THESMANEWS

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Home care is the next area of care in Singapore that needs to be developed. To be effective, it has to be multi-disciplinary.

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SMA FOCUSES ON HOME HEALTH CARE

A Home Care Committee has been formed in the Singapore Medical Association and chaired by its President, Dr Cheong Pak Yean and co-chaired by Dr Mary Ann Tsao, President of the Tsao Foundation. Members of the Committee represent the breadth of organisations that are involved in the delivery of home care, namely, Home Nursing Foundation, the Tsao Foundation, the Touch Community Services and the Singapore Nurses Association, Society for Geriatric Medicine, Singapore and network of voluntary nursing homes. The Division of Elderly Services in the Ministry of Health is also represented in this Committee.

The Committee held its first meeting on 30 July 1997 and identified 3 immediate tasks.

Three tasks ahead

1. Development of training module and support of Home Care Technical Committee for ITE
   - Curriculum • Competency profile • Skills and standard • Tasks for supervised field training • Assessment • Monitoring • Identification of curriculum development group • Identification of trainers • Identification of field placements • Development of course structure
2. Development of home care system
   - Define mechanism for supervising trained home care assistants (ie patient care assignments; quality monitoring; reporting structure etc.)
   - Define structure for employing and assigning trained homecare assistants
   - Liaise with various groups and bodies to plan and implement home care system
   - Define approaches to home-based medical care system in Singapore context. There are a variety of approaches which can include:
     - physician who provides out-patient medical care and liaises with nurse/home care assistant
     - home-based multi-disciplinary team (doctor, nurse, social worker etc.) who provide and coordinate on-going care in patient's home)
3. Homecare Association
   - Consider need for Home care Association for future development and monitoring of the home care sector.

Training of the Home Health Care Assistants

The Committee has identified several goals for the ITE Home Care Assistant Module, which will be developed as an additional module to the existing ITE Healthcare Training programme.

Goals & objectives

1. Provide supportive care at home, eg. personal care, home maintenance, errands and escort services to increasing numbers of community-based elderly. Such care provided will help shorten length of hospital stay and delay premature nursing home placement
2. Support and maintain functional abilities of elderly and support quality of life
3. Support and decrease stress on family caregivers and support value of care of elderly within family setting

Major roles of home care assistants:

1. Provision of personal care services
2. Provision of home maintenance (including errands)
3. Provision of escort services
4. Support and supplement family carers

Target clients to be considered for home services:

1. Frail and physically disabled elderly
2. Other physically disabled adults (eg. paraplegic adults)
3. Elderly with mental disabilities (eg. dementia; psychiatric illnessess)
4. Adults with psychiatric illnessess (eg. schizophrenia)
5. Proposed home care programme to exclude maternal and child health

Settings to be considered for home care assistants:

1. Homes
2. Nursing homes
3. Sheltered homes
4. Day care or multi-service centres

Home care is the next area of care in Singapore that needs to be developed. To be effective, it has to be multi-disciplinary. The home care assistant is an important member of the team. ■

THE NEED FOR HOME CARE

SMA has formed a committee in association with community healthcare and other professional groups to look into the need for home healthcare. With the greying of the population and the increasing number of home-bound patients, the provision of such services would not only improve the quality of the home-bound patients but would also lessen the need for hospitalisation and nursing home care. While most doctors are familiar with the term house-call, which basically is a medical consultation at the patient's home, home healthcare is continued and continuing care at the patient's home punctuated by hospitalisation only when more complex medical and nursing care is needed.

A study done by Paul Chan et al[1] in 1984 showed that two-thirds of 954 house-calls done by 30 general practitioners over a 4 month period was for the elderly. Repeat home visits were needed for half of these patients because they were home-bound with chronic problems. Only ten percent of all patients needed hospitalisation after consultation. The average GP did about 7 to 8 house-calls per month 13 years ago as shown in this study. This is in contrast to an average of 1 to 2 house-calls per month noted during a recent audit of 20 GP enrolled in the private practitioners' stream of the Master of Medicine (Family Medicine) programme. If this were to reflect the norm, then the decreasing number of house-calls is a matter of professional concern.

A better organised ambulance service may lessen the need for house-calls by doctors for true medical emergencies. There exists however a greater medical need for healthcare to be organised around the patients' home for the frail and chronic sick elderly. It is estimated that about 5% of all elderly ie. about 11,000 presently require substantial help with basic self care tasks[2]. Attention must be paid to the training, structure and funding of such services.

Training needs to be formalised for the healthcare team. The School of Post-graduate Medical Studies has recently introduced a course leading to the Diploma in Geriatric Medicine (D.G.M.). This will provide appropriate training to complement the small number of specialist geriatricians we have. SMA has convinced the Institute of Technical Education (ITE) to develop Home Care Assistants training in parallel with the technical level of healthcare aide already developed for hospital and clinics. We are also working closely with other professional associations such as the Singapore Nurses Association so that healthcare teams can be forged. A home care conference would be organised as part of our National Medical Convention next year to facilitate dialogue. Appropriate contributions of all members of the home care team are important as more than medical care of the patient is involved.

The home is the next frontier of healthcare delivery. The medical profession must now actively explore all aspects of delivering continued and continuing care to home-bound patients.

The structure of the home care delivery has also to evolve. There are at least three possible models. One model is based on an extension of in-patient services of hospitals with departments of home care set up within the hospital structure. A second model is based on independent mobile clinics affiliated to hospitals much like the Hua Mei Mobile Clinic set up by the Tsao Foundation. A third model is based on primary care clinics in housing estates. Interested General Practitioners could be encouraged to set up home care services within their clinics' infrastructure with links to community and hospital services for the elderly.

However, these three models are not mutually exclusive. What is important is there should be close links with community and in-patient facilities such that the over-all care is cost-effective considering both the community and the episodic in-patient components. There is at present no external funding for home care. If effective home care can decrease the need for patients to be admitted to nursing homes and hospitals, then the monies used to subvent such services can be used to fund home care. Without financial support, it is unlikely that home care can be developed on a nation-wide scale.

The home is the next frontier of healthcare delivery. We are familiar with delivering care from hospitals and clinics for in-patient and ambulatory patients. The medical profession must now actively explore all aspects of delivering continued and continuing care to home-bound patients. ■

REFERENCES
1. P Chan et al. Singapore Family Physician 1985; 11 (1): 9-15.
2. National Survey of Senior Citizens in Singapore 1995.

DR CHEONG PAK YEAN

INTER-PROFESSIONAL PRESIDENTS' GROUP (IPPG)

SMA hosted a landmark meeting between the Presidents of professional organisations on 6 August 1997 at the SMA Conference Room. At this meeting, the professional bodies decided to formalise the dialogue sessions as the Inter-Professional Presidents Group or IPPG. The IPPG will be hosted by the Association or Institute which organises the Inter-Professional Games each year on a rotation basis. The organisations in the group are:
Institute of Certified Public Accountants of Singapore (ICPAS), Institute of Engineers (IES), The Law Society of Singapore, Singapore Institute of Architects (SIA), Singapore Institute of Surveyors & Valuers (SISV), and Singapore Medical Association (SMA)

The IPPG will also organise activities such as IPG as well as a public seminar on "My Dream House" and a seminar on ethics and conduct of the professionals, "Advertisements and Promotions in the Profession" in November this year.

The Law Society will undertake the chairmanship of IPPG next year as they will be organising the 1998 IPG. ■

38TH SMA COUNCIL

President	Dr Cheong Pak Yean
1st Vice President	Dr Lim Teck Beng
2nd Vice President	Dr Tan Kok Soo
Honorary Secretary	Dr Wong Chiang Yin
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Hon Treasurer	Dr Goh Jin Hian
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CARE FOR THE ELDERLY

The Ministry of Health has formed in May this year, a new division of healthcare called "the Division of Elderly Services". It is headed by Dr Ling Sing Lin. With the anticipated increase in the number of elderly people in the years ahead, this is timely. Today we have 6.9% of the population who are 65 years and older. This figure will increase to 18.4% in 2030. In absolute numbers, the increase will be from 20,9700 today to 798,600 in 2030.

The majority of the elderly, that is 93% will be healthy. The strategy in caring for these elderly is to encourage them, through mass health education as well as individual counselling, to adopt preventive and health promotive measures and to see a doctor when they have acute medical problems. Disease prevention and health promotion is just as important to this group of people as in the younger people.

There is a need for a seamless system for the elderly to move from home care to hospital care and back again to the home or nursing home.

Attention to diet, exercise and a temperate lifestyle help to maintain good health status. Specific measures to prevent falls are particularly important in the old-old, namely 75 years and older. Old people have decreased functional reserve and therefore are less able to cope with acute medical problems. The latter must be aggressively managed to prevent a vicious cycle of complications. This is an important concept that the old people themselves, their carers and attending doctors must pay attention too. It has been said that the name of the child is TODAY, meaning that their health needs cannot wait. The same can be said for the old.

There is a small percentage of the elderly who will have varying degrees of poor health status and frailty. This group of the elderly will increase in numbers with advancing age. They require varying degrees of assistance on their activities of daily living. Many may be home bound. A multi-disciplinary approach is the best way to serve their medical and social needs.

The home care assistant is an important emerging member in the multi-disciplinary team. They will complement the nursing staff in the Home Nursing Foundation. Doctors too, need to be encouraged to join this team. Family members need to be involved too. The multi-disciplinary team also includes the hospital team members: geriatricians, organ specialists, physiotherapists and nursing staff.

Caring for the elderly at home is another paradigm shift in the work of the primary care doctor and the specialist in the coming years. There is a need for a seamless system for the elderly to move from home care to hospital care and back again to the home or nursing home.

The philosophy in delivering elderly services should be appropriate and cost effective care by all sectors of the health care delivery system. It is only when we have such a shared vision could we hope to contain the cost for caring for the elderly. Collectively, we must help the elderly stretch the health dollar and make the best use of their financial resources: their own savings and the contributions of family and friends for the majority may not add up to be very much. ■

A/PROF GOH LEE GAN

SOCIETY FOR GERIATRIC MEDICINE, SINGAPORE

The Society for Geriatric Medicine, Singapore was officially launched on Sunday 3 August 1997 in a brief ceremony at Merchant Court Hotel. C/Prof Tan Ser Kiat, Master, Academy of Medicine, was the Guest of Honour. Dr F J Jayaratnam, widely recognised as the founder of geriatric medicine in Singapore, was conferred as the first Honorary Member of the Society. Formed by geriatricians and psychogeriatricians, the Society aims to:

a. promote and maintain standards of geriatric medicine and care of the elderly
b. promote the development of comprehensive geriatric services
c. promote research in geriatric medicine and care of the elderly
d. promote the training of medical students and doctors in geriatric medicine.

The office bearers for 1997 are:

President	:	Dr Ee Chye Hua
Vice-President	:	Dr Chan Kin Ming
Honorary Secretary	:	Dr Pang Weng Sun
Honorary Treasurer	:	Dr Yap Keng Bee
Committee Members	:	Dr Philip Choo
		Dr Ong Pui Sim
		Dr Teo Sek Khee

The Society will work with the School of Postgraduate Medical Studies in the forthcoming Diploma in Geriatric Medicine course scheduled to start in September 1997. An educational newsletter for doctors will be launched later in the year.

The SMA congratulates the Society on its inauguration and looks forward to working closely with it for the promotion of Geriatric Medicine in Singapore. ■

I was told by my teacher that if your students are not better than you eventually, then you are not a good teacher!

■ 32 YEARS OF CLINICAL PRACTICE - FROM TRAINEE TO TRAINER - A PHILOSOPHICAL REVIEW

This is a retrospective review of my experience from 1965 to the present, a period spanning just over 30 years, from housemanship in Penang, to being a medical officer in Kota Bahru, Kelantan, surgical trainee in University Hospital in Kuala Lumpur, registrar in the various hospitals in the United Kingdom, a surgical lecturer at the University here and finally Associate Professor and Head of the Department of Urology, Singapore General Hospital. From trainee to trainer, there was no perceptible time when I evolved from one to the other.

Housemanship

I did my medical posting under Dr Devaraj in Penang General Hospital. The first lesson I learnt from him, a wise Physician, was that "when in doubt, give the benefit of the doubt to the patient." This has been a sound advice. There had been many instances when I was glad I followed the advice and the occasions when I regretted that I did not.

In clinical practice, one is seldom 100% sure of our diagnoses, and the outcome of treatment. Usually 80% is my favourite cut off point.

We did not realise this when we first graduated from medical school full of confidence, with the new knowledge just recently acquired. In those days, there was a shortage of medical officers in Penang and we had to run the Accident and Emergency Unit as well . We were too confident of our diagnoses and used to discharge patients home even though some of them begged for admission. We mellowed subsequently when we realised the many mistakes we made, patients with abdominal colic being readmitted as appendicitis, and children with gastro-enteritis being readmitted with dehydration and shock.

My first surgical posting was with Mr Peter Vanniasingham in Penang. He was a disciplinarian and a very good surgeon. He encouraged me to take up surgery. I learned how to do circumcision from him . We were allowed only one cat gut suture and no more. This simple operation, I found out later, has so many variations that no two surgeons at the Institute of Urology did it the same way. As the saying goes, there are more ways to skin a cat than you think. I am still doing circumcision the way I learned it and have not changed because the outcome is satisfactory.

One advice to our young registrars is that as they mature and travel, they will see many new ways of doing things, but they must be discriminative, and remember that what is more important is the outcome. "New" does not necessarily mean "Better". So, do not be in too much hurry to adopt something new. Study the rationale and the outcome before you change. There are more new ways and technologies which are rejected eventually than the ones which subsequently prove to be truly progressive.

Medical Officer in Kota Bahru

In Kota Bahru, general surgery was truly general. The first bladder stone I removed was from a 10-year-old boy, not an old man with prostatic obstruction as we see nowadays. Primary bladder stone was common among children in less developed parts of the world due to poor nutrition. On the other hand, the first cleft-lip I repaired was in an elderly Malay lady who had lost all her teeth. The reason why she submitted herself to surgery was for religious reasons, to prevent saliva from dripping out when she bent down to pray since she became edentulous. That made my task easier, as she was not really bothered about the cosmetic aspect!

In general the patients in the East Coast then were very reluctant to have surgery except in an emergency. Even then, they sometimes refused and were prepared to accept their fate. I remember the night I was called to see a young boy with air-way obstruction due to diphtheria. He was already suffocating and we were pleading with his father to allow us to bring him to the theatre to do a tracheotomy. The father refused. When the boy started to gasp, we had no choice but to push the father aside, rushed for the instrument, and performed the tracheotomy in the ward, without his consent. Luckily, he survived and we were not sued for assault!

There are many rules and regulations in life, and in our clinical practice, the many guidelines. But there is always the exception, and one should not follow strictly or blindly. However, at the junior level, you are strongly advised to follow the guidelines. Only when you are more mature can you afford to bend the rules. For the senior staff, it is important for them to remember that they are there not just to ensure that the juniors follow the guidelines, but also to waive the guidelines or bend the rules when the need arises.

Surgical Trainee in Kuala Lumpur

I was fortunate to join the surgical team at the University Hospital in Kuala Lumpur soon after it was established as the teaching Hospital of the new Faculty of Medicine, University of Malaya. The team, led by Prof N K Yong was cohesive and academic. I am grateful to their guidance. I learnt not only surgical skills but also how to work as a team There was good team work among the staff, each complementing the other and not competing with each other. There were the X-ray conferences, grand ward rounds and the departmental meetings. Patients for surgery were properly vetted and there was much discussion and intra-departmental referral. Prof Yong looked after his staff well. He had a wide international network of contacts. Through that, he was able to get me a job in London when the time came for me to move on.

Registrar in U.K.

I worked as a Resident Surgical Officer (RSO) at the London Chest Hospital for six months and subsequently moved on to the Borders in Scotland as a Surgical Registrar at Peel Hospital in Galashiels. The Scottish countryside was beautiful, especially with the daffodils in spring.

Peel Hospital was a small General Hospital with about 200 beds. I worked for two general surgeons with special interests. One, Mr Frank was interested in thyroid and breast surgery, and during his free time, he would go up to the hills, up and down the valley, to hunt. The other, Mr Thompson, was interested in Urology and he would go down to the nearby river Tweed to fish! I learnt transvesical prostatectomy from Mr Thompson and saw him perform the occasional transurethral surgery using the cold punch. There was no resectoscope like what we have nowadays, and the view was poor. I had only occasional glimpses of what was happening. I did not foresee then that with the invention of the Hopkin's lens and the improvement in the diathermy machine in the next few years, transurethral surgery would rapidly replace open

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■ ON TALKING

One of the characteristic that distinguishes us from other living creatures is that we humans talk a lot more. Indeed some of us are so talkative that we are unable to keep our mouths shut despite knowing beforehand that our utterances are likely to land us in hot soup.

In comparison, lower life forms are relatively quiet. Other than during eating, fighting, dating, mating, migrating or electing a leader, when some noise may be produced now and then, most would choose to remain discreet and be diplomatically silent. Since they are lowly and therefore more vulnerable, it is a wise move on their part. Opening their mouths could seriously damage their health, for they would then reveal themselves to the enemy and attract predators. But for humans, it appears that being vocal is an integral part of our nature, and we commence as soon as we emerge from our mothers' wombs and upon given the customary whack on the bottom.

It could be that during the evolutionary process humans have developed a highly sensitive Broca's area, whose neurons have become so hyperactive, that they are constantly discharging, urging the specie to think aloud and to express itself. Modern man therefore devotes a lot of his energy praising, irritating, scolding, lecturing, criticising, insulting, accusing, making promises and brainwashing one another.

However, the type, frequency, quality and ferocity of our actions depends on our subsequent development as well, for example, the status we achieved and experience we acquired later in life. These vary from person to person, consequently not all of us are equally fluent in the activities mentioned, though we possess the same basic instinct.

Doctors, for example, rank quite poorly when it comes to expressing themselves. The medical profession, in spite of having advanced by leaps and bounds in many areas, is backward when compared to others in this aspect. Unlike politicians, religious leaders, insurance agents, second-hand car dealers and durian vendors, all of whom have attained a certain standard, most doctors are not quite up to the mark. The only consistent performer I can think of presently is Dr Lee Siew Choh.

The extent of this malaise is further illustrated by the paucity of comments from the doctors and their so-called leaders even when critical matters such as advertising and third party health care management were raised. These are bread and butter issues. One wonders why there are so few opinions from so few doctors. This stupor, impassiveness or indifference, however one likes to describe it, requires an explanation.

The root cause, I believe, can be traced back to our formative and trainee years. As far as I can remember, little was done in our medical school to teach or encourage students to talk and there was hardly time to talk when we began work in the hospitals after we graduated. Even when there were opportunities, most of us were reluctant to open our mouths for many of our superiors seemed unapproachable and worse, they appeared to be unforgiving when told the wrong or unpleasant things. The majority ended up minding their own business, working silently and unobtrusively. The few talkative ones were probably either show-offs or psychopaths.

Furthermore, some of the disciplines that our doctors specialised in provide little or no training for sharpening verbal skills. A pathologist doesn't get much speech practice from dissecting cadavers, an anaesthetist from putting people to sleep and a microbiologist from gazing at microbes.

One other significant reason is that life has been comfortable for the doctors so far. Seriously then, what is there that is so serious that we need to talk seriously about?

The above factors have led to a lack of verbal exercise and is reflected in the decline in standard and confidence. Has anyone heard a good speech, a classy story or a really funny joke from a doctor lately? This trend if not arrested could lead to the development of a vicious cycle. In time to come doctors will become even more tongue tied because of the suppression of our natural instinct which is contrary to modern evolutionary trend.

But society has changed. Doctors cannot afford to remain like this anymore. In an elitist environment, the quiet ones are often taken to be timid, ignorant, lacking in drive and spirit. We pay attention mainly to those who can talk. Speechlessness is worse than thoughtlessness. It is clear that those who are not inhibited are by far the more successful and prosperous ones.

Doctors therefore have to use their vocal cords in order not to lose out. Nature, as mentioned earlier, has prepared us well for the job. Among all animals, human beings have the best cerebral-neuro-muscular broadcasting system. All we need is to switch on.

A bad speaker is in no position to advise other bad speakers on how to speak badly. But personally I am determined to take corrective actions and for what it is worth, I'll share some of them.

First and foremost we must reinforce our belief that it is desirable to be vocal. It is not only for personal gain or glory but also it's part of our contribution to society. Just like the introduction of another candle would make a place even brighter and in no way reduces the incandescence of those which are already lighted, the introduction of another voice would often add colour, flavour, ideas, and even glamour to a discourse and in no way diminishes the stature, importance and relevance of the original speakers.

Having said that, how do we proceed? I have observed in gatherings of doctors, it is usually the same few who dominate the proceedings. I have noticed too that although some possess the charisma and the gift of the gab, are quite learned and even good-looking, the majority I found are just plain ordinary folks; the difference is that they are prepared to stand up and make themselves heard. They aren't afraid of revealing their ignorance, they aren't shy about their looks, and they couldn't care less about bad grammer and pronunciation. What they said may be second class but their attitude is first class and they improve with practice.

We should emulate them. The way to go about it is to be thick-skinned. I was told the

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THE ASEAN SHEFFIELD MEDICAL COLLEGE

The Asean Sheffield Medical College, operated by Suci Teguh Sdn Bhd, is an innovative development which will provide an opportunity for students to gain the University of Sheffield MB ChB degree by combining pre-clinical study in Sheffield with clinical study in Malaysia.

The first cohort of students has begun their studies in Sheffield and will return to Ipoh in the Summer of 1998 to commence clinical training. The college is being built adjacent to Hospital Ipoh and has extensive and modern study areas. There are clinical skills, teaching and research laboratories together with a clinical pathology museum incorporating further teaching laboratory space, IT facilities and academic offices designed for tutorial teaching. . Clinical teaching will be conducted in Hospital Ipoh (the main hospital in the State of Perak), in three private hospitals in Ipoh and other hospitals and health centres in the State.

The College is seeking to appoint Chairholders who will head Departments in the following disciplines:-

Clinical Pathology (Ref R1256A)

Medicine (Ref R1256B)

The academic titles will be conferred by the University of Sheffield.

Applicants must hold medical qualifications eligible for recognition by the Malaysian Medical Council and preferably a higher degree. They should be able to demonstrate experience and expertise in teaching at undergraduate and postgraduate levels, research and academic leadership.

There will be an opportunity to engage in private practice.

It is planned for successful applicants to take up post as soon as possible and no later than January 1998.

Salary to be negotiated by Suci Teguh Sdn Bhd.

Informal enquiries to Professor N.D.S. Bax (in Malaysia): Asean Sheffield Medical College Office, c/o Kolej Damansara Utama, Jalan SS 22/41, Damansara Jaya, 47400 Kuala Lumpur, Malaysia, tel +60(0)3 716 6029; (in Sheffield): Faculty of Medicine, University of Sheffield, Sheffield S10 2RX, UK, tel +44(0)114271 3955, fax +44(0) 114271 1777, e-mail address s.jones@sheffield.ac.uk.

Further details from Mr Lim Kok Beng, Executive Director, Suci Teguh Sdn Bhd, Asean Sheffield Medical College, Office in Kuala Lumpur (address, telephone and fax numbers as above) to whom one copy of a curriculum vitae, including details of age, education, qualifications, clinical experience, appointments record, and a list of publications, together with the names and addresses of three referees should be sent by 30 September 1997.

Please quote the reference number.

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The College will have seven academic departments:

- Clinical Pathology
- Medicine
- Obstetrics and Gynaecology
- Paediatrics
- Primary Care and Public Health Medicine
- Psychiatry
- Surgical and Anaesthetic Sciences

Academic staff will work within the College and Hospital Ipoh and there are opportunities for private practice.

The purpose of this notice is to draw attention to employment opportunities at the College. A number of Professorial appointments have already been made and further academic appointments are being phased; posts available in the first group are those listed below.

Senior Lecturers will be in post by early 1998 and Lecturers by April 1998. Academic titles will be conferred by the University of Sheffield.

Further posts at Professorial, Senior Lecturer, and Lecturer levels will also be available in Obstetrics and Gynaecology, Paediatrics and Psychiatry.

Clinical Pathology (Pathology, Medical Microbiology, Haematology and Clinical Biochemistry)

2 Clinical Senior Lecturers (Ref R1254A)

2 Clinical Lecturers (Ref R1254B)

1 non-clinical Lecturer (Ref R1254C)

Medicine

2 Clinical Senior Lecturers (Ref R1254D)

1 Clinical Lecturer (Ref R1254E)

1 non-clinical Lecturer (Ref R1254F)

Primary Care and Public Health Medicine

1 Clinical Senior Lecturer (Ref R1254G)

1 non-clinical Lecturer (Ref R1254H)

Surgical and Anaesthetic Sciences

2 Clinical Senior Lecturers (Ref R1254I)

2 Clinical Lecturers (Ref R1254J)

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Informal enquiries to Professor N D S Bax (in Malaysia): Asean Sheffield Medical College Office, c/o Kolej Damansara Utama, Jalan SS 22/41, Damansara Jaya, 47400 Kuala Lumpur, Malaysia, tel +60(0)3 716 6029; (in Sheffield): Faculty of Medicine, University of Sheffield, Sheffield S10 2RX, UK, tel +44(0)114271 3955, fax +44(0) 114271 1777, email address s.jones@sheffield.ac.uk.

Further details from Mr Lim Kok Beng, Executive Director, Suci Teguh Sdn Bhd, Asean Sheffield Medical College Office in Kuala Lumpur (address, telephone and fax numbers as above) to whom one copy of a curriculum vitae, including details of age, education, qualifications, clinical experience, appointments record and a list of publications, together with the names and addresses of three referees should be sent by 30 September 1997.

Please quote the reference number.

My pursuits in the sport spanned seventeen years and it gave me not only experiences to treasure, but also opportunities to discover and push myself.

SAILING THROUGH MEDICAL SCHOOL

I was a scrawny twelve-year-old when my father first brought me to Changi to romp along the beach while he went sailing. A beginner's course for kids soon came up, and he signed me up for it, deciding that the sport would be beneficial in moulding my character. At that age, I was only interested in having fun racing against my friends and against kids from other clubs. Never did I contemplate what I could derive from the sport or how much training and sacrifice it would take to get anywhere.

Graduating from the little bath-tub shaped Optimist (single-handed dinghy for under 15's), I moved on to racing against the big boys in the Lark, Fireball, 470, and finally the Laser. I found mixing sailing and studying manageable (I say this only in retrospect) because school timetables were flexible from junior college onwards. Hwa Chong Junior College was extremely supportive, allowing me to skip PE lessons and doing the bulk of the administrative work for me. In NUS, it was even easier as lectures and tutorials ended early on certain days, giving me the chance to train during the week in addition to the weekend sessions. Spare time in between lectures was an opportunity to work out in the campus gymnasium. School holidays was the time to read up on sail and hull aerodynamics, boat rigging and tuning,

weather systems, wind strategy, racing tactics, racing rules, and lots more.

During term, I did most of my studying at night, after the evening training sessions. As it was hard to stay awake and study after training, I forced myself to join my friends along the dim corridors of the Medical Faculty after library hours to get some work done. My clinical group helped by photocopying lecture and tutorial notes for me when I missed lessons.

When my undergraduate days ended, opportunities to work on my sailing were harder to come by – no more long school holidays, no more early days, no more between-lecture breaks. Housemanship was taxing on my reticular activating system – there were post-call aftenoons when I momentarily dozed off on the wheel while making my way to the beach, and when I got there, I couldn't help taking a five-minute nap before lugging myself and my gear out of the car. Like others, I was glad when housemanship was over. As a medical officer, my quality of life, as well as my sailing, improved.

Competition in any of the 7 Olympic classes (of which the Laser is one) is naturally keener than in the rest, making it crucial to train effectively rather than simply spending time on the water. I found that Medicine helped me in that respect - firstly by inculcating in me a systematic approach which is essential in maximizing the limited training time and also in making tactical analyses and decisions on the water; and secondly by giving me a sound knowledge of Anatomy and Physiology to help me with the physical aspects of training and nutrition.

Sailing provided me with both mental and physical challenges. My pursuits in the sport spanned seventeen years and it gave me not only experiences to treasure, but also opportunities to discover and push myself. I translate the lessons learnt into everyday life, and these are the lessons that I will carry with me through to the subsequent stages of my life. ■

DR BENEDICT TAN, EX-LASER SAILOR

THE SPORT OF SAILING - IN A NUTSHELL

Sailors and their crafts have been around for ages, harnessing the wind for transport, pleasure, and sport. The cross-section of a sail is shaped like a aerofoil, and when air flows pass it, lift is generated. It is the forward component of this lift that propels the boat. An endless variety of crafts have evolved, but they can be grouped into tri-marans (three hulls), catamarans (2 hulls) and monohulls (one hull).

Monohulls can either have a keel, in which case it is called a keelboat; or it can do without a keel and is termed a dinghy. The keel is a flat, heavy blade that extends down from the length of the hull and it serves to balance the sideways component of the lift, which has a tendency to cause the boat to heel towards its side. Dinghy sailors, which don't have the benefit of keels, counter the heeling forces by leaning out or hiking out on the side opposite the sail, using their own weight as leverage. This is where lean mass (the ideal weight for the Laser is 78 kg) as well as sustained strength from the quadriceps and abdominals are crucial. Just as each category of cars (eg. 4-wheel drives, sedans, etc.) comprises different makes (eg. Honda, Mitsubishi, etc.), each category of boats (eg. Catamarans, monohulls, etc.) comprises many makes or classes. The Laser class, Optimist class, and Contender class are just some examples of single-handed monohulls. Of the countless classes available, only 7 are raced in the Olympics.

In a race, you can have as many as 200 boats starting together, jostling with one another for a good spot on the starting line. The course is either triangular or trapezoid in shape, and it has a specific orientation to the wind with the first leg going upwind. There will also be a reaching leg (wind coming from the side of the boat) and a running leg (wind coming from directly behind) such that skills on all points of sail are tested. It usually takes between 60 to 90 minutes to complete a race and anything from 6 to 14 races constitute thc regatta. The winning boat is the one who crosses the finishing line first, after having made the best use of the elements with respect to the other boats.

Sailing as a sport has spread far and wide. I've met sailors from countries as cold as Finland to countries as hot as Djibouti, from countries as expansive as the US to countries as small as San Marino. There were 56 countries participating in the Laser class alone at the recent Olympics. ■

cont'd from N5 'ON TALKING'

story of a man who is very successful with the opposite sex. When asked what's the secret of his success, he replied, "Not my riches nor my looks, but I never hesitate or am afraid to chat up those whom I am interested in. You are bound to score if you try enough." Apparently, he began his apprenticeship early. He started by chatting up those he fancied from the neighbouring girls' school at bus-stops while still a pimply teenager.

In order to overcome our shyness and inhibition one could try his method but I am sure doctors can devise their own ways. My own training programme involves requesting impossible favours from members of my family and bank managers. I am proud to report that my epidermis is much thicker, criticisms and rebuffs have minimal effect on me and I have become more vocal.

The next step is to learn to talk well. Most doctors would not have time to attend speech and drama classes, join literary and debating societies or enrol in toastmaster courses but I have worked out a few rules.

Rule number one regards the manner of talking. One of the greatest turn off is a haughty speaker, one who assumes an imperious posture, jabs his index finger at his audience, stares at them as if they are inferior beings and talks as if he is the smartest cookie around and that he is doing you a great favour and you better appreciate it. We come across such characters everyday. Teachers, supervisors, dictators, military personnels and parents are among those who often talk like this. This we must guard against for it hurts the feelings of the listeners. They may be cowed, overawed or frightened but they will feel ill-disposed towards the speaker for nobody likes to be talked down to or made to feel that they don't really matter.

The antithesis is to speak earnestly and sincerely, in a friendly manner, treating your audience as equal and with respect. In this way one stands a much better chance of winning them over. I have started to talk to my children in this manner, giving them the benefit of the doubt that they are sensible and intelligent listeners. It is not easy in the beginning but the result is definitely encouraging.

Rule number two is not to talk too hastily. We have a tendency to shoot from the hip because of our highly reactive system but we often make mistakes, sometimes costly ones. Unfortunately, a spoken word cannot be taken back once it is mouthed. It is a good idea therefore to slow down, think first and not to be in too much of a hurry to contribute our ten cents worth of opinions.

This is not easy. However, doctors are lucky because in our work we have the opportunity to practise patience. All we have to do is to let our patients finish what they want to say first before we start. It just means spending a bit more time.

Rule number three is to say "sorry" readily if one had said something wrong. No matter how discreet, careful and well meaning we are, it is inevitable that we make mistakes sometimes. If it happens, one just has to apologise. I don't know why some people make such a fuss over apologising. It is no big deal, say sorry, and usually it spells the end of the matter. Otherwise people may not be prepared to listen to you again and at worst lead to the breaking up of friendships, marriages, partnerships, alliances and even to boycotts and wars. Human beings are rather sensitive.

Rule number four is if one wants to talk well one must be prepared to listen well too. For example, those MPs who spend time really listening to people in their walk-abouts and meet the people sessions talk well. Feedback helps the speaker because it will indicate to him or her the concern, interest and mood of the audience.

Rule number five is to speak from the heart. This dosen't need any elaboration except a reminder that those who do not will sooner or later be found out.

I must now confess that this article was written sometime ago. In the context of what is happening presently it appears that I might have greatly exaggerated the ineptitude of the doctors. In recent times more and more doctors are seen to be giving talks and making speeches, participating in seminars and forums, dispensing tips and advice all over the place, expressing themselves freely and showing oratorical skills while renouncing their traditional self-imposed vow of silence.

The public is now aware of some of the most gifted doctors in our midst. If they remained silent we would not have known of their skills, inventions and multiple talents and not have given them the respect they deserve and doctors will miss out on the reflected glory from their brainy colleagues.

Most of the article is therefore out of date and is merely a record of past thoughts. Readers can best forget what was written. Instead, if they so wish, ponder over what someone else once write: "La parole a été donnee a l' homme pour déguiser sa pensée", "Speech was given to man to disguise his thoughts." ■

GARFIELD

Venture out with realistic expectations and do not place monetary returns as the main driving force behind leaving government service.

GOING INTO PRIVATE PRACTICE

Five years ago, SMA noticed a very disturbing phenomenon in which a few GP clinics closed down within a year or two of opening, something which was hitherto unheard of. Speaking at the third SMA seminar on 'Going into Private Practice' held on 26 and 27 July 97 sponsored by Smith Kline Beecham, Dr Tan Kok Soo said that the main reasons for this were higher overhead costs, especially increased rentals and salaries, and stiffer competition. Current rentals for HDB shop units in new housing estates range from $3,000 in neighbourhood fringes to $10,000 or more in town centres. In view of this, SMA encourages young doctors who intend to go into private practice to set up clinics with at least two doctors. The overheads can be shared out among the partners and each individual doctor can work shorter hours, leaving more time for rest, CME and family life. For those who intend to buy over an existing practice, Dr Tan's advice was to examine the clinic's accounts for the past five years to assess the turnover of the clinic. This would give an indication whether the goodwill money, arbitrarily pegged at two years' net earnings, is reasonable.

From the specialist's point of view, the pastures may not be greener on the other side of the fence. Dr Roland Chong cited irregular and unpredictable hours, heavier responsibilities and staff problems as some of the difficulties which specialists in private practice could face. He urged potential private specialists to attain a reasonable level of professional competency prior to venturing out as they would have to make independent clinical decisions unlike in public institutions where they worked as a team. Preparation for private practice should start at least six months before resigning from government service.

With the passing of the new Advertising Guidelines under the Private Hospitals and Medical Clinics Regulations on 9 May 1997, private practitioners will be allowed to advertise their clinics in the newspapers, Yellow Pages, medical journals and the Internet on commencement of operation or change of address provided that such advertisements do not appear more than once in six months. They

Dr Cheong Pak Yean, President of SMA presenting a plaque of appreciation to Mr Kevin Seto of SmithKline Beecham Singapore, sponsor of the event.

must also be well-versed with the relevant legislations governing medical practice. Dr Wong Chiang Yin reminded doctors that under the Poisons Act, a register of Schedule 3 Poisons must be kept for 2 years whereas under the Misuse of Drugs Act, a separate register is required for Controlled Drugs which must be kept for 3 years. Under the labelling regulations, generic drugs must not be labelled as their original equivalent.

With regards to stocking of drugs, Dr Wong Weng Hong advised doctors to be prudent when ordering drugs and to participate in bulk purchase of original drugs from HMOs to enjoy generous discounts. Drugs costs should constitute about 20 – 25% of the total turnover of the clinic. He highlighted some pitfalls in prescribing and warned against buying unregistered drugs, dispensing expired medicine and giving repeat prescriptions for codeine-containing drugs and sleeping pills.

Mr Karamjit Sandhu of Ernst & Young told doctors that it is important to maintain proper accounts for tax purposes. 30% of the clinic's nett turnover should be set aside for tax. He advised doctors to operate their practices under private limited companies rather than sole proprietorships because of the advantages of CPF deduction for their spouses' salaries and limited financial liability. To help doctors manage their accounts more efficiently, Dr Raymond Ong developed a clinic management software which can keep track of patient records, drug inventories and accounts. He urged doctors to computerise their clinics as it would save them time and effort when preparing their clinic accounts for auditing. In recent years, HMOs have made a great impact on healthcare financing and mode of renumeration of doctors. The traditional fee-for-service payment is gradually evolving towards payment of capitation to doctors by third parties such as insurance companies. Doctors can participate in several managed healthcare schemes currently available on the market. Dr Neo Eak Chan advised doctors to consider carefully the terms and conditions offered by various managed healthcare schemes before participating in them as there is a certain degree of financial risk involved. A scheme should offer a fair capitation and must not be unduly restrictive on the doctor's professionalism.

A good turn-out at the 2-day seminars.

Medico-legal activity in Singapore is increasing and not immune from the upward trend seen in other countries in the world. Greater patient awareness of their rights and increased expectations of doctors have led to increased number of complaints received and disciplinary inquiries convened by the SMC in recent years.

On that note, Dr Tan Kok Soo emphasised the importance of the presence of a chaperon when examining female patients. He highlighted that the two cases of alleged molest received by the SMA Ethics Committee in 1996 represented the tip of the ice-berg as majority were police cases. Mr David Wee of Donaldson & Burkinshaw stressed the importance of maintaining legible, detailed and contemporaneous medical records as they offer the best defence for doctors when faced with medico-legal suits. He advised doctors to inform their medical defence organisation (MDO) immediately when an untoward incident happens that could give rise to a claim for compensation or a complaint. Under such circumstances, doctors must not reply to any letter of demand for compensation from the patient's lawyers but should forward the letter to their MDO. Medico-legal reports must be vetted by their MDO's solicitors prior to submission to the requesting party. On a positive note, Mr Wee mentioned that doctors could find comfort in the Bolam Principle referred to in 'Bolam vs Friern Hospital Management Committee (1957) 2 All ER 118'. In this case, McNair J stated that '... A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.'

The financial aspects of setting up a private practice, based on the 1996 SMA Practice Costs Survey, were presented by SMA President Dr Cheong Pak Yean. He said that the initial capital outlay could set a doctor back by between $80,000 to $100,000 with monthly fixed overheads of around $10,000. A GP working 200 hours per month would earn a net pay of between $12,000 to $15,000 if he sees about 1,200 patients per month and charges $25 per patient. This is comparable to the total monthly renumeration of a senior registrar working in a government polyclinic. Dr Cheong advised young GPs not to shift patient charges in favour of drugs but rather towards consultation. This is because the price of drugs will eventually be standardised by HMOs and made publicly known in a drug directory. He also cautioned against the 'low price trap' as it will not sustain a high patient load in the long run. Instead, new GPs, with their youthful energy, are at an advantage to provide a service differential that will form the basis in establishing a regular clientele. Dr Cheong's final word of advice to aspiring GPs was: Venture out with realistic expectations and do not place monetary returns as the main driving force behind leaving government service. ■

REPORTED BY DR AU KAH KAY

Editorial note: Proceedings of the seminar will be compiled into a monograph entitled 'SMA Practice Handbook', through the kind sponsorship of SmithKline Beecham.

Dear Sir,

I read with great interest Dr Wong Sin Hee's heartfelt article published in the July issue of the SMA News, about his unpleasant experience with two inconsiderate hospital doctors. Although I sympathise with him – what the doctors did was undoubtedly wrong – my feeling is that they meant no malice, and that they were probably young MOs. In fact, they probably did not know any better.

It is not an apology for inappropriate behaviour of course, but as someone who has worked on both sides of the divide, so to speak, let me contribute my two cents worth to the discussion. Dr Wong gave two common examples of hospital doctors' actions: firstly, dismissive treatment of an A & E patient, and secondly, giving information to patients in such a way as to seriously damage the GP's reputation. I myself have been guilty of the first, and I hope and pray that I have never committed the second.

When I think back to my days as a brash younger A & E MO, I cringe at some aspects of my behaviour. Although aware that I did not know that much, I was convinced that I certainly knew much more than the public, and so treated them as such. It has taken some years and hundreds of patients for me to learn some humility, and to realise that many of my consultations would have been vastly improved with more patience and sympathy, and less indignance and self-righteousness.

Tact and discretion, alas, are not qualities inherent in us, but are rather developed with maturity, experience and not a little guidance. Unfortunately, your average medical curriculum would rather focus on Krebs' Cycle than on the intricacies of talking to patients. My own experience of formal teaching (and this was in London in the mid-80's) consisted of a couple of sessions of role play punctuated throughout with embarassed sniggers, and marked by a psychologist whose earnest suggestion that we "share our thoughts" was met with a deafening silence.

As if the dearth of instruction is not enough, any sensitivity remaining is systematically drummed out of you. A medical student who lingers to chat with a patient after getting the history is deemed to be wasting his or her time. We expect patients to fit in with our perceptions; their stories are assiduously processed into a format acceptable to us, and a label swiftly attached, even if this is just "FON" (Full of Nonsense). Eventually, people become patients, and finally pathologies.

Is it any wonder that our doctors are graduating without any idea of how to deal with people? They might be able to rattle off causes of a lump in the right lower quadrant, but they don't know how to break bad news, or to reassure anxious relatives, yet these are tasks often delegated to the most junior and most inexperienced staff. Surely our patients deserve better than this.

What can be done to improve the situation? Structured teaching eg. with role play and video playback would help, but is no substitute for direct observation and patient contact. Both medical students and housemen would benefit from guidance by a senior doctor, not just in procedures, but in such tasks as obtaining consent and speaking to family members.

Furthermore, institutional medicine should perhaps treat more kindly those who work for it. If our young doctors are stressed and demoralised, if they lack role models to emulate, if they do not feel that they are respected and valued as individuals rather than mere drones, it would be difficult to extend the same courtesy to others.

Finally, in an ideal world, doctors (and nurses too) should work together. No carping, no back-biting, no "I'm-better-than-you-because-I-work-in-a-hospital" attitude, just mutual respect and recognition of each other's worth. If we can all remember that we're on the same side, then maybe we can start to treat each other, as well as our patients, better. It is the very least that should be expected of the caring profession. ■

Yours sincerely

Dr Noreen Chan Guek Cheng
MBBS (Lon) 1991

MOH National Healthy Lifestyle Campaign 1997 – Background paper for "Keeping Fat in Check".

The National Healthy Lifestyle Campaign is an annual event which is spearheaded by the Ministry of Health with the purpose to promote healthy lifestyle among Singaporeans. This campaign will be held from 7 September to 5 October 1997 and the nutrition focus is "Keeping Fat in Check", which incorporates the subject of dietary cholesterol and its relationship to blood cholesterol. The objective this year is to encourage Singaporeans to keep their dietary fat, dietary cholesterol as well as body fat in check.

A background paper entitled "Keeping Fat in Check" covers methods of assessing body fat and suggests practical ways of moderating fat and cholesterol intake both when cooking at home and when eating out. It also discusses the relationship between dietary fat, dietary cholesterol and health, the status of fat intake among Singaporeans and the major sources of fat and cholesterol in local food.

The paper is available from Consultation & Surveillance Section, Food and Nutrition Department of the Institute of Health. Tel: 322 2587. ■

surgery for the lower urinary tract. The pace at the hospital was not very busy and I took the opportunity to study for the Final FRCS Examination and passed.

Lectureship at the University of Singapore

It was a great relief to have passed the FRCS examination, and with that diploma, I joined the University Department of Surgery here in Singapore in 1972. Prof S C Ong was Head of the Department then. I learnt much, especially in the pre and post-operative care of patients. One important lesson from him was the constant reminder to be "one step ahead of the complications in surgery", and not one step behind, or your patients may end up, one step beyond!

For our young members, this is good advice. Always think ahead and take action. To help us to decide when to take action at the right time, I learnt another important lesson from Professor W C Foong who took over the Headship of the Department after Prof Ong, that was to be familiar with the pathophysiology and natural history of the diseases we are treating. That was his favourite theme for students in the written and the oral examinations.

As students, you may not appreciate this basic truth, but as you become more experienced, you will realise that you cannot practise good, rational clinical medicine without a good understanding of the pathophysiology and natural history of diseases. One good example is our understanding of urinary tract infections.

We used to think that the introduction of organisms into the urinary tract was more important than host resistance as the cause of urinary infection. Now, we understand that it is host resistance which is more important, and not the other way around. Introduction of a few organisms really do not matter and it is more important to keep the bladder empty to avoid infections. Therefore, patients are now relieved of their agony as soon as they arrive at the Accident and Emergency Department.

Specialising in Urology

After 4 years as a lecturer, the time came for me to specialise. Prof Ong encouraged me to take up Urology as there was a need then for more surgeons to be able to do transurethral work.

I learnt a lot of theory at the Institute of Urology, London. However, after 3 months, I was unable to obtain hands on experience. Fortunately, I managed to transfer myself to New Adddenbrooke Hospital in Cambridge to learn transurethral surgery from Mr Robert Whitaker. Cambridge was ideal for me and I achieved my objective of learning how to do a proper transurethral resection of the prostate under his guidance.

Complementing and not competing with each other was an important lesson I learnt. When I returned to the University Department of Surgery, Dr Jimmy Beng and I complemented each other in trying to establish transurethral surgery in the treatment of our patients with lower urinary tract problems. In his landmark paper, Dr Beng proved that TURP was far superior[1]. This new procedure took time to get established and we needed to collect data to support it. I helped to further the cause of transurethral surgery by publishing my first 169 cases, looking mainly at the complications[2].

We showed that TURP was safe even in our hands, and at that time we were juniors in the Department! Blood transfusion rate was 44% instead of 96% for open surgery and patients could go home in 5 days instead of 10. The mortality rate was about 1% and the permanent incontinence rate was less than 1%. By the 1980's, TURP was well established as the procedure of choice for treating obstructing prostates.

The University Department of Surgery in the Singapore General Hospital was also called the "A" unit for short. All the members would work together as A team. Dr Jimmy Beng left the Department for private practice in 1978. Fortunately he was soon replaced by Dr K H Tung and Dr E C Tan. With Tung and EC we worked as a team and helped to establish Urology as a specialty in Singapore[3].

Qualities of a Clinical Teacher

Gradually, I evolved from trainee to being a trainer in clinical practice, and learnt to be patient and calm. As trainer, our patience must have been tested many a time by trainees who do not follow our instructions, or who do things their own way. It is diffcult to remain calm when they create false passages for you to follow! However, when you look back over the long years of practice, remembering what mistakes you made when you were a trainee, it helps to calm you down.

We need to constantly remind ourselves that in clinical practice, we are in "tiger country" and have to be vigilant. As the Chinese saying goes, if you go up the mountain often enough, you will eventually meet the tiger. It is appropriate to warn our younger colleagues about the tiger in our daily practice, and it is important for them to know what to do when they see one!

Over the years, it is gratifying to see young Registrars slowly developing and maturing into Consultants in their own right, and becoming eventually better in some aspects of clinical work than you, the trainer. This is the way it should be; if not, there is no progress. I was told by my teacher that if your students are not better than you eventually, then you are not a good teacher! The challenge to you now, my younger colleagues, is to make your trainees better than you are!

Conclusion

Patients come first in whatever we do. Without patients we do not exist. In my younger days, I used to wonder why my Consultant always thanked someone for referring patients to him, giving him more work and problems. I thought the person who was referring the case should thank him! Without patients, the hospital will close. When there is a conflict of interests between others and the patient, if we remember our patient first, we will not be wrong. Sometimes in training our juniors, it is difficult to achieve the right balance. When do you allow him to carry on with the procedure and when do you take over? Does the trainee or the patient come first? The trainee must understand that patients must come first.

I would like to end by sharing with you a saying by Lao Zi, the founder of Taoist philosophy: "To be CONTENTED is to be RICH". Rich, not in terms of money or material things, but in terms of peace, tranquillity and happiness or bliss. In this way, you may live longer too. Some of you may have read about this Chinese Doctor who took the blood from a person who was happy and injected it into the mice and they appeared happy. Then, he took blood from a person who was angry and agitated and did the same. The mice died!

May peace and tranquillity be with you. ■

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A/PROF FOO KEONG TATT

Editorial Note: This article is based on the Inaugural Singapore Urological Association Lecture given by the author on 25 January 1997.

Medical Advisory Board
Mount Elizabeth Hospital

EAST SHORE, GLENEAGLES & MOUNT ELIZABETH HOSPITALS LUNG & THORACIC INTEREST GROUP

LECTURE

Thursday, 11 September 1997
1.00 pm to 2.00 pm

Topic	:	Epidemiology of Lung Cancer – More Than Smoke Or Smog
Speaker	:	Professor Lee Hin Peng Head Department of Community, Occupational and Family Medicine The National University of Singapore
Chairman	:	Dr Cheong Tuck Hong
Venue	:	Seminar Room 1, Education Centre Mount Elizabeth Medical Centre Unit 02-01 Singapore 228510
Lunch	:	Lunch is sponsored by Mount Elizabeth Hospital and will be served at 12.00 pm

THIS TALK HAS BEEN ACCREDITED WITH ONE CME POINT

ALL DOCTORS ARE WELCOME

Medical Advisory Board
Mount Elizabeth Hospital

CARDIOLOGY, THORACIC & CARDIOVASCULAR SURGERY SPECIALTY GROUP

TALK

Thursday, 25 September 1997
1.00 pm to 2.00 pm

Topic	:	Treatment of Atrial Fibrillation
Speaker	:	Dr Christopher Chew
Case Presentation	:	"Case of Very Large Pericardial Tumour" – Dr Lee Chuen Neng
Chairman	:	Dr Michael Lim
Venue	:	Seminar Room 1, Education Centre Mount Elizabeth Medical Centre Unit 02-01 Singapore 228510
Lunch	:	Lunch is sponsored by Mount Elizabeth Hospital and will be served at 12.00 pm

THIS TALK HAS BEEN ACCREDITED WITH ONE CME POINT

ALL DOCTORS ARE WELCOME

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(1:00pm to 2.00pm)
CME Monthly Calendar – September 1997

ESH

DATE	TOPIC	SPEAKER/CHAIRMAN
4th	Update of the Management of Urinary Tract Infection in Children	Drs Low Eu Hong/Loh Hung Soo
18th	Haematuria	Drs Pwee Hock Swee/Beatrice Chen
Venue	Health Education Centre, Level 3, East Shore Medical Centre	
C Person	Ng Chieh Yun, 340 8750	

GHL

DATE	TOPIC	SPEAKER/CHAIRMAN
3rd	No Frills Exercise Test – Current Status	Drs Imran Nawaz/Bobby Woo
10th	Computer Aided Micro-Neurosurgery For Brain Tumours & Epilepsy	Drs Prem Pillay/Hoe Ah Leong
17th	Closure of Cardiac Shunts in Children without Surgery	Drs William Yip/Lee Chuen Neng
24th	Breast Reconstruction in the Rehabilitation of Women with Breast Cancer	Drs Seah Chee Seng/Rexon Ngim
Venue	Lecture Theatre, Level 3, Gleneagles Hospital	
C Person	Janna Tan, 470 5656	

MEH

DATE	TOPIC	SPEAKER/CHAIRMAN
5th	Novel Approaches to Cancer Therapy	Drs Joanna Lin/Tan Yew Oo
12th	When do you need a Heart Transplant	Drs Sivathasan Cumaraswamy/Melvin Tan
19th	Yet to be confirmed	
26th	Recent Advances in MRI	Drs Samuel Ng/Robert Kwok
Venue	Doctors' Dining Room/Seminar Room 1, Education Centre, Level 2, Mt Elizabeth Medical Centre	
C Person	Angela Tay, 731 2079	

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Dear Colleagues,

I wish to inform you that I have resigned from the Department of Surgery, Singapore General Hospital and have commenced my practice at Mount Alvernia Hospital from June 1997.

My practice includes all aspects of General Surgery and my interest is in Surgical Conditions of the Breast.

I thank you very much for your support in the past and hope that I can continue to be of service to you in the future. I can be contacted at the above address and phone numbers.

Yours Sincerely,

Dr Joy Lee Siew Yang
MBBS (Spore), FRCSEd, FAMS

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