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Comparison of Regulations on Medical Professional Discipline Enforcement Institutions between the United States, the United Kingdom, Singapore and Indonesia

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Abstract

Law Number 17 of 2023 on Health served as a momentum for evaluation of the regulation regarding ethics and professional discipline enactment body for medical personnel, which includes doctors and dentists. The purpose of this research is to provide comparisons from regulations in the United States, Great Britain, Singapore, and Indonesia as an evaluation tool. Through doctrinal law method with analytical and comparative approach toward secondary data, this research found that there were notable regulation differences between the countries which could provide input for Indonesia. Analysis of professional discipline enactment body gave two key messages. One, Indonesia could give provisions on what could be subject to disciplinary actions, including legal violations that may be subject to disciplinary actions, in order to clarify the relationship between professional discipline and law. Two, Indonesia could introduce a tiered mechanism in the investigation of alleged professional discipline violations to strengthen the realm of professional discipline and affirm its position as primum remedium.

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Introduction

Medical professionals, namely doctors and dentists, bear responsibility for patients and their rights. This responsibility includes the medical professionals' skills and abilities, as well as their emotional attitude toward patients to foster a good relationship. From the patient's perspective, the responsibility of medical professionals relates to the patient's right to determine their own life and livelihood and to receive accountable information. Based on these points, it is understandable that

the relationship between medical professionals and patients is a therapeutic contract.[1] When issues arise from this therapeutic contract, medical professionals and patients may face medical disputes.[2]

There are two ways to resolve medical disputes available to the disputing parties. First, there is a medical ethics enforcement body established by two professional organizations in Indonesia as an effort to self-regulate their members,[3] which is the Indonesian Medical Association/*Ikatan Dokter Indonesia* (IDI) with the Honorary Council of Medical Ethics/*Majelis Kehormatan Etik Kedokteran* (MKEK)[4] and the Indonesian Dental Association/*Persatuan Dokter Gigi Indonesia* (PDGI) with the Honorary Council of Dentistry Ethics/*Majelis Kehormatan Etik Kedokteran Gigi* (MKEKG).[5] Second, there is a medical professional discipline enforcement body based on Law Number 17 of 2023 on Health and Government Regulation Number 28 of 2024 on the Implementation of Law Number 17 of 2023 on Health, referred to as the Professional Discipline Board/*Majelis Disiplin Profesi* (MDP). Previously, based on Chapter VIII of Law Number 29 of 2004 on Medical Practice, the MDP was known as the Indonesian Medical Disciplinary Board/*Majelis Kehormatan Disiplin Kedokteran Indonesia* (MKDKI).

The enactment of Law Number 17 of 2023 and its implementing regulations should be utilized as a momentum to establish good regulations for the medical professional discipline enforcement body. This momentum is important considering that the regulations in Law Number 29 of 2004 on Medical Practice regarding the medical professional discipline enforcement body were unclear, such as how to position the MKDKI in resolving medical disputes compared to civil or criminal judicial systems.[6]Although Law Number 17 of 2023 on Health has attempted to position the

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[1] Rospita Adelina Siregar, *Hukum Kesehatan* (Sinar Grafika 2023) 28–35.

[2] ibid 223–230.

[3] Wade L Robinson, *Practical and Professional Ethics: Key Concepts* (Bloomsbury 2021) 51–52.

[4] Ikatan Dokter Indonesia, *Anggaran Dasar Dan Anggaran Rumah Tangga Ikatan Dokter Indonesia* (Ikatan Dokter Indonesia 2022) 40 <https://idionline.org/file/file_1720414094.pdf>.

[5] Persatuan Dokter Gigi Indonesia, *Anggaran Dasar Dan Anggaran Rumah Tangga Persatuan Dokter Gigi Indonesia Periode Tahun 2022-2025* (Persatuan Dokter Gigi Indonesia 2022) 16–17.

[6] Jovita Irawati, 'Inkonsistensi Regulasi Di Bidang Kesehatan Dan Implikasi Hukumnya Terhadap Penyelesaian Perkara Medik Di Indonesia' (2019) 19 Law Review 54 <https://doi.org/10.19166/lr.v19i1.1551>.

MDP as *primum remedium* before proceeding to court through the issuance of MDP recommendation,[7] the available derivative regulations do not detail the implementation mechanisms.

Based on these considerations, this momentum should be utilized by reviewing systems that have been implemented in other countries as input for developing and evaluating regulations on medical professional discipline enforcement. The study should also consider that professional discipline and law have a relationship that, in practice, often becomes less than ideal due to the lack of synergy in norm formation between government institutions; ideally, all legal violations are also violations of professional discipline, but not all professional discipline violations are legal violations.[8] Currently, there is a lack of up-to-date research that studies and compares the regulations on medical professional discipline enforcement bodies in foreign countries, both in international and national literature. The lack of such research makes it difficult to extract regulatory points that could be considered and adopted to achieve comprehensive regulations.

Therefore, understanding that the regulations related to the MDP still require further development to support its position as *primum remedium*, this research will explore the scientific question of how the regulations on medical professional discipline enforcement bodies in the United States, the United Kingdom, and Singapore, as countries with relatively mature regulations, compare to those in Indonesia. The purpose of this research is to analyze the differences in regulations between these countries and Indonesia, understand the placement of medical professional discipline bodies in these countries as a first step that could be adopted in Indonesia, and serve as a foundation for future research on the comparison of foreign medical professional discipline body regulations with those in Indonesia.

[7] Rospita Adelina Siregar and others, 'Majelis Disiplin Profesi Sebagai Primum Remedium Berdasarkan Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan' (2024) 10 Jurnal Hukum to-ra : Hukum Untuk Mengatur dan Melindungi Masyarakat 491–505 <https://doi.org/10.55809/tora.v10i3.384>.

[8] Pukovisa Prawiroharjo, Rizky Rafiqoh Afdin and Agus Purwadianto, 'Relasi Etika, Disiplin Dan Hukum Kedokteran' (2021) 5 Jurnal Etika Kedokteran Indonesia (JEKI) 45–48.

Research Method

The research method used was a doctrinal legal method with an analytical approach to understand the meaning and application of various terms and rules in legal materials and a comparative approach to compare regulations between the countries studied. The type of data used were secondary data, which included primary legal materials such as legislation, secondary materials such as legal books and journals, and tertiary materials such as dictionaries. Data from the United States, the United Kingdom, Singapore, and Indonesia were obtained through primary legal materials via official channels (websites, correspondence) and secondary legal materials discussing the topic in these countries. The data collected through literature studies were then analyzed using normative qualitative analysis techniques. The main theory used in this research analysis was the pure theory of law, with the analysis results presented in tables and narrations.

Pure Theory of Law

In this research, the theory used as the foundation was the pure theory of law. This theory began to develop in the 20th century and is also known as "Neo-Kantianism" because it revisited the separation between *das Sollen* (what ought to be) and *das Sein* (what is), which was previously discussed by Plato and Immanuel Kant. Some notable Neo-Kantian figures include Rudolf Stammler, Gustav Radbruch, and Hans Kelsen. Kelsen was a crucial contributor to this school of thought. His thinking was influenced by his observation of Adolf Hitler, who used law as a tool to achieve political and power goals rather than to build justice.[9]

This concern was eventually poured into his book titled *Reine Rechtslehre* (Pure Theory of Law). In this work, he stated that law must be free from non-juridical elements, such as historical, political, sociological, and ethical elements, and that law must be applicable at all times and places. Kelsen viewed that law must be separated from meta-juridical thinking so that legal norms exist objectively as positive norms. The conception of law was not into abstract meta-juridical moral principles regarding the

[9] Budiono Kusumohamidjojo, *Filsafat Hukum : Problematik Ketertiban yang Adil* (Yrama Widya 2022) 15.

nature of justice but as *ius* that had been positivized into *lege* or *lex* to ensure certainty about what constitutes law.[10]

The separation between law and morality was key in Kelsen's argument. This separation was not about the external and internal behaviors required of humans by law and morality, respectively, or in other words, *what* the content that commanded or prohibited from both social orders was, but rather *how* law and morality commanded or prohibited certain behaviors. Law was understood as a coercive order aimed at realizing certain behaviors, unlike morality, which did not have sanctions like law, being limited to approval or disapproval of certain behaviors. Therefore, it was clear that law and morality were two different systems.

The implication of this separation was the relationship that arises between law and morality. If law and morality were not distinguished, there would be an assumption that there was only one universal and absolute moral order. In reality, even within the same country, there could be several different moral systems, which must be accommodated by law through the extraction of general norms to achieve justice. Through this discourse, Kelsen explained that the statement "law is morality" did not mean that law had a specific content, but that law was a social norm; it was a relative moral value, so the issue between law and morality lied in form, not content.[11]

A distinction was also made between law and fact. Law became a category of obligation or ideal (*sollens kategorie*), not a factual category (*sein kategorie*). The issues raised by law became *sollens kategorie* through positive law as *ius constitutum*, not how the law should be (*ius constituendum*). Furthermore, law was an obligation that regulated human behavior as rational beings.[12] To make legal norms an independent object separate from moral validity and empirical reality, Kelsen used the concept of *grundnorm* (basic norm), reinforced by two references.

First, he referred to the concept of *stufenbaulehre* (hierarchical structure of norms)

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[10] Mahrus Ali, 'Pemetaan Tesis Dalam Aliran-Aliran Filsafat Hukum Dan Konsekuensi Metodologisnya' (2017) 24 Jurnal Hukum IUS QUIA IUSTUM 213–231 <https://doi.org/10.20885/iustum.vol24.iss2.art3>.

[11] Hans Kelsen, *Hukum Dan Moral: Seri Teori Hukum Murni* (Nusamedia 2021) 2–12.

[12] Sukarno Aburaera, Muhadar and Maskun, *Filsafat Hukum: Teori Dan Praktik, Edisi Pertama* (Kencana 2013) 109.

introduced by Adolf Rudolf Merkl, where this concept was translated into a hierarchical structure of norms. Based on this concept, Kelsen explained that existing norms could be reconstructed into a unified legal system that was dynamic and capable of delegating authority. Second, he referred to the Neo-Kantian transcendental concept. Through this concept, the basic norm was assumed to be valid as a fundamental norm that was not part of positive law, thus forming the basis of formal and material unity. This basic norm became the initial norm and provided authority and validity.[13]

The concept of *grundnorm* was also mentioned by another legal scholar from the same generation as Kelsen, Hans Nawlasky, through his theory titled *Die Lehre von dem Stufenbau der Rechtsordnung* (The Doctrine of the Hierarchical Structure of the Legal Order). According to him, legal norms were divided into four groups: *staatsfundamentalnorm* (state fundamental norm), *staatsgrundgesetze* (state basic laws), *formelle gesetze* (formal laws), and *verordnungen/autonome satzungen* (regulations/autonomous statutes). *Staatsfundamentalnorm* was used as a substitute for *grundnorm* because the basic legal norm of a country could be changed, whereas *grundnorm* would be inherently not easily changed. In Indonesia, Pancasila and the Preamble to the 1945 Constitution of the Republic of Indonesia (UUD NRI 1945) are the *staatsfundamentalnorm*.[14]

Regulation of Medical Professional Discipline Enforcement Bodies in the United States

In the United States, the medical professional discipline enforcement body for doctors was called state medical boards (SMBs). SMBs could be found in all states, with the legal basis being the medical practice act (MPA) of each state. The origin of SMBs could be traced back to the Tenth Amendment of the Bill of Rights, which mandated states to protect the health, safety, and welfare of the public. This mandate was reinforced through the jurisprudence of the case Dent v. West Virginia,

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[13] Kelik Wardiono and Khudzaifah Dimyati, 'Basis Epistemologis Paradigma Rasional Dalam Ilmu Hukum: Sebuah Deskripsi Tentang Asumsi-Asumsi Dasar Teori Hukum Murni-Hans Kelsen' (2014) 14 Jurnal Dinamika Hukum 369–383 <http://dinamikahukum.fh.unsoed.ac.id/index.php/JDH/article/view/304>.

[14] W Riawan Tjandra, *Hukum Administrasi Negara* (Sinar Grafika 2018) 64–65.

which confirmed that states could regulate medicine and other professions through professional licensing bodies.

The general function of SMBs was to issue licenses and regulate the behavior of doctors to protect medical consumers from harm. This function was achieved by setting and propagating essential standards of medical practice through SMB examinations, establishing investigative and disciplinary processes, and increasing the involvement and oversight of doctor licensing and maintenance. Regarding the regulation of doctor behavior, disciplinary actions were directed at substandard or unethical behavior. Malpractice cases, which required proof of negligence and actual harm to the patient, were not within the jurisdiction of SMBs but may be used as evidence of ongoing unprofessional conduct.[15]

Additionally, SMBs had the authority to use cases outside of medical practice to enforce professional discipline, such as those related to personal character. The argument used was that personal character could be an appropriate substitute for competent and safe clinical practice. If there was impaired judgment that caused a doctor to behave poorly, they were likely to perform poor clinical practice as well. This argument was used in the case *Haley v. Medical Disciplinary Board*, where the Washington Supreme Court ruled that a doctor's tax fraud could raise concerns about potential professional abuse of trust and thus warranted disciplinary action.[16]

The structure and authority of SMBs varied by state, depending on the state's MPA. Some SMBs were independent bodies and held all disciplinary and licensing functions, while others were part of a higher umbrella agency, such as the state health department, with varying levels of responsibility or serving in an advisory role.[17] Some states also separated the body responsible for licensing from the one responsible for disciplinary functions.

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[15] Jacqueline Landess, 'State Medical Boards, Licensure, and Discipline in the United States' (2019) 17 Focus 337 < https://doi.org/10.1176/appi.focus.20190020>.

[16] Amrit K Bal and B Sonny Bal, 'Medicolegal Sidebar: State Medical Boards and Physician Disciplinary Actions' (2014) 472 Clinical Orthopaedics and Related Research® 28 < https://doi.org/10.1007/s11999-013-3364-1>.

[17] Federation of State Medical Boards, 'Introduction' <https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/introduction> accessed 25 May 2024.

In 1912, the Federation of State Medical Boards (FSMB) was established to oversee all SMBs in the United States and its territories. The FSMB sponsored the U.S. Medical Licensing Exam (USMLE) together with the National Board of Medical Examiners, created and maintained the Federation Physician Data Center, and supported SMBs in policy-making, advocacy, and research that shaped the quality of healthcare, doctor regulation, and continuing medical education. The FSMB essentially functioned to gather and provide recommendations for the implementation of disciplinary functions by SMBs. Disciplinary functions were returned to the SMBs or the authorized body in each state, depending on the definition of substandard, unethical, or unprofessional behavior as regulated in each state's MPA. Generally, examples of universal unprofessional conduct included:

1. Abuse of alcohol/other substances;
2. Sexual harassment;
3. Negligence toward patients;
4. Failure to act according to the standard of care in the relevant state;
5. Overprescribing medications or prescribing without clear justification;
6. Dishonesty in the licensing process;
7. Criminal convictions;
8. Fraud;
9. Inadequate medical record-keeping; and
10. Failure to meet continuing medical education requirements.[18]

The process of handling complaints from patients or other parties, such as colleagues, insurance companies, or hospitals, began with determining whether the SMB had the authority to investigate the complaint. The SMB then prioritized cases based on their impact on the public and initiated an investigation by contacting all involved parties. During the investigation, the accused doctor and the complainant received formal notice to respond to the complaint and provide relevant documents. Medical evaluations were then conducted, and the SMB determined whether a hearing should be necessary.

[18] Federation of State Medical Boards, 'About Physician Discipline' <https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-discipline> accessed 25 May 2024.

Table 1. Disciplinary Actions by SMBs in the United States

Severity Level	Disciplinary Actions
Very Severe	License revocation Denial of license registration/renewal Voluntary surrender of license Suspension of practice license
Relatively Severe	Restriction of practice abilities Probation Imposition of conditions to avoid further discipline
Less Severe	Written warning Mandatory continuing medical education Fines Administrative actions Other non-punitive actions

Source: Federation of State Medical Boards

Serious cases would undergo pre-hearing processes with two possible outcomes: a settlement agreement or a hearing. During the hearing, if an MPA violation was found, disciplinary actions would be taken, and public notice would be provided to other SMBs. Information regarding violations by medical professionals could be accessible to the public.[19] For imposing disciplinary actions, SMBs may issue sanctions based on the severity of the violation, as shown in Table 1, through mandates called board orders.

For dentists, the professional discipline enforcement body was the state dental boards (SDBs), entities similar to SMBs. The establishment of SDBs was based on the dental practice act (DPA) of each state. The general functions of all SDBs included setting licensing qualifications, issuing licenses, setting practice and behavior standards, taking disciplinary actions against violations, and creating regulations to enable SDBs to perform their duties.[20] All SDBs also had a national representation called the American Association of Dental Boards (AADB), which performed similar functions to the FSMB.[21]

[19] Federation of State Medical Boards, 'Information for Consumers' (Federation of State Medical Boards)<https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/information-for-consumers/> accessed May 25, 2024.

[20] American Dental Association, 'State dental boards' (American Dental Association) <https://www.ada.org/en/resources/careers/licensure/state-dental-boards> accessed May 25, 2024.

[21] American Association of Dental Boards, 'About us' (American Association of Dental Boards) <https://www.dentalboards.org/about-us> accessed May 25, 2024.

Regulation of Medical Professional Discipline Enforcement Bodies in the United Kingdom

In the United Kingdom, the body responsible for the professional discipline of doctors as an extension of the government was the General Medical Council (GMC). The GMC was first established under the mandate of the Medical Act 1858, which was last amended in 1983. The GMC was tasked with protecting, promoting, and maintaining the health and safety of the public by upholding proper standards in medical practice through three main functions. First, the GMC maintained and updated the official register of doctors, known as the List of Registered Medical Practitioners (LRMP). Second, the GMC set standards for medical training and education. Third, the GMC had investigative or disciplinary functions against doctors who engaged in misconduct, had deficient professional performance, received criminal convictions or warnings, had physical or mental health issues, lacked adequate English language proficiency, or were deemed unfit to practice by the responsible body. Previously, the GMC served as both investigator and adjudicator. This dual role caused concern within the UK Department of Health, as highlighted in the Shipman Inquiry. To address this, Parliament enacted the establishment of the Medical Practitioners Tribunal Service (MPTS) as a separate adjudicator from the GMC.[22]

The MPTS was a newly established adjudication body in 2011, responsible to the GMC and Parliament. The MPTS was led by a committee of five members, two of whom were doctors. This committee was responsible for delivering judicial services to doctors in accordance with the responsibilities granted under the Medical Act 1983.[23] The tribunal that processed cases consisted of three members. At least one member must have medical qualifications, and at least one member must never have had medical qualifications, with the majority of the tribunal having a legally qualified chair.[24]

The dynamics between the GMC and MPTS were interesting to observe. The GMC was the body authorized to establish guidelines that set professional standards, such

[22] John K Mason and others, *Mason and McCall Smith's Law and Medical Ethics* (Eleventh edition, Oxford University Press 2019) 12–16.

[23] Medical Practitioners Tribunal Service, 'MPTS Statutory Committee' <https://www.mpts-uk.org/about/how-we-work/mpts-statutory-committee> accessed 25 May 2024.

[24] Medical Practitioners Tribunal Service, 'Tribunal Members' <https://www.mpts-uk.org/about/how-we-work/tribunal-members> accessed 25 May 2024.

as the Good Medical Practice guidelines, confidentiality, consent, the duty of candor, and other guidelines. Good Medical Practice was the primary guideline on professional standards and ethical frameworks, covering the fundamental roles of doctors, including cooperation with patients and colleagues, the obligation to be competent in all aspects of practice, updating knowledge, being trustworthy and acting with integrity within legal boundaries, and reflecting on work performed.[25]

The GMC then carried out its function to investigate doctors who were complained against. If the allegations were serious enough and if proven, they could pose a threat to patients or the public, the GMC could refer the complaint simultaneously to the MPTS's interim orders tribunal to consider whether restrictions on practice or actions against the doctor, suspension of the doctor's license, or no action would be necessary. The GMC could also issue warnings when the doctor's behavior or actions fell significantly below the expected standards of a doctor, but restrictions on the doctor's practice were deemed unnecessary. If the doctor refused to accept the warning, the case could be referred to the investigation committee.

The investigation committee would determine how to resolve the investigation if senior decision-makers could not agree on what should happen or had issued a warning to the doctor, but it was rejected. The investigation committee would examine evidence from the GMC and the doctor in question, then conclude that no action would be needed, a warning should be issued to the doctor, or the case should be referred to the MPTS if new evidence indicated that the doctor should not practice freely. Additionally, undertakings could be made, which were agreements made by the doctor to stop certain actions, commit to working under guidance, or commit to retraining. If the doctor refused or failed to comply with the undertakings, the case would be referred to the MPTS.

It could be understood that referring cases to the MPTS may only done if there were serious and persistent deviations from the Good Medical Practice guidelines.

[25] General Medical Council, Medical Practitioners Tribunal Service, Sanctions Guidance: For Members of Medical Practitioners Tribunals and for the General Medical Council's Decision Makers <https://www.mpts-uk.org/-/media/mpts-documents/07_-dc4198-sanctions-guidance-5-february-2024_pdf-104619554.pdf>.

To determine this, the GMC conducted a realistic prospect test, which consisted of determining whether the allegations were serious enough to justify action against the doctor's registration and whether the allegations could be proven according to the required standards, or in other words, there was a high likelihood that the alleged events actually occurred.[26]

When a case reached the MPTS, the tribunal could consider imposing sanctions by examining factors that may mitigate or aggravate the case. Some considerations included remediation by the doctor, supporting testimonies, expressions of remorse or apologies from the doctor, the ability to self-reflect, previous evidence of fitness to practice issues, the circumstances surrounding the case, the doctor's personal life, and statements from responsible parties. If the MPTS found no fitness to practice issues, it may take no action or issue a warning to the doctor. If it was proven that there were fitness to practice issues with the doctor, the MPTS could agree to accept undertakings agreed upon between the doctor and the GMC, impose conditions on the doctor's registration for up to three years, suspend the doctor's registration for up to 12 months, or remove the doctor's name from the medical register. However, if deemed appropriate, the MPTS may impose no sanctions.[27]

The professional discipline enforcement body for dentistry was the General Dental Council (GDC). Initially, the enforcement of professional discipline for dentistry was included under the GMC. Over time and with accompanying needs, the Dentists Act, first enacted in 1878, was amended in 1956 and mandated the establishment of the GDC separately from the GMC.[28] The GDC aimed to protect patient safety and maintain public trust in the dental profession by registering qualified dentists, setting standards for dental teams, investigating complaints against fitness to practice, and maintaining the quality of dental education.[29]

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[26] General Medical Council, 'Our Sanctions for Doctors' <https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/our-sanctions> accessed 25 May 2024.

[27] General Medical Council, Medical Practitioners Tribunal Service (n 25) 13-22.

[28] E O'Selmo, 'The History of Dental Bodies Corporate and the Role of the BDA in Their Development' (2018) 225 British Dental Journal 353.

[29] General Dental Council, 'What We Do' (General Dental Council) <https://www.gdc-uk.org/about-us/what-we-do> accessed 25 May 2024.

The professional discipline enforcement system for dentists under the GDC was slightly different from that of the GMC. The fundamental difference was that, within the GDC, the functions of adjudication and investigation remained under the GDC. The investigative function was carried out by the registrar, case examiner, and investigating committee, while the adjudicative function was carried out by the Dental Professionals Hearings Service (Hearings Service/DPHS), which oversaw three practice committees.[30] In the first stage, a complaint to the GDC would be examined by the registrar to determine whether it could lead to allegations of fitness to practice issues. The registrar could also refer the case to the Interim Orders Committee (IOC) if necessary.

If the registrar believed there were allegations of fitness to practice issues, the case would be referred to case examiners, who must consist of two members, one being a dentist or dental service professional and the other not being either. The case examiners determined whether the case should be closed or referred to the DPHS. This determination was made through a realistic prospect test, which revealed whether there was a likelihood of the facts being proven, a legal basis being established, and fitness to practice issues being found.

The case examiners could decide to defer the case to seek further information, close the case without taking action, issue a letter of advice, issue a warning, direct the undertaking of undertakings, or refer the case directly to the DPHS. If the case examiners could not reach a unanimous decision, the case must be referred to the investigating committee[31] The investigating committee itself was tasked with considering cases where the case examiners could not reach a unanimous decision and cases that were previously deferred. The outcomes of this committee were similar to what the case examiners could decide.[32]

The practice committees of the DPHS consisted of the Health Committee (HC), Professional Performance Committee (PPC), and Professional Conduct Committee

[30] Dental Professionals Hearings Service, 'About Us' <https://www.dentalhearings.org/about-us> accessed 25 May 2024.

[31] General Dental Council, Case Examiner Guidance Manual (General Dental Council 2016).

[32] General Dental Council, 'Investigating Committee' (General Dental Council) <https://www.gdc-uk.org/about-us/our-organisation/governance/committees/investigating-committee> accessed May 25, 2024.

(PCC). The HC considered cases where the professional ability of a dentist was affected by mental or physical health conditions.[33] The PPC considered cases where the professional performance of a dentist was deficient and the deficiency caused fitness to practice issues.[34] The PCC considered cases that may lead to prohibited conduct, where the PCC would determine whether such conduct affected the accused's ability to practice.[35] Sanctions imposed by the DPHS committees may include issuing a reprimand, imposing conditions that the medical professional must meet within a maximum period of three years, suspending the dental professional's registration for up to 12 months, or removing the registrant's name from the register. The registrant could still appeal the decision within 28 days of being notified of the decision.[36]

Regulation of Medical Professional Discipline Enforcement Bodies in Singapore

The body authorized to enforce professional discipline for doctors in Singapore was the Singapore Medical Council (SMC). The SMC was established under the Medical Registration Act 1997 and tasked with ensuring the competence of medical practitioners and enforcing professional standards. This task was translated into various responsibilities, such as the registration of medical practitioners, training and education, behavior and ethics, practice standards and competence, and making recommendations regarding curricula and examinations for obtaining medical degrees. This also included the disciplinary process conducted through the Complaints Panel, Complaints Committee, Health Committee, Disciplinary Tribunal, and, if necessary, the Interim Orders Committee.

The Complaints Panel would be the first place where complaints submitted to the SMC were processed. The Complaints Panel was encouraged to forward cases to the

[33] General Dental Council, 'Health Committee' (General Dental Council) <https://www.gdc-uk.org/about-us/our-organisation/governance/committees/health-committee> accessed May 25, 2024.

[34] General Dental Council, 'Professional Performance Committee' (General Dental Council) <https://www.gdc-uk.org/about-us/our-organisation/governance/committees/professional-performance-committee> accessed May 25, 2024.

[35] General Dental Council, 'Professional Conduct Committee' (General Dental Council) <https://www.gdc-uk.org/about-us/our-organisation/governance/committees/the-professional-conduct-committee> accessed May 25, 2024.

[36] General Dental Council, *Guidance for the Practice Committees including Indicative Sanctions Guidance* (General Dental Council 2020) 13-17

Complaints Committee, with members of the committee appointed from the Complaints Panel. The Complaints Committee then conducted an investigation for a maximum of three months, unless the Complaints Panel granted additional time. The Complaints Committee could next decide to close the complaint as unworthy of further action, issue a letter of advice to the medical practitioner, refer the case for mediation, or investigate the complaint.

The results of the investigation formed the basis for the Complaints Committee in deciding how to resolve the case through various alternatives, such as issuing a warning or advice to the medical practitioner, requiring the medical practitioner to undergo specific education or training, or forwarding the case for a formal investigation to be conducted by the Disciplinary Tribunal. If the disputing parties were dissatisfied, an appeal could be made to the Ministry of Health of Singapore. Another option would be to forward the complaint to the Health Committees if the fitness to practice issue was caused by physical or mental conditions.[37]

The membership regulations of the tribunal were not significantly different from those of the MPTS in the United Kingdom, with the addition of allowing parties other than the disputing parties to attend the hearing. The hearing process in the Disciplinary Tribunal followed the concept of proof of beyond a reasonable doubt, with actions that may lead to disciplinary sanctions including:

1. Conviction in Singapore or elsewhere for crimes involving fraud or dishonesty;
2. Conviction in Singapore or elsewhere indicating a defect in character that made the person unfit to practice;
3. Found guilty of misconduct that, in the opinion of the Disciplinary Tribunal, may bring the profession into disrepute;
4. Found guilty of professional misconduct; or
5. Failure to provide professional services of a quality that could reasonably be expected of the service provider.

Specifically for professional misconduct, the cases of Low Cze Hong v. Singapore Medical Council and Ang Pek San Lawrence v. Singapore Medical Council established that there were two aspects, one of which must be met, to prove that a doctor had

[37] Gary Kok Yew Chan, Health Law and Medical Ethics in Singapore (Routledge 2021) 9–15.

committed professional misconduct. The first aspect focused on what the standard of conduct was in the context of the alleged misconduct, whether the standard of conduct required the doctor to take a certain action and when that obligation arose, and whether the doctor's action intentionally deviated from that standard of conduct.

The second aspect included whether there was serious negligence on the part of the doctor and whether the negligence objectively constituted an abuse of the authority granted as a registered medical practitioner.[38] Sanctions by the Disciplinary Tribunal varied, including written warnings and *undertakings*, changes or imposition of conditions or restrictions on the doctor's registration, financial penalties of up to SGD 100,000, suspension for up to three years, or removal of the doctor's name from the register. Other orders may also be issued, such as mandatory continuing medical education.[39] If the doctor was dissatisfied with the decision, they may appeal to the High Court.[40]

For dentistry and other dental practitioners, the body authorized to enforce professional discipline was the Singapore Dental Council (SDC) which was established under the mandate of the Dental Registration Act 1999. The SDC's tasks included monitoring the registration of dentists and oral health therapists, making recommendations regarding dental education and training, and regulating the behavior and ethics of dentists and oral health therapists.[41] The process, committees, and tribunals used were not significantly different from those in the SMC. Differences could be found in some sanctions, such as a maximum financial penalty of SGD 50,000, a maximum practice restriction of three years, and a suspension period ranging from three months to three years.[42]

Comparison of Regulations on Ethics and Professional Discipline Enforcement Bodies for Medical Professionals between the Three Countries

[38] ibid 15–19.

[39] Singapore Medical Council, Sentencing Guidelines For Singapore Medical Disciplinary Tribunals (Singapore Medical Council 2020) 10-19.

[40] Chan (n 37) 19.

[41] ibid 9.

[42] The Statutes Of The Republic Of Singapore, Dental Registration Act (Chapter 76) (Law Revision Commission 2009) 41–58.

Table 2. Differences in Regulations on Ethics and Professional Discipline Enforcement Bodies for Medical Professionals between the United States, the United Kingdom, and Singapore

Aspect of Difference	United States		United Kingdom		Singapore	
	Doctor	**Dentist**	**Doctor**	**Dentist**	**Doctor**	**Dentist**
Disciplinary Enforcement Body						
Name	SMBs (varied by state)	SDBs (varied by state)	GMC and MPTS	GDC	SMC	SDC
Legal Basis	Medical Practice Act (varied by state)	Dental Practice Act (varied by state)	Medical Act 1983	Dentist Act 1956	Medical Registration Act 1997	Dental Registration Act 1999
Functions Related to Professional Discipline Enforcement	Regulated the behavior of doctors or dentists (specifications varied by state)		GMC conducted investigations or disciplined doctors as the investigators; MPTS acted as the adjudicator	Investigated complaints against the fitness of practice of dentists as both the investigator and adjudicator	Ensured competence of doctors and enforces professional standards	Regulated behavior and ethics of dentists and oral health therapists

Table 2 (continued). Differences in Regulations on Ethics and Professional Discipline Enforcement Bodies for Medical Professionals between the United States, the United Kingdom, and Singapore

Aspect of Difference	United States		United Kingdom		Singapore	
	Doctor	Dentist	Doctor	Dentist	Doctor	Dentist
Disciplinary Enforcement Method	Investigative and disciplinary process, including imposing disciplinary actions for substandard/ unethical behavior. Cases outside medical practice can be grounds for disciplinary action (Haley v. Medical Disciplinary Board).	Investigative and disciplinary process, including imposing disciplinary actions for substandard/ unethical behavior.	GMC issued warnings or conducts investigations via investigation committee. If necessary/doctor refused undertakings, the case proceeded to MPTS for a tribunal with outcomes including no action, warnings, or sanctions.	Investigative functions were done by registrar, case examiner, dan investigating committee, while adjudicative functions were done by DPHS (still within GDC). Outcome may include sanctions.	Complaints Panel and Complaints Committee held investigative functions. Adjudicative function was held by the Disciplinary Tribunal. The burden of proof was the standard used by the doctor and serious negligence due to abuse of authority (Low Cze Hong v. SMC and Ang Pek San Lawrence v. SMC).	Did not differ far from SMC. Differences lay in the disciplinary actions.

Through the analysis conducted, the comparison of ethics and professional discipline enforcement regulations for medical professionals between the United States, the United Kingdom, and Singapore, as presented, are summarized in Table 2. Referring back to the pure theory of law as previously explained, the separation of non-juridical elements from law, as desired by Hans Kelsen, was intended to create law that would be universally applicable to communities with various moral orders.[43] What happens in moral orders was not much different from ethics, where one country could have several different ethical orders. In the medical field, one specific ethics that often forms the basis of ethics for doctors and dentists would be bioethics. This position was justified by its proponents, Tom Beauchamp and James Childress, through their explanation that bioethics was discovered through shared morality that was independent of culture, religious tradition, profession, and other identities.[44] However, bioethics was still criticized by various scholars as a theory lacking theoretical grounding,[45] reinforcing the argument that there were no universal ethics in the medical field and there was an urgent need for law to accommodate these differences.

This argument could also be extended to the realm of professional discipline when understanding that professional discipline was essentially rules of skills. Rules of skills could be defined as rules that explained to professionals how to achieve certain outcomes with norms of which would carry ethical burdens.[46] This understanding aligned with the definition of professional discipline as stated in the Indonesian Medical Council Regulation Number 4 of 2011 on Professional Discipline for Doctors and Dentists, where professional discipline for doctors and dentists contained rules and provisions for the application of science in their practice. Understanding that professional discipline was still a derivative of ethics, law must be separated from these non-juridical elements.

Referring to the pure theory of law and its relation to professional discipline, this analysis would observe how the United States, the United Kingdom, and Singapore separated the mechanisms of professional discipline enforcement from law. First,

[43] Kelsen (n 11) 2–12.

[44] David DeGrazia, 'Common Morality, Coherence, and the Principles of Biomedical Ethics' (2003) 13 Kennedy Institute of Ethics Journal 219–230.

[45] K Bertens, *Sekitar Bioetika* (Kanisius 2018) 89–95.

[46] Robinson (n 3) 155–157.

these three countries had clear provisions on what could be subject to disciplinary actions. Violations of professional discipline in these countries were strictly limited to substandard, unethical, or unprofessional behavior that did not fall under malpractice cases, such as failure to act according to service and professional standards. For example, the GMC in the United Kingdom had the Good Medical Practice guidelines that could be used as a reference for what constitutes professional conduct.[47] Additionally, Singapore had additional provisions regarding non-professional contexts that could be subject to disciplinary actions, such as criminal convictions involving fraud, dishonesty, character defects, and other convictions that may bring the profession into disrepute.[48] The United States even had a court ruling on this matter through *Haley v. Medical Disciplinary Board*, where a doctor's tax fraud could be subject to disciplinary action.[49]

In Indonesia, regulations on types of professional discipline violations were governed by Article 3 paragraph (2) of the Indonesian Medical Council Regulation Number 4 of 2011 on Professional Discipline for Doctors and Dentists. However, there was no clarity on whether legal violations could be subject to disciplinary actions, referring to the relationship between professional discipline and law.[50] Clarity on this matter would be crucial to further strengthen the realm of professional discipline so that it would not become mixed with the much stronger realm of law.

Second, these three countries had a tiered and clear mechanism for investigating alleged professional discipline violations. The United Kingdom and Singapore provided interesting examples because both the GDC and SMC had several subcommittees authorized over specific types of professional discipline violation complaints. For complaints related to potential prohibited professional conduct, the complaint would be processed by the PCC of the GDC[51] or the Complaints Committee of the SMC,[52] while

[47] General Medical Council, Medical Practitioners Tribunal Service (n 25) 9-11.
[48] Chan (n 37) 9–15.
[49] Bal and Bal (n 16) 28–31.
[50] Prawiroharjo, Afdin and Purwadianto (n 8) 45–48.
[51] General Dental Council, 'Professional Conduct Committee' (General Dental Council) <https://www.gdc-uk.org/about-us/our-organisation/governance/committees/the-professional-conduct-committee> accessed May 25, 2024.
[52] Chan (n 37) 9–15.

complaints related to physical and mental health conditions would be directed to the Health Committees in both the GDC and SMC.[53] Additionally, the GMC and MPTS in the United Kingdom were also interesting to understand because the GMC could handle complaints of alleged professional discipline violations that were mild to moderate and could be resolved through undertakings, while the MPTS would handle complaints that were serious and persistent, with the referral of cases from the GMC to the MPTS going through a mechanism called the realistic prospect test to ensure the appropriateness of the mechanism.[54] The GDC also had a similar mechanism, but there was no separation between the GDC and DPHS as the equivalent of the MPTS.

In Indonesia, Article 304 paragraph (3) of Law Number 17 of 2023 on Health only states that the MDP was tasked with determining whether there were professional discipline violations by medical and health professionals without explaining the tiered investigation process for complaints. Government Regulation Number 28 of 2024, which implemented the law, did not provide further details on the tiered investigation process. This tiered division should serve two purposes. First, a tiered and severity-based complaint investigation mechanism could strengthen the realm of professional discipline. Strengthening the realm of professional discipline would be important because the separation between professional discipline and law could not function optimally if the realm of professional discipline was not clearly defined. This could be increasingly urgent considering that the state was also involved in determining professional discipline through the Indonesian Health Council and the MDP, so differences that may arise in the application of professional discipline must be promptly accommodated.[55]

Second, with a clear realm of professional discipline, the position of the MDP as *primum remedium* could be developed from an institution that only imposes disciplinary sanctions to one that could mediate between disputing parties. Article 308 of Law Number 17 of 2023 on Health had separated the MDP as the first step in

[53] General Dental Council, 'Health Committee' (General Dental Council) <https://www.gdc-uk.org/about-us/our-organisation/governance/committees/health-committee> accessed May 25, 2024.

[54] General Medical Council, '*Our sanctions.* (General Medical Council) <https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/our-sanctions> accessed May 25, 2024.

[55] Kelsen (n 11) 2–12.

resolving medical disputes (*primum remedium*) from judicial proceedings as the last step in resolution (*ultimum remedium*).[56] This separation aligned with the pure theory of law, which viewed law as a coercive tool to create certain actions and was not limited to the parties' agreement or disagreement with those actions.[57] Therefore, for the MDP to be an effective *primum remedium*, it must have a clear mechanism for investigating complaints ranging from mild to severe so that professional discipline violations could not only be resolved but also prevented.

Conclusion

Based on the research conducted, the regulations on medical professional discipline enforcement bodies in the United States, the United Kingdom, and Singapore had three key points unique to each country. First, the United States had a classification of the severity of violations based on the investigation by SMBs to determine the appropriate form of disciplinary action. Second, the United Kingdom had a division of investigative and adjudicative functions and a separation of tasks between the GMC and MPTS or the GDC and DPHS. Third, the regulations in Singapore could explain the actions that may be subject to disciplinary actions and how the proof of professional misconduct was conducted.

Adopting these regulations in Indonesia would be important because Indonesia has recently enacted Law Number 17 of 2023 on Health and its implementing regulations, where more detailed regulations regarding the operation of the Professional Discipline Council were not yet constructed. Considering the separation between professional discipline and law, there were two things that may be adopted from the regulations in the United States, the United Kingdom, and Singapore for the regulation of the Professional Discipline Council in Indonesia. First, provisions on what could be subject to disciplinary actions, including legal violations that may be subject to disciplinary actions, must be established to clarify the relationship between professional discipline and law. Second, regulations on a tiered mechanism for investigating alleged professional discipline

[56] Siregar and others (n 7) 491–505.
[57] Kelsen (n 11) 2–12.

violations must be established to strengthen the realm of professional discipline and affirm the position of the Professional Discipline Council as *primum remedium*.

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