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CORRECTION
On page 28 of the August 2017 issue, the test rates listed in Table 1 SFL Recommended Screening and Eligibility Criteria for PRs 25 years and above should be $12.50 (w/o GST) and $13.38 (w GST). This has been corrected in the online version. We apologise for the error.
The other day, my husband shared that if he needed to see a proctologist, he really would rather see a man.

Does that make him prejudiced against women? (Gasp!) Or does this simply highlight the realities of practising medicine – that patients have a right to choose their doctors?

The answer isn’t a simple yes or no. Advances in opportunities for women have allowed for a shift in the gender profiles and traditional responsibilities of medical students and doctors. This has been more obvious in some specialties than others. These days, our patients are also more educated and aware of their right to choose.

In this issue, we interviewed Dr Jeanette Chen, who shares insights on her career and personal life. Dr Kao Pao-Tang and Dr Tan Tze Lee – who are both doctors and husbands – write heartfelt articles showcasing their journeys of raising their families, and how it was done in full partnership with their wives, who have careers of their own too.

I’m also delighted to present an article by Prof Sandy Cook, on her experience with changing gender profiles in the American medical school system, as well as with Duke-NUS Medical School. In subsequent issues, we hope to feature articles from the respective deans of NUS Yong Loo Lin School of Medicine and Lee Kong Chian School of Medicine for their perspectives.

Dr Tan Yia Swam has collected a handful of anecdotes from a small (but brave) group of doctors about perceived acts of discrimination against them. While I doubt this is pervasive, it certainly highlights that such things still exist, and should not be swept under the proverbial carpet.

We also include an interview with Dr Loo Choon Yong, who will be speaking at this year’s SMA Lecture on a highly relevant topic – Internationalising Singapore’s Healthcare. In addition, do peruse Part 1 of a discussion by Colin Liew and Tham Lijing on the modified Montgomery test, and this landmark ruling’s implications for the way we practise and document our patient encounters. Another must-read is SMA President Dr Wong Tien Hua’s column, where he discusses recent high profile cases that have thrown a spotlight on our profession’s disciplinary process.

Last but not least, Dr Leong Choon Kit will be stepping down as a member of our Editorial Board. We wish to thank Dr Leong for his many contributions to SMA News. Additionally, we would like to welcome Dr Alex Wong as a new member of our team, and wish them both all the best!

Dr Tina Tan is an associate consultant at the Institute of Mental Health and has a special interest in geriatric psychiatry. She is also an alumnus of Duke-NUS Medical School. Between work, exams and family life, she squeezes time out for her favourite pastimes – reading a good (fiction) book and writing.

Tina Tan
Deputy Editor
Dr Jeanette Chen obtained her BMedSci(Hons) and MBBCh degrees from the University of Wales College of Medicine in 1993 and 1994, respectively. She continued her postgraduate training in obstetrics and gynaecology (O&G) in Cardiff, Bristol and Birmingham, and obtained her MRCOG in 1999. Dr Chen returned to Singapore in 2000 and worked as a consultant in General Obstetrics and Gynaecology at KK Women’s and Children’s Hospital (KKH). During her time in KKH, she was awarded numerous Service from the Heart Awards and also received the Excellent Service (EXSA) STAR Award launched by SPRING Singapore (2008). She was also very active in teaching undergraduate and postgraduate medical students and obtained the Dean’s award in teaching. In 2009, she left KKH and started her own O&G practice in Thomson Medical Centre. She has been serving as an elected member on Singapore Medical Council (SMC) since 2014.
Why did you decide to become an obstetrician-gynaecologist (OB-GYN) and how was it that you came to enter private practice?

My undergraduate years were spent at the University of Wales College of Medicine. It was great because we were sent all around Wales for our clinical attachments!

My interest in O&G came about after one such clinical posting as a medical student. I was posted to a district hospital in North Wales and was one of only two students there. The maternity unit was a very busy one and as it had mainly low-risk patients, I was able to deliver 15 babies during my stint there!

Being the only female out of the two students gave me an advantage as it was easier to obtain permission from the parents to deliver their babies.

I enjoyed this speciality immensely as it dealt with women, their health issues and babies, as well as the challenges that came with this speciality, and hence decided to become an OB-GYN.

After being in the UK for 12 years, I returned to Singapore in 2000 and began working at KKH. However, I later decided to set up my own private practice at Thomson Medical Centre so that I could enjoy a more balanced work and family life. By then, I was a mother to two young children, with a rather busy husband. My decision to venture into private practice offered me the benefit of flexibility and the autonomy to be both a good mother and doctor.

How do you juggle the duties of being both a specialist and a mother of two?

Balancing work and family is never easy. One needs to be able to multitask and have a lot of family support. Being an OB-GYN means that one can be called to a delivery at any time. Living with my parents gives me the assurance that no matter what time I was called up, I could go with a peace of mind, knowing that my children will be well looked after. This synergistic arrangement had enabled me to focus on my career, while at the same time given me the ability to be there for the kids.

Do you think things have improved for female doctors in your field? Has it inadvertently become harder for male doctors?

Being a female obstetrician does have its advantages. We can understand what women go through as we have likely also journeyed through similar issues. In addition, most women are more comfortable seeing an obstetrician of the same gender. However, I also know of many male doctors who are very popular obstetricians. At the end of the day, I believe it is not the gender that is important, but a combination of experience, communicative skills, emotional intelligence and bedside manners that truly matters.

What advice would you give to a young female medical student/trainee who is considering a specialisation in your field?

O&G as a specialty requires lots of passion and nerves of steel. Decisions have to be made in split seconds and the implications of those decisions have important consequences. With the current medico-legal climate and medical indemnity issues, one should enter the specialty knowing what she or he is in for. I have never regretted specialising in O&G. I have delivered many babies in the past and I still feel much joy bringing a new life into the world each time. Helping women sort out their medical problems or even lending a listening ear has also been very meaningful.

What inspired you to serve on the SMC?

I decided to stand for the SMC elections three years ago because I felt the call to serve my profession and not just be an observer. Being in the SMC puts one in the public eye and fellow doctors have high expectations of us due to the heavy responsibility bestowed on us. As such, I aspire to be true to myself and fair in my decisions. Being in the
SMC has enabled me to look at things from a broader perspective and not just from one narrow angle. I hope that in the future, more doctors will be willing to serve as well and hence bring forth more diversity in ideas and opinions for the betterment of our medical profession.

What do you hope for the profession to achieve in the next five years?

I hope that in the future, all my fellow doctors will also find meaningful and constructive ways to contribute to our profession. This includes stepping up and taking up positions of influence and making the difference that will benefit our medical profession.

Recently, there have been a few disciplinary cases that have stirred emotions in our profession. Many have voiced their opinions. This would be an opportune time to step up and make a difference by contributing one’s time to serve the Council in various capacities. The Council is formed to regulate and maintain the high standards expected of this noble profession. Views and opinions may differ but ultimately, to enforce what is right and fair, we need competent and fair people to step up to serve.

As a woman, I have never felt discriminated or disadvantaged as a result of my gender. At the end of the day, it is your attitude and what you want to strive for in life that is important.

I grew up in a family with two brothers. My dad had always advised me that I can do anything as long as I have my heart in the right place and be compassionate in whatever I do. Being a doctor himself, he was very supportive in all my decisions. I grew up well and never squirmed away from difficult decisions or situations. I hope that this attitude will also rub off on my two girls. I always tell them to reach for the skies, as there is no limit to what they can achieve!

How do you maintain a normal family life for the kids when your husband is a public figure?

Being married to a public figure has not really changed our lives. The person I knew when I was 17 years old, the man I married and built a family with, has not changed much either. One thing we have in common is our faith in God, our sense of service and the heart to serve our community. We hope that we also set good examples to our kids and that they will grow up feeling loved, and with kind and humble hearts.

At the end of the day, I believe it is not the gender that is important, but a combination of experience, communicative skills, emotional intelligence and bedside manners that truly matters.
Recent high-profile cases of disciplinary action against doctors have set the medical profession abuzz, causing much debate and chatter in both real-world tea rooms and virtual chat rooms, accompanied by anxiety and uncertainty over the integrity of the Singapore Medical Council's (SMC) disciplinary process and the future of the medical legal environment.

Of particular concern is the case involving “serious negligence” of a senior paediatrician who failed to diagnose a child with Kawasaki disease. The doctor was charged with professional misconduct and the Disciplinary Tribunal (DT) handed down a three-month suspension of practice. The doctor appealed but the sentence was upheld by the High Court comprising three judges. This case of a seemingly “missed diagnosis” of a rare disease caused enough consternation among doctors to start an online petition to appeal to SMC, and it eventually amassed more than 1,000 signatories (or 7.5% of the 13,000 registered doctors in Singapore), possibly the largest petition of its kind to date.

This case was also brought up in parliament on 1 August 2017, with Member of Parliament (MP) Dr Lim Wee Kiak asking if there were guidelines for doctors “to send all cases for detailed diagnostic tests to avoid misdiagnosing
rare medical conditions”. Another MP Ms Tin Pei Ling commented that such judgements could eventually lead to more doctors practising defensive medicine. Senior Minister of State for Health Dr Lam Pin Min replied that the practice of defensive medicine adds unnecessarily to healthcare costs, and that doctors are expected to exercise good clinical judgement and manage patients appropriately.

I fully empathise with my fellow medical colleagues and understand why this case has generated so much angst. During the course of the days and weeks of media attention on the case, emotions have run high and doctors have called for something to be done because practising medicine seems to be getting more and more difficult in an unforgiving medico-legal environment.

I strongly urge all interested doctors to read the entire Grounds of Decision of the DT and even the appeal judgement by the Court of Three Judges to fully understand the issues involved, and to come to your own conclusions. In any case, the description of Kawasaki disease contained in the appeals judgement is so detailed that it merits continuing medical education points just for the clinical update alone.

Suspension being too harsh
Many people believed that the punishment of a three-month suspension was too harsh, as suspension from practice is something that should be reserved for the most serious of negligence cases, such as wilful misconduct and bringing the profession into disrepute. Most of us have no issue with past cases of suspension for doctors who overprescribe addictive drugs or engage in fraudulent activity, for example.

Being suspended leaves a permanent record on a doctor’s performance and will affect the doctor’s future prospect of finding employment or working abroad where a certificate of good standing would be required.

In this case, the suspension was seemingly meted out in a situation of cognitive error, a missed diagnosis of a rare illness and the making of a wrong clinical decision. The DT saw it differently and dealt with it as a case of serious negligence where the doctor had failed to follow international guidelines to act to run confirmatory tests on a number of occasions, even after the diagnosis of Kawasaki disease was considered. One of the main points of the petition to the Ministry of Health (MOH) was that the signatories felt that a censure or warning, instead of a three-month suspension, would have been more appropriate.

Cognitive error versus serious negligence
It is hard to define what constitutes serious negligence, as it depends on the context of the case, the qualifications and experience of the doctor, and the opinions of the expert witness.

It is worthwhile to note the comments of the High Court in Chia Foong Lin:

“[60] In Low Cze Hong, the court stated at [32] that “misconduct” means “more than mere negligence”. It added that “[g]ross negligence might amount to relevant misconduct, particularly if accompanied by indifference to, or lack of concern for, the welfare of the patient.” Mere errors of judgment and professional incompetence are insufficient to lead to a finding of gross negligence.”

“[61] …While we recognise that the line between an error of judgment and gross negligence could in certain circumstances be fine and that an error of judgment does not, ipso facto, constitute professional misconduct, it is the entire picture which will be determinative.”

As can be seen, it is not easy to describe or define when an “honest mistake” or cognitive error becomes serious negligence. It is a matter of degree. A simple mistake may be an error of judgement, but repeated lapses of behaviour that show no concern for patient welfare may then become a case of serious negligence. Where the line was crossed is a judgement call made by the DT and based on context. Clinical intuition is used to make snap decisions in real life, whereas deliberate decision-making is harder as it requires the doctor to follow clinical protocols and memorise decision pathways. In order to reduce cognitive error, the logical consequence is to discourage intuition and lean towards more protocol-driven practices, with defensive medicine being one of the possible undesired outcomes.

Self-regulation
Doctors have also expressed unhappiness that once found guilty of serious negligence, suspension is therefore “required” and the minimum period as set out in the Medical Registration Act (MRA) is three months. The system does not seem to differentiate between first-time and repeat offenders, although a past history of good clinical practice is given some weight.
emphasized on autonomy, it is becoming harder to justify self-regulation in the face of scepticism that such a system is maintained to protect doctors. Therefore, as a medical profession, we must work together to ensure a robust and fair disciplinary process that reinforces trust.

Improving the system

Amending the system

The minimum suspension period of three months is specified in the MRA (see Disciplinary Process on page 11), which could be amended to allow for more leeway in sentencing. There have been cases that did not warrant such a harsh sentence; even the High Court acknowledged this in Eu Kong Weng:

"[7] We agree that a suspension is called for, and if we had the discretion, we would have imposed a shorter period of suspension. However, the law does not allow us to do that as the 3-month suspension is the minimum mandated by s 45(2)(b) of the Act."

Changing the law will be a slow process as any proposed amendment would have to be reviewed by SMC and submitted to the Ministry of Health for further review. Following which, consultations with external bodies, such as the Ministry of Law, the Attorney-General’s Chambers and the public, must take place before the changes are tabled in Parliament.

Complaints Panel

The MRA provides for 100 doctors on the SMC Complaints Panel who are appointed over a two-year term. For each two-year appointment, SMC would approach public and private hospitals and medical institutions, as well as the professional bodies (eg, Academy of Medicine Singapore [AMS], College of Family Physicians Singapore [CFPS], SMA) to submit their nominations of doctors from various specialties to be considered for appointment to the Panel.

Doctors with at least ten years’ standing can volunteer to be on the Complaints Panel, bearing in mind that they are there to set the standards that all doctors have to prescribe to. Doctors who serve on the CC will also benefit from the experience and develop better awareness of medico-legal pitfalls that should be avoided. The number of doctors allowed on the panel should be increased to reflect the growth in numbers of registered doctors in Singapore.

Expert witnesses

We need more expert witnesses to serve in the disciplinary proceedings. An expert witness is one who is able to articulate the standard of care and professional conduct expected of doctors, and to give impartial and objective opinions to assist the court. The expert witness acts independently and technically does not owe any obligation to the party who engages his expertise. The problem is that we only have a small pool of doctors who are willing to be expert witnesses and come forward to spend time and contribute to the legal proceedings. We should not be quick to criticise these fellow colleagues whose opinions may result in judgements that we disagree with.

On this last note, I would encourage all interested doctors to consider signing up for the Medical Expert Witness Training programme. This is a joint collaboration between AMS, Law Society of Singapore, Singapore Academy of Law, SMA and the State Courts of Singapore. Participants are taught how to write good expert reports, and also given a chance to role play in court rooms and have a go at the “hot seat” to give evidence in mock trials. The faculty comprises trainers who are district judges, lawyers and senior doctors. In the most recent course held over three weekends from June to July 2017, ten judges and 16 lawyers participated. This was the third instalment of the programme and since then, we have equipped more than 100 doctors with the skills to be expert witnesses.

In the future, we hope to have a large pool of expert witnesses to tap on. Academic bodies such as AMS and CFPS can also be approached to provide assistance in recommending appropriate expert witnesses. Such active engagement of healthcare stakeholders would help contribute to more trust and ownership of the disciplinary process in Singapore.
The disciplinary process

The disciplinary process is specified in the MRA and its objectives are to protect the health and safety of the public, uphold standards of practice within the medical profession, and maintain public confidence in the medical profession. The MRA provides two types of disciplinary bodies – the CC and the DT, whose proceedings, deliberations and decisions are entirely independent of the SMC.

It is important to understand that the majority of complaints do not make its way to a DT. As a first cut, aggrieved patients who approach SMC are screened and advised on whether their complaints bear merit. The SMC information sheet that is available online makes it clear that SMC will only consider complaints made against doctors, and is not empowered to investigate complaints that pertain to institutional policies, such as appointment scheduling and billing. The SMC does not deal with requests for refunds, compensations, retrieval of medical records, and the seeking of apologies from doctors. The SMC secretariat members who deal with complaints as a first point of contact will also see if such cases can be resolved through facilitating communication with the institution or the doctor concerned, or through mediation. Cases that are deemed able to proceed will require a signed statutory declaration by the patient addressed to chairman of the SMC CC.

The Complaints Committee

The Complaints chairman then appoints a CC comprising one SMC council member as chair, one registered doctor of at least ten years’ standing, and one lay member. There are about 100 doctors and 50 laypersons who volunteer their time to be part of the panel in the CC. At the first CC meeting, clear cut cases with no merit and those that are deemed “frivolous, vexatious, misconceived or lacking in substance” can be dismissed. If need be, doctors who have fallen short of expected standards will be issued a letter of advice or letter of warning, or have their cases referred for mediation. In more serious or complex cases, the CC can instruct that further investigations be made or opinions sought from an expert witness before they decide to refer to the DT.

The Disciplinary Tribunal

The chairman of the DT can be a senior doctor, senior lawyer, ex-judge or ex-judicial commissioner. The chairman is advised by doctors selected from the CC. The CC members are not allowed to sit in the DT for the same case.

The powers of the DT include removing the doctor from the register, suspending the doctor for “not less than 3 months and not more than 3
years", imposing a fine not exceeding $100,000, handing out a censure or letter of undertaking, or make such other order as DT thinks fit. The doctor can appeal the decision at the High Court, also known as the Court of Three Judges, whose decision is final. SMC or MOH do not have any legal recourse to review a case after it has gone through the court of appeal.

**MRA amendments**

You might recall that the current MRA was amended in 2010, granting more powers to the CC, including the referral of cases for mediation between the doctor and the patient. That was also the time when changes were introduced to the composition of DTs with the inclusion of senior lawyers and retired judges to chair the DT. SMA gave feedback to SMC during the MRA consultation in 2009, recommending that the DT chairperson should be an SMC council member (a registered doctor) instead of a lawyer or retired judge.

In their press release published in October 2012, the SMC president explained that this was to “significantly improve the quality and pace of the proceedings before the Disciplinary Tribunals, particularly in dealing with legal issues that may arise, while preserving the fundamental principle of self-regulation.”

Following this, in January 2013, the then Director of Medical Services wrote in a letter addressed to doctors that “the DT would still be constituted with a majority of doctors so that questions of fact relating to medical issues are fully and justly considered. The legal person appointed to chair would not have a casting vote in the event of a tie and the views of the majority of doctors on the DT would prevail. To a large extent, the Chair’s role would be to manage the conduct of the hearing.”

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**DISCIPLINARY PROCESS**

**AN OVERVIEW**

**Referred by CC or SMC pursuant to s39(4) MRA**

**Disciplinary Tribunal (DT) Panel**
- (a) Panel of DT Chairman (Senior doctors/lawyers, Legal Service Officers)
- (a) Doctors from Complaints Panel

**Referred for formal Disciplinary Inquiry**

**Council Appoints DT**

**Notice of Inquiry (NOI)**
- Serves NOI with Pre-Inquiry Conference Date

**Pre-Inquiry Conference**

**DT’s outcomes at the end of the hearing if doctor is found guilty**
- (a) Remove name
- (b) Suspend not less than 3 months and not more than 3 years
- (c) Full-Reg to Restricted or Conditional-Reg
- (d) Impose appropriate restrictions or conditions
- (e) Fine not more than $100,000
- (f) Censure
- (g) Give undertaking
- (h) Make such other order as DT thinks fit

**Appeal**
- Doctor and SMC can appeal to High Court

**Complainant Appeals**
- If SMC does not appeal, Complainant can write to Minister who appoints a Review Committee, and where applicable, directs SMC to file an appeal

**Appeal Hearing before Court of Three Judges**
- Court of ‘Three Judges’ decision is final

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**References**

Meeting with SMS Dr Lam Pin Min

Several SMA Council members, including SMA President Dr Wong Tien Hua, met with Dr Lam Pin Min, Senior Minister of State (SMS) for Health, on 8 August 2017 to discuss the outcomes of the recent inquiries by the Singapore Medical Council Disciplinary Tribunals and High Court appeals. We conveyed concerns from the ground regarding potential ramifications of the verdicts. SMA also provided suggestions on how the system of self-regulation can be further reinforced and improved. Please also refer to this issue’s President Forum for more details (see page 8).

SMA 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 to work in healthcare clinics. Course participants will receive the Certificate of Completion upon their graduation from the four-day Clinic Assistant Introductory Skills Course.

Since its inception in November 2016, the SMA Clinic Assistant Train and Place Programme has trained more than 60 graduates for job vacancies put up by SMA Members at https://www.sma.org.sg/trainandplace. SMA Members can contact membership@sma.org.sg for details on how to gain access to these SMA-trained candidates for job interviews and offers. The next Clinic Assistant Introductory Skills Course will be taking place from 1 to 4 November 2017.

Feedback on table of fee range

The Office of Public Guardian (OPG) had published a table on their website highlighting a range of fees charged by psychiatrists, lawyers and accredited doctors for Lasting Power of Attorney certificate issuers. The purpose of the table was for OPG to give the public an indicative cost of doing an LPA, and was based on the average charges for the top 20 most frequented issuers in each of the three groups. SMA engaged OPG to provide feedback on the format in which the information was shared on the webpages and the webpages were subsequently amended to enhance the clarity of the information presented.

Template for Lasting Power of Attorney (LPA) Activation

SMA was engaged by the OPG to improve the medical report template for activating LPA. This template will be useful to doctors who are involved in such work. Several improvements were made, including allowing legible handwritten entries and not just limiting it to type-written entries, as well as adding an option to refer the patient to a specialist for further assessment. The finalised template can be found on the OPG website at https://www.publicguardian.gov.sg/opg/Pages/Forms.aspx or SMA’s website at https://www.sma.org.sg/ourvoice/index.aspx?ID=71, under the “Other Advisories” table. 

Dr Lim Kheng Choon is the Honorary Secretary of the 58th SMA Council. He is currently an associate consultant at Singapore General Hospital.
Throughout my years of training, I have noticed that there are some stereotypes which are quite hard to break out of. I have observed a wide range of reactions (even snide remarks behind our backs) from both colleagues and patients to myself and other female surgeons.

“You are a woman, how can you operate?”
I usually get this from a layperson. The patient’s family members are amazed that a woman is part of the operating team. They often assume that I am a nurse or that I play a clerical role.

“Oh, you are pregnant, are you sure you can operate?”
While some ask out of genuine concern (prolonged standing leads to discomfort and can trigger early labour), others are clearly dismissive. I believe that throughout the ages, pregnant women have been capable of looking after themselves and older children, while running a household or even working on farms while pregnant; so YES, holding a diathermy pen and/or laparoscopic instruments isn’t that difficult.

“You are too fierce”; “What a man-b*tch!”; “No wonder no boyfriend/not married.”
This is so rude, hurtful and it crosses so many lines that I cannot even begin to respond. It is especially so when a man replaces the woman in the same situation and the comment becomes: “He’s so decisive, firm and fair; he has devoted his life to his craft!”

“Oh you have makeup on, got hot date ah?”
Anyone can wear makeup anytime they want.

“You have such a sweet smile, my dear, you shouldn’t be in this field.”
Thank you for saying that I have a sweet smile, but that has nothing to do with being a competent surgeon.
However, now that I’m practising breast surgery exclusively, I see clearly that there are also reverse stereotypes.

“I don’t want to see the doctor in Room 4; it’s a man!”
The man is a doctor, just as I am. In fact, sometimes the man is the senior!

“I want a female doctor to do the operation for me. In fact, I don’t want any men in the operating theatre (OT) at all!”
If there’s an emergency, lady, I would want the most competent doctors and nurses in there to help, regardless of gender!

Dr ABC (Male)
I work in a small department which deals with women’s health. The gender make-up among doctors is well balanced, although it will soon start tipping more towards women. My colleagues are mostly gender-blind and we find that both men and women take to each of the subspecialties and service requirements equally, regardless of the physical demands. Although it is not a big department, we are all able to absorb the service obligations placed upon us when a female colleague takes maternity or childcare leave. There was never a sentiment that the men shouldered a disproportionate burden.

Our patients sometimes request for female doctors. While I often wonder if this is a form of reverse gender discrimination, I understand that this may be because of deep emotional reservations (cultural background, upbringing and beliefs, into a corner. I answered with a brave face but I felt shaken inside.

On other occasions, I once made the error of trying to clarify what I’d learned about a spinal condition. The surgeon I’d asked proceeded to grab and squeeze my arm to prove his point (spinal stenosis, of course). Another time, a student asked a question. For reasons beyond my comprehension, the same surgeon decided to answer the question by grabbing the front of my white coat and shaking me as if I were a rattle. I guess he thought it was funny and it wasn’t exactly assault, but each time there was unwanted and unnecessary contact.

Some might argue that since these events happened years ago, my impression of them may have been wrong or distorted. Personally, I doubt it. There were witnesses on each occasion.

I’m glad to report, however, that after being accepted into residency, I haven’t experienced any of such acts, whether overt or subtle. My colleagues and superiors have been cordial and supportive.

Dr MNO (Female)
In my residency interview, the interviewer asked how I would juggle the rigors of training and raising children. As I answered, ensuing statements implied that if I wanted kids, it meant I was prioritising family over work, and therefore I should not be admitted into the training programme as it would be a waste of time. I have only a vague recollection of the actual words said, but the meaning was clear and remains starkly so till this day. I remember my shock and indignation, and refusal to be backed or maybe even previous trauma that is not disclosed), given the intimate nature of our assessment. Nevertheless, we have a lean night call team and it can be difficult to accommodate in such a setting. Emotions run high because, as men, we too feel that we want to do the best for our patients, but yet we are unable to get past these basic obstacles. Nevertheless, I have been grateful to my female colleagues for always standing up for us in these difficult situations.

I hope that as our society matures, all healthcare workers will take the lead in promoting workplace equality, regardless of gender.
Dr PQR (Male)

The gender bias we experience in the obstetrics and gynaecology clinic is worsening by the day. A woman would walk into the clinic and immediately exclaim: “No, I am not seeing him; I want a female doctor!” It is no longer a one-off experience but a weekly occurrence. Unfortunately, this might not always be possible given that there are times when the entire clinic team is male. It also adds tremendous stress on the sole female doctor in clinic that day. Often, we tell them at length that they should not choose a doctor, but that there is the option of an upgrade if they wanted a specific doctor each time they came. Most would agree, but only grudgingly.

An even more difficult situation occurs when the entire team on call is male and the patient makes the same request. The patient will insist that a female doctor should come to the hospital from home and also question why there isn’t any female doctor in the entire hospital, not understanding the nature of how departments and call rosters are organised.

We try our best on the ground, to stick by our principles of equality to all patients. However, at times, it is really easier to just give in and hand the patient over to the female doctor. Since it makes for less work and fewer complaints, why not?

It certainly does not help if the institution seems to side with the patient when a complaint arises, and asks why it was so difficult to ask a female doctor to attend. There is absolutely no protection from these patient “bullies” who belittle male gynaecologists. I also feel the blame always falls on the males for “making it difficult”.

As a result, some of us simply give up and take the easy way out, saying, “OK, no problem, please see Miss XXX instead,” with a smile. This is set to create a dangerous spiral. It could lead to a “monkey see monkey do” situation when more and more patients start to see that they could actually get on top of the system and get what they want simply by insisting and threatening to complain.

Patient care should matter. Patients might end up with substandard care when they need subspecialty care that has only male doctors. If we were to cave in to social pressures, patients might end up seeing a generalist and may not receive the best care they can have.

Dr XYZ (Female)

During housemanship, people laughed when I told them that I was interested in orthopaedic surgery. Maybe it was because I’m rather petite. Nevertheless, I persisted.

During my medical officer (MO) posting in orthopaedics, there were a few incidents which made me feel uncomfortable, but I decided to just shrug them off and ignore them – developing, in the process, a really thick skin in preparation for the future.

Once, after scrubbing up for the OT, the consultant helped me to tie my gown and there was just a fleeting sense that perhaps there was a bit more body contact than was necessary. Besides, I hadn’t come across many consultants who would tie gowns for first-year MOs.

Another time, during an operation, I was asked to tighten a screw. As I did so, the consultant guffawed: “What a strong grip; I’m sure you can give a good handjob!” Luckily, I am not one who blushes easily, so I just put on a smile and carried on. The scrub nurse, however, scolded him: “Dr so-and-so, don’t tease the young girl!”

After a few more of such incidents, I decided to respond in kind: “Have you heard that dancing is the vertical expression of a horizontal desire?” There was silence in the OT. The consultant just shook his head and said: “Wah, MOs nowadays….” The male registrar wisely kept his mouth shut. There have been much fewer sexist and sexual jokes since.

It is perhaps a pity that I have to behave like a man to be accepted as one of the boys, or risk being the target of (misplaced) chauvinism and/or compliments. Yet when one is too manly, one gets some hurtful labels. Oh well, this is the path I have chosen and I am quite content where I am now, both professionally and personally.
Help your patients plan ahead by empowering them to decide who should act in their best interests under the Mental Capacity Act (MCA).

SHARE WITH YOUR PATIENTS ABOUT LASTING POWER OF ATTORNEY (LPA) TODAY!

3 Simple steps to complete our online module!

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2 Online modules

- **LPA Accreditation Programme**
  - As a prerequisite to being accredited, the medical practitioner (non-psychiatrist) has to undergo a familiarisation course on their roles for issuing an LPA certificate.

- **Assessment of Mental Capacity under the MCA**
  - Understanding the principles of MCA
  - Assessing mental capacity
  - Writing a Mental Capacity Assessment Report

1 Non-Core CME point for each online module

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Doctors may use this medical report to assess the mental capacity of the donor. This form can be found at [https://www.publicguardian.gov.sg](https://www.publicguardian.gov.sg).

For enquiries, please contact the SMA Secretariat at tel: 6223 1264 or email: OPG_LPA@sma.org.sg.

For more information on LPA, please visit the Office of Public Guardian website at [https://www.publicguardian.gov.sg](https://www.publicguardian.gov.sg).
1989. We met.

We married at the end of 1990. I was a medical resident at the National University Hospital (NUH), and L was a paediatric resident in the paediatric department downstairs. We both really enjoyed working in our respective departments, and the daily cut and thrust of acute medicine and paediatrics was very exciting. In those early days, the duties were onerous but were often made bearable by the sheer quality of the colleagues we worked with.

In medicine, I had the privilege of working under many eminent clinicians including Prof Chia Boon Lock, Prof Vernon Oh and Prof Lee Kok Onn, just to name a few. The daily routine of academic medicine, coupled with on-the-job training for the service component, was the oxygen that sustained me through long evenings of looking after sick patients. Working with my fellow residents was a real joy – the best experience ever. Friendships became lifelong and many of them are now eminent doctors and heads in their fields.

A “bump” on the road

Then, we made the happy discovery that she was pregnant with our first child! We had planned to have children early. But however you may plan for it, it would still be a bit of a shock when it happens. Endless questions kept popping up: “How are we going to cope with work, studies and examinations? How are we going to manage during the later part of the pregnancy? How long should she stay off work?” The months of morning sickness followed by fatigue became the daily routine then. We continued to go to work but it was hard going. As the husband, I often felt helpless as I could not do much except to give whatever emotional support I could.

When Jed was born, our married life totally changed. Carefree days were replaced by night duties without post call, with the constant need for nappy changes and night feeds. L felt that she didn’t really want to go back to hospital work as that would take her away from baby Jed. I continued on in general medicine, frantically trying to prepare for the MRCP Part 2, while trying to find time to spend with the family.

L started doing GP locums to get a break from baby duties. After a month of being confined to the home looking after Jed, getting out was a great help and the change of environment was really therapeutic for her. She would follow her boss and mentor, Dr Goh Wei Leong, on house calls and would regale me with stories about visiting the elderly in the flats around People’s Park. It was then that she found the work to be very enriching, and she started considering family practice as a career.

As the MRCP Part 2 examinations loomed, I felt totally inadequate and unprepared, fearful of failure and uncertain about the future. All of that, however, vanished like the morning mist at daybreak after we
had a minor emergency at home. That event impressed on me indelibly just how important the family is for me. Though I then passed the MRCP and was earmarked for a career in gastroenterology, my heart just wasn’t in it anymore. I couldn’t see myself continuing on in hospital medicine for the years to come; for me, long hours working in a hospital setting meant much time taken away from my wife and family. L had already decided that hospital work wasn’t for her, and that she would not go back to NUH to continue with her residency. She knew then that I was torn and unsure, and since she was planning to continue as a GP, she quipped, “How nice it would be for us to work together in the same clinic!”

After much deliberation, we finally decided to strike out together in general practice, side by side in the same clinic. We started our clinic in 1992, and have been in the same location, in the same rooms, side by side for the past 25 years.

**Our adventure in the GP heartlands**

We faced many struggles in the beginning. We had the usual financial worries about paying the rent and renovation loan. We worried about whether we would have enough work to pay our staff. We fretted about leaving our young son in the care of a maid: “Would he be safe? Would he become emotionally closer to her than to us?” As private medical work is very competitive, we had to work long hours ourselves as our turnover then was not enough to justify paying for another doctor.

As a young family with small kids, we would not have been able to manage without the help of friends and family. We were fortunate to have the support of our parents, who watched over the kids when we were at work. We often make clinical decisions together and this has led us to enhance our respective skills. As a couple, we each have our own unique skillsets, and are complementary in all that we do. We experience the same challenges, the same worries and the same heartaches. Together, we faced enterovirus 71, H1N1 and SARS, and often went home with the fear that we might bring some deadly bug back to the family. With each crisis, we learnt to appreciate each other more, marvelled at each other’s strengths, and supported each other’s weaknesses.

As the years passed, we have taken on more colleagues who helped to offload some of our clinical duties. This decision was made in order for us to devote more of our time to the family. It is an investment of time and opportunity costs to build up our family unit. Did we sacrifice our hospital careers for this life? No, we exchanged it for something way better, and built our “careers” around what is most important for us… our family!

Our children are all adults now and studying in overseas universities. As they are all in distant lands, we do miss them a lot, and take every opportunity to visit them. But, as any private GP will tell you, days away from clinic means lost revenue and that is the same for us.

But it is all worth it. It really is!

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**Legend**

1. Bonding in Busan
2. Towards new horizons!
are building a family. First comes the planning of one’s wedding. Following that, pregnancy takes so much out of you that whatever meaningful amount of sleep you get barely re-energises you. Add to that the traineeship rules that penalise you if you fall short of clinical service hours or the number of calls till the third trimester. God forbid if you even attempt to take your membership examination in the middle of all these.

And yet she did.

Mind you, she isn’t infallible. Wonder Woman she isn’t. She attempted her first membership two weeks before giving birth to our first child. She was so stressed out during the entire pregnancy that I often tell new acquaintances that my wife is practically my boss. Sympathetic laughter normally reserved for henpecked men ensues.

“At work”, I would say, as an afterthought.

That surprises them to no end, given that I am 15 years her senior and that we work in the same institution. The conversation can get awkward from then on, given that the only logical explanation is that I am bad at my job and it just isn’t cool to talk about it. The topic is then usually changed after a few jokes and some nervous laughter.

You know, it seems like the only reason a woman does better than a man is because the man is bad at it. The fact that woman can be just as, if not more, competent as men, is seemingly lost to many.

But my wife is. A fact blessedly not lost to others as well.

Nevertheless, being good at one’s job isn’t necessarily easy. We’ve all been through it. Those of us who survived the grind – that is traineeship – got spat out at the end in some semblance of the intended finished product, often slightly damaged. While those of us seniors love expounding the horror stories of our traineeship, those stories pale in comparison to what I witnessed in my wife’s own journey. The process is infinitely harder when you are a woman trying to build a career and a family at the same time.

The fact is that time is a rapidly diminishing resource when you
Dr Kao Pao-Tang and Dr Ooi Pei Ling is a husband and wife team from Khoo Teck Puat – National University Children’s Medical Institute, National University Hospital (NUH). He is the head of NUH Children’s Emergency and she is a paediatric rheumatology consultant and the deputy clinical director of the Paediatric Department. They have been married for eight years and have three wonderful children – Gracelyn (7), Gabriel (5) and Gideon (2).

She had to be induced at 37 weeks due to oligohydramnios and a case of intrauterine growth restriction. However, she went on to eventually pass her membership after two further tries, all while going through the trials of being a first-time mother.

Yet she has since gone through two more pregnancies, while maintaining a full-time clinical service, completing her traineeship and beyond.

So what have I, the husband, done to support her in achieving all these? While not one to shy away from my role as a husband and father, I haven’t had to do anything remotely self-sacrificial. The fact remains that many of her roles cannot be performed by someone else, and even if they could be, she would be reluctant to relinquish them. One of the challenges that she faces daily is how to allocate her limited resources among her ever-expanding roles.

The truth is that the solution is nothing tangible, I am afraid. It’s just support.

Surely, being in the same specialty counts towards something. She seeks solace in knowing that I am intimately familiar with the challenges she faces at work, and bad days need no explanation. She is able to reaffirm her commitment to her causes, knowing that I believe likewise. From time to time, she gets the gentlest of nudges in the right direction when she is feeling less than motivated.

From that, she has gone on to do great things.
In 2003, the National University of Singapore (NUS) lifted a quota that limited the number of women entering the MBBS undergraduate entry medical school.1 The article suggested that this action resulted in a matriculation shift such that about 50% of the entering cohorts are now women. This raises two interesting questions. Are the rates different for graduate entry programmes, like Duke-NUS Medical School (Duke-NUS); and how does that increase play out in careers and leadership positions post medical school at Singapore Health Services (SingHealth)?

Women in medical school

Historically, Singapore is not alone in having fewer women entering into the medical profession. In the US, which has a long-standing tradition of graduate entry to medicine, very few women entered medical school prior to the mid 1970’s. In my dissertation, I gathered information about women graduates from Cornell Medical School from 1950 to 1979, and I found that only 6% of the physician graduates were women through 1975.2 It was only after that time where the numbers began to rise. This is similar to data provided by the American Association of Medical Colleges (AAMC) where in 1950, only 6% of the matriculates were women.3 In 1975, the number of women matriculates was still relatively small (23%).4 One possible explanation to these earlier trends was that few women entered university in the first place in the 1950s. As the men returned from the Second World War and were given financial aid to go to College through the Veterans
Association Education Bill, women left the workforce and returned to their homes to start families. However, in 1972, the US government passed a law called Title IX, one of the Education Bill Amendments that stated:

“No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.”

This led to greater financial aid and opportunities for women to enter into universities. Not surprisingly, you start to see the increase in women entering medical schools. By 1979, the percentage of women was 33% at Cornell University. By 2000, the numbers at all US universities were at 46% and in 2016, AAMC reports that the number has risen to 50%.3,5

For Duke-NUS, which offers a graduate entry programme in Singapore, we matriculated our first class in 2007. During the first two years, we had almost twice as many women applicants and our entering class had 73% women in 2007 and 63% in 2008. It is easy to infer that these women may have had an interest in medicine prior to 2003 but sought alternative undergraduate options after being impacted by the quota limiting women entering medicine at NUS. The opening of the Duke-NUS programme in 2007 allowed for many of those women to once again consider the possibility of going to medical school after their first degree. From 2009 onward, however, the number of men and women applicants and the class distribution has been roughly 50:50, similar to the US proportions.

Women in the profession

The next question is what happens to the women physicians following medical school? The proportion of US women graduating has been similar to those entering residency; thus, they are not dropping out of medical school.7 They do, however, vary a great deal in the residency choices, with women accounting for 50% or more in specialties such as: obstetrics and gynaecology (83%); paediatrics (71%); family medicine (55%); psychiatry (55%); and pathology (55%); and very few in the surgical disciplines. In 2014, AAMC reported the distribution of women medical doctors by faculty rank in universities, a marker for career growth, and found that 51% of the women were instructors, 43% assistant professors, 32% associate professors and only 19% full professors. This presents a steady decline in representation at the higher academic levels.

Now, there are many possible reasons for this decline. Barsh and Yee found that many women drop out or get stuck along the way for career advancement in business, despite their significant numbers at entry.4 The barriers they noted were:

- **Structural**: Top leadership is not necessarily supportive of advancement and few role models are available as examples.
- **Lifestyle**: Women are often both primary breadwinners and primary caregivers, thus slowing their progress. Most top leaders do not have to balance those two roles and there are not enough flexible opportunities to permit a balance.
- **Institutional mindsets**: Women often do not ask or seek advice. In addition, there are assumptions that women will not or cannot do the job due to lifestyle issues. Furthermore, women are more often evaluated and promoted on their accomplishments, while men promoted on their potential.
- **Individual mindsets**: Women themselves tend not to ask for leadership roles.

However, women have been found to be better leaders as they are more results-oriented, more resilient, better at seeking out feedback, better team leaders, have a more robust work ethic and most importantly, are great sponsors for the next generation.8

In 2016, a Straits Times article suggested that Singapore women face many of the same mindset issues as reported by McKinsey. In addition, however, many Singapore women do not return to the workforce after having children, unlike in other countries, which has negative economic impact for organisations and Singapore.9

In a presentation at the Women in Science Network symposium in March 2017,10 Prof Wong Tien Yin looked at the distribution of SingHealth women physicians and scientists. While the percentage of women in residences was roughly equal (52%), he found similar career trends that are noted in the US – in that the proportion of specialists, heads of departments, division chairs and other leadership positions was much lower and declined as one moved up the leadership ladder.

In Singapore, however, it is possible that the quota has had a big impact on these numbers. Prior to 2008 (five years after the quota lifted in 2003), there was a limited number of women physicians graduating. Most likely, a majority of those who now hold leadership positions in SingHealth had finished specialist training back in a time when there were fewer women in the class. Furthermore, as per the reasons noted by the Straits Times article, they may have resulted in fewer women being available for leadership positions. And, if you consider the fact that most specialist trainings take five to six years, you would naturally also have fewer women finishing training prior to 2013/2014. Couple that with the time it takes to progress to leadership positions, it is not surprising to see so few women in leadership roles at SingHealth.

For Duke-NUS, our first class graduated medical school in 2011. If they went straight on through residency and senior residency without a break, they are just now (2017) receiving their junior consultancy status. So, clearly, there has not yet been enough time for Duke-NUS graduates to achieve significant leadership positions.

What can Singapore do now, for those women finishing medical school and residency to see them blossom into leadership positions within the next ten
Leadership should invest in supporting and actively role modelling the desired mindset and behaviours that support women promotions.

Monitor progress but call out and make sure there are consequences should individuals or departments not reflect a progressive mindset.

Actively sponsor high potential women (and men).

Actively promote/recognise efforts at gender diversity.

Use data to support targets, goals and aspirations.

Applying these principles along with Singapore’s residency system provide great flexibility in training progression and support – nay, even encouragement – for women returning to the workforce. We will not only see a greater percentage of women in leadership roles, but also see their positive impact in enhancing the healthcare work environments.

References
The Medical Expert Witness Training held its third consecutive run this year over a span of three Saturdays: 24 June at the Academia and 15 July and 29 July at the State Courts. This training is a joint collaboration between the medical and legal professions, namely SMA; Academy of Medicine, Singapore; Singapore Academy of Law; the Law Society of Singapore; and State Courts of Singapore.

This year’s training had 53 participants and they were from various healthcare specialties, such as general medicine, emergency medicine, forensic pathology and orthopaedic surgery, among others. The faculty comprised a team of judges, lawyers and medical trainers.

The Medical Expert Witness Training provides medical practitioners with the opportunity to experience role play sessions in actual courtrooms. This enables them to acquire the knowledge and skills in writing medical reports, be aware of pitfalls when giving oral evidence in court as an expert witness, and to acquire practical skills by being directly observed and coached in providing oral evidence in court.

Day 1 of the training commenced with an opening address by Justice Choo Han Teck and the training session covered the following topics: In General – Medical Expert, Instructions and Writing an Expert Report; Preparing for Court and Professional Issues; Testifying in Court – What to Expect and Courtroom Skills; Common Pitfalls in Writing Expert Reports; and Drafting an Expert Report.

Participants were provided with case scenarios and were tasked to write and submit reports based on their assigned role as either the plaintiff or defendant expert. The reports were then reviewed and marked by the faculty and returned to the participants.

Days 2 and 3 focused more on the role playing sessions. Day 2 started off with General session – Reviewing the Assignment and Common Errors Made, conducted by Ms Kuah Boon Theng and Mr Edmund Kronenburg, followed by the first role play session. Day 3 began with the second role play session, followed by the debrief conducted by Ms Kuah Boon Theng and Mr Edmund Kronenburg. The closing address and presentation ceremony was then hosted by District Judge Tan Boon Heng, and finally, the Address was delivered by Master, Dr S R E Sayampanathan.

The training garnered positive feedback from the participants, which included – “The marking of the paper exercise were detailed and enlightening. Appreciate the multiple reviews and effort in making it very realistic. This course will help to improve my practice.” and “Time on the stand was quite an experience. District Judge Constance Tay and Dr Joseph Sheares gave a lot of useful feedback, and Mr Siraj Omarl and Mr Leong Kah Wah were great. Thank you to all judges, trainers and organisers.”

We would like to thank all district judges, lawyers, medical trainers and participants for taking time off to conduct and participate in the training, and for making it a fruitful and enriching experience for everyone present. This training would not have been possible without the assistance, teamwork and dedication from all faculty members and the five collaborating professional bodies.

Legend
1. From left to right: Mr Gregory Vijayendran, Dr T Thirumoorthy, Dr S R E Sayampanathan, Ms Wong Peck, Justice Choo Han Teck, Ms Kuah Boon Theng, Dr Wong Tien Hua and Dr Joseph Sheares
2. Ms Kuah Boon Theng presenting the token of appreciation to Mr Siraj Omarl
What is fee-splitting or fee-sharing?
This occurs when a party takes a fee from the consultation or procedure charge by the doctor. This fee serves as a kickback if there is no relationship between the size of the fee and the actual work that is done. The party can be a third-party administrator (TPA), healthcare organisation, financial agent or another doctor who referred the patient. If there is no way for the recipient to justify doing the necessary work to deserve this fee, it becomes a potent financial reward. This reward incentivises the recipient to keep sending patients to a particular doctor and becomes the main and only consideration for referring a patient, and all other factors, including the doctor’s competency, skillset and experience, may turn out to be inconsequential. This issue is articulated in section H3 of the Singapore Medical Council (SMC) Ethical Code and Ethical Guidelines (ECEG): “In managing your patients, you must always place patients’ best interests above your personal interests and any business or financial considerations.”

Taking a fee for yourself, alongside that for the other doctors, without contributing a commensurate portion of care in collaboration with these doctors, is inappropriate. You should refer a patient to a colleague to provide a part of their care as it is in the patient’s best interests and not because you will profit from it.

When is the fee paid not considered a kickback? The answer is simply when it is commensurate with the work done by the party during the referral process. For example, if a TPA charges a flat fee for every patient that walks through the clinic doors, that fee should cover the TPA’s cost of running a managed care scheme with managers, staff, computer systems, rentals, marketing, auditing and courier services. What may not be justifiable is a tiered fee that increases according to the size of the doctor’s bill. The work done by the TPA then does not justify the increase in fees as the work is similar regardless of how much the patient is charged. The SMC ECEG clarifies this point: There may be fees that you are charged by managed care companies, TPAs, insurance companies or patient referral services that you engage. These fees ought to be proportionate to the actual work done by these companies in handling and processing such patients. It follows therefore, that such fees ought to be based on the work of the third party and not on the services that you provide or the fees you collect. Any fee that is too high in quantum could be deemed “fee-splitting” or “fee-sharing”.

Radiology practices that pay an administrative fee to doctors who refer patients to them are potentially also running foul of
the ethics of fee-sharing. This is true even when administrative fees are set up as company-to-company transactions to circumvent scrutiny as such invoices are also governed by contract law. However, doctors can justify some charges for the work done in obtaining appointments, tracing reports and contacting patients. There should be transparency in making these additional charges clear to the patients before any fee is levied on them. Since the SMA Guidelines on Fees were withdrawn, there is no explicit guiding principle to the pricing of drugs. There are holding, storage, inventory and dispensing costs that need to be accounted for. Laboratory services are another area of concern. There are procedural costs, as well as costs of hazards such as needlestick injuries, biohazardous substances and sharps disposal. In addition, work is done in tracing reports and contacting patients. These factors may justify reasonable mark-ups on the cost price.

Fee-splitting is often covert and doctors may inadvertently rationalise their way out of situations. Nevertheless, charging a reasonable fee for expertise and work done is legitimate. When in doubt, respected senior colleagues can be a source of help in providing guidance. Fee-splitting serves as a conflict of interest that may adversely affect patients if referrals are not made in their best interests. For the medical profession that values service before personal gain, it is important that public trust is not eroded by such practices.

Further reading


Dr Chong Yeh Woei has been a physician in private practice in Orchard Road since 1993. He is the chairman of the Membership Committee and the Ministry of Health Medical Advisory Panel on Driving. He has been a SMA Council Member since 1998 and served as chairman of Private Practice Committee from 2000 to 2012. He was SMA President from 2009 to 2012. He represents the SMA on the SMC Continuing Medical Education Coordinating Committee.

SMA EVENTS

OCT 2017

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A NEW TEST FOR MEDICAL NEGLIGENCE: THE MONTGOMERY TEST

Text by Colin Liew and Tham Lijing

Recent cases in the newspapers have shown that it is increasingly important for doctors to have a firm understanding of (a) their ethical obligations and (b) their legal duties to their patients. This is the first of two articles that focus on the doctor's legal duty to exercise reasonable care. The first article will explain and illustrate the new test for medical negligence. The second will explore the practical differences between the old and new tests.

For a quick summary of the present legal position, please see the appended flowchart.

Introduction

Most doctors will be aware of the legal test for medical negligence: the Bolam test (as it is commonly known). Under the Bolam test, a doctor will not have acted negligently if the act complained of is supported by other respected doctors, so long as those doctors' opinion is internally consistent and logical (also known as the Bolitho qualification). It does not matter if those doctors happen to be in the minority.

For many years, the Bolam test applied to all aspects of a doctor's practice: ie, diagnosis, advice and treatment.

But things have changed after the recent Court of Appeal decision in Hii Chii Kok v Ooi Peng Jin London Lucien. Now, the Bolam test applies to determine whether a doctor has been guilty of negligent diagnosis or treatment. A new legal test applies to determine whether a doctor was negligent in advising the patient: the “Montgomery test”.

When does the Montgomery test apply, what does it entail and why does it apply only to giving of advice? This article will answer those questions.

Diagnosis, advice and treatment

The patient-doctor interaction may include:

a. Diagnosis: the identification of the patient's affliction. Diagnosis is the process by which the doctor obtains information from the patient by taking history and physical examination, considering what further investigations are required, analysing the information and forming a provisional conclusion on what to do.

b. Advice: the presentation of the appropriate information to the patient. Advice includes giving recommendations on what should be done, providing information on diagnostic procedures and any associated risks, as well as advising treatment plans and associated risks.

c. Treatment: the implementation or execution of the cure, including medication, surgery or other procedures.

A doctor may be negligent in his diagnosis of, advice to, and/or treatment of a patient. A doctor may misdiagnose a cancerous tumour as a benign one, wrongly explain what side-effects a particular drug may have, or make a mistake during surgery by amputating the wrong leg.

Historically, medical negligence law did not distinguish between diagnosis, advice or treatment. In all cases, the Bolam test would apply. That has now changed.

In Hii Chii Kok, the Court of Appeal said that the Bolam test would continue to apply to diagnosis and treatment, but that a new test for negligence would apply to the giving of advice. This new test was called the Montgomery test, after a UK Supreme Court decision.

The reason for this change was the shift towards a more patient-centric approach to medicine. In particular, a patient should have the freedom to make an informed choice about what medical treatment (if any) he/she undergoes. In this regard, the Bolam test was outdated. The Bolam test was created in the 1950s when medical treatment was paternalistic: doctors would simply prescribe their professional view, which the patient was expected to accept unquestioningly. The court said that such a paternalistic approach was inconsistent with the modern day emphasis on “informed consent”. So a new test was needed for cases where doctors gave advice to their patients.

The Montgomery test

A patient receiving advice is not simply a passive recipient of care (as one would be when one's ailment is being diagnosed and treated). The patient plays an active role because ultimately the patient should decide on the course of treatment (if any); and the patient can make an informed judgement only if he/she has sufficient advice and information.

What is sufficient advice and information? This is a question that will be determined by the court objectively: what would that particular patient in his circumstances reasonably regard as material? The sufficiency of the advice and information will depend solely on the views of other respectable doctors (as it would have under the Bolam test).

The Montgomery test will be applied on the facts and circumstances as they existed at the time the material event occurred. The Montgomery test has three stages:

1. The patient must satisfy the court that relevant and material information was withheld from him.
2. If yes, the court will determine whether the doctor had that information in the first place.
3. If yes, the court will determine whether it was justifiable for the doctor to withhold that information from the patient.
Each of these stages deserves closer attention.

**Stage 1 of the Montgomery test**
Stage 1 of the Montgomery test asks whether the patient failed to receive any relevant and material information. Doctors ought to disclose (a) information that would be relevant and material to a reasonable patient in that particular patient’s position; and (b) information that the doctor knows is important to that particular patient in question.5

The relevance and materiality of information is assessed essentially from the perspective of the patient. Relevant and material types of information would include (but are not limited to):
(a) the doctor’s diagnosis;  
(b) the prognosis with and without medical treatment;  
(c) the nature of the proposed treatment;  
(d) the risks associated with the proposed medical treatment; and  
(e) the alternatives to the proposed medical treatment and their advantages/risks.6

The court will apply a common-sense approach to determining whether specific information was relevant and material. Doctors will have to walk the fine line between:
(i) taking reasonable care to ensure that the patient receives all relevant and material information – failing which the patient would be unable to make an informed decision; and  
(ii) not indiscriminately bombarding the patient with every iota of information – failing which the patient may simply be left more confused and also unable to make an informed decision.

For example, say a patient is contemplating a particular surgical procedure, which carries with it a number of risks. A doctor does not have to disclose each and every possible risk to the patient. Whether a risk has to be disclosed depends on the severity of the potential injury and its likelihood. Hence the risk of a likely but slight injury should be disclosed; and so will the risk of an unlikely but serious injury. But importantly, the risk of a very severe injury would not have to be disclosed, so long as the possibility of its occurrence was “not worth thinking about” – eg, because the likelihood of its occurrence is negligible, or because such a risk is common knowledge.7

To take another illustration, a doctor will have to tell the patient about the benefits and side-effects of the proposed medical treatment. The doctor must also tell the patient about the advantages and disadvantages of alternative procedures, and the consequences of having no treatment at all. But the doctor only has to tell the patient about reasonable alternatives – ie, the doctor does not have to tell the patient about fringe alternatives or treatments that are obviously inappropriate.8

Further, a doctor must disclose information that he knows (or ought reasonably to know) would be important to that particular patient.9 For example, when a doctor is taking a patient’s history, he will commonly find out the patient’s occupation. That knowledge may be important in assessing what information that particular patient would find material and relevant. Hence a very low risk of slight eye injury would be highly relevant to a professional fighter pilot, even if it might be insignificant to other people.

The doctor does not have to ensure that the patient in fact understands the information provided, but only to take reasonable care that he does.10 So while the doctor does not have to “test” the patient’s knowledge, the doctor will have to assess the ability of the patient to understand the information. The doctor will have to deliver the
information using language and at a pace that allows the patient to absorb. Understanding means that the patient must appreciate the significance of the information – hence simply reciting to the patient the statistical probabilities is unlikely to be enough.

Stage 2 of the Montgomery test
Stage 2 of the Montgomery test asks whether the doctor did in fact have the information (that was relevant and material, and not told to the patient).

If the doctor did not have the information, he cannot be negligent for failing to provide that information to the patient. But he could potentially be negligent for not having that information in the first place – i.e., negligence in diagnosis (because certain investigations were not done) or negligence in treatment (because the doctor did not realise an alternative treatment was available).

Whether or not the doctor was negligent (in diagnosis or treatment) for not having had the information in the first place will continue to be determined by the Bolam test.

If the doctor did have the information (but did not tell it to the patient), we go to stage 3 of the Montgomery test.

Stage 3 of the Montgomery test
The last stage of the Montgomery test asks whether the doctor was justified in withholding the information from the patient – i.e., was it a sound judgement that a reasonable and competent doctor would have made? If yes, the doctor is not negligent, and vice versa.

The burden is on the doctor to justify why the doctor withheld reasonable and relevant information that he knew about (as established at stages 1 and 2 of the Montgomery test) from the patient.

In general (with the exception of (b) below), the focus is not on whether other respectable doctors would have considered it appropriate to withhold that information (i.e., the Bolam test will in general not apply), but on whether it was objectively reasonable in the circumstances to have done so.

Here are some examples of when non-disclosure of information would be justified:
(a) Consent: where the patient has expressly said (or it can very clearly be inferred) that he does not wish to hear further information.
(b) Emergency: in emergency situations where there is a threat of death or serious harm to the patient, the patient temporarily lacks decision-making capacity, and there is no substitute decision-maker.
(c) Therapeutic privilege: where the doctor reasonably believes that giving the patient the information would cause the patient serious physical or mental harm (e.g., patients whose state of mind, intellectual abilities or education may make it extremely difficult to explain the true reality to them).

The interplay between the Bolam test and the various stages of the Montgomery test is summarised in the flowchart on page 29. The next article will look at the practical differences that arise between the Montgomery and Bolam tests.

References
1. After the case of Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.
2. The qualification that the body of opinion has to be internally inconsistent and logical was added in the case of Bolitho v City and Hackney Health Authority [1998] AC 232.
4. After the case of Montgomery v Lanarkshire Health Board (General Medical Council intervening) [2015] AC 1430. The test adopted in Hii Chii Kok was in fact a modified version of the Montgomery test, but this can be disregarded for present purposes.
7. Hii Chii Kok v Ooi Peng Jin London Lucien (2017) SGCA 38 at [141]. The Court of Appeal gave the example of the risk of death while travelling by automobile. No example of a risk specific to medical treatment that was negligible or a matter of common knowledge was given, but it is suggested that one example is the risk of the operating theatre burning down in a fire while the patient is on the operating table.
11. N.B. that in deciding whether the situation is so critical that there is no opportunity to provide information to the patient, the court will apply the Bolam test.
1 pm  Registration (Lunch will be provided)

2 pm  Welcome Address
  • Dr Wong Tien Hua, President, SMA

2.15 pm  Citation
  • Prof Walter Tan Tiang Lee, Medical Director, Raffles Hospital

2.30 pm  SMA Lecture: Internationalising Singapore Healthcare
  • Dr Loo Choon Yong, Executive Chairman and Co-founder, Raffles Medical Group

3.30 pm  Panel Discussion
  • Moderator: A/Prof Nigel Tan Choon Kiat, Council Member, SMA
  • Dr Loo Choon Yong
  • Dr Chan Boon Kheng, Healthcare Advisor
  • Dr Jeremy Lim, Partner & Head, Health & Life Sciences, Asia Pacific, Oliver Wyman
  • Mr Phua Tien Beng, Acting Chief Executive Officer, Singapore Operations Division, Parkway Pantai Limited

4.30 pm  Networking over Tea
INTERNATIONALISING
SINGAPORE HEALTHCARE
INTERVIEW WITH DR LOO CHOON YONG
SMF is proud to have Dr Loo Choon Yong (LCY) as this year’s SMA Lecturer. Dr Loo is the executive chairman of Raffles Medical Group (RMG). He is also the chairman of JTC Corporation and Singapore’s Non-Resident Ambassador to the Republic of Poland. He was also previously the deputy chairman of the Action Committee for Entrepreneurship, a public-private collaboration to promote entrepreneurship in Singapore; a member of the Government Economic Review Committee (ERC) from 2001 to 2003; and Chairman of ERC’s Healthcare Services Working Group.

SMF News is glad for this opportunity to find out from Dr Loo more about him and the topic he will be delivering during the SMA Lecture on 4 November 2017.

Why should Singapore healthcare be internationalised? What benefits are there to the local practice and population?

LCY: Singapore is a small country with only 5.5 million citizens and residents. The public healthcare sector is well resourced and well financed, providing 80% of inpatient care and 20% of outpatient care, of which much is substantially subsidised. This great welfare for our citizens, especially those less able to afford private care.

As for healthcare organisations in the private sector, they have the alternative of growing into the region in order to achieve size and scale. Besides growth, diversification of an organisation’s investments and risks also makes strategic sense.

In addition, as the organisation delivers quality healthcare to more communities abroad, the depth of its clinical and managerial expertise will be enhanced. Clinicians can expect to encounter diseases and conditions not commonly found in highly urbanised Singapore, and usually at later stages of presentation. All these will widen and deepen the experience of the organisation’s clinicians – to the benefit of patients at home.

When Singapore healthcare organisations expand into other countries, they bring to the local patients their brands, and hopefully their operational excellence and high standards of professionalism and care. Best practices can also be shared with the local healthcare organisations, professionals and healthcare managers. Many good and well-paid jobs will be created for the local population. In this way, the distant host countries will benefit a fair bit from such investments by Singaporean healthcare organisations as well.

How is the Singapore brand of healthcare perceived overseas?

LCY: Many people in the region look to Singapore as a very well-managed country with strong governance and high standards of professional services. They generally also perceive the medical care available in Singapore to be ethical, professional, consistent and well regulated. They know clearly that when they need to receive blood transfusion for surgery here, the blood is safe and free from any infectious diseases.

However, they are also aware that Singapore is a relatively expensive place to seek care in. The Singapore dollar is strong and getting stronger over time, relative to their native currencies.

Do locals perceive Singapore healthcare differently?

LCY: Singaporeans may grumble, but most know that they get great, safe and professional care in Singapore. Those who opt to receive care from the public healthcare institutions also know that they are getting great value for their money as their bills are substantially subsidised by the Government.

Could you tell us more about the RMG, which has since evolved into an integrated healthcare provider caring for patients in 13 Asian cities? What is the impetus for RMG’s overseas expansion? What do you think are the key success factors?

LCY: RMG is made up of physicians, nurses and healthcare managers committed to using their experience, training, learning and gifts for the benefit of all our patients. We are, as a group, continuously striving to put our patients’ safety and well-being above the financial and short-term interests of our shareholders, with the blessing of our shareholders.

Our impetus to expand overseas lies in our shared belief that we can bring the Raffles brand of compassionate team-based healthcare to more communities in the region as we scale up and grow our organisation.

The strong alignment to our shared core values among the 380 like-minded multi-specialty physicians, 800 nurses and 200 healthcare managers, is the most important critical success factor in our journey over the past 40 years.

Our adherence to strict strategic, professional, financial and execution discipline has helped us to grow smoothly and purposefully.

What are your hopes and dreams for Singapore healthcare?

LCY: I sincerely hope that more physicians, nurses and healthcare managers will commit themselves to putting their patients first in everything they do. In this way, foreign patients who come to Singapore to receive medical care, as well as those who seek care from Singapore healthcare organisations overseas, will receive what they need according to the science of medicine.

In this way, patients served, as well as their families, will find their health and lives improved. The collective reputation of Singapore healthcare organisations and physicians, nurses and healthcare managers will then be enhanced.

Aside from work, are there any sports or hobbies that you pursue in your spare time?

LCY: I play tennis regularly to keep fit and I play golf for fun. I read widely for my work and for my own education and improvement.

To sign up for the SMA Lecture, please complete the form on page 31.
When it comes to giving patients and their loved ones peace of mind about their future health and personal care, General Practitioners (GPs) can do so by seeding awareness and initiating Advance Care Planning (ACP) discussions. Being the family doctor for your patients, you are in an ideal position to discuss their values and goals for care in a setting that is most comfortable to them. By making their medical care goals and preferences about healthcare options known early, patients can be assured that their loved ones and healthcare team will know what their wishes are and be prepared to care for them when the need arises.

This also minimises crisis decision-making and potential conflicts between family members as it ensures that decisions will be made in the patients’ best interests, should they no longer be able to express their wishes. ACP can be supplemented by the Lasting Power of Attorney (LPA), which allows patients to legally appoint an LPA donee to make financial and personal welfare decisions on their behalf.

**How are ACP and LPA related?**
The ACP spokesperson is naturally suited to be the patient’s LPA donee too, as participation in the ACP discussion allows them to better understand the wishes of the patient. This in turn guides them in these roles of making decisions on behalf of the patient.

To kick-start ACP conversations with your patients, simply follow the steps of ‘ACP Support’:

**STEP 1**
Advocate future care planning...

“I’d like to talk to you about Advance Care Planning or ACP as this will help both of us to understand your values and preferences for health care options if you become seriously ill.”

**STEP 2**
Clarify patient’s clinical condition and goals for care...

“Can you share more about your medical condition and how it has changed over the past years?”

“Where and how do you want to be cared for if you become very sick?”

**STEP 3**
Pick a Spokesperson...

“Who do you trust to make decisions for you on your behalf?”

**STEP 4**
Support your patient:

a) Share the ACP brochure with them.
b) Direct them to the “My Care Wishes” workbook, which can be found on [www.livingmatters.sg/health-care-professionals](http://www.livingmatters.sg/health-care-professionals). Patients can use it to record their care preferences and wishes themselves.
c) Continue the ACP conversations at subsequent visits.

To learn more about ACP, including training details to become a Certified ACP Facilitator, or to request for ACP materials for your patients, visit [www.primarycarepages.sg/livingmatters](http://www.primarycarepages.sg/livingmatters) or contact AIC at gp@aic.sg or 6632 1199.
Birth of the
Medical Women’s Soccer Team

Two physicians boarded a flight out of Seattle. One sat in the window seat, the other sat in the middle seat. Just before take-off, an attorney got on and took the aisle seat next to the two physicians. The attorney kicked off his shoes, wiggled his toes and was settling in when the physician in the window seat said, “I think I’ll get up and get a coke.”

“No problem,” said the attorney, “I’ll get it for you.” While he was gone, one of the physicians picked up the attorney’s shoe and spat in it. When he returned with the coke, the other physician said, “That looks good, I think I’ll have one too.” Again, the attorney obligingly went to fetch it and while he was gone, the other physician picked up the other shoe and spat in it. The attorney returned and they all sat back and enjoyed the flight. As the plane was landing, the attorney slipped his feet into his shoes and knew immediately what had happened.

“How long must this go on for?” he asked, “This fighting between our professions? This hatred? This animosity? This spitting in shoes and pissing in cokes?”

History of the law-medicine relationship

The Law-Medicine Challenge, which continues till today, is a medical school tradition I hold near and dear to my heart. Under the guidance of A/Prof Paul Tambyah, we, the then student body, reintroduced the Law-Med Debates back into our annual calendar in 2007. The February 1982 issue of Vagus, the then Medical Society newsletter, depicted a young Dr Vivian Balakrishnan (now Minister for Foreign Affairs) participating in the Law-Med Debates held in December 1981. Almost 30 years later in 2008, it all came a full circle as Dr Balakrishnan donated the trophy for the Law-Med Challenge, humbly requesting for it to be named after his late mentor, Prof Arthur Lim. The Challenge today features a variety of events aside from the debates, which include floorball, touch rugby, soccer, handball and even computer.
During my three years of medical school, I played soccer for the medicine girls’ team during
the Law-Med Challenge. Needless to say, the competition with the law girls’ team was always stiff. I no longer remember if we won or lost; I just know that we had a lot of fun and I still reminisce with my teammates whenever we bump into one another along the halls of Singapore’s public healthcare institutions. Our days as soccer teammates were over once school ended. After all, with other commitments and time constraints after entering the working world, soccer was not really on the priority list as compared to, for example, sleep.

Or so I thought…

The Bench and Bar Games

In 2016, I decided to follow my husband, a lawyer and footballer himself, as he travelled with his teammates from the Law Society of Singapore (LSS) to Kuantan for the “Bench and Bar” games. These games are an annual tradition, forging competition and camaraderie between the representatives from LSS and The Malaysian Bar. The two countries take turns hosting one another for three days of non-stop games including golf, hockey and pool.

Firms block their calendars in anticipation of this annual event and lawyers are usually granted the leave they need in order to do what they need to do for their country. Without meaning to make this sound like some war, this competition is definitely intense in the competitive spirit it evokes. However, the fun and camaraderie are the bigger takeaways as evidenced by the most intense game of all – the boat race, a competition to see which team can gulp down their beers the fastest. I went there intending to relax by the pool, but I was soon sucked in by the electrifying atmosphere and went on to cheer the Singaporean lawyers at the various games.

The event also gave me a chance to reconnect with some of the women lawyers whom I used to play against on the soccer field back in school. I learnt that their team has a full squad of players and trains regularly in preparation for the game against the Malaysians, as well as the annual Inter-Professional Games (IPG) held in Singapore. In addition, I also found out that Medicine had never fielded a women’s soccer team to play in the IPG or any other postgraduate games before. Watching them play was really frustrating for me; all I wanted to do was to get on the pitch myself. That then got me wondering: Why doesn’t the medical fraternity have a women’s soccer team? With the advent and increasing popularity of women’s soccer in schools, I was sure that there would be enough players to join us.

The medical women’s soccer team

However, rallying the alumni troop turned out to be more difficult than I had anticipated. Our profession is such that everyone is just so busy and spread out all over the island. Between juggling calls, weekend rounds and personal commitments, carving out time to kick a ball around was really challenging. Eventually, some doctors did come forward, but there were not enough to form a full team. Then it occurred to me: Why am I only concentrating on forming an alumni team when there is also a school team? We are one medical fraternity after all. Before we knew it, we too had a sizeable team filled with an eclectic mix of students from various years and doctors from various postgraduate years. The first ever medical women’s soccer team has been formed!

After discussing with the women lawyers, the inaugural alumni women’s soccer match between the lawyers and doctors was set and was to be held every year in conjunction with National Day. The result of the inaugural match is unimportant at this point (you can guess what
Author’s Note
To appease your piqued curiosity, the medical women drew with the lawyers 1-1 and then lost 5-3 on penalties – not a bad result after only one informal practice session as compared to a team that had had a year of practice.

Legend
1. The lawyers (red) and doctors (white) after the inaugural alumni women’s soccer match in August 2016

Priyanka is an R3 preventive medicine resident and the captain of the medical women’s soccer team. If you’re interested in being a part of the team or to support in any way, please do not hesitate to contact her at rajendram.priyanka@mohh.com.sg.

that means), but trust me, we did our medical fraternity proud. Our dwindling fitness level was evidenced by our bursting lungs, and the aches and pains that came after the match were clear indications that running around the hospital did not provide enough exercise – a good wake up call. Luckily, we had the youth of our students to make up for that.

What is important, however, is the fact that we now have an avenue where both medical students and doctors have a chance to interact regularly. This team is bigger than just the games; it is a family and a fraternity that crosses personal, academic and working lines. It is well documented in academic medical literature that mentoring is a critical component of medical education as both the mentor and mentee benefit from the relationship. This team allows for a more informal and less-threatening way of forming mentoring relationships between the students and doctors. Since we are all going to be working together at some point, it seems only fitting that we form trusting, long-lasting relationships through the team. Besides intra-fraternity relationships being born, this annual game has also allowed us to get to know our lawyer counterparts better. Hopefully, we would never need one another’s services, but this has allowed us to widen our social circles amid our constant battle with time.

While the competition can be intense, the wisdom from entering the working world has definitely reminded all of us about what is truly important – a lesson the doctors continuously share with the students. We are a group of women who work and play hard together, and we are there for one another. When a team works this way, it should never be taken for granted. I am proud of us and the diversity of the group. As we continue to grow in numbers and strength, you’ll definitely be hearing more from us.
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Asok Kishore, MD, FRCS
Consultant, Hepatobiliary & Pancreatic Surgery, Tan Tock Seng Hospital

3.45pm Cholangiocarcinoma and Gastrointestinal Cancer
Dr Johannes Gietl, FRCS
Consultant, Hepatobiliary & Pancreatic Surgeon, Tan Tock Seng Hospital

3.00pm Oncological perspective in Hepatobiliary and Pancreatic Cancer
Dr Yen Hwee Leong
Senior Consultant, Medical Oncology, John Hopkins Singapore & Tan Tock Seng Hospital

1.20pm Discussion Panel

4.00pm Close

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Blood Pressure Variability: A Short Commentary

It is well established from epidemiological studies that elevated blood pressure (BP) is a major cardiovascular (CV) and renal risk factor with mortality from ischemic heart disease and stroke doubling with every increment in 20 and 10 mm Hg respectively of diastolic blood pressure (SBP and DBP). Conversely reducing elevated BP with treatment is effective in reducing morbidity and mortality 1.

Most of this data is based on office BP (OBP) measurement. However BP is not a constant variable but shows marked spontaneous oscillations both over short-term and long-term periods. This fluctuation or oscillation of blood pressure whether from beat to beat or over longer time intervals is referred to as BP variability (BPV). BPV is complex and includes both short-term (beat to beat, minutes to hours) and long-term (days and months, and clinic visit to visit) variations. Short-term BPV is usually defined as the oscillation of blood pressure within 24 hours whereas long-term variability is day-to-day, visit-to-visit, or seasonal. BPV can be measured by different calculations and statistical methods.

Data from studies applying out-of-office BP monitoring including home BP monitoring (HBPM) and 24-hour ambulatory BP monitoring (ABPM) indicate that average BP and the extent of BP fluctuations derived from multiple readings measured over a longer period may be an even better predictor of CV outcomes than isolated OBP readings 2.

In recent years, a range of preclinical and clinical studies have demonstrated that BPV contributes to the risk of CV complications beyond the level of BP 3. Conversely the risk of hypertensive target organ complications may be further reduced by measures that attenuate BPV beyond BP lowering 4.

Short BPV mainly reflects the influence of central and autonomic modulation and the elastic properties of arteries. On the other hand long-term BPV appears to be influenced by a wide range of life style factors, poor compliance with treatment and other clinical conditions that contribute to increased arterial stiffness.

Although estimation of short-term BPV is theoretically best determined from continuous BP recordings, intermittent, non-invasive BPAM, frequent regular HBPM and 24 hour ABPM can provide useful data for its assessment.

Many indices have been used to assess short-term BPV including standard deviation (SD) of 24 hour, day time and night time BP, and coefficient of variation (CV) of SBP and DBP but there is still a wide range opinion over the most appropriate clinical methods of measurement and statistical indices of BPV.

SD has been questioned as an appropriate index of short term BPV because it only reflects the dispersion of values around the mean, but does not account for the order in which BP measurements are obtained, and is sensitive to the low sampling frequency of ABPM.

Average real variability (ARV) of day time and night time BP which measures the average of the absolute differences of consecutive measurements has been proposed as a better index of BPV. Several studies have shown that ARV provides a better index of hypertension in hypertensive patients more accurately than SD of short-term BPV 5.

Measurement of day-to-day BPV can be performed using ABPM over consecutive days or by HBPM. Visit-to-visit BPV can be assessed by OBP measurement or ABPM. However, estimation of long-term BPV using OBP measurement requires a consistent number and interval of visits to achieve a meaningful value and does not provide data regarding BP during usual activities. The use of 24 h ABPM overcomes some of the limitations of OBP measurement but because of its obviously more complicated application and higher cost is not practical for routine use 6.

There is now extensive evidence that both short-term and long-term BPV significantly increases CV risk and target organ damage in hypertensive patients as well as in the general population 7. Short-term BPV has been shown to contribute to cardiovascular disease severity and decline in cognitive function in hypertensive patients. More recently a number of studies have demonstrated that long-term BPV (day-to-day and visit-to-visit variations) also increases the risk of target organ damage and CV events in hypertensive as well as diabetic patients. A population-based study based on data from the NHANES III, 1988 to 1994 study showed that higher visit-to-visit variability in SBP was associated with increased mortality risk over a 14-year follow-up. Visit-to-visit variability in DBP however showed no such association 11.

Since short-term and long-term BPV independently contribute to target organ damage, and CV events in patients with hypertension or diabetes, it may be expected that attenuation of BPV may confer additional benefit on CV risk.

There is in fact increasing evidence from controlled clinical trials that antihypertensive therapy can reduce short-term and long-term BPV and contribute to the prevention of CV events in hypertensive patients 18.

The efficacy of different drugs on reducing short-term and long-term BPV has been assessed in several preclinical and clinical studies which demonstrate the existence of differences between specific drugs in attenuating BPV.

In a meta-analysis by Webb et al. which reviewed the effect of different classes of blood pressure treatment on BPV the authors showed that calcium channel blockers were the most effective. The addition of calcium channel blockers to another antihypertensive drug also significantly reduced visit-to-visit BPV but adding other agents to calcium channel blockers did not contribute to further attenuation of long-term BPV 19.

The 2011 NICE Guidelines for the Clinical Management of Primary Hypertension in Adults in recognising the new data showing differential effects of antihypertensive treatments on BPV, suggest that excessive fluctuations in BP per se represent an independent predictor of clinical outcomes and recommend calcium channel blockers as the most effective treatment option to reduce BPV 19.

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