However, based on the feedback we received from several doctors, trust in the SMC is "broken". The overwhelming and uniformly consistent feedback we obtained as well as the outcomes in certain SMC disciplinary cases have demonstrated the need for reform.
70. In assessing the SMC's disciplinary process, the Workgroup sought to strike a balance between the following hallmarks of an effective regulatory system: independent, expeditious, consistent, fair and proportionate, and outcome-oriented. While the Workgroup has not recommended to rebuild the system from scratch, the Workgroup is of the view that extensive changes are required for SMC to meet these objectives.

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71. The Workgroup has made 23 recommendations in relation to the SMC's disciplinary process that can be broadly grouped into five categories:
- a. Improvements to structure;
 - b. Improvements to process and procedure;
 - c. Reforms to the role of mediation in the disciplinary process;
 - d. Enhancing training; and
 - e. Streamlining and increasing transparency in the appeals process.
72. In making our recommendations on the SMC disciplinary process, we took reference from the disciplinary process of the Law Society of Singapore and the best practices of medical disciplinary bodies in other Commonwealth jurisdictions. A flowchart of the revised disciplinary process is at **Annex G**.

(B) Improvements to structure

(1) Description of challenges

73. There are six key challenges.
74. First, a significant percentage of complaints are ultimately found to be without merit, but nevertheless take up resources to manage. 5% of complaints referred to the CCs are dismissed at the first meeting. 50% of complaints are ultimately dismissed at the CC stage after investigation, without even the need to issue a letter of warning. In the past five years, 7% of SMC complaints have been dismissed for being frivolous or vexatious. Such cases take up considerable resources, and ought to be dismissed at an earlier stage in the process.
75. Second, doctors are not given timely notification that a complaint has been made against them. Many doctors gave feedback that they would only learn that a complaint had been made against them several months down the road. They expressed that it was only right that they, the subject of the complaint, be promptly informed that an allegation of misconduct had been made against them.

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76. Third, there are concerns that the CC and DT processes are not independent, with the SMC perceived to play the role of the investigator, prosecutor, and judge. Doctors have expressed concerns that while the DT should be independent of the SMC, there is a perception that this is often not the case. Beyond this perception problem, the close working relationship between the SMC, CCs, and DTs have given rise to practices that have broken down the wall that should be maintained between the SMC and the DT. For example, the SMC appoints the DT when the complaint is referred for an inquiry by the CC. However, it also gives instructions for the drawing up of the charges as well as the prosecution of the charges. The SMC secretariat which is to provide independent administrative support to the CC and DT also falls under the purview of the SMC.
77. Fourth, the current structure is also susceptible to the reality on the ground that it has been difficult to find doctors to participate in the disciplinary process (whether to sit in the CCs or DTs, or to provide expert evidence). The Workgroup found complaints which have been held up for months and years simply because of a shortage of doctors to constitute a CC, or because there is no expert evidence available to assist the CC to assess the complaint. Whilst SMC has, in recent years, sought to unchoke some of these bottlenecks, such as by partnering with the Academy of Medicine to provide experts, much more must be done to make the process more resilient.
78. Fifth, another key weakness in the process is that CC and DT members lack familiarity with their powers under the Medical Registration Act,²¹ and how to properly exercise those powers in accordance with law.

²¹ Cap 174, 2014 Rev Ed (“MRA”).

79. This has led to serious injustice and a waste of resources. In *Lim Lian Arn HC*,²² the Court was moved to observe:

*“Doctors are human after all, and, like the rest of us, are susceptible to lapses, errors of judgment, poor record-keeping and failures of memory. It would pose an intolerable burden for each medical practitioner and indeed for society which invests in and depends on the establishment of a vibrant medical profession, if each and every one of these failures were visited with sanctions. This is why the law seeks to strike a balance between, on the one hand, providing for the imposition of appropriate sanctions in those cases where there has been a grave failure on the part of the medical practitioner with possibly severe consequences for the patient, and, on the other hand, providing a rich range of options for the counselling, education and rapid rehabilitation of those practitioners who have departed from the expected standards but not in a persistent or sufficiently serious way. **The law has always recognised the need to strike this balance, but it is sometimes overlooked in practice, as it was in this case. The result has been an ill-judged prosecution, an unwise decision to plead guilty and an unfounded conviction. In short, there has been a miscarriage of justice, with dire consequences for the medical practitioner concerned.**”* (emphasis added)

80. In this regard, the Court further noted:²³

“The underlying rationale for the three-stage inquiry [i.e. the three stage test for professional misconduct] is simple: not every departure from the acceptable standards of conduct would necessarily amount to professional misconduct...even technical or minor breaches should be dealt with in an appropriate way. It is for this reason that the MRA provides an array of measures to address a patient’s complaint and a

²² *Lim Lian Arn HC* at [1].

²³ *Lim Lian Arn HC* at [30].

doctor's misconduct without necessarily escalating the matter to a formal disciplinary inquiry..."

81. We agree with the Court's observations. However, if CCs and DTs are unaware of the "array of measures" available, there will inevitably be cases which are dealt with unjustly. This must be corrected.
82. Lastly, another common complaint pertained to the SMC's reliance on lawyers from private firms. Rightly or wrongly, the perception is that these private law firms may be more concerned with delivering convictions and high fines or suspensions, and less attuned to the SMC's and the profession's broader concerns. The fact that the SMC's lawyers were prepared to accept a \$100,000 fine being imposed in *Lim Lian Arn* (and had initially submitted on SMC's behalf that a five-month suspension would be an appropriate penalty) has only served to reinforce perceptions that they are too focused on obtaining the highest or stiffest penalty, as opposed to an appropriate one.

(2) Recommendations

Recommendation 4.1 – Establish an Inquiry Committee to filter out complaints that are frivolous, vexatious, misconceived or lacking in substance early.

83. Under the Legal Profession Act,²⁴ the Review Committee is the first body to examine a complaint lodged with the Law Society. The Review Committee may, on completion of its review, do one of two things.²⁵ It may direct the Council to dismiss the matter if the Review Committee members are unanimously of the view that the complainant is "frivolous, vexatious, misconceived or lacking in substance". Alternatively, the Review Committee

²⁴ Cap 161, 2009 Rev Ed ("LPA").

²⁵ See s 85(8) of the LPA.

may refer the matter back to the Chairman of the Inquiry Panel who is obliged to constitute an Inquiry Committee to inquire into the complainant.

84. The machinery of the Review Committee was introduced to the Legal Profession Act in 2001. Prior to this, the sifting function was performed by the Law Society Council and the Inquiry Panel. The Review Committee was introduced to serve a sifting function in the disciplinary process.
85. The context of the introduction of the Review Committee was explained by the then Minister for Law, Professor S Jayakumar at the Second Reading of the Legal Profession (Amendment) Bill 2001 (No 39 of 2001).²⁶ The Minister for Law explained that the Review Committee is intended to serve as a first sieve before an Inquiry Committee is constituted so as not to unduly tax the resources of the Law Society.²⁷ In 2008, amendments were introduced to further streamline the disciplinary process. These amendments included imposing a time limit on the period the Review Committee has to review a complaint and make a recommendation.
86. The SMC's disciplinary process can similarly benefit from an initial sieving mechanism with time limits imposed. This mechanism will ensure that certain complaints can be weeded out before a CC is constituted. We now explain what this mechanism ought to look like in the context of SMC's disciplinary process.
87. A new sieving mechanism called the Inquiry Committee ("IC") should be established. Its focus will be to triage complaints that are frivolous, vexatious, misconceived or lacking in substance early. This mechanism ensures that SMC's limited resources are focused on genuine complaints.

²⁶ *Singapore Parliamentary Debates, Official Report* (5 October 2001) vol 73 col 2195-2196.

²⁷ The Minister for Law explained: "The Law Society receives more than 100 complaints a year. More than half of them are without substance and are sifted out by the Council, while the remainder goes to an Inquiry Committee for a full inquiry. If the Council is not to sift, the caseload on the Inquiry Committees will more than double ... doubling the caseload of the Inquiry Committees will create a serious strain on scarce resources and slow down the disciplinary process. Therefore a new machinery known as the Review Committee will be set up to act as a sifting mechanism."

In this connection, the IC may require the doctor to submit a response to the complaint and set a deadline for this to be done.

88. The Workgroup recommends that these complaints be filtered within three weeks of the IC being constituted.
89. If the IC requires more time to complete the initial inquiry, it may request, and the Chairman of the Complaints Panel may grant one extension of time of up to six weeks for the issuance of the determination. There shall be no further extensions of time granted thereafter. This is designed to ensure a quicker, more expeditious process.
90. A standing Inquiry Panel comprising doctors from the Complaints Panel should be appointed by the Chairman of the Complaints Panel for a fixed period of time. Individual ICs comprising two doctors (a Chairman and a member) can be appointed from this standing panel. The requirements on standing for the Chairman of the IC should mirror the requirements for the Chairman of the CC.
91. In order to ensure effective triaging of cases, it is important that the complainant furnishes all relevant information at the outset. The complaint should be supported with documents or any other information that is necessary to back the allegation(s). SMC should be able to reject complaints which are incomplete.
92. It will be useful to have a standard complaint form which can capture essential information. For example, the complaint form should require the complainant to state his details and indicate if a similar complaint has been made to other parties such as the Healthcare Institution that the medical professional is practising at, and what the outcome of that complaint was.
93. While the vast majority of complainants are required to identify themselves and file a statutory declaration when they submit their complaints to the SMC, there have been cases where anonymous complaints have been considered because they were submitted through a public officer. The Workgroup is of the view that complainants should not have the right to

make anonymous complaints. It would be unfair for the doctor to be subjected to the stress of a complaint, when there is no further avenue to verify the accuracy of the information provided in the complaint, through the complainant. Such complaints should be channeled to the MOH's existing channel for whistleblowers, where the complainant can be more appropriately dealt with.

94. In some cases, the IC may require more information in order to decide how a complaint should be dealt with. This might be because it is not clear whether there is sufficient evidence to support an allegation which may appear to be serious. Therefore, the IC should have the power to request for information. This power will be particularly useful in circumstances where clarification is likely to be achieved by obtaining information that can be accessed relatively quickly.
95. The Workgroup received feedback that the creation of an IC would add an unnecessary layer to proceedings. Some doctors were of the view that the CC already has the power to triage unmeritorious complains and that it was simply a matter of training the CC properly to perform this role.
96. The IC has the following distinct advantages:
 - a. First, the IC allows its members to focus on assessing if the complaint may be dismissed summarily or if further investigation is necessary. At the moment, it is perceived that CC members have no incentive to dispose of the complaint quickly, where there is the "easier" and "safer" route of sending the complaint for assessment by a DT.²⁸
 - b. Second, individual CCs take time and resources to constitute. Having a standing Inquiry Panel cuts down on the time and resources required to constitute individual CCs. The Inquiry Panel will be able to deal with complaints more efficiently.

²⁸ One participant commented that CCs are sometimes inexperienced or uncertain about their powers and therefore prefer to "transfer" the risk by sending cases to the DT for further evaluation even if the case does not warrant serious disciplinary action.

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- c. Third, it will be more efficient to train and establish a single experienced standing Inquiry Panel compared to having to upskill numerous separate CCs.
97. The Workgroup reiterates that in order for the ICs to carry out this exercise of triaging properly, members of the IC need to receive adequate training and have the assistance of legal input and advice from the legal unit (see Recommendation 4.4).

Recommendation 4.2 – Remove the requirement that the Chairman of a CC must be a Council member.

98. The Workgroup has received feedback that the requirement that a Council member be the Chairman of a CC is a key bottleneck in the appointment of CCs.²⁹
99. We recommend that the requirement be removed. Any doctor with sufficient experience sitting on disciplinary committees should qualify to act as a CC Chairman. To be considered as having sufficient experience, he should have served on CCs as a member in the past, and have an astute understanding of the disciplinary process. The Chairman of the Complaints Panel will appoint each CC and will identify the appropriate member to chair each CC. We further recommend that colleges and chapters recommend willing and experienced doctors across the public and private sector as training candidates for the CC.
100. This proposal will also be supported by the recommendation to improve training for members of the CC (see Recommendation 8) to enable more doctors to serve effectively as Chairmen.

²⁹ See s 40(1)(a) of the MRA.

Recommendation 4.3 – Establish a Disciplinary Commission to professionalise and preserve the independence of the DT.

101. The perception of the lack of independence of the DT from the SMC can only be resolved by a clear separation between SMC's investigation and adjudication arms.
102. In the United Kingdom, the Medical Practitioners Tribunal Service ("MPTS") was established in 2012 to provide a clear separation between the General Medical Council's ("GMC") investigation function and the adjudication of hearings.³⁰ Further measures were also adopted to ensure the tribunal's independence. Members of the GMC cannot sit on the MPTS. The tribunal clerk and assistant, responsible for administration during the tribunal hearing, are also MPTS staff members. This was deemed to be more satisfactory from the vantage points of both patient protection and fairness to doctors.
103. We therefore recommend preserving the independence of the DT by creating a permanent and independent Disciplinary Commission headed by a President with tenure. The President, as well as the members of the Commission, should be appointed by the Minister for Health. The President of the Commission should be a doctor. The Disciplinary Commission will be responsible for appointing individual DTs, overseeing the training and qualification of members of the DT, and ensuring that the proceedings at the DT stage are expeditious. The Commission will have a dedicated secretariat that will exclusively support the functions of the Commission.
104. We further recommend enhancing procedures to ensure that there is consistency in the trial and pre-trial procedures used by each DT. Currently, the Medical Registration Regulations³¹ provide for a pre-inquiry conference.

³⁰ Following the verdict of the Shipman Inquiry which was set up in 2001, the General Medical Council introduced a number of changes to its procedures in order to restore public confidence in its ability to safeguard patient safety and to counter the perception that it is overly protective of doctors.

³¹ Medical Registration Regulations 2010 (s 733/2010).

However, timelines for holding pre-trial hearings or conferences are not fixed and each DT can regulate its own procedure. The Workgroup is of the view that improvements can be made to this process. Timelines for pre-trial conferences should be introduced. Additionally, requirements should be prescribed for pre-trial disclosure as these are critical for a fair trial. These measures will ensure predictability, transparency, and fairness in the DT process.

105. DTs will also be able to tap on the work of the Sentencing Guidelines Committee, headed by Judge of Appeal Judith Prakash, that was appointed by the SMC in January 2019. The work of the committee will guide the DTs on the appropriate sanctions to be meted out, taking into account sentencing principles. This will ensure consistency in the decisions from the different DTs.
106. Each DT should comprise two registered medical practitioners and one legally trained professional who will be an advocate and solicitor, Legal Service Officers (with the requisite experience specified in the MRA), or persons who hold or have held office as a Judge or Judicial Commissioner of the Supreme Court.
107. The Workgroup recognises that doctors are better placed than non-doctors to appreciate the technical and ethical issues surrounding medical practice. However, having a judge or an experienced lawyer will bring greater legal and forensic expertise to the determination. The judge or experienced lawyer can, among other things, ensure that the DT does not take irrelevant considerations into account and guide the other members more closely on legal matters such as the applicable standard of proof and in the forensic evaluation of the evidence.
108. Conversely, many of the more difficult cases do not involve difficult medical issues. For example, *Soo Shuenn Chiang* involved a straightforward case that had to do with a doctor's obligation to protect patient confidentiality. However, the DT wrongly accepted the guilty plea because of the failure to properly assess the facts of the case, and whether the acts which Dr Soo admitted to rose to the level of professional misconduct in the first place.

The case turned on the failure to properly understand the legal rubric of professional misconduct. In such cases, a lawyer's training and experience would therefore be more relevant to ensure that a just result is achieved.

109. It is paramount that the DTs consistently issue good and reasoned decisions that will form a consistent body of case law for future DTs to take guidance from. In this regard, having a legally-trained member sit on the DT will assist the DTs in the drafting of judgments that are legally sound and structured.
110. The Workgroup is of the view that there may be complex disciplinary cases that require a higher level of legal and forensic expertise. In such matters, the fact-finding process, as well as the issues pertaining to sentencing would be more appropriately directed by a Judge. Complex disciplinary cases should be chaired by a High Court Judge or Judicial Commissioner, who would be able to play an active role in eliciting the relevant evidence and directing the hearing. Their role as a chair is also in recognition of their standing as a High Court Judge or Judicial Commissioner. The President of the Disciplinary Commission should be given the discretion to decide on the constitution of each DT.
111. This proposal continues to preserve the principle of self-regulation within the medical profession, for the following three reasons:
 - a. First, the High Court Judge or Judicial Commissioner will only chair certain categories of cases where their expertise is of paramount importance. In any case, the Judge or Judicial Commissioner will chair the DT alongside two other members, who will be doctors. Ultimately, the discretion to determine whether the case requires a judge as the chair will lie with the President of the Disciplinary Commission.
 - b. Second, the decision of the majority of the members will be the decision of the DT. The Chairman will not have the casting vote. This will ensure that even where the judge chairs the DT, the opinion of

the judge cannot override the opinion of the doctors, if they are both in agreement with each other.

- c. Third, this proposal will also ensure greater consistency and alignment between the decisions of the Court of Three Judges when the decisions of the DTs go on appeal, and the decisions of the DT. The number of appeals to the Court of Three Judges from the decisions of the DT would be expected to fall – if so, this would show that the medical profession’s ability to self-regulate is enhanced such that intervention by the courts is called upon less frequently.

Recommendation 4.4 – Improve access to legal resources for the CCs and DTs through the creation of a legal advisory unit and a separate prosecution unit.

112. The Workgroup considers it critical that sufficient legal resources be made available to support the SMC disciplinary process. As such, it recommends the creation of a legal advisory unit.
113. The reliance on private law firms for the prosecution of DT cases should also be gradually phased out, through the creation of a separate prosecution unit, comprising lawyers or officers with experience as prosecutors.
114. The Workgroup further recommends that the members of the legal and prosecution units may be drawn from the Attorney-General’s Chambers or from the pool of Legal Service Officers, as their legal and prosecutorial experience will be invaluable to the disciplinary process.
115. Nevertheless, the Workgroup notes that especially in the initial stages of the formation of the legal unit, it might be useful to continue to retain the private lawyers to conduct the prosecution of certain complex cases, where their extensive experience in conducting the SMC prosecutions is required.

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116. This recommendation addresses feedback that there is insufficient legal support provided to the CCs at present, and that some private law firms may appear to be overzealous in trying to secure the conviction of the doctor.
117. The functions that the officers in this unit may be expected to carry out are listed in **Annex H**.

(C) Improvements to processes and procedures

(1) Description of challenges

118. The Workgroup received constant feedback that the disciplinary process has been, and continues to be, plagued by unreasonable delays.
119. Despite the High Court's exhortation in *Low Cze Hong v Singapore Medical Council*³² that the SMC ought to approach the prosecution of disciplinary cases with greater swiftness and vigour, delays continue to be a serious problem.
120. Unsurprisingly, the courts have criticised the inordinate delay that has occurred in some disciplinary proceedings. Having noted that it took more than six years for the complaint to reach the court, the court in *Ang Pek San Lawrence v Singapore Medical Council*³³ "urge[d] the SMC to scrutinise its procedures to avoid such delays".³⁴ Later, in *Ang Peng Tiam v Singapore Medical Council and another matter*,³⁵ the court found inordinate delay on SMC's part in instituting proceedings against the doctor, and emphasised that the SMC must approach the prosecution of disciplinary cases with due expedition and care.³⁶

³² [2008] 3 SLR(R) 612.

³³ [2015] 2 SLR 1179 ("*Lawrence Ang*").

³⁴ *Lawrence Ang* at [40].

³⁵ [2017] SGHC 143.

³⁶ *Ang Peng Tiam v Singapore Medical Council and another matter* [2017] SGHC 143 at [122] to [126].

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121. Such delays result in unfairness to both the complainant and the doctor. It compromises the quality of evidence and places an enormous strain on doctors. The Workgroup observes that delays are also symptomatic of other difficulties that plague current processes. For example, the challenges involved in appointing experts and to find doctors to fill CCs and DTs ultimately translate into proceedings being prolonged.
 122. Some doctors expressed frustration and anger at the ease of making complaints that might not have any merit. Some have suggested that complainants be charged a fee to make a complaint to the SMC.
 123. There was concern about the lack of transparency and clarity in the process, in the rigour of the SMC's investigative process, and the fairness and consistency of decisions made by the DTs.
 124. The Workgroup recognises that it is critical to the public confidence in the medical profession that the profession be seen to effectively regulate its own members and hold its members to the highest standards. The SMC disciplinary process must therefore be expeditious, fair, and meet ordinary standards of natural justice. Proceedings must not be unreasonably delayed and outcomes should be consistent.
 125. The Workgroup makes nine recommendations to improve existing processes and procedures. These recommendations are described below.

(2) Recommendations

Recommendation 5.1 – Introduce strict timelines to control the overall length of time a complaint takes to be resolved.

126. We recommend that steps be taken to reduce the overall length of time a complaint takes to be resolved. Ideally, the overall timeline from the receipt of the complaint to the decision of the DT (where applicable) should not take longer than 18 months, after factoring in possible extensions of time. This can be achieved through implementing stricter controls over timelines.

127. The Workgroup notes that for disciplinary proceedings under the Law Society, any extension of time granted by the Chairman or Deputy Chairman of the Inquiry Panel shall not extend beyond the period of six months from the date of appointment of the Inquiry Committee, and that generally, extensions of time are not liberally given. For reference, in Queensland, Australia, the entire investigation is generally required to be completed within a year.

128. Specifically:

- a. We propose the creation of a Disciplinary Commission (“DC”) that will oversee the fair, efficient and expeditious conduct of DT hearings. The Chairman of the Complaints Panel will perform the same function in respect of deliberations made by the IC and the CC.
- b. The Chairman of the Complaints Panel shall have the power to grant a single extension of time for the completion of the CC investigations. However, no extension shall extend beyond six months from the date of the appointment of that CC. At the DT stage, the President of the DC can grant the first extension of a maximum of three months. Further extensions at either the CC or DT stages should be made through an *ex parte* application³⁷ by the CC or DT to the High Court, and extensions may be granted for a maximum of three months at a time. The High Court may impose conditions on the extension of time. Guidelines will be set out on the factors to be considered when determining whether an extension of time should be granted. Such factors may include the complexity of the matter, the reasonableness of the time period sought, and the reasons justifying the extension of time.

³⁷ The doctor concerned ought to have no right to be heard at this application since it relates purely to matters for the CC or DT.

Recommendation 5.2 – Provide early notification to the doctor when a complaint has been made.

129. Taking a leaf from s 85(5) of the LPA, the Workgroup is of the view that doctors should be given early notification that a complaint has been made against them.
130. Section 85(5) of the LPA states that where a complaint or information touching upon the conduct of a regulated legal practitioner is referred to the Chairman of the Inquiry Panel, the Council “shall inform the regulated legal practitioner concerned that it has done so and shall furnish a copy of the complaint or information.” Similarly, in the United Kingdom, the doctor is notified once the allegation is referred for consideration. He is also provided with the documents submitted in support of the allegation.
131. The MRA should be amended to provide for such early notification and for a copy of the complaint or information to be extended to the doctor concerned. We recommend that the appropriate stage when the complaint is referred to the IC (or such person who is to constitute the IC).

Recommendation 5.3 – Introduce a time-bar against the filing of aged complaints with the SMC.

132. The Workgroup considers it unfair for doctors to be subject to complaints over matters which occurred a long time ago, where the complainant could have raised the matter earlier. With the passing of time, the doctor is less able to defend himself against allegations of misconduct.
133. We recommend that complaints which touch on the doctors’ conduct from more than six years since the complainant had knowledge of the circumstances giving rise to the complaint should not be referred to the Chairman of the Complaints Panel, unless it is considered to be in the public

interest to do so. This is aligned with the LPA where a time-bar of six years applies in relation to complaints made against legal practitioners.³⁸

- 134. A time-bar will ensure that there is fairness for both the doctor and the complainant. It will also ensure that the doctor does not lose the evidence necessary to meet the allegations raised in the complaint.
- 135. When a time-barred complaint is received by the SMC, the SMC should refer it to the President of the DC. The President of the DC will then determine if it is nevertheless in the public interest for the complaint to be referred to the Chairman of the Complaints Panel so that an Inquiry Committee may be appointed within two weeks of referral. The determination made by the President of the DC is final, but will nevertheless be subject to judicial review.
- 136. In making this recommendation, the Workgroup notes that in the United Kingdom, there is a five-year time bar for complaints, unless the Registrar considers that it is in the public interest for it to proceed. In Queensland, Australia, the Health Ombudsman may decide to take no further action when the matter of the complaint arose, and the complainant was aware of the matter, at least two years before the complaint was made.

Recommendation 5.4 – Empower the IC or CC to make cost orders against complainants.

- 137. The Workgroup is cognisant of the need to strike an appropriate balance between two considerations.
- 138. On one hand, there is public interest in creating a robust system that allows genuine or meritorious complaints to be lodged without fear of repercussions. On the other hand, the system must be able to deter

³⁸ See s 85(4A) of the LPA.

frivolous and vexatious complaints from being lodged unthinkingly or, worse, maliciously.

139. The Workgroup proposes that the IC and the CC be empowered to order a complainant who lodges a frivolous or vexatious complaint to pay to any person all or any costs reasonably incurred by that person in the proceedings. The complainant should be allowed to apply to a High Court Judge for a review of that order. The application for review should be made within 14 days of being notified of that order.
140. A comparison may be drawn to s 85(19) of the LPA.³⁹ Under the LPA, where the complaint is found to be frivolous or vexatious, the Inquiry Committee may order the complainant to pay any person costs that are reasonably incurred by that person in the proceedings before the Inquiry Committee. These costs may be recovered as a debt owed to that person if they are unpaid. The complainant is permitted to apply to a Judge of the High Court sitting in chambers for a review of an order for costs within 14 days of being notified of that order.
141. In making this recommendation, the Workgroup stresses that there is no intent to create barriers to the ease of lodgement of complaints. Cost orders against complainants will be reserved for the most frivolous or vexatious cases.

³⁹ Section 85(19) of the LPA states:

Where the complaint is found to be frivolous or vexatious –

- (a) the Inquiry Committee may, after hearing the complainant (if he desires to be heard) –
- (i) order the complainant to pay to any person all or any costs reasonably incurred by that person in the proceedings before the Inquiry Committee; and
 - (ii) in such order, specify the amount of those costs or direct that the amount be taxed by the Registrar.

Recommendation 5.5 – Allow the IC to order investigations once it determines that the complaint is not frivolous, vexatious, misconceived or lacking in substance.

142. Under the MRA, only the CC has the power to direct investigations. This requires the CC to be constituted first. This requirement can result in delays. We recommend that the IC be allowed to direct the Investigation Unit to commence investigations once it deems that the complaint is not frivolous or vexatious. This will ensure a more efficient use of time *before* the CC is appointed. Once the CC is appointed, it can assume oversight of the investigations.

Recommendation 5.6 – Allow the CC to refer additional issues during investigations to the SMC, for the SMC to make a fresh complaint.

143. We also recommend enabling the CC to have the discretion to refer other forms of wrongdoing to the SMC in cases where it discovers them during the course of its initial investigation. The SMC may then file a new complaint against the doctor, for it to be investigated further, if it deems appropriate. This is in line with the rules of natural justice, where the doctor will have clarity on the scope of the allegations he is required to answer. The doctor will be appropriately notified of the scope and nature of the investigations, and also be given the opportunity to defend himself on the new complaint.
144. Presently, the CC does not have subpoena powers. The CC should be given these powers which will allow them to hear evidence from witnesses if the CC considers it necessary for the fair and proper consideration of the complaint. In certain cases, such evidence may greatly assist the CC.

Recommendation 5.7 – Introduce strict criteria for the submission of relevant documents and evidence in relation to complaints.

145. Some complainants have a tendency to submit documents and materials in support of their case in a piecemeal fashion, both during investigations, and in appeals against the CC's decision. This is disruptive to both the complaints' and appeals' processes and can lead to significant delays in proceedings.
146. To ameliorate this problem, the Workgroup proposes that the SMC should be empowered to require complainants to submit all arguments and materials in support of their case at the outset when filing their complaints. Similarly, doctors being complained against will be required to submit all arguments and materials in a timely fashion when submitting their written explanation to investigators.

Recommendation 5.8 – Allow the SMC to make the final determination if matters should be referred to the DT and to withdraw charges at any point in the proceedings.

147. Section 49(3) of the MRA suggests that it is mandatory for the SMC to appoint a DT if the CC determines that a formal inquiry is necessary. Given the SMC's important role in acting in the public interest and in exercise of its regulatory function, we recommend that the SMC should be expressly empowered to determine whether there should indeed be a formal inquiry by the DT, if the CC makes such a recommendation. Further, the determination should be made by the SMC within one month of the receipt of the CC's recommendation. In such situations, the Council may mete out alternative punishments such as warning letters or other orders.
148. This recommendation is intended to deal with situations where the SMC is of the view that the CC has come to a decision that is clearly wrong or where new evidence comes to light. This may occur when for example, after the referral of the matter to the DT, the common expert report opines that the

charges are not made out. Where there is new evidence, Council should remit the matter to the CC so that the CC can review its decision in light of that evidence. While the SMC's final determination will not be appealable, it will be subject to judicial review.

149. Involving the SMC in the process of recommending that a matter be referred from the CC to the DT addresses feedback from the doctors at the townhalls that as the body that is ultimately overseeing the ethical conduct of doctors, the SMC should play a more proactive role in ensuring that the outcomes or judgments are representative of SMC's stance on such matters. The Workgroup also considers that this would allow Council members, in their collective wisdom, to weigh in on the evidence that has been gathered, and create an additional layer of checks and balances to ensure that only the most serious breaches reach the DT.
150. The Workgroup also notes that under the LPA, when the Inquiry Committee recommends that the Law Society prosecute the complaint before the DT, the Law Society Council has to determine whether there should be a formal investigation.⁴⁰ It is Council that applies to the Chief Justice to appoint a DT which shall hear and investigate the matter.
151. To facilitate administrative efficiency, the Workgroup recommends that the Council be permitted to delegate the responsibility to review recommendations for a formal inquiry by the DT to a smaller group of Council members that have been designated to perform this function. Should Council take this option, it should nevertheless ensure that other Council members must, at the very least, receive notifications of the decisions made by the smaller group of Council members.
152. We also recommend that the SMC should give its reasons in writing if it exercises its discretion not to follow a CC's recommendation to refer a complaint to the DT. These reasons should be provided to the doctor and

⁴⁰ See s 89(1) of the LPA.

the complainant. This ensures transparency and prevents such discretion from being abused, as the SMC's decision may still be challenged in court.

Recommendation 5.9 – Using a tribunal-appointed expert as far as possible, to reduce acrimony in proceedings.

153. Expert evidence plays an important role in establishing the standards applicable to the doctor, and in determining whether any departure from those standards are serious enough to constitute professional misconduct. There are two key difficulties in the area of expert evidence.
154. First, we are concerned that the adversarial system at the DT stage has given rise to unnecessary acrimony in the proceedings. As the ultimate aim of the expert is to assist the tribunal, cases where the experts on both sides have invariably held very polarised views and were unwilling to make any reasonable concessions, are extremely unfortunate. Second, difficulties in obtaining expert evidence have also resulted in delays and unnecessary acrimony in the proceedings. The Workgroup is of the view that these concerns can be mitigated if not resolved by obtaining the views of a tribunal-appointed expert at the DT stage, where appropriate.
155. Additionally, by requiring the tribunal to scrutinise the credentials of the expert prior to his or her appointment, there is less risk that the expert evidence would prove to be inadequate. The Workgroup further observes that it would be important for the tribunal-appointed experts recommended by the AMS and the College of Family Physicians Singapore (“CFPS”) to undergo training by the Singapore Judicial College, supported by the AMS and CFPS, on matters such as the role and duty of an expert and what would be required in an expert report in order for it to be of use to the tribunal. This would mitigate against situations like in *Lim Lian Arn*, where the Court observed that the expert evidence relied upon by the SMC was inadequate from the outset.⁴¹

⁴¹ *Lim Lian Arn* HC at [43]-[45].

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156. SMC should continue working together with the AMS and CFPS on the nomination of experts, to be utilised in disciplinary proceedings. To avoid the perception of lack of choice, the AMS and CFPS can recommend three to five experts for each matter for which an expert opinion is required. The doctor will be able to provide his views on which expert he would prefer the DT appoint in the matter, or state which expert he does not want appointed as the tribunal expert, with the ultimate decision on the choice of expert lying with the DT.
157. Nevertheless, the Workgroup acknowledges that there might be some cases for which party-appointed experts might still be appropriate. If parties can justify the need for party-appointed experts, and the DT determines that this would assist the DT in its deliberations, the tribunal may permit parties to appoint their own experts in place of, or in addition to any tribunal-appointed expert.

Recommendation 5.10 – Adopt measures to enhance the consistency of decision-making.

158. We further recommend enhancing the consistency of decisions through a number of measures.
159. The standard which applies when deciding whether or not a case should be referred to a DT for a formal inquiry should be made clear. A CC should only recommend that an inquiry be held by a DT if there is a *prima facie* case of sufficient gravity. This standard should be set out in the MRA to guide and remind the CC of the threshold that must be crossed before a formal inquiry is recommended.
160. The CC should engage in the three-stage inquiry set out by the High Court in *Lim Lian Arn* HC to ensure that this threshold is satisfied. The first stage is to establish the relevant benchmark standard that applies to the doctor. The second stage is to establish whether there has been a departure from the applicable standard. The third (and hitherto sometimes) neglected stage is to determine whether the departure in question was sufficiently egregious

to amount to professional misconduct. The Workgroup recognises that this is a fact-centric exercise and that the CC needs to be well-trained so that it can properly embark on the three-stage inquiry.

161. The following is a list of other measures which may be adopted to enhance the consistency of decision-making:
- a. Standardising the way in which charges are formulated to ensure that all charges are framed properly and with sufficient particulars.
 - b. Enhancing training and strengthening legal resources available at both the CC and DT stage.
 - c. Formation of the prosecution unit which will formulate and prosecute charges on behalf of the SMC.

Recommendation 5.11 – Expressly legislate that costs can be awarded against the SMC.

162. There are no express provisions in relation to whether costs can be awarded against the SMC. Costs have, however, been awarded against the SMC in cases such as *Lawrence Ang* and, more recently, in *Singapore Medical Council v BXR*.⁴²
163. We recommend that the MRA be amended to expressly provide that costs can be awarded against the SMC where this is “just and reasonable” in the circumstances.
164. The Workgroup considers that the framework established by the court on when cost orders should be made against the SMC strikes an appropriate balance between two considerations. The first consideration is that the SMC should not be constrained in the fulfilment or the carrying out of its

⁴² [2019] SGHC 205.

public regulatory function. The second consideration is to ensure fairness in outcomes especially where there has been injustice or prejudice to the medical practitioner.

Recommendation 5.12 – Stipulate clear rules on conflict of interests for experts, and members of the IC, CC, and DTs.

165. There should also be clearer rules on conflict of interest so that doctors are comfortable sitting on the ICs, CCs, and DTs when called upon to do so.
166. The key question to consider is whether a fair-minded observer who is informed of the relevant facts would conclude that there are circumstances that would possibly give rise to a reasonable suspicion or apprehension of bias on the part of the doctor who has been appointed to sit on the CC or DT.⁴³ The Workgroup has proposed guidelines on the types of circumstances that would not give rise to a conflict of interest at **Annex I**.

Recommendation 5.13 – Provide support for doctors involved in disciplinary proceedings.

167. Undergoing disciplinary proceedings can be a stressful experience, with the doctor's career and reputation potentially at stake. The Workgroup is of the view that more can be done to support doctors going through this process. The Workgroup notes that in the United Kingdom, the GMC provides dedicated confidential emotional support to any doctor involved in a fitness to practice case.
168. Doctors can have access to emotional support from a fellow doctor who is independent from the GMC by putting in a request to the British Medical Association. There is a dedicated telephone line, and it is also possible for the supporter to accompany the doctor to a meeting with the GMC or to the hearing (for up to two days).

⁴³ Adapted from *BOI v BOJ* [2018] SGCA 61 at [103].

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169. The Workgroup recommends that a similar scheme be implemented in Singapore, in cooperation with the AMS and other medical professional bodies, and that it be extended to cover not just fitness to practice cases, but also doctors facing the disciplinary process. This will ensure that doctors' mental and emotional well-being are attended to in the course of the disciplinary process.

(D) Role of mediation in the disciplinary process

(1) Description of challenges

170. In one of its latest decisions, the Court observed that the SMC has a range of options available in the alternative to commencing disciplinary proceedings to address complaints.⁴⁴ More should be done to channel suitable cases towards mediation (in particular). The Workgroup notes that only 14 cases were referred for mediation by the CCs in the past five years. We are of the view that a more judicious use of mediation can save time and resources downstream.
171. In this regard, the Workgroup considers that there are some types of complaints that are not suited and should not be referred to mediation. Complaints involving sexual misconduct, dishonesty and where patient safety is compromised should not be referred to mediation for potential private settlement. In such cases, the SMC's role in protecting the public interest by punishing errant doctors is paramount.
172. These recommendations to increase the use of mediation should not be seen as a softening of SMC's approach. Rather, it recognises that the traditional inquiry process is not necessarily the best solution to deal with all complaints that come before the SMC. After all, 1 in 5 complaints against doctors arise due to poor communication.⁴⁵ The Workgroup fails to see how, where it is a breakdown in communication that underlies the complaint, the

⁴⁴ *Lim Lian Arn* HC at [24].

⁴⁵ "1 in 5 Complaints against Docs due to Poor Communication". *The Straits Times*, September 18, 2016. <https://www.straitstimes.com/singapore/health/1-in-5-complaints-against-docs-due-to-poor-communication>.

inquiry process can serve to mend the broken relationship, and to rebuild the trust between doctor and patient.

173. We elaborate on the recommendations which pertain to enhancing the role of mediation in the disciplinary process below.

(2) Recommendations

Recommendation 6.1 – Empower the SMC to direct the complainant and doctors to participate in mediation upon receiving the complaint.

174. We recommend that the SMC be empowered to direct complainants and doctors to participate in mediation at an earlier stage, after the complaint has been assessed by the IC. The Workgroup has drawn up guidelines for cases that can be channelled for mediation at **Annex J**.
175. The Workgroup notes that many complaints concern poor bedside manners, miscommunication or misunderstandings between patients and doctors, or systemic issues within the healthcare system. There may be complaints concerning missteps by a doctor which are not sufficiently egregious to warrant disciplinary action. Such examples could include lapses, errors of judgment, poor record-keeping, and failures of memory.⁴⁶ Complaints of such nature which may amount to minor misconduct that could result in a letter of warning or advice can and should be resolved through mediation. Mediation can be appropriately employed for such cases.
176. We give two examples of suitable cases that were referred for mediation by the SMC and resulted in successful outcomes:
- a. A complainant underwent plastic surgery and was unhappy with the outcome. She had further alleged that the doctor had failed to give

⁴⁶ *Lim Lian Arn* HC at [1].

her proper pre-operative advice about the corrective procedures she could undertake and had diagnosed her with Body Dysmorphic Disorder instead. The CC's assessment was that this involved a mismatch in expectations as the outcome of the plastic surgery could be subjective.

- b. A complainant alleged that the anesthesiologist had overcharged him as his fees were higher than the surgeons and that he was not informed of the charges prior to the procedure. The CC's assessment was that there appeared to be some miscommunication between the complainant and the doctor with respect to the charges.

177. On the other hand, there are cases which are not appropriate for mediation. This can occur in two separate categories of cases.

- a. First, if the complaint discloses no misconduct that would warrant even a letter of advice, the complaint should (in all fairness to the doctor) be dismissed, without a further referral for mediation.
- b. Second, if the CC's investigations give rise to sufficient concerns of misconduct, the matter should be referred to the DT and dealt with within the disciplinary framework. These include serious infractions, as well as doctors facing disciplinary proceedings due to criminal convictions.

178. The Workgroup also cautions that mediation should not be used as a backdoor option for patients to obtain compensation through the disciplinary process. Doctors should not feel pressured into offering monetary compensation to complainants to achieve an amicable resolution, and stem any further investigation under the usual complaints process.

179. In keeping with the spirit of mediation which is generally a voluntary process, we do not recommend imposing sanctions for non-compliance with referrals for mediation. However, if the complainant or doctor unreasonably refuses to attend mediation, this can be taken into

consideration in ordering costs against the complainant (if the complainant is ultimately dismissed) or the medical practitioner, respectively.

180. The Workgroup has proposed a framework for the referral of cases for mediation which is set out at **Annex K**.

Recommendation 6.2 – Subsidise mediation between the complainant and doctor.

181. To further encourage both doctors and complainants to adopt mediation, the SMC can provide subsidies for the cost of the mediation, subject to a cap of a certain number of hours. Successful resolution of complaints through mediation ultimately frees up SMC's disciplinary caseload and allows SMC to focus on serious cases of misconduct.

Recommendation 6.3 – Strengthen cooperation between the SMC and the Singapore Mediation Centre.

182. There is also a need to strengthen the cooperation between the SMC and the Singapore Mediation Centre, to tap on their expertise and learn from their best practices. This will be essential especially for disputes involving doctors in private practice, or sole clinical practices, who might not have in-house resources to tap on. Complaints which come through the SMC complaints system which are suitable for mediation can be channelled to the Singapore Mediation Centre.
183. To handle the anticipated increase in caseload, more specialist mediators who can appropriately handle medical-related disputes should be trained. This will allow complainants and doctors to utilise a pool of experienced mediators, who are familiar with the issues which can arise in such mediations, and can facilitate an efficient resolution of the disputes.

(E) Appeals

(1) Description of challenges

184. Currently, the MRA provides that the complainant may appeal to the Minister for Health against a decision of the CC.⁴⁷
185. The Workgroup observed that there was a general but unsubstantiated impression among doctors, that the Minister would almost always want to err on the side of caution in at least ordering a further investigation in response to the appeal, even if the decision made by the CC appeared to be sound. This in turn prolongs the entire disciplinary process for the doctor concerned, subjecting the doctor to the need to defend himself again on the same issues. There were also concerns that fresh issues that were not part of the original complaint were being raised at the appeal. These issues that were not properly canvassed at the filing of the complaint, would now have to be dealt with by the CC, if so directed by the Minister.
186. Whilst the Workgroup was not persuaded that such an impression was necessarily well-founded, the Workgroup considered the existence of such speculation to be an indication that there could be more transparency in the appeal process.
187. The Workgroup makes two recommendations in this respect.

⁴⁷ Sections 49(10)-(13) of the MRA.

(2) Recommendations

Recommendation 7.1 – Remove the right to appeal to the Minister from decisions of the CC and replace it with a request to review the decision by a Review Committee.

188. In order to enhance transparency and accountability, we recommend that appeals from the CC's decision by the Complainant, doctor and the SMC be made to a Review Committee ("RC").
189. The RC should comprise a medical doctor, a legal professional, and a lay person. Its members will be drawn from the current members of the Complaints Panel. However, the members who constitute the CC whose decisions are being reviewed will not be able to sit on the RC reviewing that decision of the CC. The Chairman of the Complaints Panel will appoint each RC, three weeks after the application for a review is made.
190. The RC may, by majority vote, make orders including affirming the CC's decision, directing the CC to conduct further investigations or inquiries, and directing a rehearing by the CC.
191. The RC should complete its inquiry within three months from the date of its appointment. The Chairman of the Complaints Panel may grant a single extension of time of up to three months. Applications for extensions thereafter should be made to the High Court through an *ex parte* originating summons for a maximum extension of three months at a time.
192. The Workgroup observes that the CC process will be bolstered by the introduction of the Legal Advisory Unit to assist the CC on investigations, process, and procedure. Therefore, the RC should only conduct a review on whether the CC had unreasonably failed to observe the procedural requirements. In other words, the RC will determine whether there was regularity in the proceedings of the CC. It ought not be a review of the substantive merits of the CC's decision. Further, the decision of the RC should be final.

Recommendation 7.2 – Remove the right for complainants to compel SMC to appeal against a decision of the DT.

193. Currently, the SMC and the respondent doctor can appeal to the Court against the decision of a DT.⁴⁸ The SMC appoints an Internal Review Committee to audit every DT's decision, before deciding whether it should make an appeal. The complainant can also apply to a Review Committee, appointed by the Minister, to review the decision of the DT.⁴⁹ The Review Committee can potentially compel the SMC to appeal against a DT's decision, contrary to the SMC's own assessment.
194. We recommend streamlining the appeals' process by doing away with the Review Committee referred to in section 55(3) of the MRA and removing the provision that allows complainants to potentially compel the SMC to appeal. This recommendation will align the processes with those in criminal proceedings and avoid unnecessary delays as well as duplication of work. To be clear, complainants may still seek a judicial review of the DT's decision.

(F) Training

(1) Description of challenges

195. The lack of adequate training is apparent in that the DTs have, on several occasions, been unable to correctly establish if a particular case crosses the threshold of professional misconduct. Convictions have been set aside on the basis that the doctor's acts could not as a matter of law amount to professional misconduct. There have been also been occasions where the DT accepts a doctor's plea of guilt without assessing if the charge is indeed supported by the facts and evidence put before it. Both *Soo Shuenn Chiang* and *Lim Lian Arn* are illustrative of these problems. Not only have time and

⁴⁸ Section 55(1) of the MRA.

⁴⁹ Section 55(6) of the MRA.

resources been wasted on these proceedings, such outcomes have shaken confidence in the SMC's disciplinary processes.

196. Currently, members of the CCs and DTs are supposed to be trained before they perform their respective roles. SMC also invites experienced DT members to share their knowledge with newly appointed DT members. Whenever there are new developments in the law, including new judgments of DTs or the Courts, these are extended to the DT members. Special training sessions are also arranged.
197. Despite this, the Workgroup received numerous feedback that “there is a need for more training”, as the CC and DT members would otherwise be ill-equipped to handle the cases. Most medical practitioners believe that training is key to achieving fair and just outcomes. The Workgroup agrees with this observation. There is a need for a clear, structured and comprehensive programme, run by qualified trainers, that ensures all members have the requisite knowledge and skills required to take on their roles effectively.

(2) Recommendations

Recommendation 8 – Enhance training for IC, CC, and DT members.

198. Recognising that members sitting on the ICs, CCs and DTs have to be trained and credentialed, we recommend that specialist training be provided to members who sit on the ICs, CCs and DTs on law, procedure, evidential analysis and judgment drafting (for DT members). As the IC members will be drawn from the Complaints Panel, the training of the IC and CC members should be conducted holistically, with the possibility of members fulfilling either role in mind.
199. For CC members, it is imperative that they are trained to filter out the cases that are frivolous, vexatious, misconceived or lacking in substance. They should be equipped with the skills to discern what cases can possibly be resolved outside of the SMC disciplinary system through mediation, and

also what constitutes misconduct so serious that it warrants a referral to the DT. They should also be aware of the lines of investigation that need to be pursued.

200. Therefore, the Workgroup recommends that training should be provided to members of the CC on the topics we have set out in **Annex L**.
201. Members of the DT are required to know how to weigh and assess expert evidence in light of the evidence put forward by the prosecuting counsel and the respondent doctor. They need to have a good grasp of the sentencing principles, what the mitigating and aggravating factors are, as well as how to apply them having regard to past precedents. Therefore, the Workgroup recommends that members of the DT should be trained on the topics we have set out in **Annex M**. We further note that the work of the SMC Sentencing Guidelines Committee will also be a valuable resource to guide DT members on sentencing.
202. Those who undergo CC training can first be credentialed as CC members, with a view that if they undergo further training, they may subsequently be credentialed as DT members. The qualifying criteria for DT members must necessarily be more stringent. DT members should be exposed to DT hearings through sit-ins, to observe the process and procedure.
203. Continual training should also be provided to both CC and DT members, to ensure that they are kept up to date on case developments and sentencing principles. This can occur at twice-yearly intervals.
204. The DC should consider working together with the Singapore Judicial College, the Singapore Academy of Law and the Singapore Medical Association on the provision of training on subject areas such as evidential analysis, sentencing principles and judgment drafting. This will tap on the legal expertise of the existing training institutions to formulate a structured curriculum, and ensure quality and consistency in the training provided.
205. Additionally, the SMC should also consider tapping on the expertise and experience of overseas jurisdictions. Short secondments to organisations

such as the GMC in the United Kingdom, and to the office of the Health Ombudsman in Queensland can be considered by the SMC.

IV. Backlog

(A) Description of challenges

206. The Workgroup has also observed that there is a very substantial backlog of cases and this has led to cases pending for five to six years before they are heard. If there is an appeal, a final resolution of the complaint will be delayed even further. It is untenable for doctors and also patients to face pending proceedings for such long periods of time.
207. The length of time taken to resolve complaints can be financially and emotionally draining. Quite apart from that, the quality of the evidence and recollection of the events surrounding the complaint would have deteriorated by the time of the hearing. Such problems are not new. In one decision in 2008, it was reported that three years had elapsed between the time of the complaint and when the doctor was first served the Notice of Inquiry.
208. The proposals are designed to strengthen the disciplinary process which is in need of a major overhaul. However, the current backlog of cases must be cleared before the proposals we have made in this report (if accepted and implemented) can yield positive results.
209. As at October 2019, the SMC had yet to resolve 40 DT cases and 223 complaints. The longest outstanding case is a complaint that dates back to 2016. In addition, there are appeals in relation to complaints, which MOH remitted to the SMC for reinvestigations, that go as far back as 2011. Since 2010, the SMC has received an average of 165 complaints with about 15 being referred to the DTs annually. An average of 147 complaints and 10 DT matters are resolved each year.
210. Therefore, even if there are no new complaints received this year, the backlog will take four and a half years to clear. The situation is, therefore, untenable.

(2) Recommendations

Recommendation 9.1 – Devote separate resources to clear backlog.

211. Although the SMC has implemented several solutions such as negotiating an agreement with the AMS and CFPS to provide expert witnesses, which has significantly shortened the time taken to appoint an expert and improved the quality of expert reports, there is an urgent need to resource the SMC appropriately at this time to clear the current cases.
212. A reasonable estimate is that it will take about two and a half years to clear the current caseload even with the increased resources. After the backlog is cleared, the resources can then be pared down appropriately to deal with the caseload moving forward.

Recommendation 9.2 – Create a parallel system to deal with backlog and fresh cases respectively.

213. Parallel systems will have to be created if the recommended new SMC disciplinary processes are to be implemented quickly.
214. One track should deal with complaints that are submitted after the recommendations are effected. The other track should be dedicated to clearing the SMC's current backlog of cases. This will ensure that the recommendations proposed by the Workgroup, if adopted, can be put into effect expediently.

IV. Continuing Medical Education

Recommendation 10 – Introduce compulsory Continuing Medical Education (CME) on medical ethics for all doctors, in particular informed consent and the SMC Ethical Code and Ethical Guidelines, SMC disciplinary processes and pertinent medico-legal cases.

215. Currently, all doctors have to receive compulsory CME as a requirement for the renewal of their practice licenses. This is because the body of medical knowledge and evidence as well as the practice of medicine is ever-evolving and there is a need to ensure that doctors remain up to date with the major scientific developments in medicine. There is, however, no requirement for this CME to have a compulsory ethics component even though the ethical environment of medical practice is likewise evolving.
216. Currently, there is a low take-up rate for medical education on medical ethics for the general population of doctors as such courses are not compulsory. Core points for CME are only awarded for clinical updates within the specialty. There is a need to increase awareness of ethical issues and developments, such as informed consent, throughout the medical profession, as these developments can have a significant impact on the practice of medicine. Mandating that doctors update themselves on these issues will ensure that they are exposed to baseline level of knowledge on the applicable legal standards in practice that will allow them to practice effectively.
217. We recommend incentivising and tracking the completion of such courses by making such modules compulsory, and awarding core CME points upon their completion. A core medico-legal curriculum should also be developed to complement and support this proposal.
218. To ensure that doctors are familiar with the ethical obligations and kept abreast of latest applicable standards of ethical practice, we recommend that ethics education and/or training be made a compulsory part of doctors’

CME, i.e. “core points”. Currently, doctors are required to attain 50 CME points in a two-year period for license renewal. A significant portion (say 5 points) of these 50 points should and must come from CME education and training.

V. Conclusion

219. The Workgroup is optimistic that the recommendations on informed consent will allow doctors to practise with greater certainty and less anxiety about unwarranted litigation and disciplinary proceedings, while enhancing shared decision-making and restoring trust in the patient-doctor relationship. Collectively, the package of measures strike a fair balance between the patients' right to make informed decisions on treatment, and the doctors' need to practice medicine confidently and in accordance with standards that are practical and achievable. This will ultimately contribute towards the Workgroup's ultimate goal of ensuring patient safety and welfare.
220. As for the recommendations on the SMC disciplinary process, they are intended to ensure that the process is made fairer, more consistent, and transparent. The total time taken for the completion of the disciplinary process will be shortened, and the number of cases which are sieved out early in the process will increase. Only cases which warrant serious disciplinary action will reach the Disciplinary Tribunal. This will aid the overall objective of upholding the confidence and trust of both the public and the medical profession in the SMC and the disciplinary process.
221. The Workgroup would like to place on record its gratitude and appreciation to everyone we consulted. Their constructive feedback and candid sharing on how the system could be refined were invaluable.



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Co-Chair



Ms Kuah Boon Theng SC
Co-Chair



Dr S R E Sayampanathan



Adj Asst Prof Tan Tze Lee



Dr Lee Yik Voon



Dr Wong Chiang Yin



Dr Tan Swee Lin, Allyson



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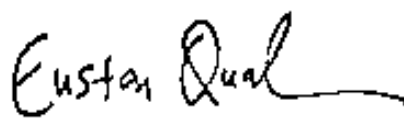
Dr Lin Jingping



Ms Mak Wei Munn



Mr Roy Quek



Prof Euston Quah

Annex A – Composition of Workgroup

Role	Name	Designation and/or Institution
Co-Chairperson	Assoc Prof Ng Wai Hoe	Deputy Group Chairman, SingHealth Medical Board; Medical Director, National Neuroscience Institute
	Ms Kuah Boon Theng, SC	Managing Director, Legal Clinic LLC
Members	Dr S R E Sayampanathan	Master, Academy of Medicine Singapore; Orthopaedic Surgeon
	Adj Asst Prof Tan Tze Lee	President, College of Family Physicians Singapore; Family Physician
	Dr Lee Yik Voon	President, Singapore Medical Association; Family Physician
	Dr Tan Swee Lin, Allyson	Paediatrician, The Kid's Clinic
	Assoc Prof Marcus Ang	Consultant Ophthalmologist, Singapore National Eye Centre
	Dr Wong Chiang Yin	Consultant, SPH Silver Care Pte Ltd
	Dr Lin Jingping	Associate Consultant, Emergency Medicine, National University Hospital
	Ms Mak Wei Munn	Partner, Allen & Gledhill
	Mr Roy Quek Hong Sheng	Executive Director & CEO, Thomson Medical Group Limited
	Prof Euston Quah	Professor and Head of Economics, Nanyang Technological University

Annex B – Workgroup’s Terms of Reference

- (1) Review, and provide appropriate recommendations on, the taking of informed consent by a medical practitioner from a patient, including the practical steps as well as any ethical and/or legal standards expected of medical practitioners in the taking of such consent;
- (2) Review, and make the appropriate recommendations on, the Singapore Medical Council’s disciplinary process, as set out in the Medical Registration Act (Cap 174), including the process by which complaints are considered and proceedings before the Disciplinary Tribunal are conducted; and
- (3) In carrying out the above reviews, to canvass the views of medical practitioners from a range of diverse practice backgrounds across private and public healthcare settings.

Annex C – Feedback on Informed Consent

A. Test for informed consent

Test for informed consent should revert to Bolam-Bolitho

- There was consensus that the *Bolam-Bolitho* Test still remains relevant and should be used instead of the *MM* Test. It is much easier and more practical to set standards on what a reasonable doctor might consider important, compared to what a reasonable patient might consider important.
 - If patients have specific concerns and raise them, this should still be addressed by the doctor under the *Bolam-Bolitho* framework.
- A suggestion was raised for the *MM* Test to only be applied for complicated procedures (e.g. surgery). For other simpler procedures (administration of paracetamol), the *Bolam-Bolitho* test could be applied instead.

Impractical to satisfy the requirements of the MM Test

- Most practitioners agreed that it was impractical to satisfy all the requirements of the *MM* Test.
 - First, it is extremely difficult for doctors to ensure that the patients understand what is explained. Factors such as language barriers (interpretation loss), level of education and patients' age impede the patient's level of understanding.
 - Second, practitioners have difficulty coming up with an effective and defensible work process to provide material information to patients within a short space of time. There is inadequate time allocated for consultations in order to provide adequate explanation, especially if it involves major procedures.
 - Third, thorough consent-taking is not possible in every setting, especially in the polyclinics. Doctors may be burdened with other onerous administrative duties, and have heavy caseloads. They are simply not afforded enough time to build a relationship with the patient.

Lack of clarity on the requirements of the MM Test

- Many practitioners on the ground do not have clarity on what constitutes relevant material for patients to provide proper informed consent.

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- There was feedback that “certain aspects of the requirements are new to the profession; practitioners are still unsure of what to do, or how to do what is required in their practice”.
 - Informed consent is very challenging because it is all about statistics and probability, and people interpret them differently. There might not be a proper doctor-patient relationship, which is required in order to know what would be material to the patient, and the public healthcare setting is not conducive to this relationship.
 - The said information could also be relevant and material at different points of the procedure – and almost exclusively at the point when something bad occurs.
 - Many routine, minor procedures can result in rare but significant or material complications. Without clear guidelines on how to manage consent for such cases, the risk of the practice of defensive medicine will become more significant. For example, a doctor commented that “there is an ongoing fear among practitioners for the need to disclose all material and reasonable information, not entirely in the process of providing patient care but to mitigate the risk of litigation.”
 - The uncertainty within the MM Test can be exploited by patients, who will say that a risk was material to them only after it occurs. Many patients simply cannot recall what the doctor had advised them on.
 - There is a need to define what constitutes reasonable disclosure of information without being too nebulous, and what constitutes proper documentation.
 - The requirements for informed consent for different specialties would differ. Practitioners differ in their backgrounds, experience and practices. Thus, legislating a standardised informed consent process would be very impractical.
 - The Workgroup should define what the basic requirement on informed consent is. This should be standardised across institutions and clusters. Chapters can provide professional inputs on the major and minor risks.

Lack of clarity on whether signed consent would mean that informed consent has been given

- There is confusion on whether signed consent would mean that there is informed consent, and why MOH policies continue to require signed consent if it may be insufficient.

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- Consent forms are sometimes very lengthy, which makes it easy for patients to say that the forms were not properly explained to them, or that they did not understand what they were signing.

B. Type of consent taking/documentation

Consent taking/documentation should differ based on the type of procedure involved

- Generally, the doctors felt that formal consent is not always required. Various categories of informed consent and documentation were suggested:
 - Formal consent – this would require written consent from patient and documentation by doctors;
 - Waiver of requirement for consent, but to retain the need to inform the patient and document procedure by doctors. This can be applied to certain routine procedures (e.g. provision of intravenous fluids, repeat procedures);
 - Waiver of requirement for consent and documentation for simple and standard procedures (e.g. blood test).

Medical paternalism still remains relevant

- There was general consensus that a larger group of patients still expect doctors to know how much information to be provided to them; in general, patients do not know what they need to know or what is material to them, in order to make a proper informed decision. The amount of information given is based on the level of education or ability of understanding that varies from each patient.
- The Singapore context also differs from the Western context – many of the elderly population are not well-informed/educated and would prefer that they be told what the doctor thinks is important for them to know. This nuance has been lost in the MMT.
- Patients often still defer to their doctor's recommendation even after provided with enough material information – this remains true even for doctors themselves when they seek treatment from other doctors. Practitioners usually withhold some information to guide their patients' into making decisions that they deemed suitable and appropriate at the time. This is usually made with neither malice nor harmful intent but is based on their professional judgment and experience.

C. Process of consent-taking

Patients should be allowed to provide input on how much information they require

- A system can be devised to allow for early discussions with the patient on how much information needs to be shared in order for them to provide informed consent.

Consent taking should be staggered

- The MMT suggests that all material information must be provided before the start of the treatment. However, patients may not need or want to hear everything at the start of the process. Any other explanation thereafter might simply be lost. Appropriate information should be released as and when the need arises, with relevant consent-taking applied at certain milestones.

Lack of clarity on team-based consent taking

- Existing advisories were written for solo practitioners and do not address practices in team-based settings.
 - There is a lack of clarity on how much responsibility doctors have to take for the procedures they have ordered but are implemented by other healthcare professionals like nurses.
- Practitioners face an inordinate number of challenges in getting proper informed consent in team settings. This is partly due to restrictions of time, exigencies of service, operational efficiency, and the lack of familiarity with the patients.

D. Issues with the ECEG

Lack of clarity in ECEG

- For example, the ECEG states that consent should be obtained for minor procedures, but there is a lack of clarity on what constitutes a minor procedure.

ECEG has been weaponised by the SMC

- The general consensus was that the ECEG was meant to act as a guide, as the text contained therein may not be relevant or applicable for all situations, and not cast in concrete.
- Many doctors lamented that the standards in the ECEG are based on ideal or ‘Expert’ levels and not on average or minimum levels. This has resulted in a lot of fear and stress for doctors on the ground, that they might be hauled to the DT for minor infractions.

ECEG should not be overly prescriptive

- The current guidelines reduce efficiency and increase healthcare costs.
- It is important to identify what constitutes guidelines, in contrast to mandatory practices. Practitioners should have some leeway to deviate away from the former if it is appropriate and justified based on the practitioners’ experience and judgement.

E. Liability of doctors for negligence

No-fault compensation policy should be explored

- Many supported the call to explore the no-fault compensation policy practiced in New Zealand. This model entails that patients who were wronged or had suffered shall receive compensation without direct implication on doctors. It is believed that patients are more concerned towards obtaining restitution rather than killing off the careers of practitioners – providing adequate compensation will shorten the complaints process while allowing affected practitioners to come out relatively unscathed – mentally and professionally.

Annex D – Feedback on the SMC’s Disciplinary Processes

A. Structure

Increase transparency in the appointment of CC/DT members

- SMC should publish the eligibility criteria of members to facilitate interested practitioners stepping up and participating in these committees.

Introduce an additional filter prior to the complaint reaching the CC

- There were calls to set up a new ‘filtering committee/level’ to sift through frivolous and vexatious complaints before they reach the CC to decrease the workload of those sitting in the CCs/DTs as well as SMC’s secretarial staff.
- There was feedback that a formalised training framework should be developed to enable the ‘filtering committee’ to have some degree of expertise and understanding to sift through the complaints.
- Some respondents noted that the Law Society has a Review Committee that dismisses cases without merit from the outset. There were calls for the SMC to consider adopting a similar framework.

Introduce advisory support for the CC

- CCs are sometimes uncertain about how to exercise their powers due to inexperience or the complexity of cases. Some CCs are also not wholly aware of, or are reluctant to use their powers (e.g. interviewing complainants and defendants, throwing out vexatious cases). This has resulted in some CCs preferring to ‘transfer’ the risk by sending cases to the DTs even though they might not warrant serious disciplinary action. Such instances would be reduced if there were a separate board/consultative body that the CCs can look to for guidance.

Introduce structural support for the CCs/DTs

- Professionalism is lacking from the current disciplinary process. The CCs and DTs require qualified, professional and dedicated support to ensure that the process runs smoothly. There should also be a dedicated Registrar to oversee the process.

Divided opinions on whether DTs should have members from the same specialty as the doctor being charged

- Some doctors felt strongly that the specialist will have relatable specialty expertise, insights, and in-depth knowledge in that particular area of practice. This would be required in order to assess whether the doctor being charged has fallen below the standards required of him.
- Others felt that there was no need for the DT to have a member from the same specialty, as long as the expert report clearly states what standard the doctor should be held to.

B. Role of mediation

Mediation is not sufficiently employed

- Many doctors felt that it is of utmost importance to try to solve or mediate complaints at the earliest onset or tackle potential problems at the root cause. By the time a case reaches litigation, both the patient and the practitioner may have already suffered in one form or another. Mediation and counselling may resolve the issue in an amicable way.
- A doctor commented that “We must all think ‘mediation first.’ Any dispute should be mediated as the first resort.”

C. Process and procedure

Delays in proceedings

- A doctor shared that the CC took a very long time to dismiss the complaint against him that was entirely frivolous.
- Another gave an example of how his father had to deal with a frivolous complaint, and the prolonged process for the dismissal of the complaint took a toll on his mental state and ultimately his ability to practice at an optimal level.

Lack of transparency and understanding of process

- Doctors were of the view that the disciplinary process has to be transparent, clear and well-defined if continued trust in the system is to be maintained.

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- There is a lack of clarity on the structure and process in handling complaints and in the decision-making. There currently exists an absence of trust in the legal proceedings because of recent landmark cases.

Adversarial nature of proceedings

- Many expressed frustration at the adversarial nature of the disciplinary process. They felt that there is an on-going perception among practitioners that SMC lawyers are “out to kill them” – private sector lawyers draft the charges and push for prosecution. A doctor commented that “there is an impression of “us” versus “them.”
- It is widely believed that once a case is sent to the DT, the defendant doctor is done for. This would have adverse repercussions on the doctor’s reputation even though he/she may not necessarily be guilty. This adds unnecessary stress, fear and anxiety.
- Overall, many felt that there should be a move towards a more collaborative/inquisitorial system. Nevertheless, some noted that this would require training on the part of the DT members in order to be implemented.

Lack of time bar for complaints

- There is no time bar for complaints that are made to the SMC, and doctors can be penalised for things that have done 20 years ago. There were calls for time bars to be implemented because the doctor would otherwise not be able to remember the details of the incident complained about, or have documentation to prove his innocence.

Frivolous and vexatious complaints are not adequately filtered

- In summary, doctors were of the view that frivolous and vexatious complaints give rise to:
 - Unnecessary stress for practitioners;
 - Wastage of time – practitioners have to potentially spend valuable time away from practice to prepare statements/responses in defense of the inquiry;
 - Unnecessary costs incurred by the SMC, plaintiff, defendant, appellant (and MOH if the appeal were to reach the Minister for Health)
- They opined that the SMC can do a better job at minimising or filtering frivolous complaints or those without substance.
 - A member of public can now submit a complaint without fear of penalty or repercussion. Some use the process as a pass/fail test – the SMC is perceived as the cheaper route for redress/recourse as opposed to a civil suit.

-
- Among the suggestions were for:
 - Fines to be levied on patients who file frivolous complaints as a further deterrent;
 - A cooling down period to be imposed for repeat complainants, especially those who persist in filing similar or frivolous complaints; and
 - The ease at which complaints can be lodged to be looked into.

Review of the complaint at the CC stage is not sufficiently thorough

- Some doctors were of the view that the CC's means of reviewing the complaint is without context. The doctors and complainants are not interviewed and are only required to submit a written explanation.
- A doctor shared his frustration that the onus is on the doctor to prove that he did not do anything wrong.
- There were also views that the investigation process is not sufficiently thorough – investigators should go beyond the notes, written accounts and other information provided.

Quality of expert evidence

- Experts who come from different disciplines may have provided inaccurate advice or reports to the legal representatives, which can lead to skewed decisions by the DT. Expert witnesses should come from the same discipline as the doctor being charged or have adequate knowledge and experience, which is not always the case.

SMC is over-eager and overly harsh in charging doctors

- SMC sometimes persists in slapping doctors with secondary charges, even though the doctor may have been acquitted of the main charge. This can cause cases to drag on for longer than it should. Not all doctors may have the fortitude to last that long; many would have succumbed to pleading guilty due to prolonged stress even though they may not be entirely at fault.
- Frustration was expressed at the ECEG being used as a quasi-Penal Code. Doctors felt that their peers were being convicted for not achieving gold standards, as opposed to falling short of minimum standards. This has resulted in a lot of fear and stress for doctors on the ground.
- A doctor commented that the DTs could be “less quick in slapping the professional misconduct label on doctors”.

Involvement of lawyers at the DT stage has led to harsher sentences

- A doctor commented that since Legal Service Officers were introduced to the DTs, the perception was that because the Chief Justice had made certain comments, or because the High Court had given a certain penalty, the DTs had to be stricter in their sentencing. The higher sentences were because there were worries that the sentence would be appealed against and overruled by the court on appeal.
- There is a perception that the prosecuting and defending lawyers decide on the outcome while the doctors and the SMC have no say. The lawyers are perceived to be “in this together”.

D. Appeals

Lack of transparency in the appeals process

- Many delays in disciplinary proceedings are caused by complainants appealing to the Minister, which often means that the case ends up being referred back to the CCs for reconsideration. Complainants will continue to pursue the case because they do not have to pay a single cent.
- Cases are sometimes reopened or thrown back to the CC without adequate justification or direction on what aspect of the case needs to be looked at in further detail.
- A doctor commented that the CC might feel that the Minister cannot be wrong and refer the case to the DT for that reason.
- The general impression is that the Minister would almost always produce a favorable outcome for the complainant. Many felt that it would be best for the Minister to leave the disciplinary process entirely to SMC to maintain its function as an independent, self-regulating body.
- There is a lack of transparency on how these appeals are processed, who had advised the Minister and whether he was provided with adequate information and advice to proceed with the appeal.
- A doctor also commented that new documents should not be brought in at the appeals stage; the appellate body should only look at what the CC had sight of when it made its determination.

E. Training

Inadequate training of CC and DT members

- Many doctors were of the view that the CC and DT members are insufficiently trained and ill-equipped. They do not know the law and the ECEG well.
 - CC members do not receive training on the differences between simple negligence and professional misconduct.
 - The CCs have no expertise in drafting charges.
 - CC members lack knowledge on the nuances of the law.
 - One doctor commented that “the DTs are led by the lawyer almost from the beginning to the end. The DT should be educated and should have the ability to disagree with what the respondent doctor is seeking.”
- Not all members of the DT are still in active practice and thus may not be aware of current difficulties on the ground.
- Even though there are training sessions for the DTs, in many of these cases the DT members do not look at ‘beyond reasonable doubt’. Instead, they look assess the case based on a ‘balance of probabilities’.
- CC members also shared that when they were first appointed to CCs, they were often not given adequate guidance or preparation. The decision-making process is also highly dependent on who the chair is, which can result in inconsistent outcomes.

F. Others

Lack of manpower to sit in the disciplinary committees

- There were suggestions that sitting on the disciplinary committees should not be on a voluntary basis. A jury-type of arrangement should be implemented for all registered practitioners. This would solve manpower problems in getting professionals to step to sit on the CCs and DTs and also teach the general masses about the legal requirements. Others were of the view that there could be an opt-out system for sitting on the SMC disciplinary committees.
- Some doctors raised the point that more incentives should be provided to those who sit on the SMC disciplinary committees. This can be in the form of financial remuneration, recognition, and waivers. A doctor commented that “not many practitioners are willing or ready to be put in the spotlight, be subject to criticism and

scrutiny, or have the capacity and empathy to put their fellow peers to the sword”. There is, therefore, the need to have a more tangible ‘carrot’ to attract more doctors to participate in the process.

Negative perception of doctors who sit on the DTs

- The general perception is that doctors who have a certain character or who have a personal agenda sit on the DTs. Many prefer to stay on the sidelines.

Inability to procure experts

- There is a shortage of doctors who are willing to give expert reports or be expert witnesses because they have to follow through with the case if it eventually goes to the DT or the court. Some experts are also afraid to be put to scrutiny, especially in the light of the backlash from recent cases.

Role of the SMC

- Some doctors were of the view that the SMC should play a more proactive role in ensuring that the outcomes or judgments are representative of SMC’s stance on the matters.
- Others said that the SMC should consider the larger implications of the decisions in the cases such as *Soo Shuenn Chiang* and *Lim Lian Arn* and how they will affect the members of the medical profession.

Consider the best practices of other professions

- A suggestion was also made for SMC/MOH to consider adopting best practices of other professions, specifically those of the Law Society in how to improve the disciplinary process.

Annex E – Legal Test for the provision of Medical Advice

This is a patient-centric test based on peer professional opinion, which has regard to patient autonomy and choice and takes into account what is material to the patient.

- (1) A healthcare professional shall be regarded as having discharged his duty of care in the provision of medical advice to his patient if the medical advice he has provided is supported by a respectable body of medical opinion as competent professional practice in the circumstances (“peer professional opinion”).
- (2) For the purpose of paragraph 1, the respectable body of medical opinion must consider whether the healthcare professional gave⁵⁰ to the patient relevant and material information that a patient in those circumstances would reasonably require in order to make informed treatment decision(s), and information that the healthcare professional knows⁵¹ would be relevant and material to the patient.
- (3) However, peer professional opinion cannot be relied on for the purpose of paragraph 1 if the court determines that the opinion is illogical.
- (4) The fact that there are differing peer professional opinions by a significant number of respected practitioners in the field concerning a matter does not in itself mean that the peer professional opinion being relied on for the purpose of paragraph 1 should be disregarded as evidence of a respectable body of medical opinion.

⁵⁰ Or arranged to give.

⁵¹ Or ought to have known.

Annex F – Draft ECEG on informed consent

- (1) Patient autonomy is a fundamental principle in medical ethics and must be respected.⁵² You must respect a patient's right to refuse tests, treatments or procedures.⁵³
- (2) It is a doctor's responsibility to ensure that a patient under his care is adequately informed about his medical condition and options for treatment (including non-treatment) so that the patient is able to participate meaningfully in decisions about his treatment.⁵⁴ In taking consent, the information provided to the patient should include the purpose of tests, treatments or procedures to be performed on them, as well as the benefits, limitations, risks and alternatives available to them.⁵⁵ Considerations should also be given as to whether the treatment involves minor or major interventions and the levels of risk, the clinical setting and the context of the consultation, and should be relevant and material to a reasonable patient situated in the particular patient's position.
- (3) A doctor should either take consent personally or if it is taken for the doctor by a team member, the doctor or the doctor's department should, through education, training and supervision of team members, ensure that the consent taken on the doctor's behalf meets with these guidelines. It is the principal doctor's responsibility to be reasonably satisfied that this has been done.
- (4) In any case, you must ensure adequate documentation of the consent taking process where this involves more complex or invasive modalities with higher risks. Other team members may provide information such as education materials to augment the patient's understanding.
- (5) In an emergency or therapeutic situation, a doctor may proceed with treatment without consent when the patient is not capable of giving consent and where the doctor deems that the patient may suffer significant harm or be exposed to inordinate risk unless the treatment is done immediately.

⁵² Taken from Section C5 of ECEG 2016.

⁵³ Taken from C6(13) of ECEG 2016.

⁵⁴ Taken from Para 4.2.2 of ECEG 2002. Added the reference to "non-treatment".

⁵⁵ Taken from C6(3) of ECEG 2016.

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- (6) A doctor may withhold information where the giving of such information would cause the patient serious physical or mental harm.⁵⁶
 - (7) Where the patient is a minor, doctors should take consent from the parents or legal guardians of minors. Where the minor is able to understand the information provided and form an opinion, the doctor should also give due consideration to the opinion of the minor.⁵⁷
 - (8) Where the patient has diminished capacity⁵⁸, a doctor should assess, at the time of taking consent, whether the patient can demonstrably understand, retain and use information/explanations provided to make and communicate a decision.⁵⁹
 - (a) If the patient is able to give consent, the doctor must obtain consent from the patient himself.⁶⁰
 - (b) If the patient is unable to give consent, a doctor should obtain consent from persons with the legal authority to make such medical decisions.⁶¹

⁵⁶ See *Hii Chii Kok* at [152].

⁵⁷ Taken from C6(14) of ECEG 2016.

⁵⁸ Section 3(2) of the Mental Capacity Act (Cap. 177A) states that “a person must be assumed to have capacity unless it is established that he lacks capacity”. Section 4(1) states that for the purposes of the MCA, a person lacks capacity in relation to a matter “if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain”.

⁵⁹ Taken from C6(19) of ECEG 2016. Reference to “at the time of taking consent”. Section 5(1) of the MCA states that for the purposes of Section 4 of the MCA, a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision; (b) to retain that information; (c) to use or weigh that information as part of the process of making the decision; or (d) to communicate his decision (whether by talking, using sign language or any other means) added.

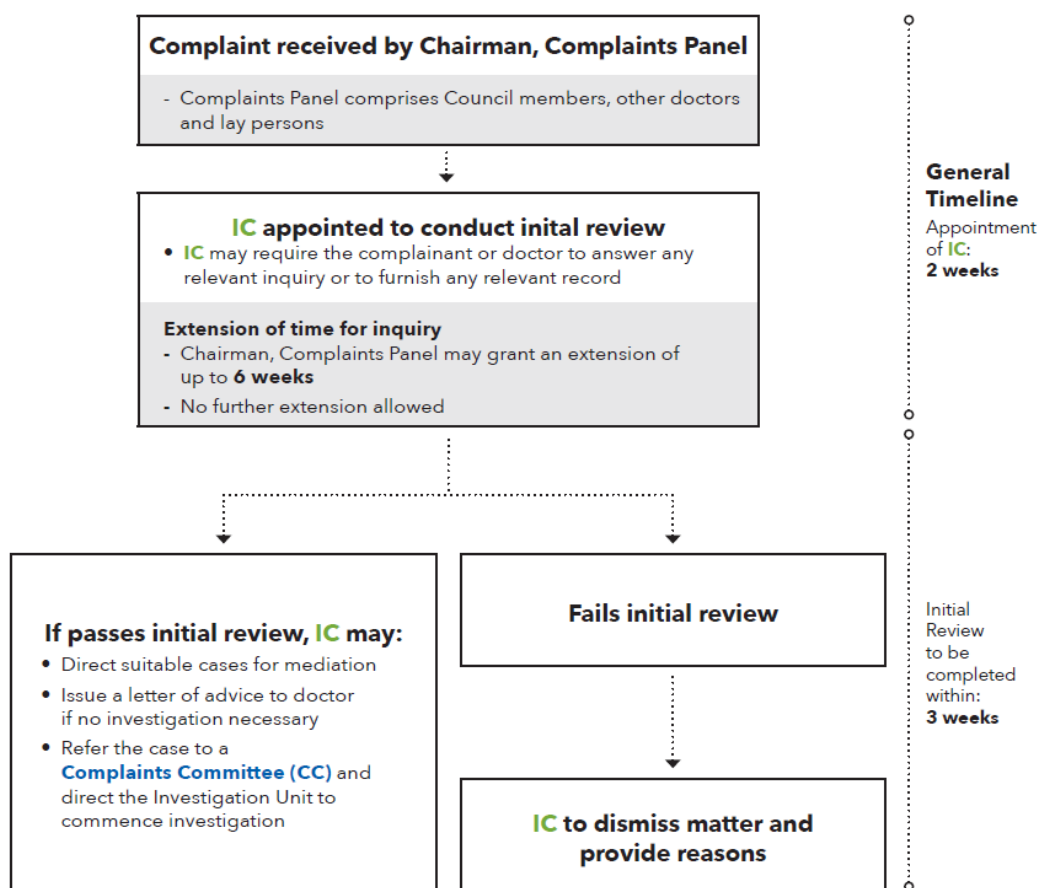
⁶⁰ Taken from C6(19) of ECEG 2016.

⁶¹ Taken from C6(20) of ECEG 2016.

Annex G – Flowcharts on the revised disciplinary process

PROPOSED FRAMEWORK FOR SINGAPORE MEDICAL COUNCIL (SMC) DISCIPLINARY PROCESS

Stage One - Initial Review and Triage by the **Inquiry Committee (IC)**



Inquiry Committee (IC) **NEW**

- **Composition**
 - 1 doctor to chair from Complaints Panel
 - 1 other doctor from Complaints Panel
- **Scope of initial review**
 - Assess whether complaint is frivolous, vexatious, misconceived, lacking in substance
- **Dedicated secretariat**
- **Legal Advisory Unit**
 - To advise **IC** on complaints

Complaints Committee (CC)

- **Composition**
 - 1 doctor to chair from Complaints Panel
 - 1 other doctor from Complaints Panel
 - 1 layperson
- **Decision**
 - **CC** members to be unanimous; otherwise, chair to have deciding vote
- **Dedicated secretariat**
- **Legal Advisory Unit**
 - To advise **CC** on complaints that can be struck out, investigations into complaints process and procedure

Stage Two - Inquiry by the **Complaints Committee (CC)**

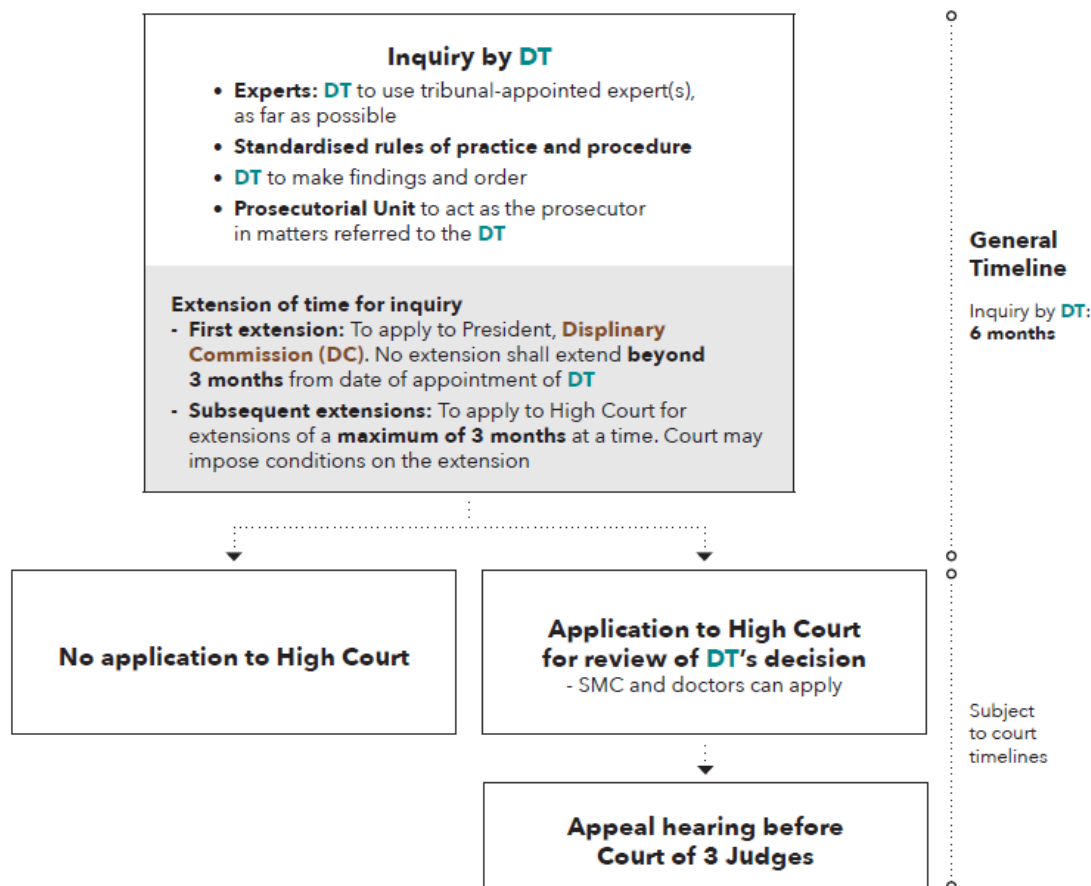


- Review Committee (RC)
- NEW**

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PROPOSED FRAMEWORK FOR SINGAPORE MEDICAL COUNCIL (SMC) DISCIPLINARY PROCESS

Stage Three - Inquiry by the **Disciplinary Tribunal (DT)**



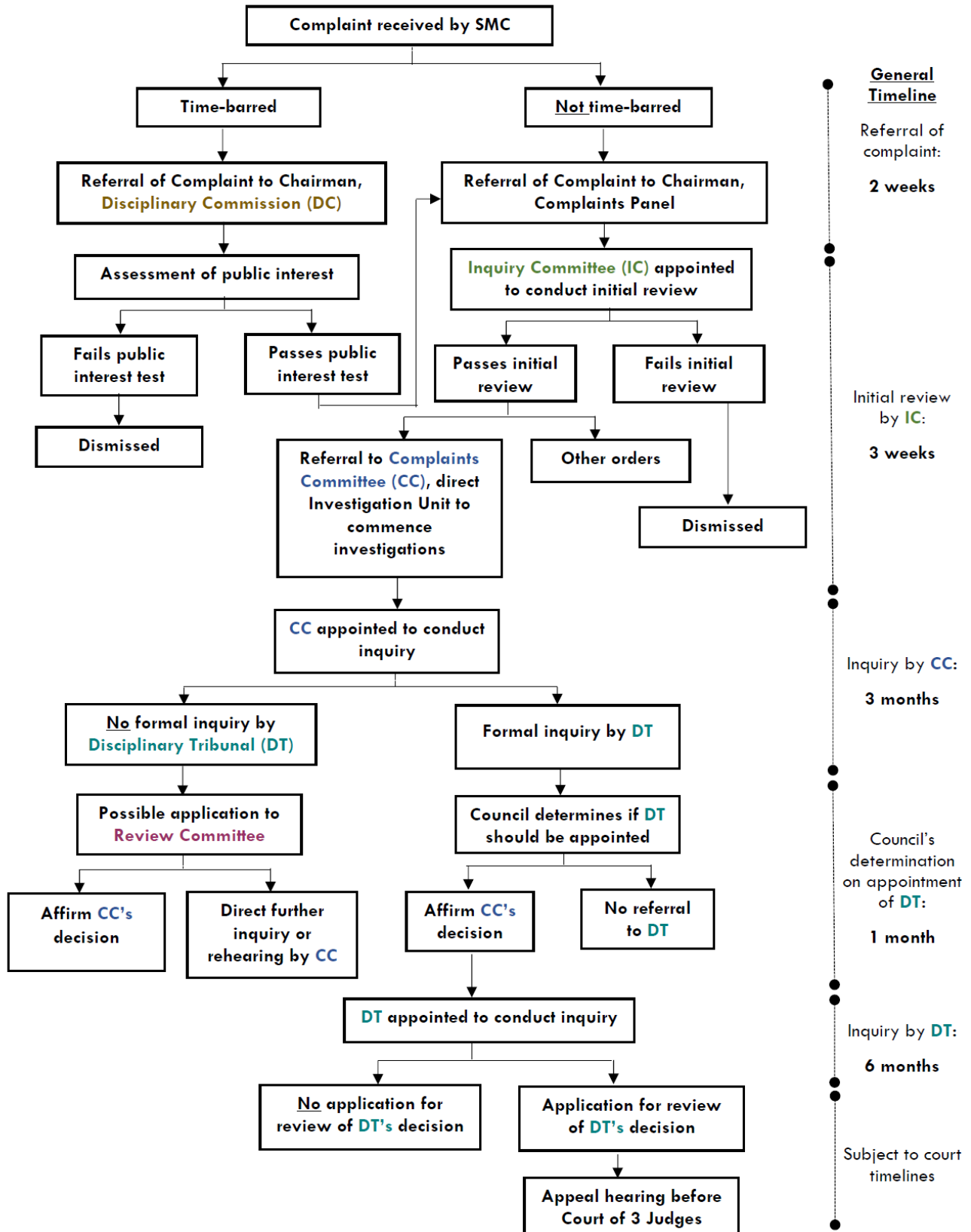
Disciplinary Commission (DC) **NEW**

- **Members of the Commission to be appointed by the Minister for Health**
 - President with tenure (Doctor)
 - Judges/lawyers (High Court judges and Judicial Commissioners, Legal Service Officers, senior lawyers)
 - Doctors (current practicing doctors with 10 years' standing)
- **Function of President of DC**
 - Assessment of time-barred complaints
 - Appointment of individual **DTs**
 - Oversee the fair, efficient and expeditious conduct of **DT** hearings
 - Oversee the training and qualification of members of the **Inquiry Committee (IC)**, **CC** and **DT**
- **DC to be supported by independent secretariat**

Disciplinary Tribunal (DT)

- **Composition:**
 - 2 doctors and 1 judge/lawyer from the **DC** comprising
 - 1 Chair (If a High Court judge or Judicial Commissioner sits on the **DT**, he will be the chair)
 - 2 members
- **Decision**
 - Decision of the majority
- **Dedicated DC Secretariat**

Overview of revised process



Annex H – Role of officers in the legal advisory and prosecution unit

The functions of the officers in the Legal Advisory Unit include the following:

- Advising the IC and CCs on assessing complaints that can be struck out at an early stage for being vexatious, frivolous or lacking in substance.
- Advising the CC on investigations into complaints, process, and procedure.
- Advising the CC on formulation of charges and referrals to the DT, including whether the particulars of the charge fall within the ambit of the complaint.
- Advising the RC on whether there was regularity in the proceedings of the CC, if an appeal is made from the CC's decision.

The functions of the officers in the Prosecution Unit include the following:

- Acting as the prosecutor in matters referred to the DT.
- Having conduct of appeals and judicial reviews.

Annex I – Circumstances that do not give rise to a conflict of interest

The non-exhaustive list below sets out the principles that doctors called upon to sit on the various committees or to serve as experts in the disciplinary process (“the appointee”) should stand guided by, in determining whether a conflict of interests exists which will necessitate that he decline the appointment.

- The appointee should not accept the appointment if he has doubt as to his ability to act impartially and independently. This is a fact-dependent exercise.
- If facts or circumstances exist, or have arisen since the appointment, which, from the point of view of a reasonable third person having knowledge of the relevant facts and circumstances, would give rise to justifiable doubts as to the appointee’s impartiality or independence.
- Doubts are justifiable if a reasonable third person, having knowledge of the relevant facts and circumstances, would reach the conclusion that there is a likelihood that the appointee may be influenced by other factors that arise from his relationship with the respondent doctor.
- The appointee’s membership in a particular cluster or group, professional association, social or charitable organisation or other organisation shall not necessarily constitute a source of conflict, despite an existing relationship of the cluster/group with the respondent doctor.
- A professional former or current working relationship between the appointee and the respondent doctor do not automatically give rise to a conflict of interest.
- The fact that the appointee and the respondent doctor had prior contact for an unrelated matter does not automatically give rise to a conflict of interest.
- However, if the appointee is the manager, director or supervisor of the respondent doctor or vice-versa, there will be a conflict of interest by virtue of this relationship.
- If the appointee is aware of confidential or privileged information concerning the respondent doctor, this may result in a conflict of interest if it affects his ability to act impartially and independently in the execution of his duties.

Annex J – Guidelines for referring cases for mediation

The decision to refer a case for mediation will be at the discretion of the IC and the CC. The IC or CC will have to justify why a case should or should not be channelled towards mediation, and provide the complainant and doctor with reasons when the case is referred for mediation.

This table sets out the categories of cases that may generally be considered suitable or unsuitable for mediation:

A. Suitable for mediation

- Complaints about the quality of treatment received where there is no indication of any serious risk to the patient or that the doctor acted significantly below appropriate standards
- Complaints about doctors' poor attitudes to patients, or failing to take their preferences into consideration
- Misunderstanding over charges, treatment plans, or other types of miscommunication
- Systemic issue within hospital or clinic
 - Waiting times, doctor to patient ratio, consultation times, changes in attending doctor
- Requests for compensation
 - Request for compensation for minor injury or discomfort to patient due to treatment that did not go as planned
- Complainant seeking closure
 - Death of a family member while undergoing treatment that was not due to any fault of the doctor
- Mismatch in expectations
 - Recovery time, treatment outcomes
- Simple negligence
 - Minor lapses in procedure such as a one-off failure to conduct a minor test/check, or a one-off failure to explain a risk to the patient
- Minor errors of judgment

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- Misdiagnosis due to error of judgment or failure of memory with no serious effect on patient

B. Unsuitable for mediation

- Any matter which would otherwise have been dismissed at the IC or CC stage, without further action being taken
- Gross negligence or overcharging
- Professional misconduct
 - Intentional breach of patient confidentiality
- Improper act or conduct which brings disrepute to profession
 - Association with and/or supporting the services provided by a person unqualified to provide medical or medical support services, dishonesty in relation to locum arrangements
- Convictions
 - Conviction of offences involving fraud or dishonesty, such as tax evasion
 - Conviction of offences implying a defect in character making him unfit for the profession, such as sexual offences or assault
- Conduct which poses threat to patient safety
 - Failure to provide adequate clinical evaluation
 - Excessive or inappropriate prescription of medicine
 - Inappropriate issuance of Medical Certificates
 - Unnecessary/inappropriate treatment
 - Delays in treatment
 - Engaging in practices which are not evidence-based
 - Inappropriate doctor-patient relationship

Annex K – Framework for referring cases for mediation

A. Referral for mediation after initial triage by the IC

1. The IC will have to complete its assessment of the case, and determine if it is suitable for mediation within 3 weeks of the receipt of the complaint by the IC. Within this timeframe, the IC would also have to assess if the case is suitable for (1) referral to the CC and for investigations to be commenced or if (2) a letter of advice should be issued to the respondent doctor, if mediation fails or if either party refuses to attend mediation.
2. If the case is suitable for mediation based on the IC's assessment, both the doctor and complainant will be informed of this via letter within 1 week of the determination. The letter will indicate that the case will be referred for mediation and should include the following:
 - a. The complaint letter;
 - b. The reasons why the case was referred for mediation (to be provided by the IC);
 - c. A standard statement on the purpose of, benefits of mediation and the purpose of the Case Statement; and
 - d. A template for the Case Statement.
3. Both the complainant and respondent doctor will have to provide their Case Statement within 4 weeks from the date of the letter, based on the template provided.
4. The IC/CC Secretariat will submit the following to the Singapore Mediation Centre, which will conduct the mediation, within 1 week of receiving the Case Statements:
 - a. Summary of case
 - b. Case Statements from the complainant and the doctor
5. The Singapore Mediation Centre will arrange for a mediation session between the complainant and the doctor within 3 weeks of the receipt of documents from the SMC.
6. Whatever is said during mediation will remain confidential so that parties can have a full and frank discussion.
7. If mediation is successful, both parties will sign the agreement reached at mediation. This will mark the conclusion of the case.

8. If mediation fails, the Singapore Mediation Centre will update the IC/CC Secretariat of the outcome.
9. Based on its earlier assessment (see step 1), the IC may then:
 - a. issue a letter of advice to the respondent doctor; or
 - b. refer the case to the Chairman, Complaints Panel, who will appoint the CC from the Complaints Panel, within 3 weeks from the date of the last mediation session.
10. If either party refuses to attend mediation, steps 3 to 9 set out above should be disregarded. The IC can then make the relevant order within 1 week of the refusal of either party to mediate, based on its earlier assessment (see step 1).

B. Referral for mediation after investigations by the CC

1. A maximum of 3 weeks after the case investigation report is received by the CC, before its timeline of 3 months to complete its inquiry is up (assuming no further extensions of time are sought), the CC may refer the parties for mediation. Within this timeframe, the CC would also have to assess if (1) a letter of advice or warning should be issued to the respondent doctor, or (2) if other orders available to the CC should be made if mediation fails or if either party refuses to attend mediation.
2. If the case is suitable for mediation based on the CC's assessment, both the doctor and complainant will be informed of this via letter within 1 week of the determination. The letter will indicate that the case will be referred for mediation and should include the following:
 - a. The complaint letter;
 - b. The reasons why the case was referred for mediation (to be provided by the IC);
 - c. A standard statement on the purpose of, benefits of mediation and the purpose of the Case Statement; and
 - d. A template for the Case Statement.
3. Both the complainant and respondent doctor will have to provide their Case Statement within 4 weeks from the date of the letter, based on the template provided.
4. The IC/CC secretariat will send the following to the Singapore Mediation Centre, who will conduct the mediation, within 1 week of receiving the Case Statements:
 - a. Summary of case
 - b. Case Statements from the complainant and the doctor
5. The Singapore Mediation Centre will arrange for a mediation session between the complainant and the doctor within 3 weeks of the receipt of documents from the SMC.

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6. If mediation is successful, both parties will sign the agreement reached at mediation. This will mark the conclusion of the case.
 7. If mediation fails, the Singapore Mediation Centre will update the IC/CC Secretariat of the outcome.
 8. Based on its earlier assessment (see step 1), the CC can then make the relevant order within 1 week of the failure of mediation.
 9. If either party refuses to attend mediation, steps 3 to 8 set out above should be disregarded. The CC can then make the relevant order within 1 week of the refusal of either party to mediate, based on its earlier assessment (see step 1).

Annex L – List of topics for training the CC

Training for the CC should cover the following topics:

- The processes and procedures at the IC and CC stages
- What constitutes a frivolous, vexatious, misconceived case, or one that is lacking in substance
- When to refer a case for mediation
- What constitutes professional misconduct
- The differences between simple and serious negligence
- What standard a defendant doctor should be measured against (i.e. an average doctor of the same specialty or practice area)
- What the standard of proof for referral from the IC to the CC, and from the CC to the DT is
- What orders the IC and CC are empowered to make, and when to use them
- How to assess the veracity of evidence

Annex M – List of topics for training the DT

Training for the DT should cover the following topics:

- The processes and procedures at the DT stage
- What constitutes professional misconduct
- The difference between simple and serious negligence
- The standard a defendant doctor's conduct should be assessed against (i.e. an average doctor of the same specialty or practice area)
- What the burden of proof is for conviction at the DT stage
- Role of experts and the quality of experts' reports
- What the applicable sentencing principles and guidelines are
- What orders the DT is empowered to make and when these orders should be made