# SMA news

For Doctors, For Patients

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**Maternity Leave** and **Training Requirements**

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# The EDITOR'S MUSINGS

Tan Yia Swam

*Editor*

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

On 31 January 2019, the Singapore Medical Council held a meeting with key appointment holders from the SMA, College of Family Physicians Singapore, Academy of Medicine, Singapore and the SMA Centre for Medical Ethics and Professionalism on the $100,000 fine's case. Dr Lee Pheng Soon, who chaired the meeting, presents a succinct report in this issue. We note that there are ongoing discussions and reserve further speculation on this matter.

On 21 January 2019, the medical profession lost a great doctor and teacher – Prof Tan Cheng Lim. Prof Ivy Ng pens his eulogy, bringing to light many of his contributions to paediatrics and also recounts anecdotes of his teachings.

As the world celebrates International Women's Day on 8 March this year, with the theme #BalanceforBetter, we too celebrate the achievements of some of our female doctors in their careers and personal lives. Three accomplished women, emergency physician A/Prof Eillyne Seow, general surgeon A/Prof Tan Su-Ming and orthopaedic surgeon Dr Tan Sok Chuen, have kindly shared their reflections on the challenges they had encountered in their careers, simply because they were women.

Over the years, as medical schools relaxed their quota and allowed more women to pursue medicine as a career, it would seem natural to have increasing equality in the workplace. However, Dr Joanna Chan and another female doctor (who prefers to remain anonymous) list the problems they face on the ground as working mothers.

Among my immediate circle of female friends and colleagues, I would say almost half of them faced difficulties in conceiving, or miscarriages and/or medical issues during pregnancy. How much of this could have been avoided? No one will ever know. While there is no point in regretting what has passed in my own life, I personally advise all young couples in medicine to seriously weigh the pros and cons of certain career or training tracks if they also plan to start and raise a family. I won't say this just to the ladies, as the decision should be made as a couple. This is a complex issue and I could go on and on about it.

Prof Helen Smith of Lee Kong Chian School of Medicine is currently leading a research project that looks into factors influencing female healthcare professionals' decisions to stay or leave the workforce, and her team describes the project and its objectives. I hope that our women doctors here can spare some time to help contribute to this and perhaps we could create an even more supportive working environment for the working mother.

In case the men feel neglected, I'm also inviting dads with young kids to share their experiences!

In seeking "balance for better", we must acknowledge that workplace discrimination still exists and recognise harassment in all its various forms. *SMA News* will soon be embarking on a series of articles to educate our readers.

Finally, how can we empower fellow women to find their own balance? And to the men, how do you achieve balance in your personal and professional relationships? For all of us, let's strive to provide equality for our patients. Their gender, race and socio-economic status should not be a deterrent in getting good-quality healthcare. ◆

# THE LIVES OF FEMALE PHYSICIANS

Once perceived as a male-dominated profession, medicine has in recent decades been a calling to many women. The number of women doctors has been steadily rising, with many going on to assume leadership roles and receive merits of excellence in their respective fields. Here, we catch a glimpse into the lives of three female physicians, as they tell their tales of adversity and triumph during their years of training and practice.

A/Prof Eillyne Seow started her training in emergency medicine in 1987. She worked in the Emergency Department, Tan Tock Seng Hospital from 1991 to 2015. She was the head of this department from 2001 to 2010 and led it during the SARS outbreak. She is presently a senior consultant in the A&E Department, Khoo Teck Puat Hospital.

A/Prof Tan Su-Ming was trained as a general surgeon. After completing her AST, she was awarded the Health Manpower Development Plan in breast surgery in Nottingham City Hospital and the Royal Marsden NHS, UK. Upon her return, she spearheaded the one-stop Breast Centre at Changi General Hospital and now heads the Breast Surgery Division.

Dr Tan Sok Chuen is an orthopaedic surgery specialist with subspecialty training in hip and knee surgery. She practised as a consultant in orthopaedic surgery at Ng Teng Fong General Hospital and was one of the surgeons with highest volumes. She now practises at The Orthopaedic Centre.

# ATTITUDES CHANGE WITH AGE AND WITH THE AGES

Text by A/Prof Eillyne Seow

"Why should you be given a place? After all, your husband may ask you to stop working and to look after your children…" was a question posed to me, an 18-year-old, during my interview in 1980 for a place in medical school.

It was at a time when the quota limiting the intake of women of each medical class was in place.

Fast forward ten years to 1990. During my exit interview with my supervisor Dr Keith Little, then director of the A&E Department, Royal Infirmary of Edinburgh, I asked whether he had any advice for me when I returned to Singapore. He paused and gave me a quizzical look. "Sometimes I seem angry when I am not…" was his cryptic answer.

Back in Singapore, I had the privilege of working with team members (within and beyond the emergency medicine community) who shared a common goal of wanting to provide the best emergency care with the resources we could get.

Processes were streamlined and standard operating procedures were changed. I was lucky that the clinicians whom I worked with, mostly men, were my contemporaries. We had studied and trained together in our younger years; disagreements could be ironed out and name-calling did not involve gender.

"Just consider the look of the machine as a '*pretty girl*'…" an elder from another clinical department said to me when I could not be persuaded to agree to the purchase of said machine for the emergency department. My face had turned red and I was doing my best not to laugh. The machine he wanted was bulkier and looked more like a "*handsome guy*".

It was as a manager and administrator that I found myself facing challenges that were gender-bias. It is unlikely that a *man* in my position would be called a *witch* or a *b**ch*.

Fortunately for me, there were administrators and clinicians (both men and women, older and younger) who were gender-neutral (*we just had to tiptoe around those who were not*).

Today, when a woman applies for medical school, I hope that she will not be posed the same question that I was asked when I was 18 years old.

# EXPERIENCES OF A FEMALE SURGEON IN THE 90S

Text by A/Prof Tan Su-Ming

The nurse looked up from the nursing station and stared at me quizzingly. "Are you the physiotherapist?" she asked. "No" I said, as I went in search of the case notes. "Oh, then the dietician?" she suggested. I shook my head, frustrated that the case notes were nowhere to be found. "Ah!" she exclaimed, "You must be the medical social worker!" while looking extremely satisfied with herself for identifying who I was. Having spotted the elusive case notes perched at the corner of the counter, I quickly took it. As I passed her, I looked her in the eye and said, "No, I am the surgeon". She stood there, mouth agape, while I went in search of the patient to reply the Blue Letter referral for a surgical opinion.

In the nineties, female surgeons were a rarity. Although I was not the first female surgeon in Singapore, I was the first in the hospital where I started my Advanced Surgical Training (AST). It was standard practice to have a large board at the nursing station of each ward, with the bed numbers, patients' names and the names of the doctors responsible for the patients next to them. Mine would be listed as "**Mr** Tan SM". Often, as I walked around the ward, the patients would call out "Missy, missy" to me for attention. ("Missy" was a local term used by patients to address the nurses, who at that time were mostly female.)

Fortunately, my colleagues and seniors did not treat me any differently from the other male registrars. In fact, they were caring and gentlemanly, and treated me like their "little sister". I had equal opportunity in terms of

training and surgical experiences. However, I also performed my duties like all the other male registrars – clinics, surgeries, on-calls and trauma activations regardless of menstrual cramps, pregnancy, etc. It was not that they were unkind, but I felt that since I had chosen this career path, I should do my fair share of work.

Surgery used to be male-dominated. The popular belief was that the blood and gore in surgery was too intimidating for the fairer sex. After explaining the indications and the nature of surgery to patients, they would then ask who their surgeon would be. When they realised that it was to be me, they had a range of reactions. Some would be in awe that I was not afraid of blood and actually capable of such complex operations. Others would be in disbelief that a slight-built, schoolgirl-looking me could possibly perform their surgery. My abilities would usually be queried. Some blatantly asked me, while others would quietly check with the nurses after leaving my room.

I am thankful for our meritocracy system where there is no gender discrimination for career opportunities, remunerations and promotions. In fact, I had the fortune of being the first female surgeon to head a department of General Surgery. Managing a department full of alpha-male surgeons was no mean feat.

Through the years, more women have taken up the challenge of becoming surgeons. In fact, more patients are requesting for female surgeons in areas of breast and perianal conditions. A recent study suggests that patients treated by female surgeons have better outcomes.[1] With equal opportunity and demand, it is no wonder that the fairer sex is gaining ground in surgery.


***Reference***

*1. Wallis CJD, Ravi B, Coburn N, et al. Comparison of postoperative outcomes among patients treated by male and female surgeons: a population based matched cohort study. BMJ 2017; 359:j4366.*


# A WOMAN IN ORTHOPAEDICS

Text by Dr Tan Sok Chuen

"You are so small built – are you sure you have the strength to do the surgery?" This question has been posed to me countless times, by patients, colleagues from other disciplines and sometimes even colleagues from the same discipline. The more vocal ones would openly ask this question and the less vocal would probably do so in their heads.

My journey in orthopaedics has been a tough one, to say the least. However, overcoming great challenges brings great satisfaction. I have learnt that technique and knowledge are more important than strength. I have learnt the value of teamwork. I have learnt that changing mindsets is a slow and long process.

I do not deny that I do get sore arms and backaches after operating on big patients. During my fellowship, I performed a knee arthroscopy on a six-foot-tall Caucasian male who weighed more than 100 kg. One of the things the surgeon needs to do during a knee scope is to support the patient's leg on his/her hips to open up the medial joint space. I did get the help of a male colleague to hold the leg up and apply a valgus force. I performed the knee scope successfully and the patient was delighted after the surgery. I helped my colleague by being his assistant in other cases; we made such a great team that our fellowship boss left us to handle most of the cases, which meant great learning opportunities for us both!

It is hard work for sure, physically and mentally, but orthopaedics is such a rapidly expanding field with new exciting technology and techniques emerging year after year. I never get tired of it. I have great support from my family and my spouse (who is also an orthopaedic surgeon), and that

certainly helps. Things became more challenging after I gave birth to my son three years ago. *(Side note: to allay the fears of radiation in orthopaedics, he was a very healthy baby)*. There is just less time for everything. However, I learnt to be more efficient, work with less sleep and also to not be shy in asking for help when needed. My bonds with our extended family strengthened with this new challenge of caring for my son.

I think that in Singapore, compared to other countries, women are given pretty much equal opportunities and I am thankful for that. Thus, I would say that the traditional boundaries and barriers to women practising orthopaedics have been softening over the years. I have great respect for senior women orthopaedists Dr Ang Swee Chai and Dr Kanwaljit Soin, whom I think were the true forerunners of "women in orthopaedics". My hopes for orthopaedics in Singapore is that it will continue to embrace gender diversity, and that women doctors who are interested in the subject matter will not be put off by traditional misconceptions about the specialty. ◆

# IDES OF MARCH

Text by Dr Lee Yik Voon

The famous Roman Statesman Julius Caesar was assassinated on 15 of March (Ides of March). We remember this event somewhat as a Roman tragedy. Unfortunately, recent events have been rather tragic in our medical landscape.

The $100,000 fine headliner resulted in a public petition with over 6,000 respondents, and a HIV leak resulted from a relationship that did not have a storybook ending.

## The fine and its implications

In the former incident, I think better communication protocol and strategy in messaging could have prevented the response. I would like to explore the case by asking these hypothetical questions.

What if the Complaints Committee had dismissed the case because the expert witness stated that informed consent is not needed for minor procedures such as an H&L injection?

What if the Disciplinary Tribunal (DT) had dismissed the case as the DT found that an injection with little or no harm to the patient does not warrant informed consent?

What if the DT had moderated the fine offered by the defence because they could foresee the impact of such a fine on our medical community and the public?

What if the doctor had not pleaded guilty and fought the case? Would the outcome have been vastly different?

If all parties involved were able to see that it would likely result in defensive

medicine, would they have persisted along the same path?

Thinking of all the "what ifs" is probably unproductive and it is wishful thinking to attempt to go back in time and to change destiny. We need to focus on the way forward for our medical community. We understand that the doctor under trial would react the way he did; he was in a dire situation and would react accordingly.

For not documenting discussion with his patient regarding side effects and complications of treatment proposed, a senior surgeon was penalised. He could not recall but there was no evidence of him documenting the consent in his notes. Yet it was evident from his documentation with other patients that he routinely takes consent for such minor procedures.

A $100,000 fine is no small sum to young doctors who already have hefty study loans to repay, and it may cripple the medical career of our younger generation of doctors. The bigger rolling snowball is the momentum and impact on the general medical landscape, on how it changes the way we practise medicine – the result, an overemphasis on defensive medicine.

As it stands, all medical practitioners will have to think about discussing the entire breadth of complications and side effects of all minor or major procedures regardless of relevance to the patient.

The Singapore Medical Council has clarified that this is not so, but important and material side effects and complications of treatment have to be discussed with the patient so that the patient can make a decision and give an informed consent. Then again, the question is "What is material to the patient?"

The DT is made up of a pool of medical practitioners no different from the rest of us. It is easy on hindsight to ask of them not to see the case in isolation but to be aware of the impact of their judgement on the larger medical community.

The question then comes, "Do we care only when our livelihoods are affected or do we step up to volunteer for the DT pool?"

If you had volunteered but were rejected, do not be disappointed as you have tried to help but for some reason you were considered unsuitable. There are other ways you can contribute to our medical fraternity and to the healthcare of Singaporeans and fellow human beings. Join chat groups and feel the pulse of our medical fraternity; read the *SMA News* and get involved in our work.

## The human factor

On the subject of the ill-fated relationship, do you share everything with your loved ones? Would you compromise your integrity to do so? If your partner is really concerned for your well-being, I seriously doubt they would cause harm to you and expect you to dismiss your ethical values. But when disagreement occurs between a couple, attempts to hurt the opposite party may result.

What would you do when you hold the access to patient database that has street value on the Dark Web? The potential of this database to create mayhem and mischief, to blackmail and extract monies, or to compromise victims, is enormous.

We have just reeled from the SingHealth data breach and unlike that, the HIV data leak is not a traditional information technology hack issue or issue of work culture. It's a deliberate leak that shows that the human factor is indeed the weakest link. How do we avoid such an incident from recurring in the future? Some have suggested not collecting the data or removing the stigma of HIV. This issue is all about privacy and data is only useful if one acts on it.

We are trained to understand how confidentiality and privacy of our patients is paramount to them. Yet we are human and we make mistakes; is it a random act of one dysfunctional individual or do we need to rethink whether it is an issue that involves the values of our society?

What is most important is not to cry over spilt milk, and not to do more "witch hunting" and be overly suspicious of one another. We should understand that all of us have a role to play in order for our society to recover from this huge setback.

I hope we all come to realise that we play a part no matter big or small. Criticising the selection of individuals who hold positions of authority and responsibility is easy on hindsight. Perhaps more research needs to be conducted on how best to select people to fill various vital positions. Indeed, how do we ensure that these positions are filled with individuals with a moral compass, critical thinking, good communication and competent skillsets as our world and its jobs are so much more complex and multifaceted today? ◆

Dr Lee is a GP practising in Macpherson. He is also a member of the current National General Practitioner Advisory Panel. He is a pet lover at heart who is the proud owner of a dog, and regularly feeds neighbourhood community cats. He also enjoys playing online war games and thinks that playing Pokemon Go is a good form of exercise.

# DO YOU NEED HELP IN YOUR CLINIC?

More than **350** job seekers have access to vacancy details published on the SMA Clinic Assistant Place and Train Programme's online portal

**30%** of these job seekers were trained during the 2016/2017 intakes of the SMA Clinic Assistant Introductory Skills Course

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# HIGHLIGHTS

## FROM THE HONORARY SECRETARY

Report by Dr Lim Kheng Choon

Dr Lim is the Honorary Secretary of the 59th SMA Council. He is currently an associate consultant at Singapore General Hospital.

### Consultation with MOH on proposed regulations for healthcare services

On 22 January 2019, SMA President Dr Lee Yik Voon participated in a consultation session with the Ministry of Health (MOH) on proposed regulations under the upcoming Healthcare Services Bill, which will replace the current Private Hospitals and Medical Clinics (PHMC) Act.

SMA provided MOH with input and requested for clarification on compliance. The consultation session was fruitful and we look forward to reviewing the amended document.

### SMACF thank you dinner

SMA held an appreciation dinner for SMA Charity Fund (SMACF) board members and deans/vice-deans of the three medical schools on 8 January 2019 for their unwavering support of the SMACF and its initiatives. SMACF was set up to provide financial support for needy medical students, helping to offset costs of medical education, living expenses and overseas academic conferences. In 2018, SMACF garnered $343,897 in donations. Since 2013, we have disbursed a total of $1.26 million to 252 students across the three medical schools. We would like to thank all donors for their generous donations. We would also like to appeal to our Members to continue supporting the SMACF. Donations can be made online at https://www.giving.sg/smacf. You may also contact smacharity@sma.org.sg for more information.

### SMC Sentencing Guidelines Committee

The Singapore Medical Council (SMC) has set up a Sentencing Guidelines Committee to develop a framework to guide the Disciplinary Tribunals on the appropriate sanctions for matters referred to them.

SMA's representative to the Sentencing Guidelines Committee is Dr Wong Chiang Yin, who is currently an SMA Council Member and a past President of SMA.

More details can be found here: http://bit.ly/2Sj0OPB.

### SMC Disciplinary Tribunal Inquiry for Dr Soo Shuenn Chiang

Following the release of the Grounds of Decision, SMA wrote a letter to the *Straits Times Forum*, which was published on 11 March 2019. The letter highlighted our concerns over the severe penalty despite the mitigating factors relating to the case, the challenges of identity authentication and the resulting erosion of trust in the patient-doctor relationship. SMA also wrote to SMC on 11 March 2019, seeking advice on the steps needed to verify the identity of patients, relatives and other healthcare professionals in non-face-to-face communications. We will continue to provide updates to Members via our Facebook group/website when they are available.

To view the letter published on the *Straits Times Forum*, visit http://bit.ly/2VOzPh8. For the reply from the SMC, please go to http://bit.ly/2CdidUz.

### New advertising regulations for hospitals and clinics

MOH has reviewed the PHMC (Publicity) Regulations, which is the current principal legislation governing all publicity conducted by private hospitals, medical/dental clinics, clinical laboratories and nursing homes licensed under the PHMC Act in Singapore.

The PHMC (Publicity) Regulations will be replaced by the PHMC (Advertisement) Regulations (the "Advertisement Regulations"), which will take effect from 15 April 2019.

The new advertising regulations and explanatory guidance can be found here: http://bit.ly/2tCjTSR.

# Meeting with SMC Following the Grounds of Decision of the Disciplinary Tribunal Inquiry for Dr Lim Lian Arn: CHAIRMAN'S REPORT

Report by Dr Lee Pheng Soon, issued 25 February 2019

## Background

In a recent Singapore Medical Council (SMC) disciplinary case (SMC v LLA), an orthopaedic specialist was fined $100,000 after pleading guilty to a charge of failing to obtain informed consent from a patient before administering a H&L injection to the wrist. This decision of the Disciplinary Tribunal (DT) has resulted in much discussion between individual doctors, within medical bodies, and even a petition to the Health Minister. Many of the concerns arose from the size of the fine (resulting from what was apparently a relatively small lapse before a common and minor procedure, which known complications were not permanent or debilitating, and where the harm which ensued was limited in nature and extent). There was uncertainty whether the decision of this DT indicated a direction towards the imposition of harsher penalties in similar cases, which would result in a more defensive approach to medical practice.

To better understand if this indeed represented a new trend important to all doctors, the SMA Council had a meeting with the SMC on 25 January 2019. After a frank and helpful exchange, the SMC agreed to the SMA's suggestion to speak to a wider audience (of representatives of the SMA, College of Family Physicians Singapore, Academy of Medicine, Singapore and SMA Centre for Medical Ethics and Professionalism [SMA CMEP]) on 31 January 2019, the exchange of which forms the bulk of this "Chairman's report", and is now shared for the interest of all SMA Members:

## SMC's presentation

SMC's Director (Legal) began with a presentation entitled "Understanding the Facts and Implications of LLA's Case: What It Actually Means and What It Does Not".

In summary, he explained that the Patient had lodged a complaint with the SMC claiming that Doctor had failed to inform her about the risks and possible complications arising from an H&L injection in her left wrist joint before obtaining her consent to treatment; and also that Doctor's advice of physiotherapy was inappropriate.

In his written explanation to the Complaints Committee (CC), Doctor admitted that he did not document the discussion with Patient about the risks and possible complications, and in fact he could not recall whether he had informed Patient about the risks and possible complications of an H&L injection. As the investigations disclosed a prima facie case of professional misconduct, the CC referred the matter to a DT for a formal inquiry.

Here, Doctor was charged with a single count of professional misconduct under section 53(1)(d) of the Medical Registration Act for failing to obtain informed consent from Patient, in particular, failing to advise Patient of the risks and possible complications, before administering the H&L injection, in breach of Guideline 4.2.2 of the 2002 edition of the SMC Ethical Code and Ethical Guidelines (ECEG).

Doctor pleaded guilty to the charge. The SMC, based on previous decided DT and Court of 3 Judges cases involving failure to obtain informed consent, sought a 5-month suspension, while Doctor requested that the DT impose the maximum fine of $100,000 or alternatively, the minimum 3-month suspension.

The DT's Grounds of Decision (GD) noted:

1) A doctor's duty to obtain informed consent from his patient is a serious one. However, not every instance or conviction for a charge of failure to obtain informed consent must necessarily attract a sentence of suspension.
2) It was good clinical practice and medical record keeping to document in the case notes that the patient had been adequately informed and was agreeable to the H&L injection.
3) It was not universal practice to take a written consent from the patient for an H&L injection performed in consultation room setting, but that it was good clinical practice and medical record keeping to document in case notes that the patient had been adequately informed and was agreeable to the injection.

However, given that the complications experienced by the Patient were not permanent or debilitating, and as the harm which ensued was limited in nature and extent, the DT agreed with Doctor's Counsel that his culpability was on the low end. DT imposed a $100,000 fine.

In the past few weeks, several questions including some misunderstandings have arisen about this case. Important examples are:

**Q1 • Will doctors be disciplined if they fail to inform a patient of ALL the risks and possible complications associated with a procedure or treatment?**

**A** • No. Doctor was charged because he did not inform Patient of ANY risks or possible complications associated with the H&L injection.

**Q2 • Must doctors inform patients of ALL the risks and possible complications that were mentioned in the GD for this case prior to an H&L injection?**

**A** • No. The risks and possible complications a doctor ought to inform a patient of, depends on the circumstances of the case. The risks and possible complications mentioned in the GD were what the DT found that the Doctor ought to have informed the Patient of on the facts of that case, and was not meant to be prescriptive for all H&L injections. The Doctor accepted that he should have informed the Patient of those risks and possible complications, and admitted that he had not. What a doctor needs to inform a patient about prior to a treatment or procedure continues to depend on the specific circumstances of the case, including the patient's particular situation.

**Q3 • Does this case change a doctor's duty to advise and inform, as laid down in Hii Chii Kok v Ooi Peng Jin London Lucien and another?**

**A** • No. A doctor should provide information and advice on risks to which (1) a reasonable patient would be likely to attach significance, or (2) exceptionally when the doctor knows or ought to know that the information would be significant to a particular patient. Doctors are not required to disclose all conceivable risks to patients.

**Q4 • Must a doctor take written consent for even minor treatments or procedures?**

**A** • No. The DT clearly stated that it was not universal practice to take a written signed consent for an H&L injection, and did not suggest that it should be.

**Q5 • If a doctor needs to document in the case notes that the patient had been adequately informed and was agreeable to the injection, is that not akin to taking written consent?**

**A** • No. As the Court of 3 Judges (the High Court on appeal from the decision of a DT case) highlighted in SMC v Peter Yong, "[i]t is important that medical professionals properly document the management of patients under their care. Properly kept medical records form the basis of good management of the patient and of sound communications pertaining to the care of the patient." However, proper documentation does not merely benefit patients; as Hii Chii Kok illustrates, it can assist to protect doctors against unmeritorious complaints that they failed to advise patients.

## Additional questions from audience present

After the presentation by the SMC's Director (Legal), the audience posed various questions. The following topics, among others, were discussed:

- The decision of the CC to refer the complaint against LLA to the DT for a formal inquiry;
- Whether the DT could or should have decided on a lesser sentence notwithstanding that the Doctor's Counsel had sought a $100,000 fine;
- The suitability of mediation in the disciplinary process;
- The severity of a sentence of $100,000 fine;
- The implications of the DT's decision for junior doctors working in public healthcare institutions and doctors who are not financially well-off;
- The capability of CC members to understand the nuances of the expert opinion they have obtained and how the opinion bears on the decision whether to refer a complaint to a DT or not; [*On this topic, the SMA CMEP has offered its resources to assist in the training of members of the SMC Complaints Panel.*]
- What the SMC staff do when a complainant approaches the SMC to lodge a complaint against a doctor. [*On this topic, the SMC's Director (Legal) informed the audience that the SMC staff are trained to counsel complainants to consider other avenues of resolution, and before the complaint is officially lodged, the complainants are encouraged to approach the healthcare institution and doctor involved first, or consider mediation, before they lodge a complaint with the SMC.*]

## Conclusion from SMC's presentation

The Doctor was disciplined because he wholly failed to inform the Patient of any risks or possible complications.

This case does not mean that a written signed consent must now be obtained for all procedures or treatments, or that all risks and possible complications must be communicated to patients.

A doctor's duty to inform or advise remains guided by the SMC ECEG (on the ethical front) and Hii Chii Kok (on the legal front).

This case does indeed emphasise the importance of adequate documentation and record-keeping.

This case should not change the way doctors are expected to practise.

**Take-away message from the meeting:** at the very least, this case confirms the general wisdom of the advice to all doctors: "Document, document, document." ◆

Dr Lee is the Chairman of the Professional Indemnity Committee of SMA. Dr Lee has a Fellowship in Pharmaceutical Medicine from the UK Royal Colleges of Physicians and an MBA from Warwick University, UK. He works part-time as a consultant in industry and part-time as a GP.

# MEDICINE THROUGH THE AGES

## Interview with Dr George Khoo and Dr Daphne Khoo

**The way medicine is practised has changed over the years, but the profound art of treating patients with utmost professionalism and heart remains the same.**
**Dr Toh Han Chong (THC), Editorial Advisor of *SMA News*, was honoured to interview Dr George Khoo (GK) and his daughter, Dr Daphne Khoo (DK), on their medical journeys through their respective eras.**

Interview by Dr Toh Han Chong
Editorial Advisor

### A different era

**THC:** Firstly, Dr Khoo, happy birthday! May I ask how old you are as of three days ago?

**GK:** I'm 91 this year!

**THC:** Wow! In a recent *Straits Times* interview, the article cited you as probably the oldest practising doctor in Singapore.

**GK:** Of those still working full time, yes!

**THC:** You have been affectionately called "Dr Rochor" in that same community. Can you tell us some of your reflections about Rochor and why the neighbourhood is so special to you?

**GK:** First of all, Rochor was known as *sio poh* or "smaller Chinatown". It's very historical as many people from the region would go there to trade. They arrived by the scores on sailing boats, bringing their produce and selling there. And of course there, you have the Indians – in Little India, the Malays – in Kampong Glam, and some of the biggest churches – Catholic, Methodist and Church of England. Then you have the biggest mosque and Indian temples there, as well as the Jewish community. So it's a really fantastic place, including being a place where one could buy exotic foods and animals, such as snakes and crocodiles.

**THC:** I understand that there was also a lot of crime in Rochor in the 1960s.

**GK:** Yes, there was a lot of poverty and crime, and I knew the king of the pickpockets.

**THC:** Was the king of the pickpockets your patient?

**GK:** Yes, he was my patient. He once had a cut *(gestures to the upper lip)* and came to see me for help, but I said "cannot *lah*, the thing has split too wide, go and see that xxx doctor who has more experience". He says, "I don't trust the person, I want you to do it". So after I sewed him up, it was still crooked. *(laughs)* There were real issues in Rochor then, especially at Middle Road where the gangsters hung out. Then you had the opium smokers. Very interesting times then – I wouldn't exchange it for the world.

### Continual practice

**THC:** How has your practice changed between operating at Rochor and Veersasmy Road?

**GK:** In Rochor, the patients were a mix – both the residents as well as from the businesses. And because I had been there a long time, I saw a lot of patients with chronic diseases as well as families. Some residents had seen me for more than 50 years, from the time they were babies. In Veerasamy Road, my patients tend to be younger and there are more foreigners. There are also backpackers and foreign workers who come for health checks and work permit check-ups.

**THC:** With over 60 years of practice, how have you seen medicine change?

**GK:** Well, in the early years of my practice, medicine was mainly based on medical acumen since we had so few tests available. We only had X-rays and no other radiology tests. We could check total white and differential counts. However, there were no liver function, thyroid or other tests. There were no blood tests for glucose either – not even urine dipsticks. We checked for diabetes by adding Benedict's solution to the urine and then heating it over a Bunsen burner. Sometimes, I would do it in my clinic, but if I were busy then I would send it to the hospital. The only treatment we had for diabetes was insulin. We used to study Materia Medica and had to reconstitute certain medicines.

Then there was a time when the pay for Singapore's Government doctors was cut substantially and many doctors left, doubling the workload for those of us who remained. My personal record was set one day when I was at the Kallang Clinic in the morning and SGH A&E in the afternoon. That day alone, I saw 582 patients altogether!

Doctors were highly respected when I first started working. When I went back to Malacca for housemanship, the traffic policeman directing traffic would salute me every time I passed by! Our houseman's quarters there were huge bungalows. However, at the same time, I had to work very hard. I was on call six nights out of seven.

**TCH:** Going back to the topic on medical school, maybe tell us about your time in medical school. You are well known to be close to Tun Dr Mahathir and his wife Siti Hasmah since the early years.

**GK:** Medical school was very good. There were 58 medical students and 18 dental students. So it was a small cohort. On the first day, the first classmate to greet me and asked if I was George Khoo was Hasmah.

**THC:** You knew her first?

**GK:** The first person I met was her.

**THC:** I hear she's a very nice person.

**GK:** Yes, her husband was a quieter person, and often kept to himself.

**THC:** Your friendship has spanned so many years since!

**GK:** We share one thing in common: we have always trusted each other. We used to have arguments about racial and political issues; I grew up in Malacca surrounded by Sikh, Indian, Eurasian, Chinese and Malay neighbours, so I was very comfortable with all groups. Times were different and much more informal then. A relative of Tunku Abdul Rahman, Malaysia's first prime minister, lived next door to my family. Tunku would often visit Malacca and would pop in to visit my father, who was then postmaster of Malacca State, just to chat.

**THC:** Do you talk about politics when you meet up with Dr Mahathir now?

**GK:** Every time we meet, the talk is all about politics. When it comes to politics, he's fiery.

**THC:** I think he was totally passionate about making Malaysia a better place.

**GK:** That's true. As he said previously, "in politics, there are no permanent friends, no permanent enemies, only permanent objectives." That's why Mahathir survives. Besides being the only prime minister elected in his 90s, he's probably the only prime minister in the world who has led governments of two different parties.

Mahathir and I get along but we don't agree on many things. Number one is that we agree to disagree on race, religion and politics.

**THC:** But that's true friendship. It's almost like a marriage.

**THC:** Are you considered an outspoken person?

**GK:** You're right. I'm a bit outspoken!

**DK:** Here, I will quote his friend who said, "What George doesn't know is not worth knowing, but sometimes what George knows is better not to know."

**THC:** So back to the Rochor neighbourhood. Dr Chan Ah Kow was also a famous GP who practised there.

**GK:** He was very good. He and I got along well.

**THC:** Did you ever regret not getting more involved in politics?

**GK:** Yes and no. I suppose I could have risen in politics particularly if I had returned to Malaysia.

**DK:** You were also very close to Dr Christopher Chen's father, who was the founding chairman of the Democratic Action Party in Malaysia.

**GK:** Yes, he was my badminton partner in medical school.

**THC:** Readers will want to know how, at 91 years old, you can still practise with so much passion and energy, and possess such a clear, sharp mind. What's your secret?

**GK:** The main thing for me is that I must stay busy.

**THC:** What about your lifestyle? Eating habits?

**GK:** I still do regular walking, and I played badminton until the age of 60. I exercise my brain and I like to talk to young people. I can get a lot of new ideas from them.

**THC:** What are your favourite books and movies?

**GK:** *The Art of War*, *Red Star over China* and *The Good Earth* are some books that I enjoy. For movies, it would be *The Manchurian Candidate*, *Gone with the Wind* and *High Noon*.

**THC:** Finally, who do you admire and why?

**GK:** Franklin Roosevelt, Winston Churchill and Deng Xiaoping. Firstly, they were all great leaders. Secondly, they all overcame major setbacks – Roosevelt had polio, Churchill struggled academically and Deng Xiaoping was purged from leadership roles twice, but they all went on to change world history nonetheless.

## The next generation

**THC:** Daphne, thanks for doing this interview with your father. The first question is, "Did your father influence you to do medicine?"

**DK:** My father was a GP and my mother was a radiographer. When we were growing up, we actually lived in hospital quarters at College Road. Doctors were allowed to stay in huge old houses on hospital grounds then. My mother used to bring me to her workplace after school sometimes. I really don't remember a time in my life when I wasn't going to Singapore General Hospital (SGH). So it was more or less impressed on us that we were a healthcare family.

**THC:** So growing up in Singapore Chinese Girls' School then Anglo-Chinese School Pre-University, your former schoolmates recount that you did really well in school without trying very hard. You were one of the top students, I believe.

**DK:** I think I peaked then. *(laughs)*

**THC:** Rumour has it that you spent a lot of time reading Mills and Boon.

**DK:** During medical school, you didn't have time to read Mills and Boon as life was very demanding then. But certainly, when I became a medical officer (MO), I would read novels during pockets of free time between patients. I don't think it happens now.

**THC:** How was medical school life for you?

**DK:** It was very hard work. It was not unusual for a third of the class to fail certain subjects at the time. In school, I think I was naturally academic, so I could do well and yet have time to pursue other extra-curricular interests. But it wasn't possible in medical school, just because of the sheer volume of work. The first ten years of one's medical career are also very tough years, which was part of the reason I did not encourage my kids to do medicine.

**THC:** Let's go back to your time in SGH as head of Endocrinology. At your farewell, they gave you a cake with the icing words saying "You Abandoned Us!" What were your feelings then, leaving the public sector?

**DK:** *(getting emotional)* I felt very, very sad. Even though I had made the decision to leave SGH and SingHealth, I cried for about a week after that. I can honestly say that the two institutions were wonderful to me, and I really felt that very much of what I have become was because of what my colleagues and teachers had taught me. My supervisors and bosses had always been nurturing and supportive. I felt sad when I left, but at the same time, I also realised that the new opportunities in the private and overseas spaces would offer development and growth. I think one thing that SGH instilled in me was the thirst for knowledge and self-improvement.

## Growing achievements

**THC:** On to your current position. What do you feel are the necessary priorities of the Agency for Care Effectiveness (ACE)? What is the important job that needs to be done?

**DK:** People are rightfully proud of healthcare in Singapore – including the fact that we are considered to have one of the best healthcare systems in the world. But one of the main problems now is cost and, associated with that, affordability. A lot of expensive health technology is coming very quickly, on the background of a rapidly ageing population and a low-tax system. People may not realise that all over the world, a large part of healthcare is paid for by taxes or insurance premiums. There is no free lunch. The challenge is in how to give people the healthcare they want at a price point that is affordable for everyone. I think the quality of our healthcare talent is not an issue, because I think that in terms of training, there are very few countries that invest as much in training, both at the undergraduate level and the postgraduate level, as we do. That's my honest opinion.

**THC:** Are we moving in the right direction where you think that we can deliver medicines which are cost effective and create policies that allow doctors to practise medicine in the most optimal and evidence-based way?

**DK:** One has to have tough conversations all round, because there are actually three parties involved. One is really the healthcare community – the providers; then of course you have the payers – could be the insurers or the Government; and then third, you have the patients, their families and the public. The question is how does one come up with systems that are perceived to be fair to all. I don't think there can be a perfect system because somebody is always going to be unhappy. But the key point then is how to have frank conversations so that people understand the rationale behind the decisions that we are making and the trade-offs. If you're going to talk about giving patients a lot of time during each visit and you're going to just use the latest technologies, it comes with a high price tag. The question is how you are going to pay for all that.

**THC:** Do you ever miss clinical medicine?

**DK:** Yes and no. These days, I'm doing clinic once a week at Ng Teng Fong General Hospital. What I like about clinical practice goes beyond interacting with the patient, although that's obviously the main thing. But it's also about the intellectual stimulation, working together in a community with your friends, including teaching others and learning from others, and the research opportunities. On the other hand, I do feel that medicine is becoming increasingly difficult to practise.

**THC:** Do you think medical school has changed a lot since your father's time to your time, to the current medical school generation?

**DK:** When I gave a talk at the National University of Singapore Yong Loo Lin School of Medicine recently, I noticed that there were very few students in the auditorium and I was told by the convenor that because these lecture clips are now put online, up to 80% of the students do not show up for lectures. Even if the students were there, many of them were either looking at their laptops or their phones; so you feel that their engagement during lecture time is not there, and that ability to build a connection with the student is now lost.

In the old days, you sat in these large halls where the professor would call out your name, and you had to pay attention because you never knew when you were going to be called upon. With today's students, you don't even know whether what you're saying is really registering. How will you inspire or influence the students when there's so little face-to-face time with them? You can do it through a video, but it's not quite the same.

**THC:** So do you think that the modern pedagogy is too detached and makes it harder to impart the values you had received as a medical student and young doctor from your teachers?

**DK:** Well, I'm concerned that in some of these models, you don't have a lot of contact time with students. I feel that is also the time where you have the opportunity to impart values.

**THC:** How was your own medical school life and memories?

**DK:** Maybe because I wasn't a "hostelite", I didn't really see that social aspect of medical school. Staying at home is quite different from staying on campus. Even in my father's time, the Malaysians had a much stronger bond than the

*Dr George Khoo and Mrs Khoo with young Daphne*

Singaporeans who tended to stay at home. But the thing about medical school is that given the very demanding nature of medicine where one is so focused on absorbing huge amounts of information every day, there wasn't all that much time to really have a great social life – at least not in Singapore.

**THC:** You have already impacted so many aspects of healthcare in Singapore, in clinical leadership, administrative leadership, private sector and policy making. What do you think is the most fulfilling to you in terms of all the accomplishments?

**DK:** What was the most impactful and what I enjoyed the most are not the same thing. The years that I enjoyed the most were actually the years I spent on research. I find that research was the most intellectually stimulating part of my career and I went through a few years where I ate, breathed and lived research. At that stage, I even started neglecting my social relationships because the work was so engrossing.

**THC:** Was this during the junior consultant time?

**DK:** It was during the consultant and senior consultant transition. But in terms of what makes the most impact, being in administration means that I get to make policy decisions that have greater impact. So what are impactful and what I enjoyed are not the same thing.

**THC:** Any comments about the resilience of young doctors which is very topical nowadays?

**DK:** I am aware that this is something my colleagues are looking into. If you look at the statistics, the numbers of patients treated per doctor per year are actually falling. As my father mentioned, his daily peak was 582, mine was 160, and in this current environment, I doubt most doctors would see beyond 50, if even that. However, there are other stressors – public expectations have changed and of course information technology adds stress. In my father's time, it was not unusual to fail medical school year after year and be held back. It could take up to nine years to graduate from what was designed as a five-year course! In my time, a third of the medical class used to fail exam subjects. I gather that is quite different nowadays and many doctors might not be forced to deal with feelings of inadequacy till they hit the wards. We could and should do more to prepare them for that transition.

## Aside from work

**THC:** You were President of the Association of Women Doctors (Singapore). How was that tenure? What was it like?

**DK:** One thing that they had fought for was the quota on women medical students in those days, which they lobbied very hard to have removed. They succeeded. I feel that that's the most significant achievement. Most of their activities nowadays are related to social activities and charity; I wish that they would broaden their scope to involve other challenges that women in medicine face. That would be my personal wish.

**THC:** It is often said that there is really no glass ceiling in Singapore for women in their career, while in some developed countries, there is a glass ceiling that's harder to see. What are your comments on this?

**DK:** I think that the glass ceiling is partially due to women themselves – me included. Women sometimes are less willing to make the sacrifices in terms of family time and personal time than perhaps men are to get to the very top. And I would say the same for myself.

**THC:** Just like your father, you look young for your age too! What's your secret?

**DK:** I have a very wide array of interests – my problem is that I'm invested in too many things. I will be 60 years old this year. Somehow, I've always gone on to bigger and bigger jobs where the complexity of the problems are greater; so while a lot of my friends are thinking of their careers winding down or considering retirement, I am still thinking about the many problems to solve! I like solving problems and I think that this keeps me mentally engaged. Of course, like everybody else nowadays, you have to make time for exercise and family and friends. And don't forget mindfulness!

**THC:** What do you do for leisure?

**DK:** *(laughs)* Aside from Facebook? It would be watching Korean dramas, playing computer games and spending time with my dogs.

**THC:** What type of games do you play?

**DK:** *World of Warcraft*.

**THC:** How does your family spend time together? I mean, you kind of just live next to your dad. *(laughs)* Do you see your dad often?

**DK:** Every day.

**THC:** Every day? But you don't live in the same house.

**DK:** We have dinner every week day. Whenever people broach the topic of me being successful in my career and managing my family and work-life balance, I remember and share that having my parents stay next door to me means that I do get to see them all the time. It also helps in terms of my not having to worry about preparing dinner, doing marketing and things like that.

**THC:** Do you have any favourite books or films?

**DK:** I'm going to sound very shallow. For movies, I like rom-coms. Because the nature of our work can be pretty tough going – really grim – so I generally like to escape from reality in my free time. I like reading romance, science fiction and fantasy novels. As for films, I like to watch Korean dramas such as *Descendants of the Sun*.

**THC:** For you, would *Descendants of the Sun* have the highest impact factor; the *New England Journal of Medicine* of Korean dramas?

**DK:** That would be the benchmark.

**THC:** Thank you both for the interview and for sharing your stories with *SMA News*. ◆

Dr Toh is a senior consultant, clinician-scientist and deputy director of the National Cancer Centre Singapore. He was the former Editor of *SMA News*. In his free time, Dr Toh enjoys eating durians and ice cream, reading, writing, rowing and watching films. Thankfully, the latter four are not fattening.

# DRY UP or SPEAK OUT?

## The Challenges of Breastfeeding as a Healthcare Worker

Text by Dr Joanna Chan Shi-En

Doctors and other healthcare workers generally make resilient mothers due to what we have already survived. A discussion with fellow doctor mothers revealed a roughly 50-50 split on whether taking care of a newborn is tougher than our year as house officers (HOs). For me, my HO year was a more anxious time and my basic needs of food, water, peeing opportunities and sleep were met less of the time.

When these tough mothers are asked to describe difficulties faced during pregnancy and beyond, one bugbear is the difficulty of doing calls (which includes setting lines, intubating and going up to 30 hours without sleep) up until 28 weeks of pregnancy. Currently, many pregnant doctors are not given a choice. "Has any doctor ever told a pregnant patient to work 24- to 30-hour shifts? Yet we do it to ourselves," says a colleague.

However, one of the most difficult concerns for mothers in healthcare is breastfeeding. The important message that "breast is best" is drilled into doctors in the public healthcare sector, because of the immunological benefits which breastmilk confers on the developing infant. There is, however, a gap between what we preach and what we are able to practise in our own practice of childrearing.

A straw poll which I conducted among mothers working in different public hospitals revealed some common threads.

### Lack of protected time during working hours

When meal breaks are short, we must make a choice between eating and pumping, which deters many mothers from pumping during working hours. Some emergency department (ED) nurses have found a way to hack the short meal break by purchasing the Freemie (a hands-free pump) to allow simultaneous eating and pumping. The Freemie is also favoured by surgeons and anaesthetists.

Theoretically, the demands of daily work may allow mothers in senior roles more leeway to pump. Unfortunately, the availability of a meal break to a doctor, whether junior or senior, is dependent on the state of the shop floor, and the presence of sick patients in crisis, and is not guaranteed, regardless of whether one owns a Freemie. In addition, this method does not drain the breast completely and cannot keep up supply without supplemental pumping before or after an already busy work day.

### Lack of appropriate facilities

For many of us who do not have the good fortune to be working in KK Women's and Children's Hospital (KKH), which was repeatedly cited by paediatric and gynaecology colleagues as the pinnacle of excellence where facilities and attitudes encouraging lactation among its employees are concerned, the experience is variable.

> "In any busy ED, our meal times can be as short as five minutes where we gobble our food down, or no time at all for meals (and to pump). [Some departments use a round robin system while others have a numbers quota]; they do not stop your queue and patient load will build up. It is not possible to pump at least once in an eight hour shift, not to mention that some shifts last longer than eight hours and most of us do not end on time."
>
> **– Junior doctor, emergency medicine**

> There was no designated lactation room. I mostly pumped in what was supposed to be a breastfeeding/diaper change room at the medical centre, but it often smelt of poo. While the department and section heads verbally supported breastfeeding, requests to have at least one lactation room in the department were denied citing space constraints. There was also no protected time for pumping as patients always come first. Needless to say, my supply dropped drastically when I returned to work when my firstborn was eight months old."
>
> **– Speech therapist**

> In my hospital, there's a lactation room with a card access system, divided into three sections by curtains. However, it's small, not the cleanest and shared with the whole hospital. Luckily, I had supportive colleagues who didn't mind when I hogged the call room to pump."
>
> **– Senior doctor, cardiology**

> In one particular institution, there were many female staff but no nursing room at all. I pumped in a tiny storeroom where blankets, wheelchairs and cardiac tables were kept; while pumping, I was often disrupted by requests to open the door. On one occasion, the milk almost spilled when they were moving a cardiac table. On another occasion, the nurse insisted on cleaning the room so I had to pump in the toilet; the staff there claimed it's the cleanest room in the building, but how can a toilet ever be clean?"
>
> **– Pharmacist**

*Note: The above three examples given are from the three different healthcare clusters, illustrating the near universal nature of the problem in the public healthcare sector.*

## Mental barrier concerning attitudes towards those who pump

Many mothers are made to feel that we are given special favour and inconveniencing the department if we take time out to pump. For a mother finding her feet again after a period of maternity leave and afraid of attracting more criticism, this mental barrier can in itself be a deterrent from pumping.

Institutional support for breast-feeding employees in our public hospitals remains primitive. Last year, at the groundbreaking ceremony of a new emergency medicine building at the Singapore General Hospital, a cheerily designed board sported a collection of "Dreams and Wishes" for the new beginning. Contributed by staff members, a prominent wish was the expressed desire for a lactation room. A Very Important Person, herself a mother, was heard scoffing, "Lactation room? Where do you have time for breastfeeding in the ED?"

With signals like this from the leadership, where indeed?

## Challenges of shift work and long calls

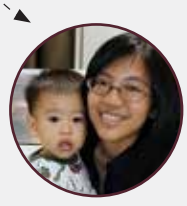
Mothers who work regular office hours may sometimes be subject to reverse cycling (where the baby latches more at night to make up for maternal absence in the day). This option is not possible if the mother is doing a call or a night shift.

Also, what they don't tell you before you become a parent is how closely breastfeeding is related to your baby's sleep. While direct latching is best done for bonding and growing, and maintaining supply, a breastfed baby who is used to direct latch is prone to feed to sleep. When the mother is on call or on shift, the spouse will be saddled with a baby used to latching back to sleep. This transfers some of the sleep debt to said supportive (or suffering) spouse. While different families have developed their own coping methods, the baby may have to be weaned off the breast altogether to avoid this if this arrangement is not tenable.

## In conclusion

It is no wonder, then, that many of us are mentally prepared to "dry up" soon after going back to work. It is in anticipation of the difficulties with breastfeeding that many female doctors and healthcare workers ask for a period of no-pay leave. However, no-pay leave cannot always be granted. Those who cannot resign themselves to a period of shorter breastfeeding than they would like may sometimes resign instead from the public healthcare sector, as in the case of the speech therapist quoted above. She was a valuable worker who nevertheless eventually felt compelled to make the choice to leave in order to breastfeed her second baby, which she felt was incompatible with not letting down her department. The irony is that as healthcare workers in a first-world nation, we ourselves may be unable to comply with the World Health Organization's recommendation of exclusive breastfeeding for the first six months of life. ◆

Dr Chan is an emergency medicine doctor expecting her third child. She was kindly allowed ten months off work after her first two deliveries to breastfeed as the prospect of pumping on a busy shift was too daunting, but will have to make it work for the third one when she returns to work after four months.



# Maternity Leave and Training Requirements

## – A Baby's Birth Month Makes a Difference!

Text by Anonymous

"Upon Residency Advisory Committee's recommendation, the Joint Committee on Specialist Training has reviewed and approved that your traineeship period be extended by XX days…"

At first, I wondered if there had been a mistake in the letter. After all, this was the second time I had taken maternity leave, yet the extension of the traineeship period was much longer this round. One of my colleagues in another department soon provided the answer. My first child had been born towards the end of the year and thus my maternity leave happened to straddle two separate six-month postings (with twice the number of "leave of absence days" that counted towards training). However, my second child was born in March, and my entire maternity leave fell within a single six-month posting.

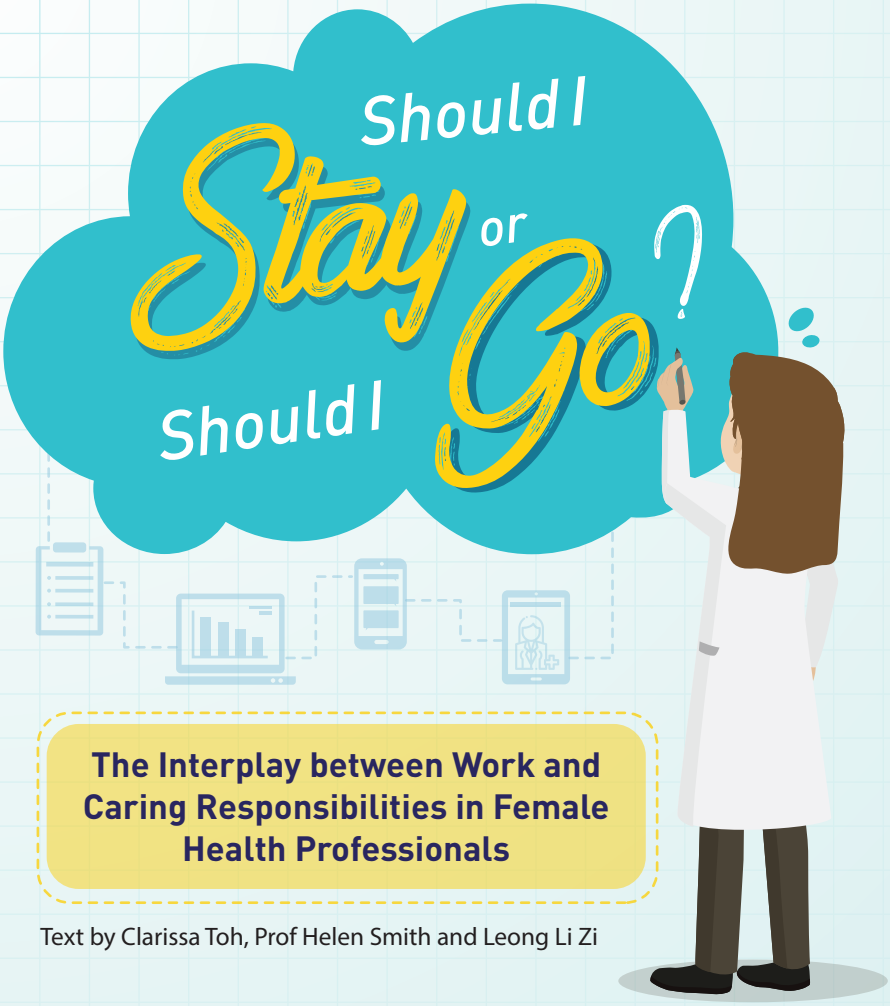
Upon asking around, I realised that some of my more savvy colleagues, who had known this in advance, had tried to time their pregnancies or split their maternity leave to take advantage of separate blocks of "leave of absence days". Thus, they were able to maximise the amount of maternity leave that would count towards training. However, should we really have to go to such lengths for the sake of our residency training? After all, the total amount of leave taken is still the same – logically, the month that a baby is born in should have no impact on how much extension of training time is required. In addition, not everyone is fortunate enough to time their pregnancies so perfectly.

Perhaps some would say that I was naive not to think about such issues before starting my family – however, I was simply not aware of the implications for training. I graduated medical school and served housemanship overseas, so I was relatively out of touch with the local training environment. Like any mother, when I did get pregnant after several months of trying, my concerns were the health of my baby, delivery arrangements and childcare options. To be frank, how this affected my training was the furthest thing from my mind.

Some disclosure required here – I am currently working in a rather male-heavy specialty, and at the time of my pregnancies, there were few senior female colleagues who could provide me with training-related maternity leave advice. Furthermore, our training programme had recently changed, and my seniors had mostly commenced their training under the old Basic and Advanced Specialist Training system with different requirements and leave policies. I am sure that if you asked the current bosses/supervisors, few could tell you off the cuff what the current policies are!

For the sake of future female doctors in the same shoes (pending further changes of policy), it would be ideal if the residency advisory committee could make their training-related maternity leave policies clear from the start – for instance, adding a specific section pertaining to this in the contracts we sign. And of course, for the sake of fairness and logic, the month in which a baby is born should not make a difference. If need be, we can always make up for a posting in different months – there are plenty of out-of-phase medical officers and service registrars around for this to work in practice. ◆

The author is a mother of two. She did her undergraduate medical degree in the UK and is currently is working as a registrar in one of the SingHealth institutions.




# The Interplay between Work and Caring Responsibilities in Female Health Professionals

Text by Clarissa Toh, Prof Helen Smith and Leong Li Zi

The retention of female health professionals in the workforce has been predominantly lower than that of their male colleagues. This situation is likely to worsen because with an ageing population, the caring responsibilities will extend beyond childcare to include caring for ageing family members. Women of this so called "sandwiched generation" may face greater challenges in continuing and developing their careers.

To meet the increasing chronic disease burden of Singapore's ageing population, more health professionals are needed. This growth can be achieved by increasing the number of trained health professionals and rolling out initiatives to promote their retention in the workforce. Our research investigates the opportunities and challenges that female health professionals in Singapore face while balancing their careers and caring responsibilities, and how these responsibilities influence their decisions to remain in, return to, or exit the workforce. The study will be conducted in three phases: reviewing existing knowledge, talking to female health professionals in Singapore, and conducting a nationwide survey.

Our literature review of recent publications explored the factors that influence female health professionals to remain in, return to, or exit the workforce in Asia-Pacific countries. Findings from 74 relevant articles suggest that multiple factors influence individuals' decision to practice. Personal characteristic factors include age, marital status, health, personality and psychological traits, and level of commitment towards family, among others. Key decision-making factors are work relationships and organisational structure and culture, which include policies, opportunities for professional development, a sense of calling towards their profession, and a sense of fairness and security. Altogether, these factors contribute to the development of job satisfaction, a sense of commitment, job stress, and burnout. Based on these factors, healthcare professionals evaluate remaining in, returning to, or exiting the workforce. Unfortunately, none of these studies originated from Singapore, making our work essential to develop a deeper understanding in the local context.

Phase Two of the study will involve interviews and focus group discussions with doctors, nurses and allied health professionals to broaden our understanding of the impact that important others and work arrangements have on career choices. In the final phase, we will conduct a representative survey to quantify the prevalence of the challenges faced. This will enable us to prioritise initiatives that could optimise contributions by female health professionals in the workforce while also maintaining their caring responsibilities.

If you would like to contribute your views of the opportunities and challenges faced by female doctors, we invite you to participate in our study. To be eligible, you need to be a female doctor (Singaporean/Permanent Resident) who has been registered with the Singapore Medical Council for at least three years. If you are interested to participate or wish to know more about this study, please contact Clarissa Toh at clarissa.tohws@ntu.edu.sg or 6592 2481. ◆

(L to R) Clarissa, Prof Smith (principal investigator) and Li Zi are part of the Family Medicine & Primary Care team at Lee Kong Chian School of Medicine. They are working to understand female health professionals' decision to remain in, return to, or exit the professional workforce.

# In Memory of Prof Tan Cheng Lim (1939–2019)

Text by Prof Ivy Ng, Group Chief Executive Officer, SingHealth
Photos by KK Women's and Children's Hospital

Prof Tan Cheng Lim, a well-respected pioneer in the field of paediatrics, passed away peacefully at home on the evening of 21 January 2019. It was a quiet and gentle passing, just as he was in life. It was with deep sadness that I, together with many who have been encouraged and mentored by him, came to terms with this.

Prof Tan graduated in medicine from the University of Singapore in 1964. He was awarded the Colombo Plan Fellowship to train in Paediatrics in Australia and obtained his postgraduate qualifications at the Royal Australasian College of Physicians in 1969. He received subspecialty training in paediatric haematology and oncology at the Royal Children's Hospital in Melbourne, Australia. For over two decades, Prof Tan headed the Singapore General Hospital's (SGH) Government Department of Paediatrics, then largest paediatric department in Singapore, and was instrumental in its transformation to be the foundation for a children's hospital when KK Women's and Children's Hospital (KKH) opened in 1997. He was appointed KKH's Chairman of the Division of Medicine from 1999 to 2002, and Emeritus Consultant and Associate Dean from 2004.

He was appointed leadership roles on numerous committees, some of which include: Chairman, Expert Committee on Immunisation, Ministry of Health; President, Singapore Paediatric Society; and Chairman, Chapter of Paediatricians, Academy of Medicine, Singapore. He was also a member of the Singapore Medical Council Complaints Panel, KKH Ethics Committee and SingHealth Institutional Review Board, among others.

The many awards conferred upon Prof Tan are a testament to his dedication to public healthcare and community service. Some of these awards include the Albert Lim Award (1983), Public Administration Medal (Silver) (1984), Ruth Wong Award (1987), Kim Seng Community Clinic Long Service Awards (1996 and 2003), Singapore Children's Society Long Service Awards (1998, 2001, 2003 and 2008), Healthcare Humanity Award (2004) and the SingHealth Distinguished Golden Achievement Award (2013). In 2010, Prof Tan was also conferred the SMA Honorary Membership, the highest honour that SMA can bestow. Additionally, the Tan Cheng Lim – CCF Professorship in Paediatric Oncology was established in his name in 2015.

Prof Tan is warmly remembered with gratitude and fondness. In his many years of service as a clinical professor at the National University of Singapore Yong Loo Lin School of Medicine, it is no doubt that he positively influenced and impacted the lives of many young medical students and aspiring paediatricians.

He exemplified the dedicated educator long before we recognised clinician educators or defined "protected time" and teaching honorariums. As a medical student, together with my fellow clinical group mates, I remember how he would diligently meet us and

1

patiently tutor us in the intricacies of the care of a child with acute leukaemia. Later, as an inexperienced paediatric trainee, I still shiver at the remembrance of the weekly grand teaching rounds (or "clown shows" as we nervously called them), where we would make "clowns" of ourselves as we struggled to answer Prof Tan's concise yet difficult questions. Despite our fumbling and thick-headedness, he always remained kind and patient while still exacting high standards from us all.

When I spent two years away in the US as a fellow training in medical genetics, he would take time to write me a letter every month to encourage and update me on the department's activities. That blue aerogramme letter with his neat distinctive writing was always a welcome sight.

When I returned with some bright but, at that time, very unconventional ideas like setting up a national registry for thalassaemia and a DNA Diagnostic and Research Laboratory, he gave strong support and helped me as a young associate consultant (or senior registrar as we were called then) make the case to the then Director of Medical Services, Dr Chen Ai Ju, and the SGH Medical Board so we could hire the first scientific officer in a clinical department.

Like many others, when I became a consultant, I started toying with the idea of leaving the public service and joining the private sector. I remember how Prof Tan spoke to me and reminded me of how much more we can impact patient care when we stay in public service. He shared that a single clinician could help care for maybe 50 patients a day, but as a leader of a department, you could multiply the impact to many more patients when the right culture and policies are in place. Needless to say, I was compelled by his reasoning and have tried to follow in his footsteps to do my best in public service.

I know his impact and influence was wide and all whose lives were touched by him were inspired to do the right thing with passion and integrity. When he stepped down from official leadership positions, he continued to play an active part as a mentor and encourager to many. I was certainly one of the fortunate ones to get his regular messages of greeting and uplifting.

There are so many memories of the lessons I've learnt from Prof Tan, but one that stuck and has defined my approach to patient care comes from an incident during one of the grand rounds. It was a busy day in the paediatric wards and in the middle of the grand round, a particularly anxious and demanding mother of a patient came to him to complain about her child's abdominal pain. This mother had been trying to a number of us and we expected Prof Tan to send her away with one of us juniors to deal with her issues, but what he did next spoke louder than any lessons he could have taught us. He interrupted the round and went with her, all of us in tow, and attentively listened while she poured all her woes and concerns on him. He examined the child and patiently reassured the mother.

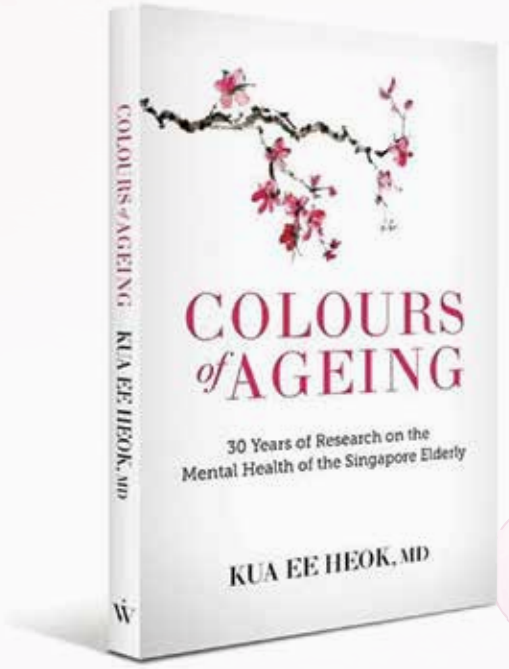
Prof, you have always had patients at the heart of all you do. You have left us but your memory will be held close and dear. We will continue to strive to build on the strong foundations you have laid and press on towards better care and outcomes for our patients. ◆

***Legend***

*1. Photo of Prof Tan for a Festschrift in honour of him in 2014*

*2. Prof Tan and Prof Ivy Ng with a team of doctors at the KKH Department of Paediatrics' Christmas Party 2004*

# Looking into the MENTAL HEALTH of SENIORS




Review by Dr Tina Tan, Deputy Editor

## Colours of Ageing

Author: Kua Ee Heok
Number of pages: 154
ISBN: 978-9811119460
Type of book: Hardcover
Publisher: Write Editions (US)
Year of Publication: 2017

When I received my copy of Prof Kua Ee Heok's latest book, *Colours of Ageing*, I expected a summary on "30 years of Research on the Mental Health of the Singapore Elderly" (which is precisely what the subtitle is) and I wasn't disappointed. Yet, far from a dry tome of research summaries and journal abstracts, the book highlights the singular goal of Prof Kua's cumulative years of research – to show that older folks, even those with mental health problems, can age with dignity and grace. In fact, that is the title of one of his other books, *Ageing with Dignity and Grace*, a two-volume collection which houses his well-known semi-fictional novel *Listening to Letter from America*. The latter, which I also highly recommend, reads like a book on World War II and is told through the collective perspective of several elderly folk in a day centre.

Back to *Colours of Ageing*; as I read through Prof Kua's description of his various research projects, I often wondered, "Well, why didn't I think of that?" A research centre at a shopping mall and a therapeutic garden – these ideas came from someone who has wisdom to impart to the next generation, who has seen and experienced much, and therefore knows what he's talking about. Even the name of the shopping mall research centre, TaRA, resonated with me. I had to wonder whether the author and his team realised that Scarlett O'Hara's family home in *Gone with the Wind* was named Tara. The film itself is a grand age of 80 years now and watching it would probably serve as a great form of reminiscence therapy.

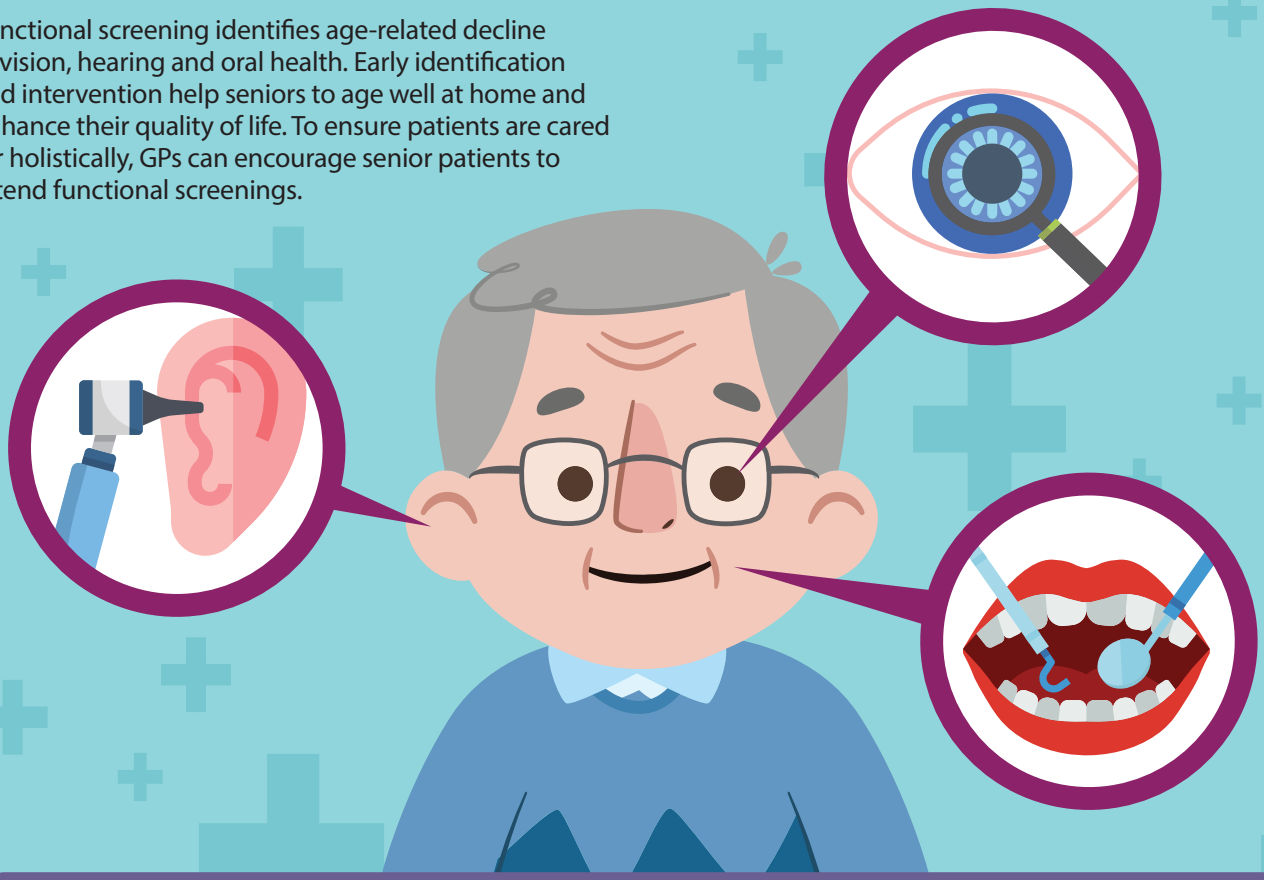
I recommend this book to anyone interested in caring for the elderly. There are nuggets of wisdom for doctors, researchers and caregivers alike. Personally, I took away three key things from this book, which I will be sharing with my elderly patients, or any older person who wants to know how to stave off memory problems and achieve a sense of wellbeing. The three key things are to listen to music (especially the oldies), take up gardening and play lots of *mahjong*. Of course, now that I'm thinking of *Gone with the Wind*, I do wonder if I can add "watch old films" to that list. I'd probably have to do a research project on that, if someone else hasn't already thought of it.

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

# HELPING SENIORS AGE WELL WITH FUNCTIONAL SCREENING

By Agency for Integrated Care

Functional screening identifies age-related decline in vision, hearing and oral health. Early identification and intervention help seniors to age well at home and enhance their quality of life. To ensure patients are cared for holistically, GPs can encourage senior patients to attend functional screenings.



## PROJECT SILVER SCREEN (PSS)

In January 2018, the Ministry of Health (MOH) and the Health Promotion Board (HPB) rolled out "Project Silver Screen (PSS)", a national functional screening programme for seniors, with the aim of screening 45,000 seniors aged 60 years and above annually over the next five years.

The Community Networks for Seniors (CNS), People's Association (PA) and the Silver Generation Office in the Agency for Integrated Care (AIC) provide active support in close co-operation with MOH and HPB, and have helped over 40,000 seniors attend functional screening, supported by PSS since January 2018.

PSS supports basic functional screening for hearing, vision and oral health at subsidised rates for all citizens above 60 years old. It is non-chargeable for Pioneer Generation Citizens, S$2 for CHAS card holders, and S$5 for all other citizens.

Depending on the results of a functional screening, seniors may be referred to the relevant community or medical centres for further evaluation. With effect from 3 July (for Ophthalmology SOCs) and 20 November 2018 (for Ear, Nose & Throat (ENT) SOCs), PSS participants who are Singapore Citizens and Permanent Residents (PRs), will be eligible for subsidies at Specialist Outpatient Clinics (SOCs) based on the prevailing SOC subsidy framework when referred to a public hospital's Ophthalmology and ENT SOCs under PSS.

As part of the Senior's Mobility and Enabling Fund, seniors who require spectacles will receive PSS vouchers at PSS functional screenings. Seniors diagnosed to need other assistive devices such as dentures and hearing aids will also receive PSS vouchers after further post-PSS evaluation.

Seniors who wish to attend functional screening may refer to the latest PSS schedule online and walk-in at their preferred screening session for registration. If you have a patient who needs assistance with attending a screening, please leave their contact details via the Singapore Silver Line and AIC will arrange for someone to assist them.

**For more information on Project Silver Screen, such as the latest functional screening schedule, please visit www.projectsilverscreen.sg, or call the Singapore Silver Line at 1800 650 6060.**

# CRUISING the SHANNON

Text and photos by Dr Lim Huiling

Every year, my husband and I go on a trip to celebrate our wedding anniversary. Last year, we decided to try something a little different from the luxury ocean cruises we had been going on for the past few years. During our honeymoon years ago, we had cruised along the Llangollen Canal in Wales on a little canal boat. It was beautifully idyllic to drift along at our own pace, parking the boat anywhere that looked interesting and enjoying the countryside. We looked forward to more of the same in last year's trip.

This time, we chose the lower Shannon and its loughs (lakes); this river runs southwards from near the Northern Ireland border, dividing the western and eastern parts of the Republic of Ireland. It played a very important role in Ireland's social, cultural, military, economic and political history.

## Pre-trip preparations

We looked forward to seeing the famed lush green views of the Emerald Isle and her ancient ruins lost in the mists of history and legends, while floating blissfully along in a little floating home. We rented a small but completely equipped two- to three-berth motor cruiser from Carrickcraft (one of the larger boat hiring companies), and decided to start our week-long journey from Banagher, a little river port that was closest to Clonmacnoise – the most magnificent ancient Christian site.

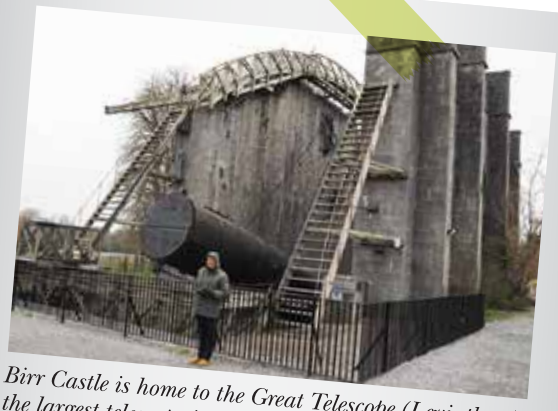
We made the booking and took tutorials, which included modules and videos on how to steer, park and care for the boat, online through their website. We also learnt how to navigate the river according to the charts provided and what all those little green, red and white signs sticking out of the river bed meant. Finally, we took an online test and were qualified to rent and drive the boat on our own.

## Hello, Banagher

There was an option to be picked up by the boat company from Dublin airport but we decided to rent a car instead since it was cheaper to rent the car and keep it sitting in the boatyard for the week. We thank God for that as it turned out that we needed the car very much over the week! The drive was easy and we passed through gorgeous rural scenery on our way there.

We arrived on a cold, wet day in Banagher, a small town with one main street comprising several pubs, restaurants and a lone (but surprisingly well stocked) supermarket and nary a touristy shop in sight. Our boat was ready for us and we were immediately taken out on the water to assess our competence at handling it, and we passed with flying colours – *phew*!

Unfortunately, we were then informed that the "mini beast from the East" was expected that weekend (St Patrick's Day weekend). The "mini beast" was a large arctic air mass blowing down from Siberia and was expected to bring subzero temperatures, cyclonic winds and heavy snowstorms. We were advised



*Birr Castle is home to the Great Telescope (Leviathan), the largest telescope in the world in the 1840s*

not to cruise during that time and to stay in a sheltered harbour. The boatman gave us an extra electric heater and some blankets, wished us luck and left us to it. Basically, we only had two days of cruising before the storm was expected – what a dampener on our plans!

Nevertheless, we spent the rest of that evening familiarising ourselves with the boat, stocking up the kitchenette and getting our first taste of an Irish pub.

## Casting off towards Clonmacnoise

The next morning, we woke at sunrise to beautiful weather and brilliant blue waters, and immediately cast off towards Clonmacnoise. We soon discovered that cruising on a river is very different from puttering along a canal. We had to constantly watch out for navigation markers and compare them to our charts to ensure that we stayed on the correct side of the channel and not end up grounding ourselves on the river bank.

The task was made harder as the river banks were flooded and the edge of the visible water could actually be the middle of someone's garden. Additionally, we could not just dock anywhere we liked, but only at designated jetties. With some practice, and struggles, we made it safely to our destination – Clonmacnoise.

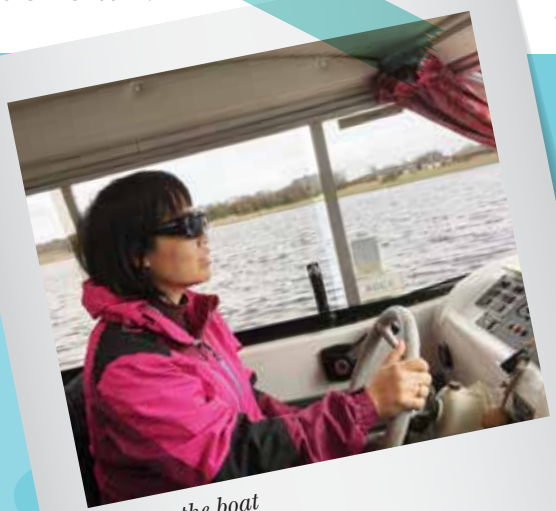
Clonmacnoise is an ancient monastic site founded in the sixth century and was a renowned centre for religion and learning. Set in verdant green undulating grounds on the banks of the Shannon, most tourists arrive by road but its beauty is best appreciated by approaching it from the water. As we drew near, the morning light and rising mist created an ethereal view; as we rounded a bend in the river, we started to see the first of the ruins seemingly glowing and surrounded by a halo. It was like a scene that came straight out of a movie, but so much more breathtaking. We were able to berth our boat at the jetty just under the site (we became quite good at reverse-parking and parallel-parking!)

We took our time wandering around the ruins of a cathedral, many side chapels (called temples), two well-preserved round towers (which served as refuges against Viking raids), three intricately carved high crosses and many Early Christian gravestones.

## Snowed in!

As we got back into the boat, the sky started to pour again. As visibility was poor, we had to peer through binoculars to find the river markers. The journey was slow going and it took a lot of steering to stay on course as the wind was quite strong, the water choppy, and we were going against a strong current. My idea of cooking a pot of soup for lunch while on the go to warm up the cabin and our insides only added to the condensation fogging up the windows.

As we headed towards Athlone, the biggest town on that stretch of the river, the intermittent rain made everything looked grey, and flooded the lush scenery we were expecting. There were many different large flocks of birds that flew alongside us and



*Driving the boat*

*Clonmacnoise bathed in ethereal morning light*

*Woke up to find ourselves snowed in*

Dr Lim is a family physician in private practice. She divides her time between her family, her practice, volunteering with the College of Family Physicians Singapore and Ministry of Health committees, and conducting Marriage Enrichment classes for her church. She is married to dental surgeon Dr Anthony Goh and they take annual honeymoons for their wedding anniversary.

*Dining on board*

we were able to observe them closely as they circled, dived and fed. Other than that, there were no signs of life at all – we seemed to be the only people crazy enough to still be cruising on the river!

After spending a night in Athlone, we headed back to Banagher intending to head south towards Lough Derg but decided to heed the weather warnings and take shelter at the homeport. We awoke the next morning to find everything blanketed in snow. The roads were too icy for driving as well, so we spent most of the day cuddling and catching up on emails!

We also walked into Banagher and watched the St Patrick's Day parade. It was a rather informal little affair involving local hobby groups, school children and some livestock, all braving the unseasonably cold weather, fortified by lots of Irish whisky and ale!

Subsequently, the weather remained too bad for cruising so we decided to just use the boat as a hotel and drove around visiting the sites with our car. The most noteworthy site in the area was Birr Castle, the site of the Leviathan of Parsonstown, the largest telescope in the world completed in the 1840s. It is located in a large, beautifully maintained garden and quite a marvellous sight to behold.

After this slow respite, we embarked on a rushed second week in Ireland. We drove around the rest of Ireland, visiting the pretty coastal town of Kinsale, navigating the vast rocky moonscapes of the Burren, driving the famous Ring of Kerry and the Dingle peninsulas, marvelling at the awe-inspiring cliffs and coastlines made famous by *Star Wars* episodes VII and VIII, and walking on the Giant's Causeway. But this adventure, of course, is a whole new story for another time…

To most people, this trip may have been considered a washout, but it was a good trip for us as we had lots of cosy couple time. On hindsight, if we embarked on this trip again, I would do it with a few more crew members to make it easier to handle the boat. I would also do it later in the year – possibly in May – when the weather is better and the daylight cruising hours are longer. ◆

# PRIVACY AWARENESS

## Understanding your legal and ethical obligations

25 May 2019, Saturday
1 pm to 5 pm
Novotel Singapore Clarke Quay,
Level 5, Cinnamon Room
2 CME points (Subject to SMC's approval)

| | |
|---|---|
| 1 pm | Registration<br>(Lunch will be provided) |
| 2 pm | Updates on the Personal Data Protection Act |
| 2.40 pm | Privacy and Confidentiality – Ethical, Professional and Common Law Aspects |
| 3.40 pm | Managing Patient Data |
| 4.10 pm | Questions and Answers |
| 4.30 pm | Closing |
| 5 pm | End of seminar |

### SPEAKERS

- Dr T Thirumoorthy, Immediate Past Executive Director, SMA Centre for Medical Ethics and Professionalism
- Mr Christopher Chong, Senior Partner, Dentons Rodyk & Davidson LLP
- Ms Keleen Wee, Manager, Publicity & Engagement, Data Innovation and Protection Group, IMDA

### WHO SHOULD ATTEND

- Healthcare Professionals
- Healthcare Administrators
- Clinic Owners and Staff

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1. Visit **https://www.sma.org.sg/coursesfordoctors**.
2. Log in to your membership portal.
3. Search for "Privacy Awareness".
4. Fill out the form and click "Submit".

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ALL GUESTS TO BE SEATED BY 7.15PM

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We would like to invite motivated anaesthetists (doctor) who have the leadership skills to pioneer a new department, have the mentoring heart for the training of junior doctors and nurses, have a keen mind for innovation/research and to help implement new standards for patient safety and comfort, join SNEC as full-time clinicians. The incumbent will be required to provide high quality anaesthetic services and preoperative risk assessment, patient preparation for general anaesthesia and management of post-operative care.

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- Engaged in active clinical practice for the last 3 years.

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**Requirement**

- MBBS or postgraduate qualification registrable with the Singapore Medical Council
- At least 3 years of ophthalmology practice experience
- Highly adaptive and possess excellent interpersonal and communication skills

*Interested applicants to email your CV to chong.kai.xian@snec.com.sg*

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*(Ref: HO1811017)*

**2. Service Resident Positions for Experienced Doctors without Full Registration**
(Anaesthesia / Anatomical Pathology / Cardiothoracic Surgery / Emergency Medicine / Family Medicine / Internal Medicine / Neurosurgery / Paediatrics / Radiology)

*(Ref: HO1809010)*

The Hospital Authority (HA) invites applications from experienced doctors who are not fully registered with the Medical Council of Hong Kong and yet have acquired relevant postgraduate qualifications set out in the Requirements to serve the community of Hong Kong. For details, please visit http://www.ha.org.hk (choose English language, click Careers → Medical).

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***Application***

Application should be submitted online **on or before 31 March 2019 (Hong Kong Time)** via the HA website http://www.ha.org.hk.

***Enquiries***

Please contact Ms. Melanie TAM, Hospital Authority Head Office at + 852 2300 6542 or send email to tml128@ha.org.hk.


A.M aesthetics
亚联盛医疗

## ACCRELIST MEDICAL AESTHETICS

Previously known as Refresh Laser Clinic, we have been recently acquired by Accrelist, a public listed company in Singapore, and it is our plans to grow more aesthetic & laser clinic outlets in Singapore and in the region.

We are looking for a Resident Doctor (registered with the Singapore Medical Council) position in one of our clinics.

### Requirements

- Medical qualification registrable with Singapore Medical Council
- You must have keen interest and passion in aesthetic practices
- Good communication and interpersonal skills
- Strong drive to improve your personal aesthetic skills and grow the practice

### Job Summary

You are required to perform/operate ablative and non-ablative lasers, IPL, RF, Chemical Peel, Botox, Fillers and Thread Lifts.

### We provide

- Competitive salary package with commission scheme, a wholesome career plan with options of profit sharing and equity ownership
- $18k to $25k basic + % commission (depending on seniority)
- Good career prospects
- Positive environment
- Comprehensive training will also be offered through a mentorship program with a seasoned doctor of 14 years' aesthetic experience locally and also internationally with doctors from Korea, Japan, Malaysia, Thailand and Taiwan. It is our vision to make you a master of fillers, botox and threadlifting

If you are a doctor with no prior experience but has a strong passion for aesthetics and good attitude to learn; OR

If you have prior experience in aesthetics but wishes to expand your training in injectables or threads or wishes to grow your practice, we welcome you to join us in our vision to grow Accrelist into a regional force.

If that fits you, do write to us by emailing to: **recruit@refresh.com.sg**.

**Please indicate your expected salary and date of availability. We regret that only shortlisted applicants will be notified.**

# NOVENA VITILIGO MEDICAL CENTRE

We are looking for two positions to run our new clinic at Novena Medical Centre:

**DERMATOLOGIST** | **RETIRED DERMATOLOGIST**

## REQUIREMENTS

- MBBS and postgraduate qualification registrable with the Singapore Medical Council
- Relevant experience is an advantage
- Good interpersonal and communication skills
- Good professional ethics

## BENEFITS

- Comprehensive benefits
- Attractive remuneration package including bonus
- Profit sharing

**For interested applicants including foreign-trained doctors, please email your full resume to: hr@vitiligo.com.sg.**

**10 Sinaran Drive #11-05 Novena Medical Centre, Singapore 307506**
For more information, please visit www.vitiligo.com.sg

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National Cancer Centre Singapore
SingHealth

**DEFINING TOMORROW'S MEDICINE**

We are hiring! Join our team of doctors and look forward to a rewarding career!

**Resident Physician**

You will be supervising junior doctors and assist in day-to-day running of clinical services and evaluation of patients in the Ambulatory Treatment Unit (chemotherapy unit).

**Job Requirements**

- Possess basic medical degree and postgraduate qualification recognised and registrable with the Singapore Medical Council for full or conditional medical registration
- Possess BCLS and ACLS certification
- Has at least 3 years of clinical experience at Medical Officer level
- Good interpersonal skills

Apply online at
**https://www.nccs.com.sg/careers**

SingHealth DukeNUS
ACADEMIC MEDICAL CENTRE

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VERITA HEALTHCARE GROUP

Verita Healthcare Group is searching for a Dermatologist with knowledge in all areas of general and aesthetic dermatology to join our busy and expanding practice located at the heart of Orchard Road. If you are a Certified Dermatologist who can treat patients with a variety of skin conditions, and also have a keen interest and experience in cosmetic dermatology, we would like to talk with you.

**Requirements**

- Medical Degree with specialisation in Dermatology.
- Singapore Medical Council registration
- Proficiency with medical cosmetic lasers, ultherapy, thermage, etc
- Experienced with Botox, dermal fillers and other aesthetic procedures

**What we provide**

- Fully equipped 3000 sq ft aesthetic clinic space in the heart of Orchard Road
- Top of the range medical and aesthetic equipment, highly trained and experienced staff, and a large existing patient base
- Attractive remuneration and benefits
- Opportunity to be part of our global medical and scientific advisory board

Please send your curriculum vitae to:
**melissa.chong@verita.com**

Cambridge Assessment
Admissions Testing

# We provide the tools to help you select those who will succeed in medical studies and careers:

- BioMedical Admissions Test (BMAT)
- Cambridge Personal Styles Questionnaire (CPSQ)

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**Find out how we can help enhance your selection process:**
admissionstesting.org/institutions
seapenquiries@cambridgeenglish.org

# GRADUATE DIPLOMA IN MENTAL HEALTH

## Mental Illness: Early Help Makes a Difference

1 in 7 adults in Singapore has experienced a mood, anxiety or alcohol abuse disorder in their lifetime.

Some may not be aware that mental disorders can be treated. The earlier help is given, the better the recovery outcomes.

General Practitioners (GPs) and primary care doctors are often the first touchpoint for patients with underlying mental health conditions. You can make a difference to their mental wellness by identifying their needs and providing help early.

The Graduate Diploma in Mental Health (GDMH) is specially tailored for GPs and primary care doctors – equipping you with the knowledge and skills to assess, identify and manage various psychiatric conditions as part of holistic patient care.

Participants can look forward to a broader curriculum with a **new module on Personality Disorders and Psychological Therapies** in the next intake.

**At the end of the 12-month course, participants will be able to:**

- **Identify various types of mental health conditions**
- **Be familiar with the principles of treatment approaches for different conditions**
- **Apply assessment methodology for different mental health conditions**
- **Acquire management skills and prescribe basic psychiatric medications**

Registration for Sep 2019 intake opens **25 Mar – 1 Jul 2019**.
Visit **www.imh.com.sg/education** for details.

Government subsidy is available (subject to terms and conditions)

For enquiries, contact:


Nirhana 6389 2831 nirhana_japar@imh.com.sg

Sharifah 6389 2246 sh_syed_zainuddin@imh.com.sg


Organised by:

INSTITUTE of MENTAL HEALTH
National Healthcare Group

NUS National University of Singapore