SMA news

For Doctors, For Patients

VOL. 49 NO. 2 | FEBRUARY 2017 | MCI (P) 034/01/2017

A HEART TO SERVE

GP CME SYMPOSIUM 2017

HAEMATOLOGY IN A NUTSHELL - PRACTICAL KNOWLEDGE FOR PRIMARY PHYSICIANS

11 March 2017 (Sat) | 1pm - 4pm (Registration and lunch from 1pm)

Approach to the highs and lows of white cell counts – The What, Why and How

Dr Ng Chin Hin, Consultant
Department of Haematology-Oncology
National University Cancer Institute, Singapore (NCIS)

Too much or too little red cells – What should you do?

Dr Melissa Ooi, Consultant
Department of Haematology-Oncology
National University Cancer Institute, Singapore (NCIS)

The ups and downs of platelets

Dr Tung Moon Ley, Associate Consultant
Department of Haematology-Oncology
National University Cancer Institute, Singapore (NCIS)

This symposium will take the GPs through what abnormalities may be detected on an initial full blood count, what preliminary investigations to perform and when a tertiary referral is warranted.

Learning Objectives:

1) Learn how to interpret and assess the clinical importance of abnormal blood counts
2) Learn what preliminary tests to perform for these patients and when it is necessary for tertiary referral

Venue

NUHS Tower Block
1E Kent Ridge Road, S119228
Auditorium, Level 1

To Register

Login to the NUH GP CME Portal: www.nuhcme.com.sg for more information.

Organised By

National University Cancer Institute, Singapore
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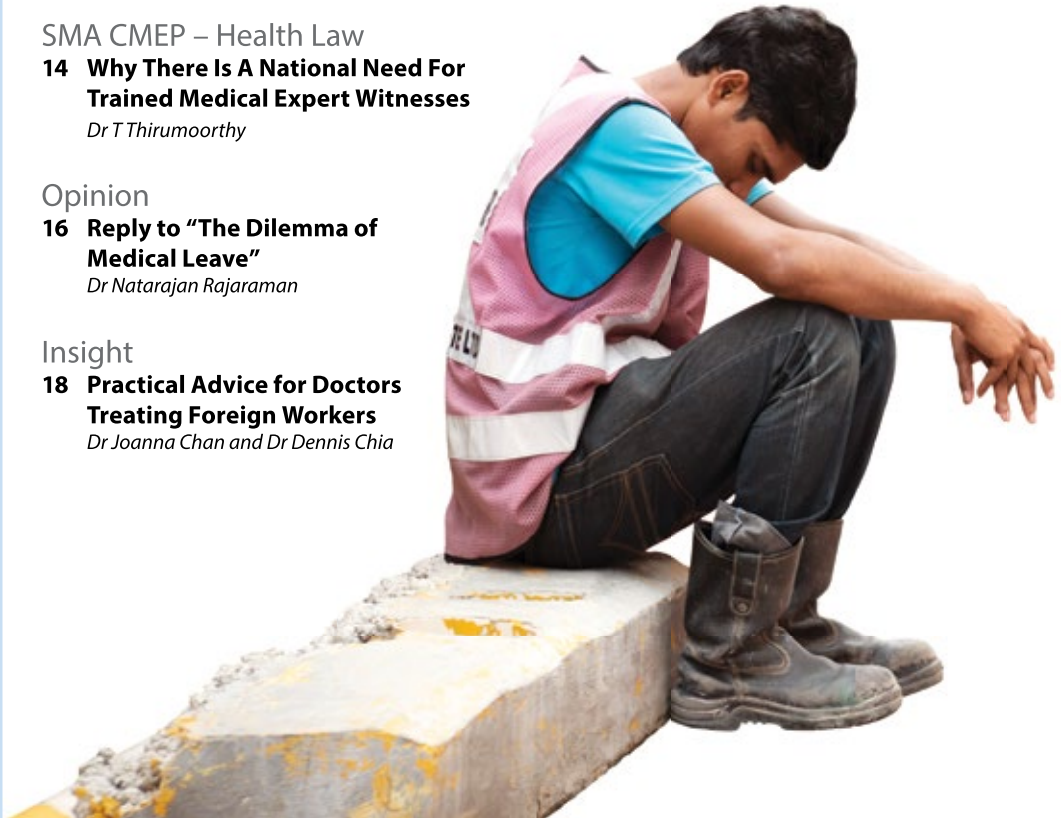


THE EDITOR'S MUSINGS

Dr Tan Yia Swam is a consultant at the Breast Department of KK Women's and Children's Hospital. She continues to juggle the commitments of being a doctor, a mother, a wife and the increased duties of *SMA News* Editor. She also tries to keep time aside for herself and friends, both old and new.

You must have heard *ad nauseum* by now the complaint: "the holidays are too close together!" (I'm sorry but I just had to say it once again.) The sound of "Jingle Bells" playing in malls was quickly replaced by that of "Auld Lang Syne" (which lasted two days) before quickly turning into "Dong Dong Qiang". The weirdest version I have heard so far in the shopping mall is a soundtrack of Lunar New Year songs performed with handbells – a strange blend of Christmas and the Lunar New Year.

In our multicultural Singapore, I believe we celebrate and respect the festivities of all the races and religions. Some common themes of such major festivals include family, goodwill and thanksgiving.

This February issue highlights humanitarian efforts undertaken by our colleagues. I think the pieces here should be made compulsory reading for all medical students, jaded doctors, as well as doctors and patients who complain too much. After reading through them, it was difficult not to cry for the pain and suffering that people in some parts of the world are experiencing, especially victims of war, famine and/or natural disasters. I am full of admiration for the colleagues and staff who have served or are serving in these areas. I am also thankful for the peace and prosperity in our country, and for my own job stability. One small New Year's resolution: I must not complain the next time some administrative problem arises in my clinic!

Our Feature article is an interview with Dr Vivien Lim, an endocrinologist who has been heavily involved in humanitarian work beyond the call of duty. She is the peer coordinator of Doctors Without Borders (Médecins Sans Frontières [MSF]) in Singapore. Dr Lim Chin Siah also shares his experience serving with MSF, in the Kunduz Trauma Centre in northeast Afghanistan from 2013 to 2014.

Dr Natarajan Rajaraman replies to Dr Alex Wong's piece on the dilemma of medical leave that was published in the August 2016 issue of *SMA News*, with a well-written and referenced article on how such a situation might have arisen from local laws and regulations. Dr Joanna Chan and Dr Dennis Chia draw on their experience in treating foreign workers and provide some practical tips on how one can best help this underprivileged group of patients.

Dr Lawrence Soh writes on his decades of experience in contributing to charity and humanitarian work: from providing money, supplies and time, to personally venturing out there.

Enjoy reading this with a cup of joe, as we end on a light-hearted note with Dr Daniel Fung's piece on his lifelong fascination with my second favourite beverage (after alcohol!).

I wish you good health, good wealth and much happiness in this year of the Fire Rooster. ◆

Yia Swam
Editor

GOING THE EXTRA MILE – INTERVIEW WITH DR VIVIEN LIM

Dr Vivien Lim (VL) graduated from the National University of Singapore Medical School in 1998 and was accredited as a Specialist in Endocrinology in 2008. After she completed her training, she was awarded the Health Manpower Development Plan Scholarship by the Ministry of Health to gain wider experience in complex cases of endocrinology in the Mayo Clinic, Rochester, Minnesota, US. She is currently the president of the Endocrine and Metabolic Society of Singapore and works in Gleneagles Medical Centre.

Upon Dr Lim's return, she worked as a consultant in Khoo Teck Puat Hospital (KTPH) and the Diabetes Centre, where she ran clinics in general endocrinology as well as diabetes, bone and calcium, and adrenal/pituitary, in addition to providing thyroid and fine needle aspiration cytology services. Dr Lim also held the post of programme director of the endocrine residency programme in KTPH, and was appointed as a senior lecturer in NUS Yong Loo Lin School of Medicine.

Dr Lim has a passion for humanitarian causes and has been involved in several missions in Africa and Asia. For her active participation, she was awarded the Healthcare Humanity Award in 2014.

What first stirred your desire to participate in humanitarian missions?

VL: I have to say that I would have to think back a long time and I can't actually remember a time that I did not dream of going on a humanitarian mission! I think it must have been the documentaries that I was exposed to as a child – the ones focusing on refugee camps in Africa and the severe deprivation that they faced. There were also scenes of malnourished children and trauma victims. I wanted to help them and play a part in making life better for them. This ultimately prompted my career choice as a doctor and spurred me on through medical school and the subsequent years of training.

What are some of the duties of a peer coordinator of doctors with the Médecins Sans Frontières (MSF)?

VL: My duties include representing Singapore at the Annual General Meetings held yearly in Hong Kong (HK) and to be a voice to be heard there. I also help out with and support activities that the HK office sets out in Singapore, and aid in gathering the various MSF peers in Singapore.

What does a typical day on the field of a disaster site look like?

VL: I have been on a few missions but I'll focus on the six-month mission to Mount Elgon, Kenya in 2008. The population was caught in-between the rebels and the militia, and the local health system disintegrated. There were many locally displaced people living in tents. Note that as they are displaced within the country and do not cross country borders, the correct term for them is *internally displaced people* instead of refugees. MSF, or Doctors Without Borders as they are known here, went in to provide medical aid to the population. I was the medical doctor in charge of the mission and had four nurses, three medical officers and three psychological officers under my charge. We were based in Kapsokwony and supported a health centre in Kopiro, which was higher up the mountain, as well as supplied medical aid to five different areas, some of which were camps for internally displaced people.

A typical day during a mission would comprise waking up bright and early in the morning, at times literally as the cock crows, for breakfast followed by a morning briefing for the medical team. The team then heads off on the range rover to one of the designated areas of medical aid

and we covered five areas – one for each day of the week. Depending on where the site was and the day's road conditions, it would take us anywhere from 30 minutes to two hours to get on site. You need to understand that this is on a mountain with no paved roads and certainly no street lamps. Hence, on a bad day (eg, rainy days), the vehicle might end up getting stuck and we would all have to get out and push! On Saturdays, we would go to the medical centre in Kopsiro where part of our medical team is stationed with a base.

Once we arrive at the site of medical care, we'll set up clinic. Many a times, there will already be a queue waiting for us. We deal mainly with primary healthcare needs and, occasionally, trauma cases. At the same time, one of the nurses will be vaccinating children, and the psychology officers will have a separate tent/area for their consults. Many of the patients there live through trauma – physical and/or sexual. Emergencies that require hospitalisations or minor surgeries will have to be transported to a hospital in Kapsokwony, the town in which the main MSF medical team is located.

Being the only doctor on that mission means handling calls 24/7. If there was an emergency that required MSF's attention, I'll be the one who receives the call and dispatches the nearest available team to the patient for assessment and, if required, transportation to the nearest hospital, which is usually about two to three hours away from the patient's location.

What is the most memorable mission you have been involved in?

VL: The thing about missions is that they are all choked with many memories – good and bad – which all form part of the entire experience. All the missions are memorable in their own way and it is difficult to have to choose one. However, if pressed, I would have to go with the mission with MSF in Mount Elgon.

Why was it memorable? I guess it was so in many ways. First off, I was stationed in an entirely different continent – Africa. Everything was different, from the food to the working and living environment. Then, there was the fact that I had been working towards this mission for what seemed like all my life. Moreover, Mount Elgon was a beautiful place with untamed wilderness, where the villages situated higher up in the mountain do not have electricity and the landscape is unmarred by the accoutrement of civilisation in the form of telephones and electricity poles. The first night I was there, I had to attend to a prolonged labour in a village high up on the mountain. Imagine: I had just touched down at base when I piled into a range rover through rough terrain at night on the first day there! Thereafter, it was working in the environment that I had envisioned since young and doing the work that I had decided to devote myself to.

And let's not forget the camaraderie and bond forged between team mates working and living together. It was one pretty unforgettable experience. As a Singaporean, food is very close to my heart and I certainly would never forget the time that I almost turned vegetarian! Unbeknown to the *suaku* (Hokkien for naïve) Singaporean in me, I did not register that the cute goat chancing upon my working area, and whom I exclaimed over and took copious pictures of, would end up on my plate that same evening!

What are your biggest personal challenges during this humanitarian mission?

VL: These can be separated into personal and professional challenges. I guess many would say that a major challenge would be the relative lack of security, and it's certainly so when compared to Singapore. We were not allowed out after dark and had to be accompanied by a local at all times. However, what I personally felt were more challenging include:


1

Personal

- **The culture shock**. The region's pace is slow compared to the bustling city life in Singapore, and there is an obvious difference in gender status. I remember seeing two queues at one of the medical health areas – one long line for the females and the children they carried, and another much shorter line for the males. The elders were all males.
- **The lack of privacy**. I come from a nuclear family of just four people under one roof. There, I had to share the same compound with up to 30 to 40 people at one time and that took some getting used to.
- **The constant scrutiny**. I am not sure how celebrities tolerate this. You need to understand that the people there are very poor; there is hardly any entertainment and life is hard. When they see a stranger or a mzungu, and especially given the rarity of Chinese people there, they will stare and wave at you, especially the kids. This happens every day, whenever you travel on the white range rovers with MSF logos. The kids will hear you in advance and throng the road to wave at you. Sometimes, when you return from a day of hard work, you are so tired and just want to ignore the world and recover. But the thought that this might be one of their rare sources of entertainment makes it very difficult not to return the greeting, which became rather mentally exhausting over time.

Professional

- **The lack of equipment and facilities.** For example, we didn't have spacers for delivery of asthma puffs, so we used an empty mineral water bottle instead. We only had oxygen masks and no intubating sets. If a patient collapsed, the nearest hospital with an Intensive Care Unit was more than three hours away.
- **Adapting to working in a completely different environment.** Having a roof over one's head or working in a tent is a luxury. Forget about proper flooring or handwashing facilities! You make do with whatever is at hand and if you don't have it, you improvise. You learn how to prioritise needs and sometimes make the tough decision of not being able to help a patient. This is especially so if you are there for an acute care situation and the condition presented is chronic and you lack the means to treat it.

Do you have any advice for medical students and doctors who would like to volunteer their time for humanitarian causes?

Plan ahead! If you are aspiring to go into organisations such as MSF, you need to know that they have certain entry requirements. These will be documented in the official webpage. For many doctors, if not all, they require a minimum commitment of one year in many circumstances. Depending on what role you are applying for (eg, physician), they might require tropical medicine experience. Working in Singapore does not automatically qualify you for it! I had to do a Diploma in Tropical Medicine and Hygiene in the Liverpool School of Tropical Medicine. Moreover, you will need to plan exactly when you are going on the mission, given that you might have residency followed by fellowship. The logistics of taking leave might be tricky. If you are committed to humanitarian work, be prepared that your career might need to be put on hold temporarily while you venture off.

Also, do not be overeager to go when you are still a junior. You are there to serve. Hence, you have to ensure that you are not a burden to the team in terms of both medical terms and maturity. Personally, I went on my mission after finishing my exits. This gave me sufficient experience in making tough decisions, and the maturity of mind and medical experience stood me in very good stead as I was the sole doctor on that mission. ◆

Legend

1. A close up photo of a MSF clinic

2. During the mission to Ormoc, for Typhoon Haiyan

3. Everyone gets out and push!

4. Helping out with dispensing medicine

CLINICAL DECISION-MAKING (PART 2): INTUITION *vs* RATIONALITY

Text by Dr Wong Tien Hua

In my column on mentorship published in the September 2016 issue of *SMA News* (https://goo.gl/55dYkV), I wrote that medicine is an "uncertain art" because we deal with patients who present as unique individuals – human beings that vary in biological make-up and susceptibility to disease – and each has different perceptions and beliefs about their illnesses. Many external factors alter the narrative of each presenting patient, such as social settings, occupational exposure and community support.

The societal expectations for medicine, however, stand in contrast. Because technological progress offers very precise diagnostic tools and ever-increasing options for treatment of specific diseases, the public often expects medicine to be a precise science. The development of evidence-based medicine (EBM) is an attempt to improve the precision of diagnosis and clinical outcomes.

This is then an uncertain art where each patient is different, versus a precise science where diseases are well defined and treatment pathways are worked out through scientific trails. How then do doctors make clinical decisions in light of these seemingly opposing realities? If medicine was such a precise science, will the time eventually come when machines replace the diagnosis and decision-making process?

In the October 2016 issue of *SMA News* (https://goo.gl/y9wD5B), I looked at one part of the decision-making process – the role of intuition. This is a doctor's ability to rapidly assess a given situation, identify the problems and come up with a provisional diagnosis in order to make a clinical decision. In clinical settings, doctors use heuristics or mental shortcuts all the time to cope with the different streams of information coming from all directions, process the data and ultimately make some sense of it. Intuition therefore helps doctors to deal with essentially uncertain situations. The problem with intuition is that it requires time and experience to refine, and it is subject to biases, leading the doctor down the wrong path. There is indeed a fine line between "a good call" and "jumping to the wrong conclusion".

Thinking fast, thinking slow

Nobel Memorial Prize in Economic Sciences laureate Daniel Kahneman, in collaboration with Amos Tversky, proposed that the human mind operates in one of two modes: a fast-thinking System 1 that is intuitive, automatic and operates largely in our subconsciousness, and a slow-thinking System 2 that is deliberative, analytical and requires conscious attention.[1]

It is interesting that while we think of ourselves as fully conscious and reasoning individuals who make deliberate choices, and are able to will our bodies to move in directions of our choosing, the surprising fact is that a large part of how we think and act operates entirely on a subconscious level.

Imagine the task of driving a car: a complex undertaking that we perform without effort, which requires us to react very rapidly when road conditions change. This is our System 1 at work – our intuitive self, operating effortlessly on reflex and practised skill. Now, think about the time when we first sat behind the steering wheel in driving school: we had to concentrate to remember to adjust the seat position, angle the rear view mirror, check that the gear shift is in the parked position, insert key to start the engine, scan around to assess oncoming traffic, disengage the parking brake, and then step (gently) on the gas pedal. That was our deliberative System 2 at work, requiring effort to control our responses in unfamiliar situations. (On a side note, that was also how I failed my first driving test as I had left out the "fasten seat belt" step as above.)

The engagement of System 2 is slow, hard work, and very stressful. The good news is that once you start driving regularly, your motor skills become more practised and habitual. Eventually, the undertaking becomes effortless.

Once we become skilled at a particular task, the demand for mental activity and energy decreases. Because slow System 2 requires so much effort and concentration, something neither easy nor enjoyable, people are more inclined to operate predominantly on the fast System 1. As with physical labour, cognitive exertion follows the "law of least effort" and, according to Kahneman, laziness is built deep in our nature. Doctors are no different.

Rational thinking is hard

In clinical decision-making, doctors engage System 2 when they are in an

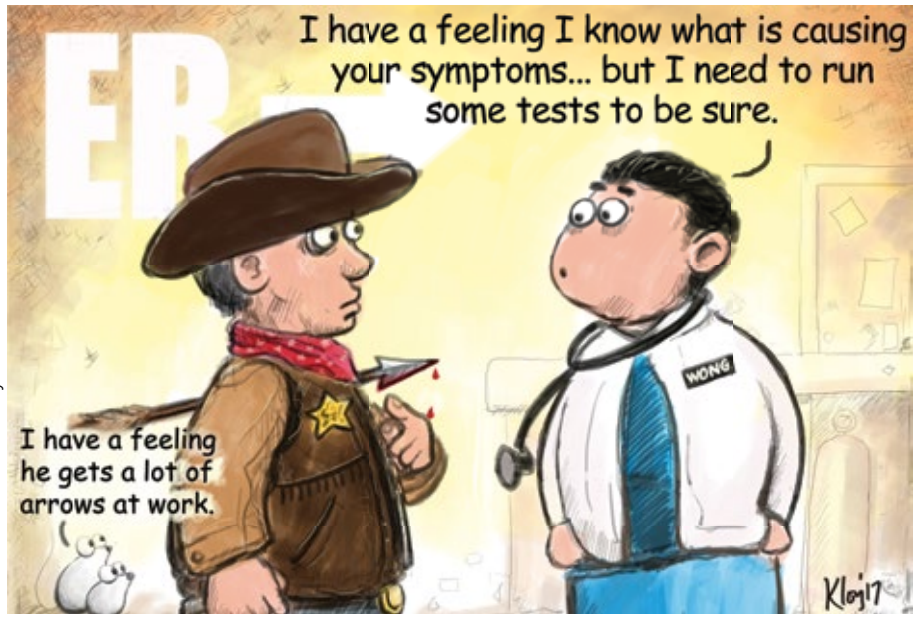


Illustration: Dr Kevin Loy

unfamiliar situation, when they cannot tap on any previous experience, or when they feel that a case is either too complex or critical to simply rely on intuition. Medical students and residents toil long and hard to memorise textbooks, learn theories and understand the research behind the science of medicine. This slow and excruciating process is necessary to build up the body of knowledge that allows the mind to recognise a disease when it is clinically presented.

In 2005, David M Eddy coined the term "evidence-based medicine", offering a unifying definition for it.[2] In EBM, knowledge derived from epidemiological research and clinical trials are incorporated into guidelines and protocols. Clinical guidelines provide a formal analysis of best available evidence, presenting an objective and *rational* approach to clinical decision-making. EBM has been shown to promote consistent treatment and better clinical outcomes, setting expected standards for patient care and safety. For doctors in training, EBM fills the gap where there is lack of clinical experience. Applying EBM may not be intuitive at first and doctors need to overcome the initial tedious process of understanding and absorbing clinical guidelines – a slow System 2 process.

However, there are limitations to the use of guidelines. Individuals presenting with symptoms of disease do not always fit neatly into categories based solely on diagnostic criteria; the population samples may not be alike and guidelines do not take into consideration the context of the patient's illness.

Decision-making trees and algorithms are still not able to override the intuition of an experienced clinician. Machines are not yet able to make decisions based on ethical considerations, such as social justice and the respect for patient autonomy.

Improving clinical decision-making

Now that we know most of our decisions are based on a fast-thinking System 1 process, the task at hand is then to improve our clinical intuition to reduce bias and increase accuracy.

We can improve intuition by being open to new ideas and learning experiences. Having a broad clinical exposure in the early stages of our careers is very important. There is no substitute for clinical experience; learning from seniors and having a good mentor will help to make up for the shortfall. Do not be afraid to take on busy postings or clinics; treat them as opportunities to gain maximum exposure to clinical cases.

EBM needs to be incorporated into daily clinical practice in order for it to have an impact. Education and knowledge is the fast-track to insight. The more EBM is practised, the sharper one's intuition becomes. During a code blue crash in the ward, there is no time to pull out the advanced cardiac life support chart to guide one on the use of intravenous adrenaline, or to leisurely read the instructions on the use of the defibrillator; these need to be part of one's intuitive response.

Take time to reflect. Intuition is a feedback loop where positive outcomes are reinforced and mistakes become lessons learnt. Case studies and morbidity and mortality rounds provide important feedback on what went well and what did not. Connect the outcomes of these cases with your initial impressions to see how accurate your intuition was and how they could have been improved. Always be prepared to adjust your first impressions when new data become available as the illness progresses.

Finally, a good doctor-patient relationship is critical in making the right clinical decisions. Intuition is knowing what your patients need and what is in their best interest, without having to launch into lengthy technical explanations and trying to second-guess their intentions. Patients must be engaged in open discussion and allowed an opportunity to share their ideas and values. They should also collaborate with the doctor in the management of their illness. Shared decision-making is about journeying with the patient, navigating through the data and information, and facing uncertainties together. ◆

References

1. Kahneman D. Thinking, fast and slow. New York: Farrar, Straus and Giroux, 2011.

2. Eddy DM. Evidence-based medicine: a unified approach. Health Aff (Millwood). 2005; 24(1):9-17.

Dr Wong Tien Hua is President of the 57th SMA Council. He is a family medicine physician practising in Sengkang. Dr Wong has an interest in primary care, patient communication and medical ethics.

HIGHLIGHTS

FROM THE HONORARY SECRETARY

Report by Dr Daniel Lee

Dr Daniel Lee Hsien Chieh (MBBS [S'pore], GDFM [S'pore], MPH [Harvard], FAMS) is Honorary Secretary of the 57th SMA Council. He is a public health specialist and Deputy Director of Clinical Services at Changi General Hospital.

2017 Annual General Meeting (AGM)

Do mark your calendar for SMA's upcoming AGM. The details are below.

Date: 9 April 2017, Sunday

Time: 2 pm to 4 pm (Buffet lunch served from 1 pm onwards)

Venue: Alumni Auditorium
Level 2, Alumni Medical Centre
2 College Road
Singapore 169850

Please send an email to szeyong@sma.org.sg if you wish to

1. Confirm your attendance (for both the AGM and lunch);
2. Submit resolutions and/or proposed constitution amendments;
3. Submit nominations to fill the ten vacancies in the next SMA Council.

All completed forms should reach us by 12 noon on 1 March 2017.

Recent indemnity discussions

SMA was informed of a change in the medical indemnity provider for public sector hospitals. In the interest of our members, we met up with representatives from Jardine Lloyd Thompson Group and Medical Protection Society on various occasions to assist during this time of transition, as well as to seek clarification on questions that were raised to us by concerned SMA Members.

Clinic Assistant Train and Place Programme

SMA has developed a Clinic Assistant Train and Place Programme, with the support of the Employment and Employability Institute, to train predominantly unemployed members of the public who are interested in working in healthcare clinics. We hope to place these SMA-trained clinic assistants in the clinics of SMA Members who are hiring. Course participants who complete the course will receive the Certificate of Completion for the SMA Clinic Assistant Introductory Skills Course.

After two runs, each in November 2016 and January 2017, we have trained more than 40 candidates for the vacancies put up by SMA Members on our online platform at https://www.sma.org.sg/trainandplace.

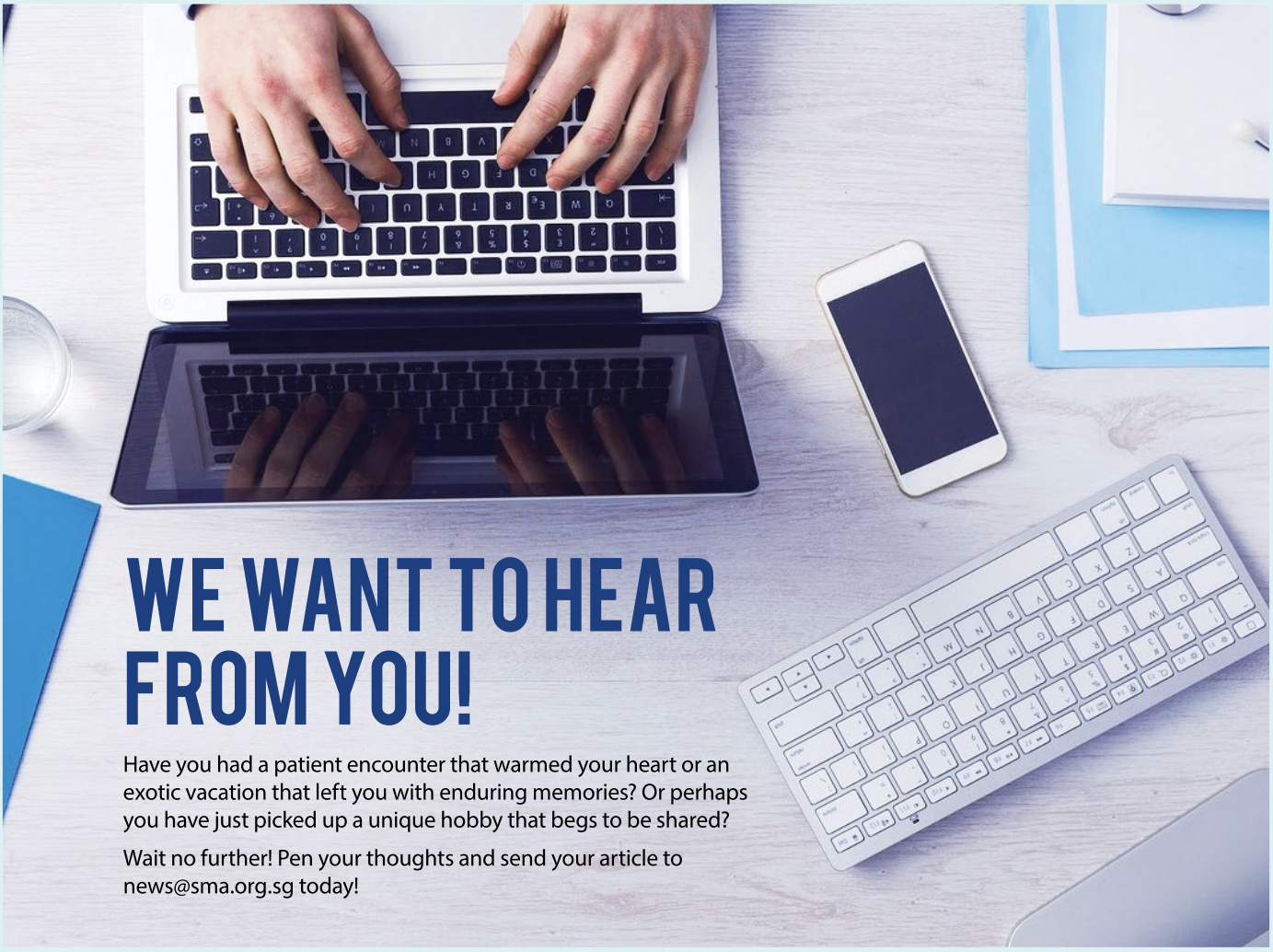
SMA members can contact membership@sma.org.sg for more details on how to gain access to these trained candidates for job interviews and job offers.

Visit by Canadian Medical Association President

On 5 January 2017, SMA received a courtesy call by Dr Granger Avery, President of the Canadian Medical Association. Dr Avery met with Dr Wong Tien Hua, President of SMA, and discussed various issues relating to healthcare policies, ethics and professionalism. ◆

SMA EVENTS
MAR–MAY 2017

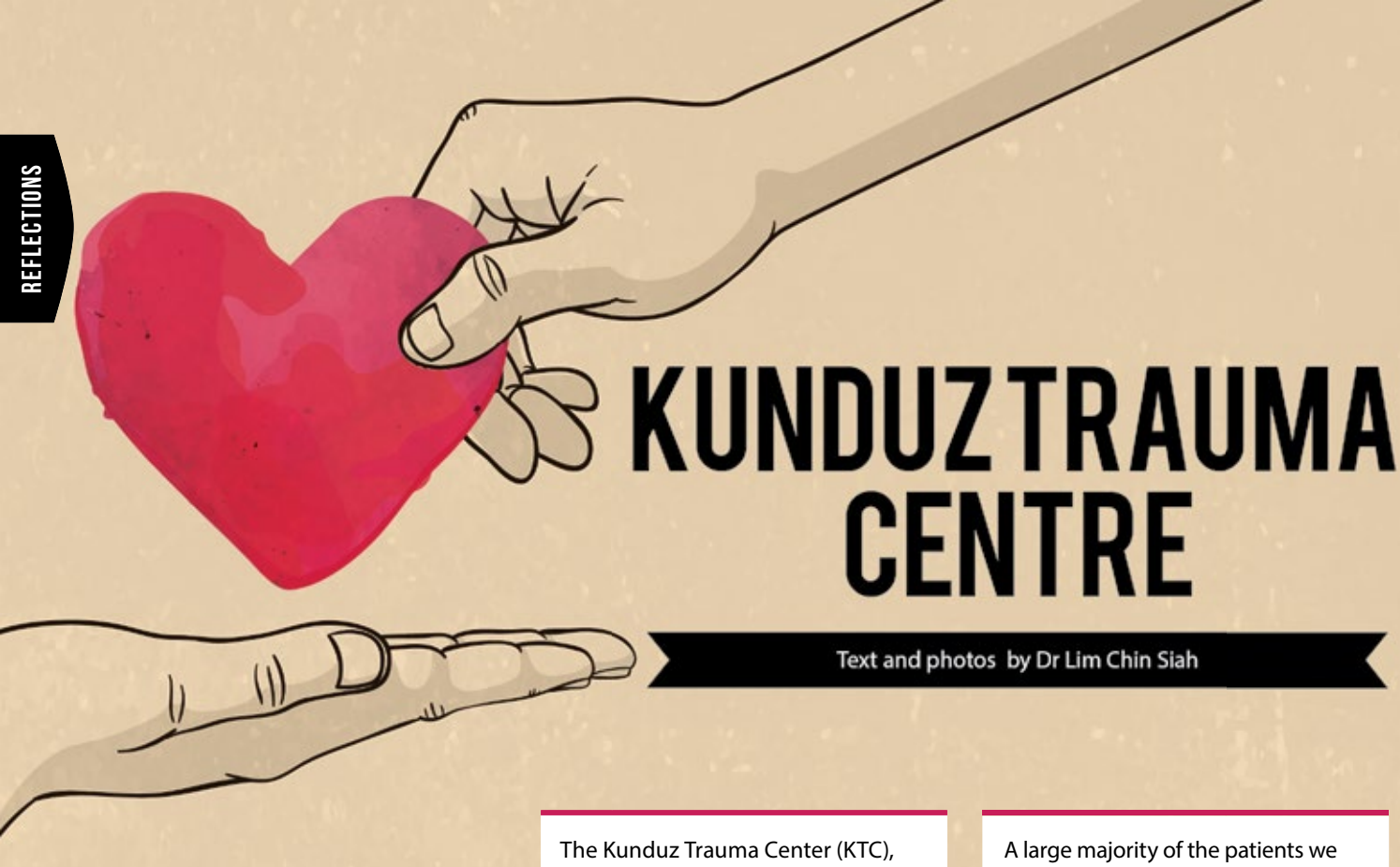
DATE	EVENT	VENUE	CME POINTS	WHO SHOULD ATTEND?	CONTACT
CME Activities					
10 Mar Fri	Medico-Legal Forum 2017	Supreme Court, Auditorium	Max 4	Legal and Healthcare Professionals	6332 4388 les@sal.org.sg
8 Apr Sat	SMA Seminar: Tax Obligations on Medical Practice	One Farrer Hotel & Spa	2	Doctors	Jasmine 6223 1264 jasminesoo@sma.org.sg
Non-CME Activities					
6 May Sat	SMA Annual Dinner 2017	Regent Hotel	NA	SMA Members and Guests	Mellissa 6223 1264 mellissa@sma.org.sg



WE WANT TO HEAR FROM YOU!

Have you had a patient encounter that warmed your heart or an exotic vacation that left you with enduring memories? Or perhaps you have just picked up a unique hobby that begs to be shared?

Wait no further! Pen your thoughts and send your article to news@sma.org.sg today!



KUNDUZ TRAUMA CENTRE

Text and photos by Dr Lim Chin Siah

The Kunduz Trauma Center (KTC), located in northeast Afghanistan, was opened by Médecins Sans Frontières (MSF) in August 2011 to serve the community caught in the frontlines of the ongoing conflict. It has a linear structure of healthcare delivery: from patient admission via the emergency room (ER), to the operating theatre, to the intensive care unit (ICU), the general wards and outpatient department. There is even a physiotherapist to assist with rehabilitation of war victims and a psychologist for the staff and patients to seek mental health assistance from. X-ray, laboratory and blood bank facilities are also available, albeit with limited capacity. I would dare suggest that the KTC was the best trauma hospital in the country, or even in the region, and it was fully operated by MSF.

To provide quality and timely care to the victims of conflict, the KTC focuses only on trauma patients. Patients without an injury, whether from a road traffic accident, war-related incidents or even a fall, would be turned away. The local community knows this and the fact that they abide by this unspoken rule reflects the acceptance and respect they have for MSF's role in the community.

A large majority of the patients we see are the war-wounded – both innocent civilians, unlucky enough to be caught in the crossfire, and the fighters from whichever armed group (MSF does not take sides).

Mass casualty plan

The siren blared in the background as Dr Bashir, our local medical supervisor, attended to a child in the ER. He was not at all surprised to hear the siren break the tedium of a waiting room full of children who have minor road traffic accident-related injuries. An hour prior, there were unverified reports of a suicide bomb attack at the market of an adjacent town not too far from Kunduz. Multiple casualties were expected but unconfirmed. The siren was confirmation that the mass casualty plan (MCP) had officially been activated. Everyone jolted into action without a hint of panic. Dr Bashir took his position at his designated red area in the resuscitation room of the ER. Suddenly, Drs Ares, Omar and Joya – the ER doctors who were off duty that day – appeared and donned their coloured vests. They came once they had heard the initial rumours. Like so many others, they chose to remain in Kunduz

Dr Lim Chin Siah is a consultant emergency physician at Singapore General Hospital.

Legend

1. Dr Osmani with the patient who survived a penetrating head injury

2. Bed crunch situation

3. The KTC ER team

even when the fighting intensified. Instead of leaving for safety, they stayed to help their people.

The first wave of patients arrived via trucks, driven by well-intentioned members of the public who scooped up any casualty they saw. Dr Bashir went about his task of managing the patients who have been triaged red – those with penetrating thoracic and abdominal injuries, bowel eviscerations, mangled limbs, head injuries and the like; clearly, he had done this umpteen times before. The surgical team was subsequently kept busy throughout the night as well. We saw a total of 54 patients for that particular mass casualty incident (MCI) that evening.

Have a little faith

After the chaos died down, the nurses informed Dr Bashir about a category black patient who was still alive, surprising everyone. The triage category black patients (impending death and deemed unsalvageable) were placed in a special room, attended by doctors, nurses and mental health counsellors. This patient was a young man with a penetrating head injury, likely from shrapnel. We did not expect this patient to survive, but he was trying his best to prove us wrong. Dr Bashir immediately attended to him and handed him over to Dr Osmani, the resident ICU physician at KTC. I was a little hesitant about a patient with a very poor prognosis taking up a precious ICU bed. What if there were another MCI? But Dr Osmani insisted and told me to have a little faith. The other surprise was that there actually was an ICU bed available after the MCI.

Perhaps unsurprisingly, with the amount of time and faith that Dr Osmani dedicated to this particular patient, it was almost inevitable that he would somewhat recover. And he did. After almost a month of nothing more than nasogastric tube feeding of Plumpy'Nut and basic nursing and wound care, this young man woke up. *You'd be forgiven if you thought this was a script for a medical drama.* Dr Osmani's feeling of elation and accomplishment was beyond words. "I told you, I told you," he kept repeating. Truth is, we should have known better; this was not the first time Dr Osmani had insisted we admit a seemingly unsalvageable patient to the ICU.

Maybe, sometimes all we need is just a little faith, and a committed ICU physician with an empty ICU bed.

That fateful night

On the night of 3 October 2015, the KTC was directly hit by US airstrikes. The hospital was hit repeatedly during sustained bombings by the coalition forces. Theories are rife about the reasons for the attack, but the fact remains clear that a healthcare facility was targeted, putting the lives of the patients and healthcare workers at extreme risk. During the attack, MSF staff (many of whom returned to help despite it being their off day) were still working to save patients and fellow colleagues injured in the blast. One can only imagine what that night was like. 14 MSF staff members were killed in the bombings, including Dr Osmani; and it really doesn't help the grief to know that his body, along with some others, were burnt beyond recognition and never identified.

Dr Joanne Liu, President of MSF, said it best.

"This was not just an attack on our hospital — it was an attack on the Geneva Conventions. This cannot be tolerated. These Conventions govern the rules of war and were established to protect civilians in conflicts — including patients, medical workers and facilities. They bring some humanity into what is otherwise an inhumane situation."

That night, Kunduz lost their only active hospital. MSF lost years of hard work making the KTC what it was. KTC staff and patients lost their lives and others lost family members and friends. But there is hope. In a seemingly never-ending conflict, the KTC is being rebuilt and it's only a matter of time before it will resume operations to serve Kunduz once again. ◆

For a blog entry posted by another active MSF doctor on that fateful night, visit http://msf-seasia.org/blogs/16924.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WHY THERE IS A NATIONAL NEED FOR TRAINED MEDICAL EXPERT WITNESSES

Text by Dr T Thirumoorthy

The evidence in a medical expert report and the testimony offered by a medical expert witness is often a critical component in arriving at an equitable, timely and fair decision in any medical dispute. This is applicable in the courts of law, especially for medical negligence cases, medical disciplinary tribunals of professional misconduct or even in the complaints committees and peer-reviews of hospitals and professional bodies. Expert witnesses provide independent assistance to the court or tribunal through unbiased opinion supported by good reasons and evidence, and founded on facts relating to matters within their expertise.

Role of a medical expert witness

An expert witness possesses special knowledge and experience in a subject that enables the expert to give opinions and draw conclusions relevant to the case to impartially and objectively assist the court or tribunal in its work. The expert witness is expected to articulate the standard of care in medical negligence and professional conduct in disciplinary tribunals, and give an opinion supported by good arguments and evidence as to whether the standards are met.

The standards or opinions articulated by an expert witness must withstand the scrutiny of logical analysis, be internally consistent and consistent with advances in medicine, for the expert witness to be accepted as being reasonable, responsible and respectable. In legal jargon, this is called the Bolitho test of reasonableness. When there is a range of reasonable opinions, the expert is obliged to consider the extent of that range in the report and to acknowledge any issues that might adversely affect the validity of the opinion provided. In other words, for the report to be accepted by the court, the expert must have considered all sides of the issues and not just the one that favours the instructing party.

The expert's duty to the court overrides any obligation to the person who is instructing or paying the expert. This means that the expert has a duty to act independently and not be influenced by the party who retains and pays him/her.

Need for education and competence

Writing a medical expert witness report is a highly disciplined and skilled task with accepted and prescribed formats. In addition to writing a good

report, medical expert witnesses may be required to appear in court to give oral testimonies and be cross-examined to verify facts and defend the expert reports. An effective medical expert witness needs to be trained, experienced and competent. Giving oral testimonies or "being put on the stand" can be a nervous and anxious experience, especially for the unprepared. The medical expert witness training courses create a safe and guided learning experience, with simulations in expert report writing and the delivery of oral testimony and cross-examination in court.

Untrained, unskilled and incompetent expert witnesses could mislead the courts or tribunals to an inappropriate conclusion or make dispute resolution complex, wasteful and costly. In the absence of good local medical expert witnesses, the courts have to depend on foreign medical experts to articulate the professional standards. The dependence on foreign medical experts who may not be aware of or sensitive to the local context and culture of medical practice here could be sub-optimal for all parties concerned in the dispute.

Benefits of education and training

Doctors who have completed the medical expert witness training acknowledge having discovered a vast new area of knowledge in medico-legal medicine and experienced a safe hands-on experience in writing reports and giving oral testimonies. In fact, many of them found improvement in their clinical practice and the documentation of their case notes. Doctors who become experienced in serving as medical expert witnesses find the work challenging in terms of time and effort, but at the same time intellectually rewarding as it improves their medical knowledge and clinical reasoning skills. In addition to serving the cause of justice and the needs of society, medical expert witnesses are appropriately remunerated financially.

Some doctors are concerned about the legal liability involved in being a medical expert witness. Medical defence organisations regard providing expert opinion as an integral part of professional duty and practice. It is prudent to verify this and keep the membership with medical indemnity organisations current. Good communication between the medical expert witness and the instructing lawyer is the key to getting the issues and scope clear and right. A medical expert witness acting in good faith, exercising reasonable skill and diligence in drafting the expert opinion, is always the best defence to any negligence claim.[1]

A need to be filled

As our society continues to develop and educational level of the public improves, there is a commensurate increase in expectations of the performance and behaviour of doctors, and a demand for greater transparency and accountability of both the medical profession and healthcare institutions. The uncertainty in and complex nature of medicine, together with the rising cost of healthcare, contributes to greater medico-legal disputes between patients and families on one side, and medical practitioners, healthcare professionals and hospitals on the other.

In such disputes, the interests of the patients, public, hospitals and profession are best served when clear, comprehensive and objective expert witness reports and testimonies are made available to the courts of law and disciplinary tribunals. Well-researched and well-written medical expert witness reports often clarify the facts and lead to an early negotiated settlement outside the adversarial, stressful and expensive arena of the courts and disciplinary tribunals. Competent and mindful medical expert witness reports play a key role in less adversarial alternative dispute resolution processes.

Excellent medical expert witness training courses have been organised by SMA and the Academy of Medicine, Singapore, under the leadership of the Singapore Academy of Law and in partnership with The Law Society of Singapore and the State Courts of Singapore. Medical professionals across all specialties should take advantage of such exceptional opportunities. ◆

Dr Thirumoorthy is the immediate past director of the SMA Centre for Medical Ethics and Professionalism and he is playing a supportive role in the development of the Office of Professional Affairs of the Academy of Medicine, Singapore.

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REPLY TO "THE DILEMMA OF MEDICAL LEAVE"

Text by Dr Natarajan Rajaraman

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

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

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

Healthcare system roots of this dilemma

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

Employers' incentives to influence MC

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

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

Healthcare financing model allowing employers undue influence on doctors

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

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

Possible healthcare system/policy solutions

Modify work-related accident reporting criteria

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

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

Calibrate penalties on employers for reported workplace accidents

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

Change the payer

Singapore mandates employer-purchased medical insurance

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

What doctors can do in everyday practice

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

Develop MC guidelines

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

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

Become familiar with policy surrounding migrant workers

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

Conclusion

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

Dr Natarajan Rajaraman is an associate lecturer in the Saw Swee Hock School of Public Health, currently working as a medical educator in Sierra Leone. He has an interest in education, vulnerable populations in Singapore and globally, and the strengthening of health systems.

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PRACTICAL ADVICE FOR DOCTORS TREATING FOREIGN WORKERS

Text by Dr Joanna Chan and Dr Dennis Chia

Low- and semi-skilled foreign workers in Singapore who are holding a Work Permit are often involved in manual labour in the shipyard and construction industries. These are the patients who face the highest risk of workplace injuries, yet encounter the greatest barriers to receiving healthcare in our country. They tend to be poorly aware of their rights and may refuse necessary treatment due to misconceptions that they will have to foot the hefty medical bills themselves. To compound the problem, doctors tend to be ignorant about the consequences that our sometimes unthinking actions may have for the worker – for example, the act of giving the medical certificate (MC) to the employer instead of the worker.

In Dr Natarajan Rajaraman's article (see page 16), he examines the limitations of a healthcare system which "pits medical practitioners' financial interest against their ethical obligation" when it comes to prescribing medical leave for foreign workers. In the absence of existing regulatory guidelines on medical treatment of these workers, it is the individual doctor who will either be of great help or hindrance to the ill or injured worker in his healthcare journey, depending on his or her alertness to the issues that these workers face.

This article hopes to address, in part, the question: What can doctors do in everyday practice, while awaiting better systemic safeguards for the workers? Here are some useful pointers, and facts about foreign workers' legal rights, for all doctors to bear in mind while treating this vulnerable group of patients.

Dos and don'ts to observe in daily practice

Document history clearly in consultation notes

Bear in mind that a worker's compensation claim may depend on the documentation at the time of his first presentation. This may be in the A&E or a different context, such as the GP clinic.

It is essential to ask the worker if an injury was sustained during the course of work and document this clearly. It is equally important to document if the worker comes in alone or accompanied by a supervisor. Versions of the history sometimes diverge during the Work Injury Compensation Act (WICA) claims process, during which the employer may dispute the worker's version of the story. Thus, the first documentation should accurately reflect who gave the history. The worker may be charged with lying (this carries a jail term) if the Ministry of Manpower's (MOM) investigating officers do not believe the worker's account or if it is challenged by other employees. List the name and designation of the accompanying persons and the language in which history is given, as it is possible that history may be taken entirely from a supervisor in a language the patient does not speak.

Document every injury to facilitate any retrospective claims from the worker. Any injury not documented would mean that the worker is not covered for said injury and would not be able to receive adequate compensation. Take a real-life scenario for example: a worker who falls off a ladder may present with both an elbow dislocation and back pain. As the first attending doctor, we may be very excited about the dislocation and document it well but may neglect the back pain. As a result, during the claims process, MOM does not recognise the back pain as having resulted from the injury.

Doctors who are first-line providers should be cognisant of the importance of their documentation as it is their often-scanty notes which are referred to

i) When employers or workers file an incident report.

ii) When doctors fill up the MOM WICA claim incident form.

iii) If a civil suit is filed by the worker.

iv) If a court case is brought against the worker for lying.

Give the worker the discharge summary and MC

Non-governmental organisation (NGOs) that help foreign workers report that these workers are sometimes denied access to their MC or medical records.[1] Without being able to refer to their MC, workers may be unaware that they were prescribed light duty rather than medical leave. Absence from their work during a period of light duty means that they will not be paid for their days of rest, as they are only paid for medical leave or hospitalisation leave while off work. The latest edition of the Singapore Medical Council (SMC) Ethical Code and Ethical Guidelines (ECEG) published in 2016 reinforces that "where possible, medical certificates must be handed over only to patients themselves".[2] A copy may be made for the employer only if the worker gives consent.

Explore the reasons why a foreign worker refuses essential treatment

Foreign workers sometimes refuse life-, limb- or function-saving medical treatment or hospitalisation due to misconceptions or unwillingness on the part of the employer to pay for their treatment. Doctors are sometimes able to address these barriers, which may include

a) The patient's inability to get a letter of guarantee (LOG) from their employer for hospitalisation (without which they have to pay a thousand-dollar deposit for hospitalisation, which is beyond their capability);

b) The patient's belief, or the employer's threat, that the hospital bill will become a "debt" to their employer, which they will have to pay off; and

c) The patient's fear of repatriation when their employer finds out they are injured.

The LOG is a guarantee from the employer that the company will cover the worker's hospital expenses and it is required for the admission of foreigners. For a non-workplace injury, if the employer is reluctant to issue the LOG, a letter from the doctor stating that hospitalisation is **"immediately and medically necessary"** may help to facilitate the process.

Admissions for all work pass holders can still proceed without the LOG at many restructured hospitals (you could check with your Business Office to see

if this applies to your institution). If a worker presents outside office hours with a medical condition which requires hospitalisation (eg, appendicitis) but their human resource (HR) personnel cannot be contacted outside office hours to provide the LOG, the patient can still be admitted to the hospital, though they should inform their employer that they are proceeding with the hospitalisation. The Business Office will then contact the employer/HR in the morning to sort out the LOG. If the employer declines to pay for the hospitalisation, the Business Office will lodge a complaint with MOM.

However, if the worker does not personally agree to stay in hospital, doctors cannot keep him in the hospital against his will if he has capacity.

Be aware of resources outside the hospital

If you fear that a patient is being prevented from accessing treatment and may require a social worker to follow up for the patient's safety, you may refer him to HealthServe, an NGO that employs case workers to aid foreign workers in navigating around barriers they may face in obtaining healthcare. The foreign worker can call the general office number, 6743 9774, and the staff will assess their need and refer them to a HealthServe case worker or another suitable NGO.

Do not under-prescribe MC

When a foreign worker is given an MC for a duration of four days or more (whether consecutive or not) for an injury sustained at the workplace or due to work exposure, the employer will have to submit a mandatory incident report to the MOM within ten days. Employers may thus request for fewer days of MC to be prescribed to avoid reporting a worksite accident. The SMC has issued repeated circulars to remind doctors not to be influenced by third parties in this matter. The 2016 ECEG also includes the reminder that "Medical certificates must be issued to patients only on proper medical grounds arrived at through good clinical assessment. You must not take into consideration extraneous factors such as who pays for the consultation, what benefits the patients may receive, or what the employers' preferences may be."[2]

Summary of the Dos and Don'ts in Daily Practice

1. Document the following

a) Whether or not the injury sustained was a workplace injury.
b) Who accompanied the patient (eg, colleague, site supervisor, safety officer).
c) Who gave the account of events leading to the presentation.
d) All injuries (however minute) to ensure that the patient has a basis for future claims.

2. Provision of MCs

a) All copies should be given to patients.
b) Provide copies to employers only if the patient is agreeable.
c) Check in advance whether the patient has to submit the original copy of their MC to their employer and, if so, consider furnishing a copy for that purpose.
d) Do not under-prescribe MC/light duties (especially at the request of the patient's employers unless the patient is agreeable).
e) Before prescribing light duties, verify with the patient or employer that the company is able to make provisions for the patient and document in the notes. Otherwise, please consider giving medical leave instead.

3. Discharges against medical advice/refusal of treatment

a) Explore the underlying concerns and try to address them. This will often require discussions with the patient and his employer.

4. Available resources

a) HealthServe (NGO) available at 6743 9774
b) Report suspected breach of work-pass conditions to MOM:
   - Email: mom_fmmd@mom.gov.sg
   - Tel: 6438 5122/6317 1111
   - MOM website: http://www.momgov.sg/eservices/services/reportan-infringement
c) Report under-prescription of MC:
   - To MOM: mom_oshd@mom.gov.sg
   - To SMC: enquiries@smc.gov.sg / 6372 3141

Frequently Asked Questions

1. Who bears the medical costs incurred for non-workplace illnesses and injuries?

The employers are obliged to pay for the medical costs for all non-work-related illnesses and injuries incurred by their foreign workers. This is mandated by law, as stated under the Employment of Foreign Manpower Act (Chapter 91A), under the Employment of Foreign Manpower (Work Passes) Regulations 2012.[3]

The employer shall be responsible for and bear the costs of the foreign employee's upkeep and maintenance in Singapore. This includes the provision of medical treatment.

The foreign worker may be made to bear part of any medical costs in excess of the minimum mandatory coverage only if

a) The foreign employee's agreement to pay part of any medical costs is stated explicitly in the employment contract; and

b) The part of the medical costs paid by the foreign employee does not form more than 10% of his fixed salary every month.

Part of the medical costs incurred is offset by compulsory insurance coverage, as mandated by law. Foreign workers are currently covered by work injury insurance for an amount up to the compensation limits under the WICA and non-workplace medical insurance of up to S$15,000.

2. When can a foreign worker claim for compensation under the WICA?

A foreign worker may claim compensation under the WICA[4] if

a) He is presently under employment;

b) Suffers personal injury; and

c) The injury arises out of and in the course of his employment.

The WICA sets out some situations in which a foreign worker is deemed to be injured in the course of his employment. This includes injury sustained while going to or back from work, or due to an accident that occurs on a transport operated by his employers.

The WICA also makes it clear that employers are not liable in certain situations, such as if it is proven that an injury was due to the employee having been under the influence of alcohol or a drug not prescribed by a medical practitioner, or an injury was sustained in a fight or attempted assault, unless for instance, in self-defence.

3. In the event of a dispute over whether the injury is a workplace injury, what can a foreign worker do?

In the event a foreign worker sustains injury in the course of his employment but the employer refuses to permit him to see a doctor, to bear the medical expenses of the worker, or to pay medical leave wages, the foreign worker may lodge a report with MOM via its website.

MOM may investigate the matter and take appropriate action, including requiring the employer to bear the foreign worker's medical expenses, if the injury was found to have occurred in the course of his employment.

Doctors who suspect coercion of the worker or obstruction of his access to care by the employer may email mom_fmmd@mom.gov.sg to report suspected breach of work-pass conditions.

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Dr Joanna Chan Shi-En and Dr Dennis Chia are emergency medicine senior residents under SingHealth and National University Health System, respectively. They have witnessed many foreign workers refusing medical treatment during the course of their practice and decided to find out and share some answers to the questions they had regarding how doctors can make a difference for this group of patients.

Acknowledgement

We would like to thank Colin Chia and Jeff Chua from HealthServe and Christine Pelly from Transient Workers Count Too for providing input. ◆

HUMANITARIAN SERVICE: A GP'S PERSPECTIVE

Text and photos by Dr Lawrence Soh

"This is the first time I have been seen by a doctor." These were the words of a 40-year-old Nepali man in the far western part of the country. He suffered from filariasis with hydrocele, and was unable to marry due to the stigma of having a large "private part". Through preventive medicine, we were able to transform the life of this man and many others, in a truly meaningful way.

Reaching out

Ever since I started my general practice in 1989, I wanted my clinic to be a platform for charitable and humanitarian work. Over the years, I have taken great pleasure in being able to fulfil this ambition, in many cases through the sacrifices and generosity of patients and co-workers. I have been able to donate monies, drugs, equipment and surgical supplies; provide expertise on medical relief; conduct community health outreaches and supply interactive health education models.

For the last 30 odd years, my greatest fulfilment has come from doing regular overseas humanitarian work. Although these trips caused my periodic absence from my practice, my patients in Singapore often enquired about my humanitarian work and were pleased to be able to support by contributing donations. They have donated money to relief efforts during the tsunami in Sri Lanka, the purchase of an ambulance for an elderly home in Nepal, and water supply engineering works for a village affected by the earthquake in Sichuan, among other projects. My clinic staff and fellow doctors, as well as drug companies, also contributed by providing administrative help, medical supplies and finances when needed.

My life motto has been to go to areas of the greatest need. This means visiting areas that are usually more remote, with little or no medical care and facilities available. Travelling to such places can be dangerous due to longer travel times and the high risk of landslides and floods. I have been privileged to travel to and administer aid in Sri Lanka (Kirinda, Hambantota and the Tamil Tiger area), Sarawak (Kapit), East Timor (Com), China (Yi minority areas) and Nepal (Surkhet, Kanchanpur, Pahalmanpur and Tikapur).

There have been moments when I feared for my safety too. These include sleeping in an Iban headhunter's longhouse in the malaria-endemic town of Kapit, being stuck in a vehicle in a fast-

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flowing river and in landslides on mountainous roads, being caught in a riot and road blockade, and sleeping in an old school quarter that was infested with ants, frogs and snakes.

Serving the needy

"Please come back again to help us," was the parting line from a health station doctor in the remote village of Taliangshan, China. This remote Yi minority village, situated at an altitude of about 3,000 m, is one of the poorest in this mountainous region. Such places are unpopular with local medical staff due to the harsh living conditions, treacherous terrain, frequent landslides, extreme weather and a lack of proper sanitation and water supply.

For seven continuous years, I visited this village of about 300,000 people. Then, I was the Health Fair Program Leader to about 30 healthcare workers of a non-governmental organisation (NGO). We provided health education at the town square, ran the outpatient clinics/health stations and performed surgical procedures alongside our local counterparts, as part of the training programme for the local hospital. With the steady upgrade of the facilities and improvement in standard of care, it was an incredibly rewarding year when we learnt that the local need had reduced to the point where further health fairs became unnecessary.

Over the last ten years, my relief effort has been focused on Nepal, especially in the needy Terai region. Together with an NGO and the local regional councils in Kathmandu, we conduct medical camps usually in the far western regions. We would bring in a small team from Singapore and enlist more than 20 local staff, including school teachers, nurses, doctors and dentists, to be part of the team to help with crowd control, translation and medical or dental work. Activities include pre-registration, community broadcasting, triaging, consultation, treatment, minor surgical procedures, dispensing, health education and counselling.

It doesn't stop here

It is a privilege to think that I might continue to be able to contribute effectively to bringing relief to those in need, or perhaps inspire others to do so. I find one quote particularly inspiring in this regard.

"Twenty years from now, you will be more disappointed by the things that you didn't do than by the ones you did do. So throw off the bowlines. Sail away from the safe harbour. Catch the trade winds in your sails." – Mark Twain

Although I am now in "semi-retirement", having sold two of my practices and closed my night clinics, I consider my journey of humanitarian work to have just begun. Life is short and humanitarian work is a large component of my remaining "bucket list" that includes traveling to parts of the world I have never visited.

I believe that Erma Bombeck's quote is one that we should all consider more in every aspect of our lives: "When I stand before God at the end of my life, I would hope that I would not have a single bit of talent left and could say, 'I used everything you gave me.'" ◆

Legend

1. A makeshift consultation room in a rural school classroom

2. The crowd at the medical camp in Tikapur, Nepal

Dr Lawrence Soh is a GP and occupational physician with Shalom Clinic & Surgery. He is also an adjunct lecturer in family medicine at NUS Yong Loo Lin School of Medicine and a fellow of the Academy of Medicine, Singapore, in occupational medicine. He volunteers with MSI Professional Services and other NGOs. His hobbies include travelling and extreme sports, including marathoning, scuba diving, skiing and mountain biking.

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By **Agency for Integrated Care**

Haze in 2015

It is hard to predict when a public health risk may strike. It can be caused by different diseases ranging from mild to very severe. To safeguard the health of the nation and to stay prepared for potential health threats, MOH partners clinics to support them with the Public Health Preparedness Clinics (PHPC) scheme. Introduced in 2015, the scheme enables clinics to provide subsidised treatment and medical supplies during public health emergencies.

One such public health emergency is the severe haze crisis. Thankfully, 2016 passed without incident. Despite such peacetime, much work was undertaken last year to help prepare for any future situations.

For instance, a huge step forward was the launch of electronic online submission. It allows instant claims submission, real-time tracking and speedy processing of claims, streamlining work processes and relieving administrative burdens. GPs will also be reimbursed in a timely manner with this enhancement. Another potential benefit for participating PHPCs include time saved during submission of claims, allowing GPs and clinic staff to focus on other tasks, improving productivity and efficiency at the clinic.

The new PHPC module is up and ready for use on CHAS Online. Participating clinics simply need to log on to the portal to submit haze claims, if the need arises.

Being on board with PHPC

As one of the PHPC clinics, the Yang & Yap Clinic and Surgery advocates educating both their own staff and the public about personal hygiene and vaccinations to protect themselves and their families. "I believe that the best measure is education," said Dr Theresa Yap.

To sidestep infection, Dr Yap, a general practitioner at the clinic, recommends avoiding visiting those countries with the risk of potential outbreaks. It is advisable for someone developing symptoms after returning from source countries to quarantine themselves until a diagnosis is made.

Mask fitting session with PHPC clinics in 2015

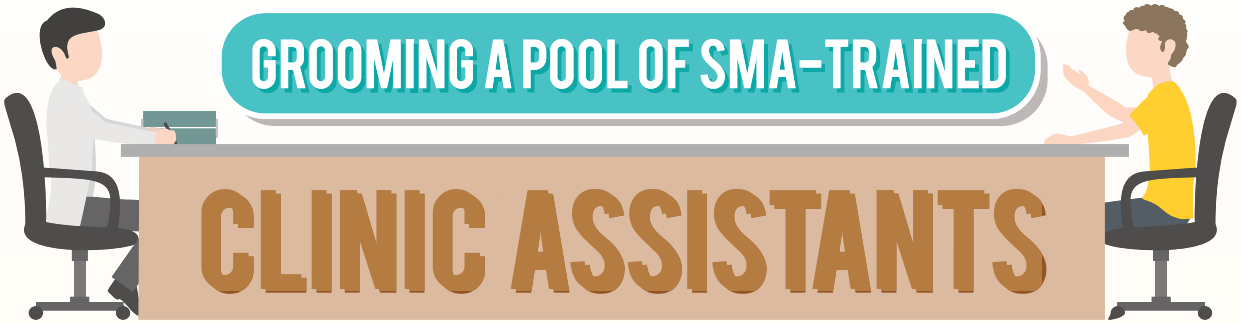
Dr Yap says that the PHPC scheme helped to prepare her clinic for public health threats in many ways. As part of the scheme, her clinic receives training and support, such as a mask-fitting training session in which the clinic took part in. The training session was organised by Agency for Integrated Care (AIC), Ministry of Health (MOH) and Health Promotion Board (HPB) to educate both doctors and staff on the proper fit and use of masks. Says Dr Yap, "Being able to order the right sized mask is important. Otherwise it defeats the purpose of using it."

"Being able to order the right sized mask is important. Otherwise it defeats the purpose of using it."

— Dr Theresa Yap, Yang & Yap Clinic and Surgery

JOIN US TODAY!

Recently, AIC took the initiative to thank the PHPCs for keeping the nation safe from public health emergencies. A red inverted umbrella was specially created and given to all 683 PHPC clinics. If you would like to join us and receive this gift, please write to us at **gp@aic.sg** today.



GROOMING A POOL OF SMA-TRAINED CLINIC ASSISTANTS

- Text by Mellissa Ang, Assistant Manager, Membership Services -

SMA started the year on a good note with the second edition of the Clinic Assistant Introductory Skills Course, which took place from 11 to 14 January 2017. One week prior to commencement of the course, participants attended a job preview to understand more about the Train and Place programme and the expectations of a clinic assistant. 16 of them then took on the challenge and joined the course.

In early January, while interested members of the public were being screened by SMA Secretariat staff, some SMA Members were also making their own preparations for the second batch of SMA-trained clinic assistants. These members added and edited details about clinic vacancies via their SMA membership portal. During the first edition of the course, SMA Members who were keen to hire clinic assistants could only interview participants on the last day of the course. This time round, ten interested clinics and medical groups chose from the limited interview slots available all through the four-day course to do a face-to-face assessment of the course participants and take the first pick for their clinics.

On the first day of the course, all participants were briefed and given unique login IDs to access the Train and Place Portal on their smartphones and SMA laptop, where they could view the complete list of clinic vacancies across Singapore. Excited chatter spread across the auditorium as participants scrolled through the list of more than 60 clinics with at least 80 vacancies offered. They then had the option to either book an interview slot with the ten clinics and medical groups during the course duration, or contact other potential employers personally via email or phone for job opportunities.

One of the programme participants, Miss B Mahalekshmi, grasped the opportunity and readily signed up for seven interview sessions spread throughout the four-day course. Miss Mahalekshmi shared that her family and friends had encouraged her to explore employment in the healthcare industry due to her caring nature but she had not entertained that thought until she chanced upon the SMA Clinic Assistant Train and Place Programme. As Miss Mahalekshmi was proactive in her search for employment through the opportunities offered by SMA and its members' clinics, the 42-year-old ex-administrative assistant was unfazed by the one-month placement criteria for all participants to be eligible for the 90% e2i course subsidy. She opined, "The interview sessions that SMA arranged for all participants at the end of each day motivated me throughout the course and provided me with ample employment opportunities at the get-go! I'll definitely recommend the SMA Clinic Assistant course to my family or friends who are keen to take on clinic assistant positions." Miss Mahalekshmi was the first SMA-trained clinic assistant, among her cohort, to secure a clinic assistant job just two days after she completed the course.

If you are looking for SMA-trained clinic assistants for your medical practice, you can create new vacancies on our online platform by logging into your membership portal at https://www.sma.org.sg/trainandplace. Alternatively, you can contact Mellissa Ang (mellissa@sma.org.sg) or Denise Jia (denisejia@sma.org.sg) for direct access to the course graduates. This service is provided free of charge for SMA Members and their clinics. ◆

Legend

1. The second batch of graduates from the SMA Clinic Assistant Introductory Skills Course

2. Participants learning communication skills through group work

3. SMA Members' clinics and medical groups conducting interviews with participants

THE MOUNTAINS ARE CALLING AND I Must Go

Text by Hargaven Singh Gill • Photos by Mental Muscle

Mental Muscle and its conception

"Mental Muscle" aims to raise public awareness of mental illnesses that burden Singaporeans, highlight the need for social support for these individuals, and dispel some of the social stigma surrounding them. Our team of six students from NUS Yong Loo Lin School of Medicine (NUS Medicine), comprising Ho Jun Kiat, Huang Juncheng, Keith Ching Wei Jie, Navkaran Singh, Thaddaeus Tan Jun Kiat and me, travelled to Kathmandu, Nepal, from 18 to 25 December 2016. There, we ran along the Kathmandu Valley Rim, covering a distance of 200 km in five days – making us the first in history to complete such a trail as a team. Our intention was to undertake a mentally and physically demanding race (hence the name "mental" and "muscle") to draw attention to the project and ongoing outreach efforts.

Preparation and milestones

Our team is the second batch to undertake such a challenge for this cause. Previously, a group of four medical students successfully ran the 250-km Sahara Race through the Namibia Desert.

With a tight timeline of four months, our team trained hard for the trail, while juggling schoolwork and the administrative tasks of our project. The key events leading up to our race included the Newton Challenge (32 km), The North Face 100® (100 km) and the Standard Chartered Marathon Singapore (42 km). During those races, we each carried backpacks weighing five to eight kilograms to prepare us for the trail in Kathmandu, where we would be carrying our own water, food supplies and gear throughout the run.

We aimed to raise $25,000 for our project, with funds being channelled primarily to the YouthReach division of the Singapore Association for Mental Health (SAMH). We strived to meet this goal by reaching out to friends, corporate organisations, charity events and publicity platforms.

With a larger team than last year and a shorter time span, the toughest part of preparation was in acquiring equipment and sponsorships. We went knocking on the doors of many companies with our team manifestos in hand and despite many rejections, the team was not dismayed because we knew that those struggles we faced paled in comparison to those faced by our peers with mental health illnesses.

During our preparation, we were fortunate to have the guidance of our mentor, A/Prof Tay Sook Muay (Department of Anaesthesiology, Singapore General Hospital). Her department and institution funded part of the operational and race costs, and aided us when our project hit a roadblock. We were also fortunate to be guided by Singapore's top marathoner, Dr Mok Ying Ren, and Dr Kumaran S/O Rasappan (who summited Mount Everest), both of whom shared their expertise on running and managing Nepal's terrain. Although this project is not officially under the purview of the school, the Dean's Office shared their expertise on framing safety measures and organisational frameworks for a smoother execution of our project. We also had supportive friends who trained with us, actively disseminated our outreach efforts, and contributed time and money to our cause.

Kathmandu Valley Rim

Upon arrival at Tribhuvan International Airport, we took a 30-minute drive to our accommodation in Thamel – the heart of Kathmandu's tourism industry. It was bittersweet having to leave this tourist hotspot in less than 24 hours while knowing that we would return to this reward after our five days of labour.

Raj and Narayan, the two ultramarathoners acting as our leads on the run, met us for dinner on the first evening and we were swept away by their stories. Raj completed a 1,076-km marathon in 17 days, and Narayan *accidentally* finished as a second runner-up in a prominent UK marathon, beating hundreds of participants. Physical limits clearly did not apply to them.

The trail run started promptly at 7.15 am on Day 2 of our arrival. Within minutes, our team saw what it meant to be two of the Nepal's top ultramarathoners as we quickly lost sight of our running leads. Despite slowing to our pace and running 200 km, they did not

break a sweat or sustain any form of injury.

No amount of training could have fully prepared us for the unpredictable terrain and the frequent elevation changes varying between 1,300 m to 2,600 m. There was a mix of gravel, sand, mud, vegetation and roads amid upslopes and downslopes. Despite the challenges, our time was filled with laughter and camaraderie, knowing that we are a team fighting for the same cause. Our favourite moments included the time we ran on the ridge lines and when we got lost on the third night. On both occasions, we did not know the destination or how long more the trail would last. However, when we gave up the need for certainty and trusted in those shepherding the team, we learnt to live fully in the present and in the company of those who mattered.

"There is magic in these mountains", Raj would say, and he was quite right. Running on the ridge lines, away from the buzz of the city, provided a quiet respite for our minds to reminisce as 2016 drew to a close. Being at the highest points of Kathmandu allowed us to transcend our personal limits and worries, and acquire new perspectives to bring forth into 2017.

Outreach and outcomes

Is this the end of our journey? Certainly not. Completing this adventure marked the start of another chapter of our lives and sparked our passion for trail running. It is, and will always be, an enlightening experience to watch the grace at which trail runners propel themselves onward despite fatigue; for isn't life about plunging our next step forward with courage and tenacity while leaving behind a trail of footprints for others to follow?

After successfully completing the five-day Kathmandu Valley Rim run, we were thankful to be home in time for Christmas. Our team quickly turned our focus to our fourth year professional examinations as well as outreach efforts – conducting talks and workshops on mental health awareness and the development of mental resilience with junior colleges. We are also conducting interviews with individuals enrolled in the programmes carried out by SAMH.

In the past five months, we reached out to around 70,000 individuals via Facebook alone. Online outreach efforts will include interviews with individuals with mental health illnesses, and quizzes created around their stories to engage the public.

Alongside publicity and outreach efforts, we continue our fundraising efforts. We are progressing towards our goal of $25,000, but we are not stopping there. Our team will give it our best shot to champion this meaningful cause: raising awareness for mental health.

Many of us may have experienced moments of fatigue and despair, where we may be constantly fighting to stay afloat. In such times, assurance that things are going to get better is often what we need. It is the reason for what we do and that provides us strength, and our team would like you to be a part of that reason, as we venture forth in our efforts.

For more information on Mental Muscle, check out the website: http://www.mentalmuscle.org/ or follow us on Facebook: http://facebook.com/mentalmuscle. ◆

SMA and the SMA Charity Fund support volunteerism among our profession. *SMA News* provides charitable organisations with complimentary space to publicise their causes. To find out more, email news@sma.org.sg or visit the SMA Cares webpage at https://www.sma.org.sg/smacares.

Legend

1. The team feeling joyous while holding up our project banner after completing the 200 km trail

2. The team having a memorable final dinner at the same restaurant as their first meal in Nepal

Hargaven Singh Gill is a fourth year medical student at NUS Medicine. He has a passion for rugby and tries to incorporate that same enthuse into other aspects of his life. He likes to hike and meet new friends on the trail, or spend the day with a good cup of coffee and book in hand.

My Love Affair

Text by Dr Daniel Fung

I was first introduced to her when I was in medical school. It started innocuously enough. My good friend told me she was a good companion for long study nights. She blended well among my books and her fragrance was invigorating. She tasted gorgeous and I was hooked. What started as innocent flirtation became a lifelong relationship. I am of course speaking of the beautiful yet ubiquitous brown bean called coffee.

My very first thoughts were: a few sips to burn the midnight oil – what harm would it do? But with each sip, I became more dependent on it to stay up for a few more hours. Before long, I was drinking every day and then it was several cups a day. Nowadays, I drink about five cups of coffee every day and I have attended two coffee seminars with a famous American coffee chain. What is it with this bean anyway?

History of coffee

Coffee is one of the most highly consumed beverages in the world, perhaps only after water and tea. It has been reported that over 50 million cups are consumed every day. Historically, it has been described to have originated from Africa, although its exact origins are mired in myths rather than actual history. One such story is of a monk who found the berries of a coffee plant. After boiling and drinking it, the monk had boundless amounts of energy which kept him alert during long evening prayers. The cultivation and trading of coffee began in earnest in the Arabian Peninsula and by the 15th century, it was widely enjoyed and exotically called the "Wine of Araby". Public coffee houses, or *qahveh-khaneh*, became common in many cities and were often referred to as "schools of the wise" because drinking coffee was associated with scintillating intellectual exchange. Coffee houses spread to Europe and then to the Americas by the mid-1600s. Thomas Jefferson, one of the founding fathers of the US, has been quoted saying that coffee is the favourite drink of the civilised world.

Besides Africa, coffee plantations began to spread worldwide — the Dutch brought it to Indonesia and the French brought it to Central America. Today, coffee is cultivated in over 70 countries but primarily in the equatorial regions of America, Asia and Africa. The two most commonly grown types of coffee are the highly prized Arabica beans and the less costly but hardier Robusta beans. Arabica beans need cooler highlands while Robusta beans can grow in almost any condition with a greater crop yield and double the amount of caffeine and antioxidants. Most of our local coffees, including instant coffee, are from Robusta beans which have high acidity and bitterness levels. Arabica beans, which originated from the southwestern highland forests of Ethiopia, are almost exclusively used in gourmet coffee.

How to enjoy coffee without guilt

Drinking coffee is like wine tasting; it can be an experience rather than just a quick fix. For those who prefer quick fixes, a small espresso cup of the finest Arabica beans is an elegant alternative. There are actually people — called "cuppers" — who specialise in coffee tasting. For the rest of us, it's best to enjoy coffee by considering its qualities which can be divided into three main elements: aroma, taste and body.

Aroma refers to the smell of the coffee. Various descriptions have been given to these aromas, such as earthy/medicinal, chocolate-like/nutty, floral/sweet and fruity/citrusy. The next time you pick up a cup of coffee, take in the scents before you take a sip.

Taste refers to how the coffee feels as it touches your taste buds. The most obvious is acidity, which can be described as the sharpness of the coffee taste. In addition, you will also find bitterness, often associated with the roasting process, and this is often followed by sweetness and other tastes. To fully enjoy coffee, take a sip by slurping it in (which causes one to spray the tongue with the drink) and enjoy the tastes that it creates. Swoosh it within the mouth so that it covers all the taste buds. As doctors, we all know how taste buds in the front of the mouth recognise sweetness followed by saltiness and sourness. Right at the back are the taste buds that recognise bitterness.

Body is described as the feel of the coffee as it enters your mouth. It is the viscosity and richness of the coffee (without milk or sugar) as it moves inside your mouth. Body is affected by the brewing method. Drip or filter brewing produces a lighter body, while using a French press or espresso machine (like the types you see in coffee houses) gives a heavier body as it captures the essential oils within the coffee.

I used to drink coffee with milk and sugar. In fact, hazelnut latte was my

favourite drink until I attended a course that taught me to try coffee in all its nakedness, which if you are a whisky drinker, means "straight". I have also learned to pair my coffee to enjoy the experience. Pairing black Arabica coffee is an art and you need to know the three qualities of the coffee in order to pair it better. Here is a simple guide. First, identify the taste of your coffee and look for foods that can complement it. For example, sweet cake will complement a coffee that is acidic. Milder and less acidic coffees will go better with lighter foods such as fruits. Savoury foods tend to go better with more earthy coffee blends. My breakfast usually consists of an apple and a French roast (without milk or sugar). I find that this combination is a good way to start the day. However, don't take my word for it — try pairing different foods with your coffee.

The medical benefits (and risks) of coffee

A simple PubMed search on coffee will generate more than 11,000 entries. If you narrow it down to reviews, there are over 1,000 entries. Coffee has been purported to have many benefits as well as a number of risks. In 1991, the International Agency for Research on Cancer listed coffee as possibly carcinogenic in relation to bladder, pancreatic and ovarian cancer. Recently, evidence has been deemed inadequate and other reviews suggest that it lowers the risk of skin cancer. A recent review in the open access journal *Molecules* looks at 26 published intervention studies and suggests that long term coffee consumption (rather than the odd cup) produces an increase in glutathione (an important blood antioxidant) levels and reduces DNA damage. The authors also suggest possible long-term benefits against chronic metabolic and cardiovascular disease, as well as a reduction of the risk of stroke. Another review suggested that coffee consumption may reduce the incidence of gout, although its effects on hyperuricemia are less clear. One review suggests that more than two cups of coffee a day can reduce the risk of liver fibrosis, cirrhosis and even cancer. Even some dentists are suggesting that coffee provides some potential dental health benefits. Interestingly, its benefits on mental health are questionable, with several reviews suggesting its association with depression and the risks of dependence. It does appear to assist in reducing cognitive decline with age.

I would probably propose a balanced approach to coffee which suggests that, when taken in moderation, it can be part of a healthy diet, and an excellent start and end to a wonderful day. Bon appétit! ◆

Dr Daniel Fung is an avid drinker of coffee, an interest he shares with his wife, Joyce, and their five grown-up kids. He still helps to top up their Starbucks card and hopes to introduce this drinking passion to future generations of the *fung-mily*. The rest of his time is spent in his work as Chairman Medical Board at the Institute of Mental Health.

For Doctors, For Patients

SMA Seminar: Tax Obligations on Medical Practice

Date: 8 April 2017, Saturday
Time: 1 pm to 5 pm
Venue: One Farrer Hotel & Spa
CPE Points: 2

The 2017 Budget Statement will be delivered in Parliament on 20 February 2017.

Find out how the budget measures are of relevance to you as a medical practitioner and how it will affect your business. The seminar will highlight the tax obligations of a medical practitioner and how your business can take advantage of any tax planning opportunities.

Who should attend?
Clinic owners (especially new owners and those not represented by tax agents), and representatives who are responsible for the preparation and filing of the Income Tax Return and other corporate tax matters.

1 pm	Registration (Lunch will be provided)
2 pm	Tax Obligations of a Medical Practitioner *Mr Shajahan, Principal Tax Auditor, (Individual Income Tax – Ruling & Compliance Branch), Inland Revenue Authority of Singapore (IRAS)*
2.30 pm	Productivity and Innovation Credit (PIC) Scheme – Find Out What's New! *Mr Lo Yeow Fong, Senior Tax Officer (Individual Income Tax – Self-Employed Branch), IRAS*
3 pm	Budget 2017 and Its Relevance to Medical Practitioners *Mr Stephan Chew, Principal Consultant, Summit Planners Pte Ltd*
3.45 pm	Tax Planning *Mr Stephan Chew, Principal Consultant, Summit Planners Pte Ltd*
4.30 pm	Questions & Answers
5 pm	End of Seminar

Please return this slip for *SMA Seminar: Tax Obligations on Medical Practice* to **Jasmine Soo, Singapore Medical Association, 2 College Road, Level 2, Alumni Medical Centre, Singapore 169850. Tel: 6223 1264, fax: 6224 7827 or email: jasminesoo@sma.org.sg.** A confirmation email will be issued to all applicants.

Name: _____ MCR no.: _____ Specialty: _____

Contact no.: _____ Email: _____

Mailing address: _____

I would like to (inclusive of GST)

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(SMA Member: complimentary, Non-member: $80)

☐ Register my staff to attend on my behalf. Name of staff: _____
(SMA Member: complimentary, Non-member: $80)

☐ Register both myself and my staff for the seminar. Name of staff: _____
(SMA Member: complimentary, Non-member: $100)

By registering for this event, you consent to the collection, usage and disclosure of personal data provided for the purpose of this event, as well as having your photographs and/or videos taken by SMA and its appointed agents for the purpose of publicity and reporting of the event.

Mode of payment

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Expiry date: _____ / _____ CVV2/CVC2 no.: _____

☐ Cheque *(payable to Singapore Medical Association)*
Bank: _____ Cheque no.: _____
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Established clinic for rent at Block 78B Telok Blangah Street 32. No renovation needed. Take over medicine and office equipment free. $5,000 per month. Contact 9623 0692 Dr Cheng.

Loyang Point, Pasir Ris has a medical clinic space available. Clinic established for 20 years & doctor has new commitment. Good location. Reasonable rent. Next to busy dental practice. Please call Dr Ang at 9137 0612 or email ang_family141@hotmail.com.

Mount Elizabeth Novena/Gleneagles Medical Centre. Mount Elizabeth Novena clinic for sale. 581 sq ft. High floor. $7,200 psf. Available immediately. Gleneagles clinic for rent. 670 sq ft. $17,000/month. Available April 1st. Please SMS/call 8354 4530. No agents please.

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NUS National University of Singapore | Division of Graduate Medical Studies
Yong Loo Lin School of Medicine

The Graduate Diploma in Occupational Medicine (GDOM), offered by the Division of Graduate Medical Studies (DGMS), National University of Singapore, aims to provide comprehensive skills to doctors in general practice and specialists who wish to have a better understanding of the occupational aspects of their specialty and to be able to implement program to protect and promote a healthy workplace in line with the Total Workplace Safety and Health (Total WSH) Initiatives.

Emphasis is placed on the importance of offering a total and integrated workplace safety, health and wellbeing program. The new curriculum will also include "Fitness-to-return-to-work" assessment, management of workers with common chronic diseases and a project to start a Total WSH program at a workplace.

Successful candidates would be awarded the GDOM and would also be eligible to apply to be a Designated Workplace Doctor (DWD) with the Ministry of Manpower (MOM).

New course syllabus offered for 2017!

2017 Graduate Diploma in Occupational Medicine Course

Course Dates:	July 2017 - December 2017, consisting of 6 modules and must be taken in sequential order, with further details at http://medicine.nus.edu.sg/dgms/our-programmes/graduate-diploma-programmes/occupational-medicine.shtml
Course Fees:	S$ 6257.40, inclusive of GST & $20 non-refundable application fee
Application Period:	Monday, 6 February 2017 to Friday, 31 March 2017
Class Intake Size:	Maximum intake of 25 participants
Contact:	Joanne Tan (Ms) MD3, Level 2, 16 Medical Drive, Singapore 117600 Tel: (65) 6516 4527 / (65) 6601 4888 Email: joanne_tan_gf@nuhs.edu.sg

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We invite candidates,with the passion and ambition to be at the forefront of medical aesthetics & dermatology to apply.

Beyond Wellness Group has a strong track record in helping doctors realise their full potential with capital, administrative and branding support.

Candidates can email their resume and format of engagement (i.e. Full Partner, Salaried Partner or Fully Salaried) with remuneration expections to **recruit@beyondwellness.com.sg** | Only shortlisted candidates will be contacted.

Applications are Confidential

From the creators of
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Make life better.

Hey doctor, dont just save lives, make them beautiful too.

Refresh Aesthetic Group is looking to fill a resident doctor (registered with SMC) position in one of our clinics. You are required to perform/operate ablative and non-ablative lasers, IPL, RF, Chemical Peel, Botox, Fillers and Thread Lifts.

We offer competitive pay and comprehensive training. You must have keen interest in aesthetic medical practices, fun loving and always with a caring heart.

Email/Fax your resume to us to apply

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Singapore 369977
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E: recruit@ refresh.com.sg

Toa Payoh Central, Bedok Mall, Tampines Mall, Lot1 Shoppers' Mall

www.refreshlaserclinic.com.sg

Parkway Pantai

Parkway Pantai Limited (PPL) is the largest private healthcare provider and operates Mount Elizabeth Novena Hospital, Mount Elizabeth Hospital, Gleneagles Hospital and Parkway East Hospital - all accredited by Joint Commission International (JCI).

Our Accident and Emergency department / 24 hour clinics provide first-line treatment for a full range of medical conditions, including management of critical and life-threatening emergencies, to the treatment of walk-in patients 24 hours a day.

All our medical and surgical specialists are well-trained and ever–ready to support the handling of emergencies effectively and efficiently. By adopting a team approach towards the management of emergencies, we ensure the smooth and expedient management of all patients.

We invite dedicated individuals who are passionate and driven to join us as:

Resident Physician (A&E/ 24 hours Walk-In Clinic)

Based in Gleneagles Hospital, you will be part of a team of dedicated doctors and paramedical staff providing comprehensive care to our patients. You will also play a key role in the maintenance of clinical standards and the delivery of a Parkway service experience to our patients.

At Parkway, we provide sponsored postgraduate training opportunities in addition to a comprehensive suite of benefits. Join us for a challenging career and opportunities for personal development.

Requirements:

- Basic medical qualification registrable with Singapore Medical Council
- Possess a valid practising certificate from the Singapore Medical Council
- At least 3 years of clinical experience post-housemanship.
- Postgraduate medical qualifications and relevant experience are advantages
- Good oral and written communication skills
- Good interpersonal skills
- Good team player

Kindly email: **steve.tan@parkwaypantai.com** or call **9670 0472** for a friendly discussion.

www.parkwayshenton.com

SMA Clinic Assistant Train and Place Programme

SKILLSFUTURE ACCREDITED

INTERVIEW AND RECRUIT SMA-TRAINED CLINIC ASSISTANTS BECAUSE...

THE PERSON BEHIND YOUR CLINIC COUNTER *MATTERS*

Supported by:

e2i
Better Jobs For Life
Employment and Employability Institute

This service is provided free of charge for SMA Members and their clinics.

The first two SMA Clinic Assistant Introductory Skills Course sessions concluded in November 2016 and January 2017, respectively. Course graduates were trained in basic skills required of a clinic assistant, such as managing infection control, performing ECGs, and collecting and despatching biological specimens. Visit https://www.sma.org.sg/trainandplace and log in to your membership portal to indicate your clinic's vacancies if you're interested to interview and hire SMA-trained clinic assistants during their course duration.

Third SMA Clinic Assistant Introductory Skills Course	19 to 22 April 2017
Fourth SMA Clinic Assistant Introductory Skills Course	19 to 22 July 2017
Fifth SMA Clinic Assistant Introductory Skills Course	25 to 28 October 2017

If you're unsure about your membership login details or have any queries about the programme, please email Mellissa Ang (mellissa@sma.org.sg) or Denise Jia (denisejia@sma.org.sg), or call them at 6223 1264.

Asia Radiology

May 19 – 20, 2017 | MAX Atria @ Singapore EXPO

The 2017 RadiologyAsia Conference, themed "Bringing the State of the Art Imaging to Clinical Practice", brings incredible value to attending delegates. The conference will feature 74 topics, over 50 renowned speakers and 4 tracks. Passes are priced at **SGD275** for radiologist and **SGD145** for allied health professionals (academics, radiographers, nurses and technicians). Register for your conference pass at www.radiologyasia.com

Conference Speaker Highlights

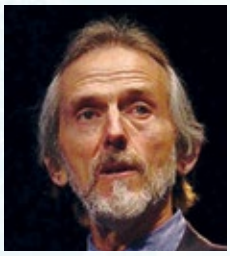
Wilfred Peh
Head of Department of Diagnostic Radiology, Khoo Teck Puat Hospital Clinical Professor, Yong Loo Lin School of Medicine, National University of Singapore

Tchoyoson Lim
Senior Consultant, Department of Neuroradiology, National Neuroscience Institute

Vincent Chong
Professor of Radiology, National University of Singapore, National University Health System Singapore

Howard Rowley
Joseph Sackett Professor of Radiology, Professor of Radiology, Neurology and Neurosurgery, University of Wisconsin, Madison, USA

Richard Wiggins
Director of Head and Neck Imaging, University of Utah Health Sciences Center



Michael Brant-Zawadzki
Senior Physician Executive, The Ron and Sandi Simon Endowed Chair, Neurosciences Institute

Please visit official website www.radiologyasia.com for conference programme and speakers biographies.

Register today to secure your delegate pass

Categories	Normal Rate (7th Dec '16 to 28th Apr '17)
Radiologist (including physicians and residents)	SGD 275
Singapore Radiological Society/College of Radiologists, Singapore Members	SGD 260
American Society of Neuroradiology (ASNR) Members	SGD 260
Allied Health Professionals (Academics/ Allied Health Lecturers/Radiographers/ Nurses/ Technicians)	SGD 145
Medical Students & Spouses	SGD 100
Business track pass (access to the business track on 19 May 2017 only)	SGD 85
AIRP Resident (Full access to RadiologyAsia Conference & AIRP workshop)	SGD 475
AIRP Non-Resident (Full access to RadiologyAsia conference & AIRP workshop)	SGD 575

** All prices are subjected to 7% Goods and Services Tax (GST)*

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Contact our registration team
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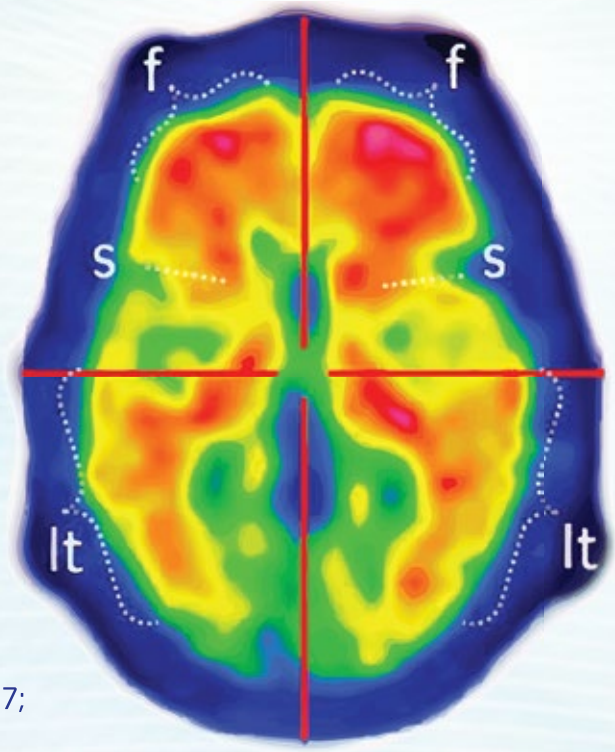
RadLink
PET and Cardiac Imaging Centre Pte Ltd

What if we could discover **ALZHEIMER'S DISEASE** earlier?

You can potentially plan your future 10-20 years before clinical onset of disease with only 10-20 minutes spent in a PET scanner.

Flutemetamol-F18 will be available in Singapore in Q1 2017; already approved by U.S. FDA and commercially available in Europe and Japan since 2015.



Positive colour scan using Flutemetamol-F18

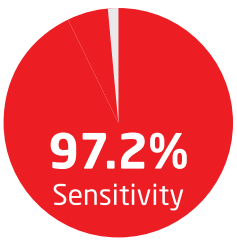
First-ever Positron Emission Tomography (PET) scan to screen for early onset of Alzheimer's Disease

One in 10 people

above 60 years of age in Singapore suffers from Alzheimer's Disease or a form of Dementia[1]

More than 83%

of people surveyed want access to early and accurate diagnosis[2], even if the disorder is incurable.



Soon, your patients can have access to Singapore's first-ever PET scan that offers up to 97.2% sensitivity[3] in preclinical onset screening for Alzheimer's Disease. **This PET scan may detect beta amyloid plaque build-up by up to 20 years before the disease actually manifests.**

RadLink PET and Cardiac Imaging Centre
290 Orchard Road, #08-05/06 Paragon Medical, Singapore 238859

Call the RadLink PET centre marketing team for more information:
Yvonne Tay +65 9699 7772 | Joey Chan +65 9765 3156 | Susan Long +65 9690 6980

And for restructured hospitals, please call:
Josephine Seet +65 9760 5926 | Elise Hong +65 9067 1016

References:
1. Http://www.straitstimes.com/singapore/health/one-in-10-people-over-60-have-dementia-new-singapore-study-claims. Accessed 4th December 2016.
2. Based on a global survey conducted by Milward Brown, "*The Value of Knowing - Neurology*".
3. Hatashita S, Yamasaki H, Suzuki Y, et al. *[18F] Flutemetamol amyloid-beta PET imaging compared with [11C] PIB across the spectrum of Alzheimer's disease*, European Journal of Nuclear Medicine and Molecular Imaging. 2013.