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“How time flies” is soon going to be an over-used phrase of mine... every editorial I write seems to start with it! In this case, my maternity leave flew by and I officially returned to work in mid-February. Working mums can relate — while I miss my baby a lot, it does feel good to be back full steam doing something that I trained ten years for!

**FOR DOCTORS...**

This issue features an interview with Dr Teoh Ming Keng, a vascular surgeon who is now a medico-legal advisor with the Medical Protection Society (MPS). He highlights the key differences between MPS and an insurance company. This is in continuation of an earlier article on medical indemnity published in our November 2015 issue (https://goo.gl/PvrE1J). As mentioned before, MOH Holdings has changed their cover provider from MPS to Aon Risk Solutions (Aon) and SMA News is now working on an interview with Aon, which will be published in a later issue. In continuing education on medico-legal matters, Ms Rebecca Chew, a partner at Rajah & Tann Singapore LLP, has penned an article that describes the principles and processes that go on in a disciplinary hearing.

Dr Wong Chiang Yin writes about his trip to China, where he represented SMA in attending the centennial celebrations of a long-time partner, the Chinese Medical Association.

I am pleased to announce the first of a series of articles on pioneer doctors, in which we had an in-depth interview with Dr Jerry Lim and the late Dr Moses Yu. We will continue this series in the coming months in order to celebrate the doctors who contributed to the beginnings of our local healthcare system. It is ambitious work and I hope for our readers’ participation in additional nominations and recommendations so that SMA News can record and document the lives of our local heroes.

Also in this issue, Dr Desmond Wai offers tips on how to make referrals in the private setting. Dr Leong Choon Kit describes the wide range of practices and services GPs offer and shares his ideas on how to structure our primary healthcare services for the benefit of both doctors and patients.

**FOR PATIENTS...**

Dr Tan Su-Ming gives us another touching snippet of how she looked beyond the illness of her patient and saw him as a human being with vulnerabilities. Dr Wong Wee Nam retired earlier this year and he relates his emotional farewell and reflections on his career of serving patients, healing the sick and providing succour to those in need.

Medical student R R Pravin contributes an article on the role of art therapy for paediatric patients. A group of Year One students from NUS Yong Loo Lin School of Medicine participated in Project Sothea, which provides free health screening and education for rural Cambodians. I am glad that our local students actively involve themselves in volunteerism and write in to share their experiences. Being in a first world country with readily accessible healthcare resources, many of us, both doctors and patients, have taken for granted the conveniences we enjoy. It is all too easy to complain of a two-hour waiting time in an air-conditioned clinic when the fact is that in some of our neighbouring countries, it may take two hours just to get to the nearest hospital! I want to thank the doctors and nurses who lead such trips or supervise students on such projects — thank you for giving your time to help those in need and by being mentors to our young colleagues.

We would also like to thank all readers for supporting Life in Pixels, SMA News’ very own photography competition, for the past two years. Stay tuned for the new competitions ahead! In next month's newsletter, we shall turn our attention to physicians’ health, providing everyone with a not-so-subtle reminder to lose weight after all the feasting over the Lunar New Year period!
CLEARING THE FOG: YOUR MEDICAL INDEMNITY OPTIONS —
INTERVIEW WITH DR TEOH MING KENG, MPS

The past year has seen big changes in medical indemnity affecting many Singapore doctors. At the start of 2015, there were two main providers of medical practice indemnity. These were the Medical Protection Society (MPS) and NTUC Income, and their models differed according to their heritage — individual membership in a “mutual”, and individual protection from an insurance policy, respectively. In May 2015, the cover provided to all doctors employed by MOH Holdings (MOHH) was changed to a new “group-cover” arrangement coordinated by a third player, an insurance broker — Aon Risk Solutions (Aon). MPS also changed the (till then occurrence-based) cover for obstetricians to a claims-made model. These changes resulted in many doctors asking themselves whether their current cover was ideal (or sometimes, even “adequate”).

SMA and its council members thus received many queries from doctors asking how these changes would affect them and sometimes even a request to suggest “what’s best”. Clearly, no indemnity model is perfect, and they differ in their characteristics and features in such a way that individual doctors need to decide which would be the most suitable for their type of practice. In conversation with the Minister for Health, the SMA Council directly voiced concern that individual doctors might be prevented from choosing the model of protection they felt suited them best.

To help provide background and generic information to its members, SMA published an article on the ABCs of medical indemnity models in Singapore in the November issue of SMA News (https://goo.gl/Pvre1J). Both authors are council members who have read much about the topic. Even so, SMA News thought it would be good for readers to know what a full-time medico-legal professional had to add. Dr Benny Loo, representing doctors-in-training in the SMA Council, thus interviewed Dr Teoh Ming Keng, a vascular surgeon for many years (his last ten years of practice was in Singapore, mainly at the Singapore General Hospital [SGH]) who now works as a full-time medico-legal advisor in the MPS, based in London.

As a medico-legal advisor with knowledge about indemnity and litigation risks, were there other points the authors should have emphasised in their article on medical indemnity? Have they missed out on anything important?

The most important point is who is the one needing protection? Whether it is the employer or the individual who pays the membership subscription or insurance premium, it is the doctor who gets sued, who is complained about, or who faces a Medical Council or criminal investigation. Therefore, decisions about the level of protection needed, the type of indemnity (occurrence-based or claims-made), whether it is capped and what other benefits are provided should be made by the doctor.
Doctors often don’t think enough about the details of their professional protection and the indemnity they have access to — but these very details determine the quality and extent of support available when they need help with a complaint, regulatory hearing or claim.

**What is the difference between MPS and an insurance company?**

Our decades of experience mean that we have developed a real understanding of the needs of our members and the environment in which they work. We recognise that a doctor with 20 years of experience faces different challenges as those at the start of their career. Our medico-legal advisors are experienced doctors with legal training and they have access to expert panel lawyers. These lawyers are based in Singapore and have extensive experience working in the medico-legal field.

Most doctors know of MPS and our long-term commitment to Singapore. MPS was established in 1892, has been in Singapore for over 40 years and has grown to be an international organisation with over 300,000 members. We have stood by our members and weathered the good times and bad when others have not. Many of you would have been aware of commercial insurers such as United Medical Protection, which ceased business in 2002, leaving many members in Singapore without cover — and many are now members of MPS.

Doctors should also be aware of the wide range of benefits that MPS offers, beyond access to indemnity for claims. MPS can provide assistance with actions against members such as Singapore Medical Council inquiries, criminal investigations, patient complaints, hospital disciplinary hearings, coroner’s inquiries and adverse outcome reporting, alongside advice for those facing ethical and medico-legal dilemmas.

**What is MPS doing to help doctors prevent claims?**

It is an uncomfortable reality that many doctors are increasingly likely to face a complaint or claim during their career. Our aim is to support them with the ongoing challenges of modern practice through expert advice and education.

With more than 120 years of experience in supporting and defending medical practitioners, we have a unique insight into why things go wrong and why litigation and complaints arise.

We use this to promote risk management through our workshops, E-learning platform, publications, conferences and lectures, as well as by working together with local medical regulators and healthcare providers.

In March, we will be holding seminars covering the practical approach to consent and I hope to see as many members there as possible, where they can seek advice on any concerns or problems they have, from our medico-legal advisors and lawyers.

**Wow! In your answers above, you sound very much like a person trained in “the business of protecting doctors”.** Younger doctors are often interested in pursuing careers beyond “pure medical practice”. To end this interview, please tell us a bit about your background and how you ended up an expert in the medico-legal field.

I was lucky to have had a rewarding and enjoyable career as a vascular surgeon, having trained and practised in the UK, Malaysia and finally ten years in Singapore. As a surgeon at SGH, I was always acutely aware of the stresses of avoiding and managing adverse outcomes. It therefore seemed like an excellent fit to devote one’s life to helping doctors improve their professional experience, avoid medico-legal problems and improve patient safety, and to be able to do this as part of MPS, an established international membership organisation devoted to providing support, advice and education to doctors. Being a medico-legal advisor involves using my medical and surgical experience, medical networks and knowledge of healthcare systems and medical law to help medical colleagues.

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**EDITOR’S NOTE**

As there are still many junior doctors with questions about the Aon cover that the MOHH has bought for them, *SMA News* will try to include in a later issue an interview with a senior representative of Aon for further education.

**PROFILE**

**INTERVIEW BY**

DR BENNY LOO

Dr Loo is a senior resident in paediatric medicine at KK Women’s and Children’s Hospital. He looks forward to a morning dose of caffeine and plenty of patients’ smiles every day.

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**SMA NEWS / MAR 2016**
Thank you to all SMA Members who continue to be part of the SMA Membership in 2016 by renewing your subscription and making early payment through various avenues — auto deduction, our new online payment portal, as well as via cheque or credit card.

The lucky draw winners of the two 38-mm Stainless Steel Case Apple Watches with Milanese Loops worth S$948 are Dr Teo Kian Tong and Dr Lynette Low. Congratulations to both! Read what SMA means to these two lucky winners and their hopes for the Association below.

**DR TEO KIAN TONG**
I joined SMA in 1974 soon after graduation; I wanted to get hold of the SMA car decal to display on my windscreen to show that I have “arrived”. Through the years, as I grew chronologically advanced, I also grew to appreciate the important role that the Association plays in leading, representing, encouraging, unifying and protecting us. The world changes; the expectations and aspirations of Singaporeans change. It is my fervent hope that the SMA understands and adapts to these new changes so as to meet the higher demands of a newer generation of Singaporeans.

**DR LYNETTE LOW**
Being a member of the SMA has allowed me to keep abreast of the current medical, legal and ethical affairs. The Association does well to provide educational support and advice for its members through courses, publications and circulars, among other avenues. It acts as a good platform for members to voice their views, on top of being the voice of the fraternity. Other membership benefits include discounts with selected partners, targeted advertisements, events, leisure reading material in SMA News, and for me, winning the Apple Watch!

Keep a lookout for upcoming events and courses organised by SMA and register for them without any hassle through your membership portal at https://www.sma.org.sg. With our combined efforts, we will continue to work towards being a stronger representative voice for the medical profession in Singapore in 2016 — For Doctors, For Patients.

All SMA Members in good standing by 31 January 2016 would also receive an exclusive membership gift pack comprising an SMA lanyard and Post-it pad, as well as limited time offers from some of our promotional partners, valid until 30 May 2016.
Choosing a personal insurance policy is probably not the favourite activity on one’s to-do list. It can be bewildering and frustrating to sift through various plans from different companies to compare the coverage, the premiums and the exclusions, and then weigh the costs and benefits of each proposal. Does one pay a higher premium for better coverage with less deductible, or take a risk and choose to pay less annual fees because your money could be better spent elsewhere? You could be pouring money down the drain for decades without ever realising any benefit. On the other hand, if you were unfortunate enough to suffer a major illness, having a good insurance policy would help to mitigate the financial pain. Ultimately, it is about buying ease of mind because the future is unpredictable.

For doctors, purchasing medical malpractice protection used to be a relatively simple affair because there were not many providers in the market and there was no requirement to choose from a plethora of plans. Furthermore, the indemnity plans you paid for did provide ease of mind both for your professional practice and your retirement.

Good things do not seem to last forever, as the medical malpractice landscape is set to change in the near future. There are more providers coming into this niche market now, which makes choosing a suitable product more complicated. More importantly, the landscape is changing because the future is becoming harder to predict, for both doctors and insurers.

OCCURRENCE-BASED VS CLAIMS-MADE COVER
Before I go on, I would need to bring up two core concepts of cover in medical malpractice insurance — occurrence-based cover and claims-made cover. Dr Lee Pheng Soon and Dr Bertha Woon wrote an excellent article and explained this in detail in the November 2015 issue of the SMA News. If you have not yet read it, the article “Your Medical Practice Protection: Know your ABCDEs Before Something Goes Bump in the Dark” should be a good reason for you to fetch that issue from your waiting room, recycling bin or bedside reading pile (or simply download it online at https://goo.gl/PvrE1J).

The diagram provided summarises the two types of malpractice cover. When
an adverse event occurs at some point in your professional career, there will usually be a time gap between the occurrence of the event to the time that the patient files a complaint against you. Occurrence-based cover offers protection when the doctor had been paid-up at the time when the adverse event “occurs”. Claims-made insurance requires that the doctor be continuously paid-up not only at the time of the adverse event, but throughout the time until the “claim” is made against the doctor.

The wild card in this relationship is the time gap. The period when the consequences of an error manifest itself may be short, for example, in an immediately obvious surgical error, or long, as in delays in mental development years after a difficult delivery.

In occurrence-based cover, the protection afforded is almost “permanent” because the protection covers time gaps without limit. In Singapore, the malpractice insurance that the majority of doctors had was that of occurrence-based cover offered by the Medical Protection Society (MPS). As long as you were a member of MPS when the incident occurred during your professional practice, you were (mostly) entitled to medical protection and access to legal defence even if you had stopped practising years after the event occurred. This provided doctors with ease of mind.

Under a claims-made insurance policy, you have to be covered under an insurance plan at the time a claim is filed in order to enjoy coverage. The protection ceases when the doctor stops paying his premiums (e.g., upon retirement, when changing indemnity schemes or when changing employers). Because of this, you would need to purchase insurance coverage even after you have stopped practising. This is the so-called “tail” or “run-off” cover.

Occurrence-based cover is great to have but it is becoming increasingly expensive to run because the insurance providers cannot possibly predict the future of litigation in the next ten, 20 or 30 years, especially in an era of rising healthcare costs and a litigious society where extraordinary amounts of damages are handed down by courts in western countries. Premiums for occurrence-based cover have been increasing annually and disproportionately across different fields of practice. There is now a 20-fold difference in premium between a GP and a doctor practising in a high-risk specialty.

These problems came into the limelight recently when MPS stopped offering occurrence-based cover for obstetricians in Singapore, switching to a claims-made basis for all new policies instead. Obstetrics is a notoriously difficult field to predict future claims because of the long period where a claim can be made against the obstetrician. In Singapore, a patient has up to three years after turning 21 years of age to lodge a complaint against the doctor. Obstetricians found themselves having to choose to either remain with MPS and accept the limitations of the new claims-made policy or switch to another provider such as NTUC Income. Some obstetricians nearing retirement even decided to stop practising obstetrics altogether, in order to avoid having new deliveries coming under a claims-made policy. SMA had to work closely with MPS to keep communication channels open and provide answers for all our members; even those in other high-risk specialties were wondering whether they would be next to be converted to claims-made cover. (For the record, MPS reassured them that other specialties were not affected).

Claims-made policies are more predictable for providers, who are able to look at the claims paid out of the policies from recent past years and adjust premiums accordingly. The premiums in claims-made policies are lower than that for occurrence-based cover and translate into savings for the doctor. The amounts saved could be used to eventually purchase tail cover after the doctor stops professional practice.

OTHER FACTORS

There are other factors to consider when choosing a suitable provider, such as the assistance provided, presence of risk management courses to keep premiums in check and the reputation of the company. These factors are thoroughly explained in the aforementioned article in the November 2015 issue of SMA News. The point is that choosing a provider should be done carefully, after understanding the differences and nuances of each scheme. Doctors who are nearing retirement are understandably more concerned as to which plan would provide better ease of mind, but junior doctors should also be aware of the choices available to them as they will be parting with significant amounts of money over the span of their careers.

The SMA will continue to run regular columns and articles to educate our readers on this important aspect of professional practice.
HIGHLIGHTS
FROM THE HONORARY SECRETARY

UPDATES TO FITNESS TO DRIVE GUIDELINES
Changes have been made to pages 8 and 9 of the SMA Medical Guidelines on Fitness to Drive booklet with effect from 11 February 2016. These amendments align the Guidelines with recent changes to the Road Traffic (Motor Vehicles, Driving Licenses) Rules, that allow motorists holding Class 4, Class 4A or Class 5 driving licenses (i.e., “heavy vehicle drivers”) to continue driving heavy vehicles until they turn 75 years old, if they pass an annual enhanced medical examination and proficiency driving test.

SMA members can download the Addendum from the SMA website https://www.sma.org.sg (under “Publications” tab).

MEETING WITH AON RISK SOLUTIONS
In 2015, Aon Risk Solutions (Aon) took over medical indemnity coverage for doctors employed by MOH Holdings (MOHH). SMA received queries from members regarding the change. Some were unaware of the change until alerted by colleagues, while others were concerned about how the change affected the protection accorded to doctors in the event of a claim.

SMA met with Aon on 19 January 2016 and is currently working with Aon to help clarify concerns raised.

DIT COMMITTEE MET UP WITH REPRESENTATIVES FROM RESIDENTS’ COMMITTEES
The SMA Doctors-in-Training (DIT) Committee met up with representatives of Residents’ Committees/Council from various sponsoring institutions and discussed the current training environment and information sharing in various Residency programmes.

Having received feedback from the Residents’ Committees representatives, the SMA DIT Committee will regularly engage various stakeholders to work towards a more conducive environment for our doctors-in-training on the ground.

CALLING ALL SUBMISSIONS
The SMA News team is constantly on the lookout for new article submissions and we’d love to hear from you. If you are passionate about a particular specialty, medical condition, hobby or travel destination which you think might be of interest to our readers, send in your written article to us at news@sma.org.sg today!
The Chinese Medical Association (CMA) celebrated its centenary on 14 December 2015 in Beijing. SMA was honoured to be invited to witness the event, which was held in the Great Hall of the People, facing Tiananmen Square. The outgoing President of CMA and former Health Minister, Dr Chen Zhu, gave an account of the association’s activities and programmes during his five-year term as president. This was followed by a wide-ranging speech by Deputy Prime Minister Liu Yandong, describing in detail the many challenges the healthcare sector in China faces and some of the strategic steps needed to address these challenges. She also recognised the many historic contributions by CMA towards the improvement of public health in China. This was followed by a ceremony in which 30 eminent physicians were presented with a special award by CMA to commemorate its 100th year.

The occasion was also an opportunity for us to catch up with an old friend of SMA, Prof Zhong Nanshan, who was the former President of CMA and the unofficial SARS hero of China. Prof Zhong was also the SMA lecturer in 2008 who delivered “Preparing for the Next Flu Epidemic: 5 Years after SARS… Lessons Learnt”.

On 15 December 2015, CMA elected its new office bearers for a five-year term and Dr Ma Xiaowei was elected as President. He is also the Deputy Director of the National Health and Family Planning Commission (NHFPC) of the People’s Republic of China (the Health Ministry was merged with the Family Planning Commission to form the expanded NHFPC about two years ago).

In the afternoon, SMA representatives met with the delegation of CMA, headed by the newly-elected Vice President, Dr Su Zhi. The two associations then discussed potential areas for future cooperation and exchanged gifts.

On a personal note, there was a palpable sense of nostalgia on my part as it was my third time attending anniversary celebrations of the CMA. The first was 20 years ago when I attended the 80th anniversary as a young council member, together with the then President, first Vice President and Honorary Secretary of the SMA. How time flies!

TEXT BY
DR WONG CHIANG YIN

Dr Wong Chiang Yin is a public health specialist. He has been in the SMA council for more than 20 years and was the President of SMA from 2006 to 2009. His professional interests include hospital administration, health policy and regulation. He has been around long enough to know that very bad things can happen in healthcare as a result of good intentions.
A TRIP DOWN MEMORY LANE

INTERVIEW WITH DR JERRY LIM AND DR MOSES YU

A Pioneer’s Contribution to the Beginnings of the Singapore Armed Forces (SAF) Medical Services. Dr Jerry Lim (JL) and Dr Moses Yu (MY) share with Dr Jipson Quah (JQ) their precious memories in the military during the 1970s.

HOW IT ALL STARTED

**JQ:** Dr Jerry and Dr Moses, you have had illustrious careers in your respective fields and have also served Singapore with distinction, notably within the SAF. Do tell us how it all started.

**JL:** Dr Kwa Soon Bee, then director of Medical Services, knew of my enthusiasm for the military because prior to that, I served in uniformed groups. Before I went to Edinburgh to study medicine, I had one year to fool around with, so I got enlisted into the Singapore Volunteer Constabulary. When Dr Goh Keng Swee and the late Mr Lee Kuan Yew wanted to start the army, they realised they needed to establish formal medical services and so Lee Kuan Yew asked Dr Kwa to assemble a group of public-spirited doctors to serve Singapore.

Kwa Soon Bee very diplomatically phoned several of us, and 14 of us agreed to volunteer as the pioneer batch of medical officers. We were sup sup shui (Cantonese for insignificant) fellas, but you may know some of us: Drs Lo Hong Ling, Richard Hin Yung (Obstetrics and Gynaecology), Lim Kuang Hui, Arthur Lim (Ophthalmology), Cheong San Thau (Surgery), William Chew Loy Soong, Chan Swan Tong, Wong Kum Leng, Richard Chin Keng Huat, Wong Yuen Poh, Lee Soo Choo, Moses and myself.

Dr Arthur Lim, as the President of the SMA then, gamely volunteered and led as a model example. This, despite being somewhat overweight, and having no clue of how to march or what the Bahasa parade square commands meant.

**MY:** Gearing the uniform, they couldn’t find a belt that could fit Arthur Lim… He was too big! [laughs]

**JL:** When it was time for commissioning, they wanted to commission us as Second Lieutenant, two pips. Yeoh Ghim Seng heard about it, he turned round to Lim Kim San, who was then the Minister of Interior & Defence, and he says, “You do that, I’m going to take all my doctors out.”

**JQ:** So what was your training like, in the 1970s?

**JL:** All 14 of us went through nine months of officer cadet training. We spent at least three evenings a week and one weekend every month in training, for nine months. We were paid a “princely” sum of 40 cents per hour.

I enlisted at the age of 39 and the average age then was 41. The moment I finished my clinic shift at five or six o’clock, Moses Yu and Arthur Lim would come and pick me up at my clinic, which was at Chulia Street and we’d go to Beach Road where the People’s Defence Force (PDF) headquarters used to be. There were 14 of us, not one dropped out and we all graduated with a full military passing out parade.

**MY:** Arthur Lim, president of SMA and Richard Yung, my old classmate, said to me, “Come, come, come”. So I said, “Good lah.”

**JL:** Arthur was my classmate, but he never dared to approach me. [laughs]

**JQ:** Why did he say that?
JL: Because he said to Lim Kim San, “Minimum, Captain.”

MY: And so, we were all commissioned as Captains.

JL: There were PDF units all around Singapore. Moses and I were posted to 14PDF. We were in charge of the medical side of 14PDF in Queenstown. So whenever there was an exercise, we had to go and supervise. Actually nothing lah, we just had to make sure they had their medical supplies with them. The others were posted to different PDFs. Then after that, they decided that we would all be of better use in the Reserve medical units that were being built up.

MY: The first Field Hospitals were being established as part of the divisional level logistics support, Logistics Field Support Groups (LFSG). The first Field Hospitals were tented units. These developed over time to the trailer based units and today’s Combat Support Hospitals.

THE PIONEER VOLUNTEERS

JL: When we joined, Dr David Roy Paul was the Deputy Chief Medical Officer, (subsequently Chief Medical Officer [CMO] for a brief moment but he was soon succeeded by Dr Seet Lip Chai). We used to have briefings with visiting military and civilian doctors from Australia, New Zealand, UK, America, Sweden, etc. We also had the opportunity to visit them and gained much insight into how war injuries were managed and how military medicine was practised. Memories of the Korean War, Vietnam War and Six-Day War were still relatively fresh then.

The most famous of all the 14 pioneer volunteers, was Dr Richard Hin Yung. Richard was a partner in Tow Yung clinic, an obstetrician-gynaecologist. Richard and Kwa Soon Bee, of our whole batch, were the only two non-regulars promoted to full colonels, so that’s the respect we earned as volunteer doctors. Richard’s real love was actually the army; he used to buy journals from America and Britain to read all about the various campaigns. Richard Yung and I were very close and we used to go on holidays together. Anyway, when he was in the army, he was totally different. He was our big boss and even Moses had to take orders from him.

Richard Yung, famous Colonel (Dr) Richard Yung, more military officer than doctor. He used to go into his clinic in his number 4, and would even see his patients in the military uniform.

MY: After his clinic, he got to go back to exercise. No time to change.

JL: Richard was so good that he was put in charge of the first field hospital deployment exercises. And when you ask Moses, what those were really like. We used those heavy canvas marquee tents...

MY: The marquees! And the nurses, they were very good. They go out to the field, five days with no bath, no basic necessities, they come back filthy and dirty but that is how we all started. The nurses were really the backbone of the SAF Volunteer Medical Corps.

JL: So at one of our exercises, Richard Yung said to me, “We are going to have an inspection.” I said, “So? So what?” He said, “I want you, to take photos”, because I was the official cameraman.
“I’ve arranged for you to go with the army photographers in helicopter.” And I went, it’s an opportunity. One strap here, one strap here [gestures], and carrying three cameras with the helicopter going over. I tell you, all that was holding me were these straps. The pilot after about five or six rounds, he asked, “Sir, enough or not?” I answered [laughs], “More than enough.”

Then on that same exercise, who should come to inspect but Dr Goh Keng Swee, our Minister of Defence. We were on one side, in rank and file. Unfortunately, one of the doctors was too generous and had gone down to town in the early morning and bought big buckets of char siew bao for everyone. Luckily we didn’t take, because the rest got food poisoning. My goodness, we had to hold up black curtains to let the girls go.

THE FOND MEMORIES

JL: Our dining-ins were stylé (slang for being stylish) you know, we used places like the Singapore Swimming Club, Shangri-La, Tanglin Club, Mandarin Hotel. They were all very pukka-pukka and enjoyable. We used to always make it a point to invite all the people that mattered. People like the Chief of Defence Forces, General Winston Choo and all the high-ranking military officers.

We also used to entertain our foreign visitors a lot. Colonel Seet Lip Chai, who was CMO then, would rope in about five or six of us and host private dinners in various popular Chinese restaurants. We all got really drunk, I tell you.

Once I had to fetch one Vice-Admiral, one Air Force Major-General and one Army Colonel, all medical doctors, from Shangri-La, so I drove them. We took them to this restaurant at the World Trade Centre. We all kept toasting with the hua dio ji (Chinese wine) and these three gentlemen got so drunk, they all vomited in my brand new BMW.

When we reached Shangri-La, I called the security guard, “Hey, you bring me three wheelchairs.” [laughs]

MY: No, but the attendant could not find wheelchairs in Shangri-La, and these people were big. So the attendant brought in the hotel porter trolley, put the luggage and the general on it and pushed him up to the room. By the time we came down for the second one and reached the room again, the first one had fallen off the bed. [laughs] So funny, this kind of thing cannot forget.

JL: I was living in Draycott Drive which was five minutes away, so I went back to the hotel...
MY: Whole night wash car.

JL: After I washed my car, Colonel Lim Kee Boon, then Commanding Officer of the Officer Cadet School, helped me to clean the car at two o’clock in the morning. We washed the whole car.

There are a number of other doctors you could speak to about the military. Dr Yeo Khee Quan, orthopaedic surgeon, I went to see him yesterday. He was with us in the army as well.

MY: Very much younger than us.

JL: Low Cheng Hock was one of our younger officers. He was with me in my field hospital, very good. Nice young men, we could always rely upon them. I ordered to go and they would carry out. Very nice men. There’s also Colonel Seet Lip Chai, the CMO then.

Be nice if you people could arrange, maybe a tea party or so, then I try and invite some of these people, just a simple tea party or have a little bit of wine and get people like Moses and some of the older people to come and meet the younger generation of doctors. You just listen to them and learn from their experiences.

JQ: It would be an honour, Dr Jerry and Dr Moses, and I am sure our readers, both young and old, will be delighted to read about it in the SMA News.

Writer’s note: Dr Moses Yu, as our readers might know, passed away at the age of 81, shortly after this memorable interview. SMA News hopes to reach out to other senior doctors, with the help of our readers, to learn more from their invaluable experiences. If you are keen to contribute in any way to this series, please contact the SMA News team at news@sma.org.sg.
Many GPs encounter the scene above and much more in our daily practice. What are some common features in these questions? Two things sprung to my mind: diversity and survival.

THE DIVERSE GP WORLD
The GP world is not a homogeneous one. For that matter, the medical world is never homogeneous. No two doctors will give the exact same answer and yet both are likely to be correct.

General practice specialises in generalism and it covers a huge spectrum of services — from birth, pre-marriage and pre-pregnancy to the grave. It extends to those who are well, are acutely sick, who suffer from chronic diseases and many more. It treats, prevents, beautifies and maintains health and well-being. Nothing escapes the GP realm.

Yet in reality, there is a limit to how much a GP can learn in his lifetime, let alone become an expert in every aspect. Therefore, each GP’s passion, interests and factors that will bring in the much needed income will determine how each practice is going to be.

For instance, I am an asthmatic with bad atopy. I have frequent gastric pain and a strong family history of cardiovascular conditions. Naturally, when it comes to choosing Continuing Medical Education seminars and
courses to attend, I tend to narrow my selections down to these topics. As I learn more about these conditions, my patients self-select themselves to see me mainly for these ailments too.

I believe my colleagues when they tell me they do aesthetics because they love to see people beautiful. Who doesn’t? I also believe my colleagues when they tell me that they want their patients to eat well and prevent illnesses. After all, which doctor did not start out with this ideal?

Because of these, and with the full autonomy every private solo GP has, we shape our practices as such. This gives rise to a plethora of varying GP practices which then became a hurdle when the Regional Health Services (RHS) and the Ministry of Health (MOH) sought to engage the GPs for help with right-siting patients.

Streamlining the services provided by the GPs is the obvious solution. However, it would reduce the effectiveness and the efficiencies of the private sector. The free market principle should as far as possible be allowed to operate and create the widest spread of the types of GP clinics.

For the same free market principle, some GPs may aspire to work in the public sector, while others prefer to be in the community hospitals or perhaps as interns in the tertiary hospitals. Every one of them should be encouraged to excel in the areas they have chosen.

Instead of streamlining them or generalising everyone into one mould, it is better to let everyone flourish and at the same time create a system to help the public select the services they need.

A UNIFIED GP GARDEN WORLD

“Let a hundred flowers bloom,” A/Prof Goh Lee Gan often said whenever we discussed primary care matters, quoting a Chinese saying. The challenge is then to create a beautiful garden by arranging all these different beautiful blooming flowers.

First idea on my mind is to create chapters. There can be a group of GPs doing mainly community hospital work, another group working among our specialists in the tertiary hospitals by moving patients out into the community, and a third group of community GPs receiving the public and patients.

Another permutation would be in the types of practices offered. Some GPs prefer to see patients with chronic diseases, while others prefer treating acute conditions or attending to contract patients, patients for screening, or wellness and aesthetics practice.

With proper division and labels, the public will not be confused. Similarly, MOH, RHS and the Agency for Integrated Care will have an easier time in right-siting patients. Even the young family physicians will probably have a clearer picture of where they want to work at or who they can aspire to be.

However, with all these divisions, the fraternity will also have to determine the core to the GP world. If not, it will be fragmented.

Wherever GPs are placed or choose to work, they will have to fulfil the statutory obligations. For example, a GP may focus on home visits and provide mainly palliative care, but he should still clock in some hours doing the usual duties such as treating acute and chronic conditions.

If employment terms restrict such opportunities, the GPs can always do pro bono work at charity clinics like HealthServe or Karuna Clinics.

SURVIVING THE PRIVATE WORLD

All doctors are smart and hardworking. We know how to survive. That is why the Ethical Guidelines becomes relevant and important. Without it, some practitioners may get very creative.

In the forthcoming instalments of the “GP Matters” column in SMA News, I will have a few GPs share their start-up experiences. Meanwhile, there are two upcoming events that those in the private sector can look out for.

First, the World Immunisation Week, initiated by the World Health Organization, will be held from 24th to 30th April 2016 with the theme Close the Immunisation Gap. It is a good time for GPs to help review our patients’ vaccination records and update them if necessary.

The second event is the World Family Doctors’ Day, first launched by the World Organization of Family Doctors, to be held on 19th May 2016. Although it is a day to celebrate the GPs, we can always use the opportunity to focus the event on the public and our patients.

When we put the public at the heart of what we do, we know for sure that we will not only survive, but thrive and do well. ◆
“If one does not become a middleman, a guarantor, or a matchmaker, one can live well for three generations.”
— A Cantonese proverb

BEING A REFEREE
Some time ago, an old friend asked me to recommend to him a plumber to fix a leaking tap at home. I gave him the contact of my plumber who fixed a blocked drain for me a few years ago, at a reasonable price.

Several weeks later, my friend complained that the new tap kept leaking water and the same plumber had to go back three more times to do additional works. The tap was finally fixed but at additional costs. My friend wasn’t too pleased with the plumber.

Well, this is life. Sometimes a plumber works well for you, but they may not be up to the expectations of your friend. This is probably the reason why it’s never easy to be a middleman or a matchmaker.

However, as doctors, when we refer our patients to other doctors, we act as the matchmaker. Making a referral in restructured hospitals is easy: just contact the respective specialist registrar on-call will do; but in private practice, there is no such list. In this article, I would like to share my thoughts on the art and science of making referrals in private practice.

PRINCIPLES OF REFERRALS
The first principle is that doctors are responsible for the outcome of the referrals, at least in the eyes of the patients. Patients do complain or even scold when the doctors they are referred to do not meet their expectations. At times, it was the doctors’ bedside manners, charges or the clinical outcome. As for others, it’s due to unrealistic expectations of the patients. It is the referring doctor’s duty to set the right expectations of the patients, as well as to ensure that their clinical problems are solved in a cost-effective manner.

The second principle is that our patients’ interest and welfare should be the most important consideration while making the referral. Generally speaking, we should refer our patients to the best doctor available for their problems.

WAYS THAT DO NOT LEAD TO MORE REFERRALS
In my opinion, here are some strategies that do not attract referrals.

OPENING CEREMONIES WITH GOOD FOOD AND WINE
When I first started my private clinic, a colleague jokingly said it would be important to have a lavish opening ceremony. Doctors who were wined...
and dined at the ceremony would likely feel obliged to refer at least one patient back.

It should not work that way. We should not refer patients to doctors just because they dined and dined us.

**GIFTS DURING FESTIVE SEASONS**

It’s good to give festive gifts like mooncakes for Mid-Autumn Festival and dumplings for Dragon Boat Festival to your friends. But don’t rely on gifts in exchange for referrals.

It is also incorrect to refer patients to a colleague after receiving favours from him or her. The 2011 Singapore Medical Council Ethical Guidelines actually states that one has to declare any such interest to patients before making a referral. According to Corrupt Practices Investigation Bureau’s website, receiving or giving any gratification as an inducement to a person to do any act may be perceived as corruption, so we ought to be careful.

In fact, it is probably safer to NOT refer patients to colleagues who give us gifts.

**TRADING REFERRALS**

I have ever received a referral letter from another specialist that ended with “Thanks for seeing my patient. I do look forward to helping you manage your patients.” Doctors have also been heard grumbling, “I have been referring patients to him (another specialist), but he never refers any patients back to me. And I recently found out he has been referring his patients to another doctor of my specialty.”

There are several possible reasons why colleagues do not return patient referrals. Most likely, the referring doctor feels that there are better specialists available. Secondly, the colleague could have received more referrals from another specialist in the same specialty. Thirdly, they may not have suitable referrals for me. Lastly, my colleague may not feel obliged to refer back to me, as they may actually perceive that they had done me a favour for seeing my patients.

So when referring patients to a colleague, the only expectation is for him or her to take very good care of the patient.

**HOW SHOULD REFERRALS BE MADE?**

**EXPLAIN TO THE PATIENT WHY HE NEEDS A REFERRAL**

This is the most important step in the whole referral process. Patients must understand clearly why they need to see another doctor. Otherwise, patients may not turn up for the appointment or even if they turn up, they may not follow the recommendations of the referred doctor.

**ASK THE PATIENT FOR THEIR PREFERENCE**

It is good practice to ask patients if they have any doctors in mind. They might have heard of or are familiar with a particular specialist that they would like to be referred to. Sometimes, patients have special requests, such as language ability, gender and even age. Most of my female patients prefer female gynaecologists. And while some prefer older-looking doctors, others don’t want me to refer them to doctors who are too old (of course, looks can be deceiving).

**INFORM THE REFERRED DOCTOR**

There is always a reason why the primary doctor makes a referral. The primary doctor should thus write a referral letter or make a phone call to indicate reason(s) for referral, as well as any special patient issues.

**SELECTING THE RIGHT DOCTOR TO REFER**

Here are some principles I employ when making a referral.

**WORK WITH PEOPLE YOU TRUST, TRUST THE PEOPLE YOU WORK WITH**

Trust takes time to build up and history often repeats itself.

When a patient requires an appendectomy, I would recall my last case of appendicitis (with good surgical outcome) and ask the same surgeon to do the job. If I have no prior experience in a particular specialty, then I may ask my medical colleagues for advice. Anaesthetists and scrub nurses often provide reliable advice as to the best surgeon as well.

Many new specialists join private practice every year and we do need time to observe them before entrusting patients to them.

**KNOW YOUR PATIENTS, KNOW YOUR COLLEAGUES**

To find a suitable specialist for the patients, we need to know the patient’s problem. Some problems are simple and general, while others are sophisticated and extremely specific.

For simple complaints like obstructive sleep apnoea, most pulmonologists, neurologists, and ENT specialists can handle it well. However, for patients with metastatic intrahepatic cholangiocarcinoma, someone with special interest in digestive tract malignancy would be required, as compared to a general medical oncologist.

It is good to put in effort to find out which doctor is strong in which field and subfield through casual interactions. For new doctors whom I newly meet, I often asked them about their subspecialist interest, their research interest and their HMDP subspecialty.

But some new doctors “oversell” their skills. One general surgeon ever told me he can handle most surgical conditions, including digestive tract, thyroid, breast, craniectomy and lung resection. I had no way to verify his claims but I find it difficult to believe that one can be skilled at treating every part of the body.

**AVERAGE OUT THE REFERRALS**

Some referrals are “good referrals” that all specialists love (eg, nice, respecting patient with epigastric pain requesting a gastroscopy during office hours), while some are “not-so-good referrals” (eg, high risk cases such as a 93-year-old patient with
left ventricular ejection fraction of 25%, presenting with melena and haemoglobin of 5g/dL).

To be fair to our colleagues, we could consider directing all cases to the same doctor or specialist to average out. I ever heard of one anaesthetist complaining that one particular surgeon only called him for emergency operations after midnight, while the surgeon never called him for daytime elective cases.

In private practice, some patients have payment problems but as doctors, we still have to solve their problems. Once, a foreigner presented to me for abdominal pain. He had perforated appendix and had a prolonged hospital stay after appendectomy, but he had no insurance or adequate savings to pay for his hospitalisation. The surgeon who operated on my patient did not get paid (nor was I). In a way, I owed the surgeon a favour and I tried referring more cases to him after that to average out.

**REFERRALS BACK TO COLLEAGUES**

It was mentioned earlier that patient referrals are not forms of trading or transaction. Just because a colleague refers his patients does not mean I am obliged to “return” one to him. But when a colleague does refer his patients, we are able to see how good, attentive, meticulous and skilful he is during the process of co-managing the same patient.

I ever worked with a new surgeon who referred me his patient with Crohn’s disease. Clinically, it was a tough Crohn’s case with fistula/abscess/stricture. The surgeon skilfully solved the patient’s surgical problems and I was called in to manage the medical aspect of Crohn’s. That was the first time I worked with him and I was very impressed by his surgical skills. That led me to make further surgical referrals to him. I refer to him not because he referred to me, but because I was impressed by his work.

**HONESTY IS THE BEST POLICY**

I ever referred a patient with what I thought was abdominal hernia to a general surgeon for surgical repair. After I discussed the case with him over the phone, he felt that my patient probably had divarication of rectus abdominis sheath and asked me to refer to a plastic surgeon instead.

I was thankful for his honesty and I started referring patients to him because of it.

Another patient of mine came with metastatic intrahepatic cholangiocarcinoma. He had already failed second-line chemotherapy, and had consulted six medical oncologists. He wanted a seventh opinion, which I did. The seventh medical oncologist told him success rate for third-line chemotherapy for intrahepatic cholangiocarcinoma is less than 10%. Weighing the cost and adverse effects with poor success rate, he felt that the patient should stop chemotherapy and just receive the best supportive care. Again, the seventh oncologist gained my respect as he told the patient the truth and not what the patient wanted to hear.

**ANSWER WITH A SIMPLE YES OR NO**

If I don’t know who to refer to, I simply admit that I have no one to refer. And if I do not know the preferred doctor of my patients, I reply that I don’t know.

Recently, a patient with rectal cancer consulted me for a second opinion. He saw a surgeon prior to seeing me and he asked me if his surgeon was good. I simply replied, “I have not worked with him before, so I don’t know.”

**GET FEEDBACK FROM PATIENTS**

It is good to ask for feedback from patients after referring them to colleagues. Such feedback can then act as a guide for making future referrals. It is also important to evaluate the negative comments to determine if the fault lies with the patient or colleague.

There was a female patient who presented to me for abdominal pain. As she was having pelvic inflammatory disease with pelvic abscess and perihepatitis, I called for both a gynaecologist and a general surgeon to help. The patient complained that both looked too young and inexperienced and requested I called someone older. I ended up referring to alternatives who looked older. Laparoscopy was done and her pelvic abscess drained. Though she was dissatisfied with the first two doctors, I continued to refer to the first two doctors as there was no cause for doubt in their skills.

**COST-EFFECTIVENESS**

It’s our duty as doctors to get the most cost-effective treatment for our patients. By looking at the charges of other doctors for patients and keeping track of the fees of different surgeons and the outcomes for the same surgery, one can get a sense of who is the most cost-effective doctor for the respective surgeries.

If the surgical outcome is not up to satisfaction, I will not refer to them even if their fees are low. However, if several surgeons can do an equally competent lap cholecystectomy, it’s our duty as the referring doctor to choose one with the most appropriate surgical fees for the patient.

**CONCLUSION**

Our patients expect us to get them the best deal, ie, the best doctor for their problem in the most cost-effective manner. When our patients consult the doctors they are referred to, they entrust their health to our judgement and recommendation. It is our responsibility to find them the best doctor, in terms of skills, expertise and cost.
GRAND PRIZE WINNER 2015

Congratulations to our Grand Prize Winner, Dr Deshawn Tan, whose winning entry won the hearts of more than 300 voters! Dr Tan walked away with a Canon DSLR EOS 100D kit, kindly sponsored by Canon Singapore Pte Ltd!

I bought my first DSLR during my graduation trip to Iceland and UK, and it has since sparked off my interest in travel and landscape photography. I was fortunate to have met and received valuable advice from professional photographers and fellow hobbyists alike, which have greatly improved my photography skills.

The themes in 2015, in conjunction with SG50, were interesting and they encouraged me to think out of the box and to frame each shot carefully. The winning photo was actually taken during one of the National Day Parade rehearsals with the Marina Bay Sands lotus pond in the foreground, against a clear and cloudless sky. I thus managed to capture the opening salvo of fireworks during the blue hour. Winning the Grand Prize was an affirmation to the efforts I put into each shot.

LUCKY DRAW WINNERS

Two lucky winners were randomly picked from the pool of voters who chose Dr Tan’s winning photograph. They have each won a Crumpler camera bag and a Canon Digital Ixus lanyard with a 16GB thumbdrive.

Ding Si Yan   SXXXX566H  Adeline Low   SXXXX721I

Thank you to all participants for your support of Life in Pixels 2015!
Each year, the Board of SMA Charity Fund (SMACF) meets up with the SMA Medical Students’ Assistance Fund (SMA-MSAF) award recipients during the appreciation dinner organised by the NUS Yong Loo Lin School of Medicine (NUS Medicine). On top of meeting the recipients, SMACF also uses the opportunity to share the role it plays in the education of medical students and the development of future medical professionals. More importantly, SMACF wishes to educate medical students on the importance of maintaining the tradition of giving back to the community and through doing so, shape the future of healthcare for the benefit of everyone.

The dinner, held on 23 February 2016 at the 21 on Rajah Restaurant, Days Hotel, was hosted by NUS Medicine. In attendance were Prof Hooi Shing Chuan (Vice Dean Education), A/Prof Rajendran Kanagasuntheram (Assistant Dean, Education Student Affairs), A/Prof Marie-Veronique Clement (Assistant Dean, Education Student Affairs), Ms Mathilda Lim (Associate Director, Development, Dean’s Office) and Ms Betty Lee (Assistant Director, Development, Dean’s Office) from NUS Medicine and 18 award recipients. Three Board directors and two staff representatives from SMACF were present as well.

Dr Noorul Fatha As’art (Director, SMACF) commenced the dinner by addressing the award recipients. She reminded the students that pursuing academic excellence is important and shared how SMACF can support the
students’ learning journey. Dr Noorul also reminded the students to keep the giving tradition in the medical fraternity going, even after they complete their medical education, ensuring that future medical students, like them, are able to focus on their education because of the financial support they receive.

Prof Hooi then concluded with a speech in which he expressed appreciation for the financial support provided by the SMA and SMACF through the SMA-MSAF. The SMA-MSAF was not set up solely to provide underprivileged medical students with financial help, but also to serve as an avenue for the medical profession to give back and support the future of medicine, to emphasise the importance of collegiality and giving, and to maintain the tradition of giving among medical students. The evening was particularly meaningful as representatives from SMA and SMACF had the opportunity to meet the bursary recipients face-to-face to discuss the latter’s concerns, academic lives and hopes for the future.

Over the years, bursary disbursed under the SMA-MSAF programme has been increasing. In the last two years, SMACF saw an increase in the needs of the medical students, with more underprivileged medical students requiring additional financial support towards their living expenses. Needy medical students from all three local medical schools benefit from the SMA-MSAF programme.

With the conclusion of the Medical Students Living Expenses Survey and the scheduled release of the study in the new Academic Year 2016/17, SMACF will carry out an internal review on the bursary quantum to be disbursed.

“You will eventually graduate and proceed on to become a doctor, and you will face many social and ethical challenges. Remember this day. Remember that you have been a beneficiary of the SMA-MSAF. Remember that when you were in need, the profession was there for you. Remember to practice ethically and support the students who come after you.”

Indeed, this message which was poignantly shared by Prof Wong Tien Yin (Chairperson, SMACF), with the bursary recipients from NUS Medicine during the appreciation dinner held in 2014 is a constant reminder that the future of healthcare is going to be driven from what we build today!

— Teo Qi Tian, M5
Having done many disciplinary hearings over the years, it is quite evident to this author that parties frequently envelope various arguments under the cover of natural justice in an attempt to set aside disciplinary tribunal decisions. This article seeks to give some simple insights as to what encompasses principles of natural justice in disciplinary hearings. To begin with, the principles of natural justice are not unique to disciplinary hearings. They apply to all manner of legal proceedings including arbitration proceedings. The continued challenge for courts in Singapore is to determine which of the challenges genuinely fall within the ambit of breach of natural justice and, further, whether the breach would entitle the court to set aside the disciplinary tribunal’s decision. In analysing this issue, the author hopes that members of disciplinary tribunals would have a better idea of rules of natural justice and avoid straying from the accepted parameters of these rules in the adjudication process.

WHAT IS NATURAL JUSTICE?
These rules are concepts derived from English law and captured in two Latin maxims: *nemo judex in causa sua*, which means the adjudicator must be disinterested and unbiased, and *audi alteram partem*, which simply means parties must be given adequate notice and opportunity to be heard. The rules of natural justice can be recast as a duty to act fairly in all circumstances and includes the rule against bias and the right to a fair hearing. The scope of the rules of natural justice is often not disputed, but the rules themselves as a concept are generally flexible in application and dispute arises in the application of the rules. Given the rise in arbitration proceedings, many of the cases relating to breach of natural justice relate to arbitration proceedings. In analysing this issue, the author has also examined cases involving parties’ attempts to set aside arbitral awards on the grounds of breach of natural justice. In the author’s view, the various issues that can be gleaned from an examination of these cases would be equally useful in the context of disciplinary tribunal proceedings.
SOMETHING ALLEGATIONS OF BREACH OF NATURAL JUSTICE
Essentially, the factual circumstances under which an allegation for breach of natural justice may be raised are not closed. Members of the disciplinary tribunal should be mindful of their role to ensure that the respondent is given a fair hearing. Appended below are some examples of the accusations of breach of natural justice that may be raised against adjudicators and how, in a disciplinary tribunal setting, such accusations may be avoided.

(a) Rule against bias
Based on the author's experience, this accusation is often raised in an attempt to set aside the disciplinary tribunal decision. The key issue to bear in mind is that a decision made in breach of the bias rule must be set aside regardless of whether the bias was actual or apparent.4 The accusations of bias may relate to past dealings of the members of the disciplinary tribunal with the respondent which raise a suspicion of bias.5 From the author's experience, such accusations may even go as far back as when the respondent began medical practice. The accusation may also arise from the conduct of members of the disciplinary tribunal in the course of the hearing which showed an attitude of bias towards the respondent.6,7,8 Sometimes, the bias may have taken the form of predetermination or prejudgement which tainted the eventual decision.8 Members of disciplinary tribunals are therefore reminded that such accusations may not be limited to their conduct during the inquiry hearing but may also arise from their conduct outside of the disciplinary hearing. It is critical for all members of the disciplinary tribunal to avoid discussing or making any comments on the case at hand outside of the hearing especially prior to the pronouncement of the findings of the disciplinary tribunal. Such comments or remarks may be relied on by a respondent in alleging bias against the member of the disciplinary tribunal or the disciplinary tribunal itself.

(b) Right to cross-examination
This accusation relates to the disciplinary tribunal depriving a respondent of a fair hearing by failing to enable him to fully exercise his right to cross-examination.10 There is a body of case law that provides that it is part of the principles of natural justice to afford the party a fair opportunity to challenge by cross-examination witnesses called by the other party or in the case of a disciplinary hearing, the prosecution. In short, a respondent whose livelihood or professional reputation is at stake should be given fair opportunity to cross-examine and/or challenge the evidence adduced against him. For members of a disciplinary tribunal, there may be a tendency to consider that certain lines of cross-examination undertaken by a respondent or his counsel is not relevant to the issues or matters at stake. In such a situation, the disciplinary tribunal should be careful not to prevent a respondent or his counsel from exercising his right of cross-examination. That does not mean that the tribunal should sit back and allow a respondent or his counsel to ask all manner of questions of the witnesses but a right balance must be struck. The respondent should not be placed in a position where he has not been given sufficient opportunity to challenge the evidence adduced against him. This accusation may be raised if the tribunal interjects unnecessarily or excessively while the respondent or his counsel is carrying out cross-
examination or prevents the questions from being asked.

Notwithstanding this point, this does not mean that if the respondent chose to appear in person without legal counsel, the disciplinary tribunal would be obliged to afford him a higher standard of natural justice and would have to assist him in the cross-examination process or to warn him of the legal implications of not fully exercising his right of cross-examination.11 As rightly noted by Lord Denning in Pett v Greyhound Racing Association Ltd, 12 “It is not every man who has the ability to defend himself on his own.” However, the mere fact of the absence of cross-examination does not render the tribunal decision unfair or that there was breach of natural justice. The issue is whether the disciplinary tribunal had afforded the respondent a fair hearing. If there was fairness in the process, then the decision of the tribunal should not be impeached. Under Section 51(4) of the Medical Registration Act, it is noteworthy that the disciplinary committee is not bound by any written laws relating to evidence. This is consistent with the notion that disciplinary tribunals are masters of their own procedure, but this is still subject to the principles of natural justice.

(c) Omission to consider all evidence and submissions
The role of a disciplinary tribunal is to consider all the evidence and submissions presented by a respondent and his counsel as well as the prosecution before reaching a decision on the charge/complaint.13 Any failure or omission to do so may constitute a breach of natural justice for not giving the respondent a fair hearing. This can be a challenge where the respondent raises a myriad of different arguments, some of which are framed ambiguously or presented in a manner that is difficult to understand. If there is any uncertainty, it would be advisable for the disciplinary tribunal to clarify with the respondent or his counsel on the points of submission he wishes the disciplinary tribunal to consider and the evidence relied on in support. With this clarification, which should be noted, there is less likelihood of a disciplinary tribunal overlooking any submission raised. Having said that, even if there is a breach of natural justice in this regard, the court may not necessarily set aside the disciplinary tribunal decision. The respondent has to further establish that the breach was causally linked to the decision and would have led to a different outcome had the submission or evidence been considered.14,15

The author has emphasised the importance of considering all the submissions and evidence presented by the respondent. Equally, members of the tribunal must be mindful not to allow extraneous facts to influence or determine their decision. In disciplinary proceedings involving professionals, it is not uncommon for the members of the disciplinary tribunal (who are members in the same professional field) to have chanced upon information relating to the complaint/charge. Members of the disciplinary tribunal must avoid taking the information in question into account in their decision-making process. Unless the information is properly adduced as evidence in the inquiry hearing, they should be strictly excluded from the deliberations. Ultimately, any finding or decision of the disciplinary tribunal must be premised on the evidence properly adduced in the inquiry hearing and based on permitted inferences drawn from the evidence through logical reasoning.

References
2. Soh Beng Tee & Co Pte Ltd v Fairmount Development Pte Ltd [2007] 3 SLR(R) 86 at [43].
3. Kok Seng Chong v Bukit Turf Club [1992] 3 SLR(R) 772 at [40].
6. Tan Tiang Hin Jerry v Singapore Medical Council [2000] 1 SLR (R) 553 at [59] to [64].
9. Sim Yong Teng v Singapore Swimming Club [2015] 3 SLR 541 at [58].
13. Front Row Investment Holdings (Singapore) Pte Ltd v Daimler South East Asia Pte Ltd [2010] SGHC 80.
14. Front Row Investment Holdings (Singapore) Pte Ltd v Daimler South East Asia Pte Ltd [2010] SGHC 80.
15. LW Infrastructure Pte Ltd v Lim Chin San Contractors Pte Ltd [2013] 1 SLR 125.
As at 1 March 2016, the closing date for the receipt of nominations to the 57th SMA Council and resolutions or proposals for constitutional amendments,

(a) Ten nominations had been received to fill ten vacancies in the 57th SMA Council. In accordance with Article VIII section 3b, these ten members shall be duly elected at the AGM. The names of the ten members are as listed in the AGM Agenda.

(b) No resolution or request for Constitution amendment was received.

In accordance with Article XI section iv of the SMA Constitution, the following documents are available at the end of March on the SMA website (https://www.sma.org.sg/agm) for members to read online and/or to download. Members who have opted for hardcopies will receive the documents by mail.

1. The Agenda for the 56th SMA AGM.
2. The Annual Report of the 56th SMA Council which compiles the following documents:
   i. Unconfirmed Minutes of the 55th SMA AGM;
   ii. Reports on the activities of the SMA, its committees, organisations under its governance (including the SMA Charity Fund) and its affiliate for the year; and
   iii. Audited statements of accounts for the year ended 31 December 2015 which are presented in the CD attached at the back of the Report.

Members may confirm their attendance for the AGM and request for a printed copy of the Annual Report by returning the AGM Response Slip to the SMA Secretariat via fax: 6224 7827 or email: gekeng@sma.org.sg, or respond online at https://www.sma.org.sg/agm.

Looking forward to seeing you at the AGM on Sunday, 17 April 2016.

DR DANIEL LEE HSIEH CHIEH
Honorary Secretary
56th SMA Council
Today is the first day of the new year. It is also the start of my retirement. There are mixed feelings inside me.

There is a certain sense of sadness about leaving everything that has become a part of your life. The familiar room that you have spent almost your entire waking hours in, the loyal staff who have stayed to assist you for years, the patients and their families who, in the course of long contact, have become your friends, and the people in the neighbourhood where you worked in and are more familiar with you than the local politician.

As a community doctor, you serve a patient from the cradle to the grave. It is unavoidable that you ought to share the joy of a birth, the happiness of a newly-wed, the pains of chronic diseases in the elderly and the grief of the family whose member has completed his or her life journey. There is also the immense satisfaction when you treat a poor and indigent patient who cannot afford your service and shows his gratitude by giving you the mandarin oranges that his boss gave him for Chinese New Year.

Rudyard Kipling, the famous writer, knew the daily suffering that doctors go through. In a speech to graduating medical students, he said: “It has long ago decided that you have no working hours that anybody is bound to respect, and nothing except extreme bodily illness will excuse you in its eyes from refusing to help a man who thinks he may need your help at any hour of the day or night. Nobody will care whether you are in your bed or in your bath, on your holiday or at the theater. If any one of the children of men has a pain or a hurt in him you will be summoned. And, as you know, what little vitality you may have accumulated in your leisure will be dragged out of you again.” Yes, that’s a doctor’s life!
Yet in a way, I am relieved that I am retired and I look forward to a new chapter in my life. No need to drag myself out of bed when I am tired. No routine to follow. No goals to set. Just take life free and easy and go with the flow (逍遥自在).

The last month was a period packed with emotions as patients streamed in to collect their final prescription or just to bid me farewell. The many tears and choked voices left me with a heavy heart. I had expected only old aunties to be saddened by my retirement but there were some surprises.

One big, middle-aged Malay man cried uncontrollably as he hugged me. An elderly Indian lady in traditional sari not only hugged me but also gave me a kiss on my neck.

Yesterday, a young scholar who was back on holiday from Boston heard that I was retiring and he immediately rushed down to my clinic to thank me and to say goodbye as he had to fly back to Boston last night. He told me he enjoyed reading my articles online. I didn’t have the heart to tell him I was also thinking of retiring from writing. Writing on national issues to a seemingly apathetic population is like playing the zither to a cow (对牛弹琴). Before I could tell him, he said, “A lot of my friends in Boston also like to read your articles. You have a cult following there.” With such encouraging words, I suppose I should change my mind and continue writing?

Our policy-makers should realise this: healthcare is not a commodity that should be bought and sold. After all, the greatest joy in medicine is not in the money you get from patients, but the gratitude you earn from them. It is grateful patients who make your job satisfying.
Project Sothea is a student-led project under the Rotaract Club of Singapore (City), which comprises enthusiastic Year One and Two medical students and dedicated doctors from various fields. For the past six years, the team has been working with the Khmer Foundation for Justice, Peace and Development (Khmer Foundation) and Peaceful Children’s Home II (PCH II) in Cambodia. Project Sothea reaches out to hundreds of Cambodians each year, with health screenings, health education and developmental efforts as the main modes of service.

In December 2015, we embarked on our sixth trip. It was yet another successful effort — our health screening programmes reached over 500 people and a host of new initiatives were introduced.

As first-timers, we did not truly know what to expect prior to the trip. However, the warm welcome we received from the children at PCH II gave us a glimpse of the hospitality we would experience over the next few days and strengthened our resolve to reciprocate the Cambodians’ unencumbered affection through our efforts.

Over the course of the screenings, we observed many noteworthy trends, which reflected the harsh realities of life for the rural Cambodians, with undernourishment featuring prominently. Most of the schoolchildren were in the lowest stratum of the Cambodian height-and-weight percentile charts, with a good number falling under the lower few percentile bands.

A new addition to this year’s trip was house visitation conducted for the immobile who could not attend our screenings. These included pregnant women, stroke patients and elderly patients with lower limb fractures. Together with our passionate doctors, we reached out to over a dozen families. Through these visits, we learnt the value of medical care and the change it can bring to the lives of the impoverished.

One of the residents we met during the house visits presented with a severe hip injury from a bad fall years ago. She had been walking on all fours since her injury, as her legs were unable to support her weight. On the advice of Dr Barbara Helen Rosario, we, with the arrival of our friends from International University in Phnom Penh and Battambang, were ready to proceed.

We conducted screenings in Kamping Puoy, PCH II and Sra Kaew over six days. Our screening process comprised registration, measurement of height and weight, taking of vital signs, health education, consultations and pharmacy stations. Health education was conducted during waiting periods.

The authors are Year One medical students from NUS Yong Loo Lin School of Medicine. They are members of Project Sothea and will be continuing with the project this year.

PROFILE

DEEPANRAJ

Deepanraj loves reading and is always keen to catch a movie. He also aspires to travel widely to discover new worlds and friends.

MICHELLE LEE

Michelle has always been passionate about community service, having been in the interac club and worked with children with autism. She aspires to travel around the world and help people in poverty.
the geriatrician in the team, we arranged for an adjustable pair of crutches for the patient. In just the space of an afternoon, we saw a lady who had been confined to the limits of her house being empowered to move around on her own with a simple aid.

However, it was not all good news. There were a few instances where villagers presented with chronic ailments that required long-term care. Recognising our constraints, the team did feel a tad disheartened for being unable to provide for these individuals.

It was during such occasions that the words of Dr Winston Lim, one of the accompanying doctors, offered us encouragement. He shared that it meant a lot to the rural Cambodians when they see Singaporean doctors come to their villages to treat them. The knowledge that they were receiving treatment from some of the region’s best was in itself a source of joy and comfort to them. He explained that our willingness to reach out to these communities possibly engendered the kind of intangible benefits that could not be replicated by the mere provision of material resources.

This message reinforced our determination to continue to help as many people as we could to the best of our abilities. These experiences would also give us the solemn understanding that we cannot possibly provide long-term solutions to the problems faced by the villagers. If our presence provided symptomatic relief, then the cure would be to inspire and empower the Cambodian communities to share resources and manpower to solve prevalent issues.

One way we helped in this aspect was by furnishing the village health post with a new delivery bed, basic surgical equipment and first-aid kits. We felt that this was particularly important, as the nearest hospital was two hours away by road and virtually impossible to get to after dark.

Furthermore, we saw great potential for sustainability during our engagements with the KNGO youth volunteers, who would continue to conduct lessons for the villages throughout the year in our absence.

Following our training methods and syllabi, these volunteers will conduct health education at our two beneficiary villages, covering a host of topics ranging from sanitation to contraception. As the volunteers have tertiary education and hail from that region, they possess both the technical knowledge on the aforementioned topics as well as the cultural sensitivity required to overcome any sociocultural hurdles.

Meanwhile, our medical and nursing peers from International University gave us the conviction that we would soon be able to pass the baton to them. Tean Mengheang, a fourth year medical student said: “I want to become a doctor and set up a camp like this during the holidays every year.” Project Sothea hopes to nurture more medical students like Tean in the years to come and to give them the opportunity to learn and serve their fellow countrymen in need. In a decade or so, we aim to have health screenings run by Cambodian students themselves.

Our gratitude extends to the doctors who provided invaluable guidance on the ground, as well as International University, Khmer Foundation and KNGO for their heartening support. Overall, this trip was meaningful beyond measure, teaching us the importance of reaching out to our neighbours, cherishing what we have and seeking to give whenever we can.

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### Profile

**Samantha Foo**

Samantha has been playing the clarinet since the age of nine and is passionate about music. Also, she loves nature and always finds time to go on outdoor trips.

**Legend**

1. Geriatrician Dr Barbara performing an examination on a pregnant lady at one of the house visits in Sra Kaew
2. Project Sothea members training the KNGO youth volunteers for their subsequent health education lessons
3. A child at PCH II playing with one of our educational tools during the health screening
A child’s mind is an intricate lattice of evolving synapses. Children with acute or chronic life-threatening or life-limiting illnesses may struggle to express their complex thoughts and emotions due to their inability to process and rationalise their internal turmoil. Medical treatments can be developmentally traumatising for such children, hence, there is a need to bridge the inadequacies of medical therapy to ensure the holistic psychological well-being of a child.1

Art therapy is a bridge which effectively condenses a child’s kaleidoscope of emotions into a singular pictorial representation. It is a powerful vehicle2 that transports a child from an intense and unfamiliar environment to the safer realms of their imagination and perception of their reality. Art restores their distorted vision of their illness, normalising and humanising their treatment process. It reinstates their Disney-like innocence and trust in the world.

The mediums used during the art therapy sessions were crayons, colour pencils and watercolour paint.

**ART THERAPY AT WORK**

**SIBLING MAGIC**

“Can I draw something before seeing the doctor? I am anxious about receiving my chemo today.” Ian, a ten-year-old boy from Bangladesh, was one of our first clients for the day. After he was diagnosed with acute lymphoblastic leukaemia (ALL) a year ago, where he first presented with knee pain, he came to Singapore with his family to seek treatment. He is currently undergoing his fourth cycle of chemotherapy which includes high dose intravenous methotrexate and vincristine. These are chemotherapy medications with a propensity to cause severe side effects such as fatigue, nausea, vomiting and alopecia. He has been admitted several times for life-threatening fever episodes.

Based on my interaction with him, Ian is a pensive yet pragmatic child who reflects before his actions.

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R R Pravin, a Singaporean medical student, shares his reflections on art therapy for paediatric oncology patients he encountered during his child psychiatry elective at the National University Hospital of Singapore.
has been proven to be effective when Studies have shown that art therapy resolve his fear of chemotherapy. He started painting a blue sea and continually looked at the art therapist, asking if she knew what he was portraying. She patiently answered, allaying his anxiety.

That day, Ian painted his father’s village of birth which he visited often when he was younger. Art transported him to a familiar setting with a comforting sense of nostalgia. Based on our interpretation, the house possibly represents a form of refuge and the tranquil scenery likely a projection of his personal hope to quell his anxiety before his treatment. However, the lonely house by the river could symbolise his isolation as a result of his condition, which may have taken him away from his friends, as represented by the various brown houses in the distance. His concrete comprehension of his condition translated into a well-crafted painting laced with simple but intricate details, possibly symbolic of the psychosocial and emotional aspects of his quotidian life.

Before and after their art therapy sessions, children are required to score their feelings on a feeling thermometer which objectively measures improvements or otherwise in their psychological state. A rating of ten, the highest score, equates to the patient feeling fantastic and one, the lowest score, indicates that the patient is feeling extremely down. Before painting, Ian scored a two and after the session, he scored a ten which was a vast improvement, reinforcing the effectiveness of art in helping him resolve his internal conflict of facing his fear of chemotherapy.

Studies have shown that art therapy has been proven to be effective when integrated with the multidisciplinary treatment of such conditions. Children with chronic illnesses can also develop paediatric depression or post-traumatic stress disorder from frequent blood-taking, hospitalisations and invasive procedures such as lumbar punctures, bone marrow aspirations and surgeries.

Soon, Ian’s three-year-old younger sister, Jamie, joined him and started drawing her family. She portrayed Ian without hair in an orange cap, clearly noting the physical side effects of hair loss on her brother. She painted Ian blue, since he was wearing a blue T-shirt. These observations show us the simple, concrete manner in which she is expressing Ian’s illness. Ian also acknowledged that Jamie was close to her Mummy which is why Mummy is carrying Jamie in her drawing and Ian is next to his Daddy. The use of shapes and symbols to characterise her thoughts is representative of the pre-schematic drawings from her age group. The use of vibrant colours and her drawing of her complete family is testimony to her concept of unity in the family, which is a positive reflection of her mental state amid the challenging times Ian is enduring.

Art therapy also allows siblings of the family a concrete platform to vent their worries, queries, frustrations and guilt about their sick sibling’s condition and their reactions to the turbulent changes in the family dynamics. Art helps to validate their emotions and for younger siblings like Jamie, art is their verbal tool to reveal their understanding and opinions of the situation.

A YOUNG WARRIOR

Four-year-old Lily is a little girl from Indonesia who was diagnosed with early precursor B-cell ALL a year ago. She was on her first cycle of high dose intravenous methotrexate and vincristine with similar side effects Ian experienced. She had also been previously admitted several times for life-threatening infections. This little warrior had braved many storms but was too young to realise the immense strength she possessed. She was a quiet maestro of her emotions and undeniably adorable.

At the beginning of the session, she looked anxiously at me, the newcomer in her usually familiar sessions of art therapy. She then started with isolated dots of different colours on a blank canvas. I urged her on, verbally validating her actions. She then went on to connect the dots, mixing two colours as our therapeutic relationship developed and she became more familiar with me. As she drew, she repeatedly made sounds of exclamation, “cling” and “vroom”, clearly enjoying the experience. She was much less inhibited than when we first met. She then started mixing all the colours together and made daring swirls across the canvas which culminated into the end product, before she abruptly exclaimed “RAINBOW!”

The clearly satisfied “Leonardo Da Vinci” sat back for a moment, admiring her work, before she laid down her paintbrush and gestured towards the sink, signalling that her masterpiece was complete. The painting process had been cathartic for this little girl who must have vented her convoluted emotions onto a blank canvas, producing a rainbow, and relieved all her tension within — another benefit of art therapy.

Lily’s pre-schematic portrait represents the utopian mind which fervently grasps onto the innocence of childhood to shield her from the
of treatment is unique. They deserve to be different since they are all special in their own ways. After all, art endorses freedom of expression.

CONCLUSION

In conclusion, after having observed and participated in art therapy in both paediatric oncology inpatient and outpatient settings, art is a powerful albeit simple tool to build a therapeutic relationship with a child. Art is also evocative of complex thoughts translated into emotions that could help patients and their siblings create an individualised picture of their circumstances in a healthy way and ensure that the patient continues to develop normally psychologically. Art does not set boundaries but instead opens a window of opportunities for the unwell child. It allows them to have a sense of control since they cannot have control over their illness. After all, the world is but a canvas to our imagination.

ACKNOWLEDGEMENT

I would like to thank Dr Celine HJ Wong, Consultant, National University Hospital of Singapore Child Psychiatry Department and Ms Yenn Ang, Art therapist from the Children’s Cancer Foundation for their advice and support.

References

# SMA EVENTS APR – MAY 2016

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## Non-CME Activities

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For those who have been to Venice, you would have enjoyed sitting on the gondola plying through the maze of canals across the city. If you love the serenity of water towns, be certain not to miss Wuzhen, China.

Lauded as the Venice of the East, Wuzhen lies within the triangle formed by the scenic cities of Hangzhou, Suzhou and Shanghai. With a history spanning more than 5,000 years and boasting of unique canals, stone pathways, oriental bridges and houses, Wuzhen exudes a combination of ancient charm and modern sophistication.

Night had fallen by the time we reached Wuzhen and although I was exhausted from the two-hour-long journey from Hangzhou, the coolness and bustle of the town instantly re-energised me. We had a quick meal at a three-storey inn restaurant and while admiring the breathtaking scenery from the second floor, my imagination started to run wild. After all, the ancient-looking wooden inn that we were dining in resembled the one featured in the award-winning movie, *Crouching Tiger, Hidden Dragon* (minus the exciting fighting scenes of course).

After the meal, we made our way to our hotel which is tucked in the most central part of the town. Since going by foot would be too taxing, we hopped on to the convenient

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**PROFILE**

**Dr Chie Zhi Ying**

Dr Chie Zhi Ying enjoys freelance writing and singing. She writes for *Lianhe Zaobao*, *Shin Min Daily News* and *Health No. 1*. She can be reached at chiezhiying@gmail.com.

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**Legend**

1. The Wu Zhen water town exudes ancient charm and modern sophistication
2. Sailing down the waterway under the moonlight is a magical experience
3. Our hotel is well furnished and comfortable
4. The famous Dye House with characteristic blue cloth drying on frames
trams, which run round the clock fetching visitors to and from their destinations. The chilling wind caressed my face as the tram sped down the corridors. How refreshing! Upon arrival, we found the hotel to be well furnished and had an oriental air to it. After we unloaded our luggage, it was time for us to explore the mysterious water town.

**ENCHANTING NIGHTSCAPE AFTER DARK**

Strolling on cobbled ground in the chilling autumn wind, with a picturesque scene unfolding in front of my eyes was simply exhilarating. I could not help but prance around in dizzying excitement as I snapped away with my camera. Interestingly, photos captured from different angles seemed to produce vastly different views of the charming city.

Each canal is spanned by stony arch bridges and lined by ancient wooden houses. Glowing red round lanterns and graceful willows dance in the night wind, casting shimmering reflections on the quiet waters. What’s more, the houses are well furnished with spacious courtyards and verandas. You can choose to explore the different parts of the canals on foot or take the many boats that ply the waterways.

Sailing down the waterways under the bright moonlight, I felt myself being transported to ancient times as I imagined myself walking in the shoes of an ancient Chinese scholar while sipping fragrant tea and reciting romantic poetry. Much of the ancient town has been carefully preserved and it’s simply enthralling to admire the quaint houses while walking beneath the delicate stone bridges. Everything seems to glimmer in the dark, making the experience magical.

While crossing one of the arch bridges on foot, a melancholy voice caught my attention. I turned around just in time to catch a glimpse of a huagu (flower drum) opera performer dancing and singing on the second floor of an inn house. There is also a shadow puppet theatre in town for those who enjoy the ancient art form.

If you’re a night owl, fret not! There is a myriad of pubs, cafes and restaurants (both Western and traditional Chinese) to choose from, where you could relax and take in the entire scenic view of the canals. You could see people downing mugs of beer and bantering in pubs while others sipped on hot Chinese tea and munched on snacks in the adjacent teahouses. Truly a fine example of the East meeting the West!

**CULTURAL SIGHTS BY DAY**

In the day, Wuzhen returns to her simple and peaceful state and one can slowly appreciate the local culture and history.

The town itself is divided into four sections: north, south, east and west. In Xizha (western section), the highlight would be the amazing scene of the "Bridge within a Bridge", created by two ancient bridges; the Tongji Bridge that crosses the river from east to west and the Renji Bridge that runs from south to north. In this area, there is also a soy-sauce-making house with big urns of soy beans fermenting in the sun and one can vaguely smell the fragrance wafting through the morning air.

In Dongzha (eastern section), the Mao Dun Museum is a place of interest. This is the former residence of Mao Dun, a well-known Chinese revolutionary writer. Also in the vicinity is a famous dye house with rolls of its characteristic blue printed cloth hanging in the sun for drying.

In addition, there is the signature bustling water market where merchants sail on boats peddling goods and food to locals just like how it was done centuries ago. You could also purchase locally brewed beer that were highly regarded by the Ming dynasty imperial family.

Alas, my stay in Wuzhen was brief and I was not able to explore more of its museums and local folk culture. However, the enchanting experience has left me fond memories and I look forward to going back in the near future as a short getaway from city life.
The National Healthcare Group (NHG) Mobile Community Health Centre (CHC) has been bringing accessible and affordable healthcare services directly to patients living in Central Singapore since November 2014. The mobile unit is part of NHG’s vision to provide integrated community care by working with partners like General Practitioners (GPs) to empower patients to care for themselves.

This mobile CHC is the latest addition to five other CHCs located in Tampines, Bedok North, Bedok South, Jurong East and Tiong Bahru.

The bus makes monthly stops at more than 20 locations, such as community centres and residential HDB car parks, around the central districts — including Ang Mo Kio, Bishan, Geylang West, Macpherson, Serangoon, Toa Payoh and Hougang — providing convenient services to the elderly patients who are unable to travel long distances.

Retrofitted with medical equipment for diabetic retinal photography and diabetic foot screening, the mobile CHC supports clinical care offered by GPs. Patients with chronic conditions such as diabetes, hypertension and high cholesterol can be referred by GPs to the mobile centre for screening and nurse counselling services.

More than 40 GP clinics in the central region have referred patients to the mobile CHC in the past year, and about 300 patients have benefited from its services.

Dr Yik Keng Yeong, from Tan & Yik Clinic & Surgery, is one GP who refers his patients to the mobile CHC. “The introduction of the mobile CHC made things much more convenient for my patients,” he says. “In the past, patients had to go a bit further to get screened, but the problem was that older patients can neither drive nor travel long distances on their own. By the time they navigate their way around unfamiliar places, it would have taken up a whole day.”

Furthermore, since visits to the mobile CHC are by appointment only, Dr Yik’s patients have found that the CHC services are efficient and time-saving.

Dr Yik can get information on the bus’ schedule via the mobile CHC webpage (partners.nhg.com.sg) or contact the hotline before referring his patients for scheduled appointments. One example is that he can refer patients to the Bishan Community Centre, which is just a few minutes’ walk from his clinic. According to him, none of the patients he has referred to the mobile CHC has had a problem locating it. He can even make arrangements for the
bus to be parked outside his clinic to render services, if at least 10 patients are present for screening.

Although some of his patients were initially skeptical, Dr Yik says that they were impressed with the services offered by the mobile CHC. "It took some gentle persuasion to get them to visit the centre the first time around, but none of them have come back to me expressing any displeasure," he says. "Apart from it being so close by, the staff are patient, the experience is pleasant and the service is inexpensive."

Patients have found that the fees for services at the CHCs are comparative to that of polyclinics. Community Health Assist Scheme (CHAS) and Pioneer Generation cardholders pay subsidised rates for services at the CHCs.

Dr Yik also appreciates the quick turnaround time for test results, enabling him to review the results and follow up with his patients in a timely fashion. "It's great that the mobile CHC works closely with GPs to make this process easy and efficient. At the end of the day, what is most important is that we can help patients the best we can."

For appointments, enquiries and the full schedule of the services of NHG mobile CHC, please contact:

**CHC Hotline:** 9088 5562
**E-mail:** chc@nhg.com.sg
**Website:** partners.nhg.com.sg

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**Other Community Health Centres**

<table>
<thead>
<tr>
<th>Community Health Centre</th>
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<tr>
<td>Eastern Community Health Centre (Bedok North)</td>
<td>6446 7200</td>
<td>Eastern Health Alliance (EHA)</td>
</tr>
<tr>
<td>Eastern Community Health Centre (Bedok South)</td>
<td>6449 5419</td>
<td></td>
</tr>
<tr>
<td>Eastern Community Health Centre (Tampines)</td>
<td>6782 6885</td>
<td></td>
</tr>
<tr>
<td>Jurong East Community Health Centre</td>
<td>6665 1290</td>
<td>SATA CommHealth</td>
</tr>
<tr>
<td>Tiong Bahru Community Health Centre</td>
<td>6376 0158</td>
<td>Singapore Health Services (SingHealth)</td>
</tr>
</tbody>
</table>

In addition to the NHG Mobile CHC, you could also refer your patients to the other five CHCs, which offer services that include Diabetic Retinal Photography, Diabetic Foot Screening, Nurse Counselling, Physiotherapy and Dietetics. If you would like to make referrals or know more about the other CHCs, you can find more information at [www.primarycarepages.sg/CHC](http://www.primarycarepages.sg/CHC).
**MISCELLANEOUS**

34 sqm Paediatric clinic for lease from June 2016. Shared overheads negotiable. Please contact Ms Prunella 9626 7607.

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Mount Elizabeth Novena Medical centre unit for rent. Approximately 620 sq ft. Next to lift lobby. Good layout, can partition 2 consultation rooms. Attractive rental terms. Please call Cleo at 9382 5939.

Connexion Medical Suite clinic space available immediately for rent. 646 sq ft. Directly linked to Farrer Park Hospital, hotel & spa, MRT. 12th floor. Bare finish. For specialists only. Please call Steven Chia +65 8133 4933; Crystal Yu +65 8121 9326.

Serviced clinic for rent at Mount Elizabeth Novena Hospital. Fully equipped and staffed with IT support. Immediate occupancy. Choice of sessional and long term lease. Suitable for all specialties. Please call 8668 6818 or email servicedclinic@gmail.com


Established Obstetrics & Gynaecology Clinic in Far East Plaza, area about 1360 sq ft freehold, large patient base, fully equipped with minor OT and restroom, able to accommodate two doctors, available from April 2016. Contact (65)8139 5077.

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- Learn management skills and prescriptions of medications

For more information, please visit www.imh.com.sg/education. You may also contact:
Nirhana Binte Japar: 6389 2831 / nirhana_japar@imh.com.sg
GDMH Administrator / GDMH@imh.com.sg

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We regret that only shortlisted candidates will be notified.

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# Gleneagles Singapore

**Demystifying Malaise and Giddiness**

Treatment and Screening Options

**GLENEAGLES HOSPITAL 18th ANNUAL SEMINAR**

GP & Specialist Forum

Grand Hyatt, Grand Ballroom 1 & 2, Level 3

23 April 2016, Saturday, 12.30 pm to 4.55 pm

## Programme

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.30 pm</td>
<td>Registration &amp; Lunch</td>
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</table>
| 1.30 pm | **Opening Ceremony**            | **Welcome Address by Dr Vincent Chia**
|        |                                 | Chief Executive Officer, Gleneagles Hospital                            |
|        | **Opening Speech by Dr Bertha Woon**                                        | General Surgeon and Chairman of CME and Organising Committees            |
|        | **Event Chairperson: Dr Loh Boon Kwang, Ophthalmologist**                    |                                                                           |
| 1.40 pm | **When is Giddiness an ENT problem? ENT Causes, Diagnosis and Treatment**    | **Dr David Lau, Otorhinolaryngologist**                                  |
| 2.15 pm | **Endocrine Differential Diagnoses for Dizziness / Malaise**                 | **Dr Richard Chen, Endocrinologist**                                      |
| 2.50 pm | **The “Civil War” within Your Body, What is It and How Can It Affect You?**  | **Dr Lui Lai Lee, Rheumatologist**                                        |
| 3.25 pm | Tea Break                       |                                                                           |
| 3.45 pm | **Restless Hearts and Spinning Heads**                                       | **Dr Peter Ting, Cardiologist**                                           |
| 4.20 pm | **Is It All in the Mind? The Link between Psychiatric and Physical Symptoms** | **Dr Calvin Fones, Psychiatrist**                                         |
| 4.55 pm | **End of Session**               |                                                                           |

## Registration

Closing Date for Registration: **15 April 2016 (Friday)**

To register, please email or fax your Name, Address, Email, MCR and Contact Number to:

<table>
<thead>
<tr>
<th>Mun Yee: +65 6349 5762</th>
<th>Email: <a href="mailto:munyee.fo@parkway.sg">munyee.fo@parkway.sg</a></th>
<th>Fax: 6738 9584</th>
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</thead>
<tbody>
<tr>
<td>Jolene: +65 6349 5753</td>
<td>Email: <a href="mailto:jolene.sil@parkway.sg">jolene.sil@parkway.sg</a></td>
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</tbody>
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Please visit our website for more information: [https://www.gleneagles.com.sg/event-annualseminar](https://www.gleneagles.com.sg/event-annualseminar)

**NOTE:**
- Programme subject to change without prior notice
- This event will be accredited with CME Points
- Registration Fees: Complimentary for doctors
- Please bring along your SMC Practising Certificate (blue card as shown on the right) on the event day for verification and scanning of attendance